Trust Board Meeting in Public

Thursday 30 May 2024, 10:00 – 13:00
Seminar Rooms 4 & 5, Learning & Research Building, Southmead Hospital

A G E N D A

No.	Item	Purpose	Lead	Paper	Time
OPENING BUSINESS					
1.	Welcomes and Apologies for Absence	Information	Chair	Verbal	10.00
2.	Declarations of Interest	Information	Chair	Enc.	-
STANDING ITEMS					
3.	Minutes: Public Board: 28 March 2024	Approval	Chair	Enc.	-
4.	Action Log	Approval	Trust Secretary	Verbal	-
5.	Matters Arising	Discussion	All	Verbal	-
6.	Chair's Briefing	Information	Chair	Verbal	10.05
7.	Chief Executive's Briefing	Information	Chief Executive	Enc.	10.15
KEY ITEMS					
8.	Patient Story	Discussion	Chief Nursing Officer	Enc.	10.25
9.	Freedom To Speak Up (FTSU) Bi-Annual report	Discussion	Chief Finance Officer	Enc.	10.40
QUALITY					
10.	Quality Committee Upward Report	Information	NED Chair	Enc.	11.00
PEOPLE					
11.	People & EDI Committee Upward Report	Information	NED Chair	Enc.	11.10
BREAK (5 mins)					11.25
12.	Long-Term Workforce Plan	Discussion	Chief People Officer	Enc.	11.30
FINANCE, IM&T & PERFORMANCE					
13.	Integrated Performance Report	Discussion	Chief Operating Officer	Enc.	11.55
14.	Finance, Digital & Performance Committee Upward Report 14.1. Finance Report Month 1	Information	NED Chair	Enc.	12.25
GOVERNANCE & ASSURANCE					
15.	Audit & Risk Committee Upward Report	Information	NED Chair	Enc.	12.35
16.	Provider License Self-Certification	Approval	Director of Corporate Governance	Enc.	12.45
CLOSING BUSINESS					
17.	Any Other Business	Information	Chair	Verbal	12.55

18.	Questions from the Public	Information	Chair	Verbal	-
19.	Date of Next Meeting: 25 July 2024	Information	Chair	Verbal	-
20.	Exclusion of the Press and Public	Approval	Chair	Verbal	-
END					**13.00**

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. • Chair and Trustee of Second Step. • Trustee of the SS Great Britain Trust. • Trustee of the Robins Foundation. • Member of the Labour Party • Elected Member of Bristol City Council.
Mr Richard Gaunt	Non-Executive Director	• Non-Executive Director of Alliance Homes, social housing 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-Water (a Halma manufacturing company). • Director, Radcom Technologies Limited (dormant company). • Director of ASL Holdings Limited (a Halma company – IoT solutions). • Director of Invenio Systems Limited (water loss consultancy). • Non-Exec Director of Advanced Electronics Limited (a Halma fire safety company).
Professor Sarah Purdy	Non-Executive Director	• Professor Emeritus, University of Bristol. • Fellow of the Royal College of General Practitioners. • Fellow of the Royal College of Physicians. • Fellow of the Royal College of Physicians Edinburgh. • Member of the British Medical Association. • Member, Barts Charity Grants Committee. • Shareholder (more than 25% but less than 50%) Talking Health Limited. Indirect Interests (ie through association of another individual eg close family member or relative) via Graham Rich who is: - Chair, Armada Topco Limited. - Director, Talking Health Ltd.

Name	Role	Interest Declared
		- Chair, EHC Holdings Topco Limited.
Dr Jane Khawaja	Non-Executive Director	• Employee and Member of the Board of Trustees, University of Bristol. • Director of Gloucestershire Cricket Foundation. • Commissioner, Bristol Commission on Race Equality.
Mr Shawn Smith	Non-Executive Director	• Bluebells Consultancy Ltd (sole shareholder). • Governor of City of Bristol College. • Trustee of Frank Water. • Elim Housing Association (Board member).
Ms Maria Kane	Chief Executive	• Advisory Group Member of CHKS, a provider of healthcare intelligence and quality improvement services (remuneration donated to charity). • Visiting Professor to the University of the West of England (unremunerated).
Mr Steve Curry	Chief Operating Officer	• Nothing to declare.
Mr Tim Whittlestone	Chief Medical Officer	• Director of Bristol Urology Associates Ltd: undertakes occasional private practice (Urology Specialty) at company office, outside of NBT contracted hours. • Chair of the Wales and West Acute Transport for Children Service (WATCh). • Vice Chair of the South-West Genomic Medicine Service Alliance Board. • Wife is an employee of the Trust. • Director of 3RO Ltd (providing medical advice to international NGOs etc).
Mr Glyn Howells	Chief Financial Officer	• Nothing to declare.

Name	Role	Interest Declared
Professor Steve Hams	Chief Nursing Officer	• Visiting Professor, University of the West of England. • Director, Curhams Limited (dormant company). • Independent Trustee and Chair of the Infection Prevention Society. • Associate Non-Executive Director, Surrey Heartlands Integrated Care Board. • Husband is employed by Oxford University Hospitals NHS Foundation Trust. • Affiliate Member, Bristol and Avon St John Priory Group.
Mr Neil Darvill	Chief Digital Information Officer (to NBT and UHBW) (non-voting position)	• Wife works as a senior manager for Avon and Wiltshire Partnership Mental Health Trust. • Stepbrother is an employee of the Trust, working in the Cancer Services Team.
Mr Peter Mitchell	Interim Chief People Officer (non-voting position)	• Nothing to declare.

DRAFT Minutes of the Public Trust Board Meeting held virtually and in Learning & Research Building, Seminar Room 4 on Thursday 28 March 2024 at 10.00am

Present:			
Michele Romaine	Trust Chair	**Maria Kane**	Chief Executive Officer
Sarah Purdy	Non-Executive Director	**Glyn Howells**	Chief Finance Officer
Kelly Macfarlane	Non-Executive Director	**Steven Hams**	Chief Nursing Officer
Richard Gaunt	Non-Executive Director	**Neil Darvill**	Chief Digital Information Officer
Jane Khawaja	Non-Executive Director	**Steve Curry**	Deputy Chief Executive & Chief Operating Officer
Shawn Smith	Non-Executive Director	**Dr Samir Patel**	Medical Director Workforce
Omar Mashjari	Associate Non-Executive Director	**Jacqui Marshall**	Chief People Officer
Darren Roach	Associate Non-Executive Director	**Peter Mitchell**	Interim Chief People Officer
In Attendance:			
Xavier Bell	Director of Corporate Governance & Trust Secretary	**Elliot Nichols**	Director of Communications
Tomasz Pawlicki	Corporate Governance Officer (*minutes)*	**Sarah Margetts**	Deputy Chief People Officer
Presenters:			
Emily Ayling	Head of Patient Experience *(present for minute item TB/24/03/07)*	**Hannah Little**	Assistant Chief Nursing Officer for Cancer Services *(present for minute item TB/24/03/07)*
Shelley Thomas	Divisional Director of Nursing for ASCR *(present for minute item TB/24/03/07)*	**Lucy Kirkham**	Trust Guardian for Safe Junior Doctor Working *(present for minute item TB/24/03/13)*

TB/24/03/01	**Welcome and Apologies for the Absence**	**Action**
	Michele Romaine, Trust Chair, welcomed everyone to the North Bristol Trust (NBT) Trust Board meeting in public. The Trust Chair also welcomed members of the public and staff who were observing the meeting. Additionally, Michele welcomed Peter Mitchell the new Interim Chief People Officer. Apologies were noted from Tim Whittlestone, Chief Medical Officer (Dr Samir Patel, Medical Director Workforce was deputising).	
TB/24/03/02	**Declarations of Interest**	
	No Declarations of Interest were received relating to the agenda, nor were any updates required to the Trust Board register of interests as currently published on the NBT website and annexed to the Board papers.	
TB/24/03/03	**Minutes of the previous Public Trust Board Meeting**	
	RESOLVED that the minutes of the Public Meeting held on 25 January 2024 were approved as a true and correct record of proceedings.	
TB/24/03/04	**Action Log and Matters Arising from the Previous Meeting**	
	Xavier Bell, Director of Corporate Governance & Trust Secretary, presented the action log and noted that action 82 had been closed. **RESOLVED that the updates to the Action Log were noted and no matters arising were raised.**	

TB/24/03/05	**Chair's Business**	
	Michele Romaine requested that the Board confirm its support for her to sign off the Digital Health Petition on behalf of North Bristol Trust (NBT) in response to Frank Hester's remarks about Diane Abbott, which had recently been reported in the press. Michele provided an update on the Chair's Business and outlined her latest visits, including a: • Visit to the Chaplaincy to discuss and learn about the support provided to the staff and patients by the Chaplaincy team. Michele gave an example of the team going above and beyond to help families who had lost babies and shared an observation of the lack of space for confidential conversations. Michele spoke about the importance of creating this space for the team. • Visit to the Dialysis unit where she saw the positive environment created for patients and families in the unit. • Visit to the Midwifery team and the roll-out of the BadgerNet system. Additionally, Michele noted the improvements brough about by the new MRI scanner at Cosham Hospital and the positive environment within the department. **RESOLVED that the Chair's briefing was noted and that the Digital Health Petition be signed off on behalf of NBT.**	
TB/24/03/06	**Chief Executive's Briefing**	
	Maria Kane, Chief Executive, presented the Chief Executive's Briefing. In addition to the content of the written report, the following was noted: • The Trust remained under pressure with increased numbers of no criteria to reside patients. • NHS England planning guidance had been received and the Trust was alining the operational planning for 2024/2025 with the guidance. • The publication of the Joint Clinical Strategy and the positive response from staff. • Maria had delivered a presentation at the National Genomics Board on the Generational Study and clinical genetics work in the South West. • The positive Black Maternity Matters training day which took place in March 2024. • The Senior Leadership away day which took place in March 2024 and focused on planning for the next year 2024/25 and recognising the national context alongside challenges. • The Bristol City Council Serious Youth Violence Roundtable where Maria joined the Bristol Mayor and other leaders. Maria noted the ongoing work with Trust clinical teams and community partners to provide support for the communities and raise awareness. • Maria had attended a kidney transplant surgery and praised the positive work that the team were doing. Additionally, Maria thanked Jacqui Marshall, Chief People Officer, for her committed service to the Trust over the past six years and wished her all the best on her future endeavours. Maria welcomed Peter Mitchell, who was joining the Trust as the new Interim Chief People Officer. **RESOLVED that the Chief Executive's briefing be noted.**	

	Emily Ayling, Hannah Little and Shelly Thomas joined the meeting.	
TB/24/03/07	**Patient Story**	
	Steve Hams, Chief Nursing Officer, introduced the Patient Story and welcomed Emily Ayling, Head of Patient Experience, Hannah Little, Assistant Chief Nursing Officer for Cancer Services, and Shelley Thomas, Divisional Director of Nursing for ASCR, to the meeting. The team presented John's story, outlined the timeline of John's pathway and explained John's experience. After playing the Patient Story video Shelley explained the actions taken by the team after receiving the associated PALS concern. Hannah noted that the story provided wider opportunities for improvements, particularly regarding communication and delivery of sensitive news to patients. Hannah noted the ongoing efforts with divisional leaders to enhance patient communication and collaboration with the Patient Experience team in developing a survey for better insight into sensitive news delivery. Kelly Macfarlane, NED, asked if the team provided follow-up communication to patients after delivering sensitive news. Hannah confirmed that follow-up appointments were always provided to patients who have received any sensitive news, particularly if they have received a cancer diagnosis. Kelvin Blake, NED, questioned if the learning opportunities had been shared with University Hospital Bristol and Weston (UHBW) NHS Foundation Trust. Hannah confirmed learning opportunities were shared with UHBW and outlined the ongoing work to improve patients' pathways and cancer services. Following discussion the Board recognised the need to improve how sensitive news and diagnostics results are delivered to patients and highlighted the importance of communication, noting that patients' personal situations should be considered when delivering sensitive news. The Board asked to pass the condolences to the family of John who sadly passed away after filming this story. **RESOLVED that the Board welcomed and noted the Patient's Story and thanked the team for all their work.** *Emily Ayling, Hannah Little and Shelley Thomas left the meeting.*	
TB/24/03/08	**Joint Clinical Strategy**	
	Dr. Samir Patel, Medical Director for Workforce, presented the Joint Clinical Strategy which had been developed during February-May 2023. Samir outlined that the strategy highlighted the approach that NBT and UHBW took to work collaboratively to pursue the shared vision of 'seamless, high quality, equitable and sustainable care'. Samir positively noted that the strategy had been well received by staff and the public. Board members welcomed the positive reception of the strategy and applauded everyone involved for their hard workand acknowledged the need to continue the positive collaboration. Sarah Purdy, NED, reiterated the importance of working with the community and partners alongside UHBW. Samir agreed and advised of the ongoing collaborative work with communities such as the unified approach to secondary care. **RESOLVED the Board noted the Joint Clinical Strategy.**	

TB/24/03/09	**People Strategy**	
	Jacqui Marshall, Chief People Officer, and Sarah Margetts, Deputy Chief People Officer, presented the updated People Strategy and reflected on the last five years' achievements of the People team. Jacqui outlined that the strategy had been updated for its final year to include reference to the new Clinical Strategy, the work of the Acute Provider Collaborative, and key strategic workforce priorities under the following areas: • Acute Provider Collaborative – Recruitment • Long Term Workforce Plan • Equality, Diversity & Inclusion (EDI) Plan • Commitment to our Community • Long Term Retention Plan • Enhancing People Services Additionally, Jacqui outlined the ongoing “commitment to our community” work and engagement and the long-term retention plan. Michele Romaine questioned if this had been shared with UHBW. Jacqui confirmed that it had been shared and detailed the ambition for NBT and UHBW teams to collaboratively work on future strategy improvements. Kelly Macfarlane inquired how progress would be measured, Jacqui advised that progress was tracked through national data returns and explained the ongoing internal targets to ensure progress was monitored. Kelvin and Steve Hams, Chief Nursing Officer, welcomed the positive progress within the workforce agenda, particularly with recruiting Health Care Assistants and Nursing staff. The Trust Board congratulated Jacqui and the People team on the positive progress and achievements. **RESOLVED that the Board approved the updated People Strategy and the ongoing work on workforce and EDI.**	
TB/24/03/10	**Quality Committee Upward Report**	
	Sarah Purdy, NED and Committee Chair, presented the Quality Committee Upward Report and highlighted the following key areas: • The report on the NHS Digital Regulation 28 Notice on allergy information, thanking the IT and Clinical Leadership on moving this work forward. • The Positive work on Deteriorating patients and improvements • WHO Checklist Compliance and improvements and the Committee recommendation for it to became a “Watch Metric” • Updates on Maternit Incentive Scheme Steve Hams provided an update on the year five Maternity Incentive Scheme payment and explained that NHS Resolutions had reviewed the information sent to them by NBT on safety indicator one and as a result, the Trust had now passed the all maternity safety actions and received a return on the NHS Resolution fee.	

	The Trust Board agreed for the WHO Surgical Checklist compliance to become a 'watch metric' and noted the ongoing work on Deteriorating patients. **RESOLVED that the Board:** • **welcomed the Quality Committee Upward Report and received assurance on the activities the Committee had undertaken on behalf of the Board** • **agreed for the WHO Surgical Checklist compliance to become a 'watch metric'.** {Break}	
TB/24/03/11	**Patient & Carer Experience Committee (PCEC) Upward Report**	
	Jane Khawaja, NED, presented the Patient & Carer Experience Committee Upward report and highlighted the following key areas: • The innovative patient story in the form of a poem received by the Patient Experience team which reflected the positive impact that volunteers and Fresh Arts Programme had on patients and relatives. • The ongoing work on improvements for patients and staff with Learning Disability and Autism in Learning Disability and Autism Annual Report 2023-24. • The assurance received on the progress of the Emergency Department Audit by Autistic Patients action plan. • The collaborative work with the veteran's group work and the Young Carers Programme. **RESOLVED that the Board noted the report for assurance and the business undertaken by the Patient & Carer Experience Committee on behalf of the Board.**	
TB/24/03/12	**People & Equality, Diversity, and Inclusion (EDI) Committee Upward Report**	
	Kelvin, NED and Committee Chair, presented the People & EDI Committee Upward Report and noted the discussion on: • The launch of the retention strategy • The launch of the "Commitment to the Community Plan" and the use of workforce data from the community to establish the best outcomes for the Trust workforce gaps. • The ongoing work within Health & Safety (H&S) on violence and aggression to raise awareness and provide support to staff. Michele Romaine commented on a recent incident of violence & aggression in the community and highlighted the need to review H&S in the community areas where NBT staff deliver services. Michele requested that an update be brought back to the Board to provide assurance on the safety of community staff, particularly regarding Midwifes given the recent incident. **RESOLVED that the Board noted the People & EDI Committee Upward Report and received assurance on the activities the Committee had undertaken on behalf of the Board. The Board agreed for update be brought back to the Board to provide assurance on the safety of community staff.**	GH/SH
TB/24/03/13	**Guardians of Safe Junior Doctor Working (GOSW)**	
	Lucy Kirkham, Trust Guardian for Safe Junior Doctor Working, presented the Guardians of Safe Junior Doctor Working report and discussed the current	

	Junior Doctor contract challenges. Lucy outlined the key changes made to the contract, following the contract refresh in 2019 including: • The leave for life-changing events • The breaks for nights shifts • The cost of overnight accommodation • the cost of travel home and reasonable expenses • Exception reporting Additionally, Lucy presented data on Junior Doctorssickness absence, and gap management. Lucy highlighted that NBT was in a good position for 2024-2025 to potentially diversify and stabilise some parts of the Patient Group Directions (PGD) workforce by expanding the physician associate (PA) posts. Lucy outlined the key GOSW Positives such as positive engagement in Patient Group Directions, Less Than Full Time Training (LTFT) and a new Mechanism introduced to allow a breach of average hours accurate calculations, aswell as concerns for the GOSW team: • Data accuracy – core clinical vacancy, causes of sickness • Locum fill rate was above 85% • Payment for locum breaks – differences around the collaborative • Optimisation of locum uptake Jacqui commented on sickness data and advised that of services that were accessible to all team such as Occupational Health and Staff Psychology Team. **RESOLVED that the Trust Board discussed Junior Doctor contract changes and that any issues regarding the contract would be included in the next Guardians of Safe Junior Doctor Working report to Board.**	
TB/24/03/14	**Integrated Performance Report**	
	Steve Curry, Deputy Chief Executive & Chief Operating Officer, introduced the responsiveness section of the Integrated Performance Report (IPR) and presented a summary across four key domains of urgent and emergency care (UEC), elective care, diagnostics, and cancer performance. • UEC: Steve explained the challenges which included increased Emergency Department (ED) attendances, recent periods of industrial action and the increasing number of no criteria to reside patients. • Cancer: Steve outlined the Faster Diagnosis Standard (FDS) improvements and confidence that FDS recovery plans would allow the Trust to be compliant with the 75% target in March 2024. • Referral To Treatment (RTT): Steve explained that RTT had reached the target this month (65 weeks) but it was noted it came with challenges. Michele Romaine inquired about diagnostic reporting performance. Steve Curry advised that diagnostic reporting was challenging as a result of resourcing issues but explained the ongoing work to improve the reporting position through outsourcing. Steve Curry outlined the reporting process and noted that the Trust prioritised the reporting of cancer diagnostics due to the sensitive and timely matter for treatment. Michele highlighted the importance of faster reporting to patients to enable faster patient pathway flow and requested that additional data be presented on diagnostic reporting at a future meeting Michele and Steve Curry discussed the workforce challenges, specifically with Sonographers and Radiographers and noted that despite this the Trust managed well through the 2023-2024 winter pressures. <u>Quality, Safety and Effectiveness</u>	

Steve Hams, Chief Nursing Officer, and Tim Whittlestone, Chief Medical Officer, highlighted the following key areas:

- The Perinatal Mortality Review Tool (PMRT) and the feedback from a recent case that would be used to inform cultural improvement work on the postnatal ward.
- There were no new Maternity and Newborn Safety Investigations (MNSI) referrals during the relevant period
- The ongoing work to target pressure injuries
- System preparations for the measles outbreak . It was noted that NBT would focus on adults and UHBW on children.
- The community outbreaks of whooping cough and the work to help patients and staff.

Shawn Smith, NED, queried the actions to minimise falls within the Trust. Steve Hams explained the work to improve bathroom support for patients by installing handles on the walls and improving the lighting throughout the wards. Shawn Smith also questioned the fall reporting processes. Steve Hams described the reporting process and provided reassurance that the processes were robust and well embedded across the Trust. It was noted that all cases should be logged on the Datix system and reviewed at divisional meetings.

Jane Khawaja raised concerns regarding the increase of medication incidents. Steve Hams explained that the increase was the result of the better reporting systems in place and provided assurance on the ongoing improvements work. The Board discussed the medication control systems in place in-depth and requested that additional information on Control Drugs (CD) recording be brought to the next Trust Board meeting.

Following a query from Kelly Macfarlane re International Nurses, Steve Hams explained the support in place for the nurses such as the Adapt Program and communication training. The Board discussed the day-to-day experiences of International Nurses and recognised the need to ensure they are supported.

<u>Research and innovation</u>
Dr Samir Patel took the paper as read and had no additional comments.

<u>Workforce</u>
Jacqui Marshall, Chief People Officer, highlighted the following key areas:

- The ongoing work to reduce vacancies
- The Patient First vacancy target was reached for 2023/24
- The prioritisation of staff well-being and ongoing work to support staff with their well-being
- The ongoing work to reduce temporary staffing
- The new appraisal system that would go live in April 2024

Maria Kane inquired about the new appraisal system particularly how it would be communicated to staff. Jacqui explained that the new system would improve the appraisal process and that the launch would be supported by the Communications team.

<u>Finance</u>
Glyn Howells, Chief Financial Officer, provided an update on finance and outlined:

- The forecasting exercise with divisions to focus on the delivery of the Elective Recovery Fund (ERF) and the Cost Improvement Programme (CIP)

	• The ongoing work to address challenges in 2024/25, particularly in corporate and transformation areas • The financial impact of industrial action • The Trust's capital spend position The Board welcomed the Finance update and congratulated Glyn and the divisional teams on the achievements made. <u>Regulatory</u> The Trust Board supported and signed off on the regulatory requirement that the Trust was compliant with the NHS Provider licence. **RESOLVED that the Board noted the Integrated Performance Report and approved the regulatory compliance statements. It also agreed to receive:** • **Additional information on the recording of Control Drugs (CD) at the next Trust Board meeting.** • **Additional data on diagnostics reporting performance at future Trust Board meetings**.	**SH** **SC**
TB/24/03/15	**Finance & Performance Committee Upward Report**	
	Richard Gaunt, NED and Committee Chair, presented the Finance & Performance Committee Upward Report and highlighted the deep dive on the Stroke Service Transformation. The positive improvements in Stroke Services and care provision despite challenges in these areas were noted, particularly the importance of maintaining dedicated project resources, testing design assumptions, and improving communication. Additionally, the Trust Board was asked for approvals on: • The draft budget and release budget for the first three months of 2024/25 in advance of final budgets being set following the May 2024 submission. • The revised Finance & Performance Committee Terms of Reference. **RESOLVED that the Board received a report for assurance the Finance & Performance Committee undertaken on behalf of the Board.** • **Noted the approved Operating Plan and:** • **Approved the draft budget and release budget for the first three months of 2024/25 in advance of final budgets being set following the May submission.** • **Approved the revised Finance & Performance Committee Terms of Reference.**	
TB/24/03/16	**Audit & Risk Committee Upward Report**	

	Shawn Smith, NED and Committee Chair, presented the Audit & Risk Committee Upward Report which outlined the ongoing work with the internal and the external auditors. Shawn also noted the improvements to the risk management process and the ongoing work with the divisional team to ensure the risk register is updated appropriatevely. Maria Kane queried the preparations and any anticipated challenges for the annual audit and accounts sign off for year 2023/2024 Shawn advised of the ongoing communications with the external auditors to ensure transparency and that sufficient resources were in place. Glyn Howells explained the changes to the external audit team. Shawn reported that the draft Counter Fraud Work Plan for 2024/2025 was endorsed, and outlined the necessary actions to uphold the Trust's mandatory Counter Fraud function for the 2024/2025 financial year. Additionally, Shawn noted that the Committee approved the proposal to extend the purchase order threshold for Bristol & Weston Purchasing Consortium (BWPC) involvement but requested to receive feedback from the purchase order audit. **RESOLVED that the Board noted the Acute Provider Collaborative Upward update and the activities the Committee has undertaken on behalf of the Board.**	
TB/24/03/17	**Developmental Well-Led Review**	
	RESOLVED that the Board noted the summary and recomondation from the Developmental Well-Led Review.	
TB/24/03/18	**Any Other Business**	
	No business declared.	
TB/24/03/19	**Questions from the public**	
	Has the Trust obtained or applied to NHS England for funding to implement Martha's Rule enabling patients, families carers and advocates to access a 24/7 rapid review response from a critical care outreach team when they have concerns about a patient's medical condition deteriorating? NBT was not among the first tranche of Trusts to receive NHSE funding to support the roll out of Martha's Rule. *If the Trust has not obtained or applied for funding to implement Martha's Rule, does it intend to do so?* NBT is planning to invest in an extended our "Hospital at Night" service which will ensure it is compliant with Martha's Rule. NBT will explore what NHSE funding might be available in 2024/25 to support this work, but our investment in our extended service is not conditional on that funding.	
TB/24/03/20	**Date of Next Meeting**	
	The next Board meeting in public was scheduled to take place on Thursday 30 May 2024, at 10.00 a.m. Trust Board papers will be published on the website and interested members of the public are invited to submit questions in line with the Trust's normal processes.	

The meeting concluded at 13:09 pm

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

Trust Board - Public ACTION LOG

Meeting Date	Agenda Item	Minute Ref	Action No.	Agreed Action	Owner	Deadline for completion of action	Item for Future Board Meeting?	Status/ RAG	Info/ Update	Date action was closed/ updated
28/3/24	People & Equality, Diversity, and Inclusion (EDI) Committee Upward Report	TB/24/03/12	87	The Board agreed for update be brought back to the Board to provide assurance on the safety of community staff particularly regarding Midwifes given the recent incident.	Glyn Howells, Chief Finance Officer Steve Hams, Chief Nursing Officer.	May-24	Yes	Open	**21/05/24** - A verbal update to be provided at the TB meeting on 30/05/2024	21/05/2024
28/3/24	Integrated Performance Report	TB/24/03/14	88	Additional information on the recording of Control Drugs (CD) to be brought to the next Trust Board meeting.	Steve Hams, Chief Nursing Officer	May-24	Yes	Open	**21/05/24** - The Chief Nursing Officer advised that an update on this would be provided at the June Quality Committee meeting.	21/05/2024
28/3/24	Integrated Performance Report	TB/24/03/14	89	Additional data on diagnostics reporting performance to be brought to future Trust Board meetings.	Steve Curry, Deputy Chief Executive & Chief Operating Officer	May-24	Yes	Closed	**17/05/2024** - The update has been embedded in the Integrated Performance Report for the May's Trust Board meeting.	17/05/2024

Report To:	Public Trust Board			
Date of Meeting:	30 May 2024			
Report Title:	Chief Executive's Briefing			
Report Author:	Suzanne Priest, Executive Co-ordinator			
Report Sponsor:	Maria Kane, Chief Executive			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			X	
Recommendations:	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.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	No	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No	
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 during this month.

2. Background

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

3. Performance

The Trust continues to experience a high level of activity within our emergency services. There remains a high number of patients with no criteria to reside (NC2R) which having dropped at the start of May to around 21%, has now risen again to 27% at the time of writing. This has a significant impact on flow through the hospital and so impacts our ability to move patients waiting in the ED to a bed when they need it. The teams continue to work very hard to reduce the number of four hour breaches and meet the new 78% target.

Improvements in diagnostic performance continue and we have already met the 5% six-week target. Similarly, thanks to the extensive work of our clinical and operational colleagues, the Trust continues to make inroads into the cancer performance improvement targets. The NHSE Cancer Programme team have written to the Trust to confirm that due to sustained improvements in performance, we have been moved out of the Tier 1 group for cancer. They again recognised the hard work and dedication of our operational team in validating and managing the PTL, reducing the 62-day pathway backlog and the impressive progress against the Faster Diagnosis Standard – in particular for Skin.

NHS England have written in the past week to confirm that following the recent quarterly review the Trust remains in Tier 2 for elective recovery.

4. Industrial Action Update - BMA Balloting the GPs

The BMA has just announced that they are going to be balloting GPs to vote for strike action following the recent GP contract 2024/25 changes. Following the strength of the referendum vote rejecting the contract changes in March, they are now holding a non-statutory ballot on action by GP contractors/partners in England which will open on 17 June and close on 29 July.

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The ballot will be open to GP contractors/partners and, if there is a majority vote, then doctors will be able to take action immediately; the BMA will not direct GPs to breach their contracts in this initial phase. Collective action can include limiting the number of patient appointments per GP per day to the recognised safe working maximum level of 25. It can also mean GPs will stop or reduce work that they're not formally contracted to do - this could include the completion of fit notes, prescriptions or investigations which should have taken place in the hospital setting or asking Trusts to communicate with patients about re-booking hospital appointments.

5. BNSSG Integrated Care Board Joint Forward Plan

The Integrated Care Board has just published its updated Joint Forward Plan for 2024/25. This document is reviewed and updated on an annual basis and reflects the commissioning and delivery intentions for the system. The updates reflect the new NHS England planning guidance document and local priorities.

8. Mortuary Incident – Human Tissue Authority Review Outcome

The Human Tissue Authority (HTA) has updated the Trust following its review of the private mortuary access by a patient in February. The incident has been classified as a HTA Reportable Incident (HTARI) and categorised as a serious security breach. The HTA has acknowledged the evidence submitted and all of the corrective actions and mitigations that have taken place and has now closed the incident. The report will be published within the HTA's quarterly report.

9. Publication of the Infected Blood Inquiry Final Report

The final report of the Infected Blood Inquiry was published in the last week. Amanda Pritchard released an apology to all those affected on behalf of the NHS. NHS England have written to all Trusts to set out the steps that they will be taking in response to the report and these are:

- Support for those affected – providing £19 million of additional funding over the next five years to provide bespoke psychological support services for those affected and this will be rolled out this Summer.
- Support for affected staff – to request that individual employers increase promotion of their local health and wellbeing support for staff. There is also a 24/7 text helpline being set up.
- Continue to find and treat people with blood-borne viruses – for Integrated Care Boards to continue to help find any of those affected that have not yet been identified and provide access to treatment and support.
- Ensuring patients can access the right information – producing and sharing materials to ensure frontline clinicians or staff in patient-facing roles are able to provide appropriate information.
- Maintaining confidence in current blood and blood products – the infected blood and products were withdrawn in 1991. Since that date there have been rigorous processes and testing to ensure the safety of both donors and recipients.
- Assessing further recommendations and next steps – there are a number of important recommendations in the final report for the NHS. NHS England will be considering these and working alongside the Department for Health and Social Care to ensure that actions are determined and these rolled out as soon as possible.

10. Engagement & Service Visits

During this month I have been able to visit our mortuary service and accompany one of our Non-Executive Directors on a Board Insight visit to Ward 27a. I attend the recent Integrated Care Board Away Day to discuss our plans for 'Right Care in the Right Place'. I joined an Advisory Board meeting with CHKS which focused on NHS Benchmarking and I chaired the

South West Genetic Medicine Service Alliance (GMSA) Board meeting where we discussed strategic priorities and business plan.

11. Summary and Recommendations

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

Report To:	Public Trust Board			
Date of Meeting:	30 May 2024			
Report Title:	Patient Story			
Report Author:	Emily Ayling, Head of Patient Experience Sam Patel, Medical Director			
Report Sponsor:	Steve Hams, Chief Nursing Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
	X	**X**		
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
		X	**X**	
Recommendations:	The Board is asked to reflect on Jo and Jake's experience			
Report History:	None			
Next Steps:	N/A			

8

Executive Summary
Jake, a patient at NBT is attending the Board today with his mum Jo to share their experience of NBT services across a complex pathway. The key highlights of Jake's story are: 1. That NBT serves a population well beyond its conventional boundaries. 2. That staff at NBT will see complex patients whom others cannot treat. 3. That the teams at NBT can come together seamlessly to provide exemplary care for a patient. 4. That there are still things for us to improve to provide the highest standards of care. 5. The incredible fortitude of a remarkable young man who experienced a life-changing illness.

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	X
	High Quality Care – *Better by design*	X
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	X
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	N/A	
Financial implications:	N/A	

Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No, the subject of the story to not likely to impact people from other groups.
Appendices:	Appendix 1 – Patient Story (Presentation on a day)

Report To:	Public Trust Board			
Date of Meeting:	30 May 2024			
Report Title:	Freedom to Speak Up Bi-Annual Report May 2024			
Report Author:	Hilary Sawyer, Lead Freedom to Speak Up Guardian			
Report Sponsor:	Glyn Howells, Executive Lead for Freedom to Speak Up			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
		x		
Recommendations:	Trust Board is: **Asked to:** • Review the updated FTSU data, trends and themes (and organisational triangulation) • Note the updated progress on high level actions from the organisational FTSU self-reflection review (from November 2023): see Appendix 1 • Actively encourage other senior leaders to complete the national FTSU e-learning module: 'Follow-up' module for leaders; and their reports to complete assigned Listen Up and Speak Up modules • Consider and discuss further ways to support and action continued improvement of the speak up, listen up, follow up environment at NBT **Reminded to:** • Role-model and proactively and regularly communicate the value to NBT of workers speaking up, consistent with NBT's Values and Behaviours Framework, encouraging workers to feel empowered and safe to do so. A robust speaking up culture aligns with the Equality, Diversity & Inclusion plan, Patient First, Patient Safety and People Strategies (including the We Do Not Accept focus)			
Report History:	There is a bi-annual report. The last report was in November 2023, including a summary of 2023/2024 Q1 and Q2 data.			
Next Steps:	See body of report.			

Executive Summary
Effective speaking up arrangements help protect and improve patient safety and quality of care, and support and improve the experience of NHS workers through empowered, respected, and valued worker voice. Freedom to Speak Up Guardians proactively promote a 'business as usual'

speaking up culture for continuous learning through listening, active response, and positive cultural change.

Summary position on 2023/2024 data:

The data shows sustained increase in concerns raised; the majority of concerns remain related to workplace attitudes, behaviours and worker wellbeing (and impact of process and pressures), rather than patient safety/quality issues.

This report:

- Outlines the most recent data and high-level themes around concerns being raised
- Outlines steps taken to triangulate the data with other sources
- Provides updates to high-level actions, and suggested actions for NBT Leadership

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	x
	High Quality Care – *Better by design*	x
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	x
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	Freedom to Speak Up is an important mitigation for the workforce risk recorded on the Board Assurance Framework The Care Quality Commission (CQC) assesses a Trust's speaking up culture under the Well-Led domain of its inspections	
Financial implications:	The Lead FTSU Guardian role is now funded recurrently at 0.9 WTE. Funding has been allocated for a fixed term (12 month), part-time Associate Guardian role (to be advertised shortly) to increase ring-fenced time, capacity and support diversity of the FTSU Guardian team	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	Freedom to speak up relies upon a fair, inclusive, and open culture that supports all workers, including those with protected characteristics, to speak up and bring diversity of voice and experience. Demographic/equalities data of staff speaking up is challenging to collect robustly however remains an area for improvement. The Trust is working to gradually improve the diversity and representation of all worker groups within the FTSU network.	
Appendices:	Appendix 1: Updated high-level actions from the Organisational Freedom to Speak Up reflection and planning self-review. Appendix 2: 2023 National Staff Survey Raising Concerns results	

1. Purpose

1.1 The purpose of this report is to update the Senior Leadership Group on Freedom to Speak Up (FTSU) activity and themes of issues raised by colleagues at North Bristol NHS Trust

(NBT) over the past 6 months for learning and to provide assurance on the work carried out to help workers speak up and feel valued for doing so.

2. Background

2.1 Freedom to Speak Up Guardians were introduced to NBT from November 2017. The number of volunteer Guardians has varied and is now four, with an increasing network of FTSU Champions being recruited to increase visibility, awareness, reach and diversity, and to support engagement and accessibility of FTSU. A substantive Lead Guardian role (0.6WTE) was introduced in mid-January 2021 since when awareness of speaking up and the FTSU Guardian role has increased and improved (the lead role was extended to 0.9WTE from April 2023).

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

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

3. Update of data, themes and activity

The following report provides information as outlined in the NHSE FTSU guidelines:

3.1 Part 1: Assessment of FTSU cases

3.2 Part 2: Actions taken to improve speaking up culture

3.3 Part 3: Recommendations

4. Summary and Recommendations

4.1.1 Trust Board is asked to:

- Consider and discuss further ways to support and continue improvement of the speak up, listen up, follow up environment at NBT
- Role-model and proactively and regularly communicate the value to NBT of workers speaking up, consistent with NBT's Values and Behaviours Framework.
- Encourage senior leaders and their reports to complete assigned national FTSU e-learning modules (currently mandatory, although not included in Statutory and Mandatory training)

FTSU Board report May 2024:

Key take-homes from the Freedom to Speak Up (FTSU) report:

- Further increase in speaking up through FTSU
- Positively this contributes valuable information on both specific issues, and organisational themes, for improvement and learning, and contributes to consideration of organisational actions required
- Ultimately there will be a need to break the cycle of workers feeling they need to approach FTSU
- FTSU should eventually become the safety valve for a smaller number of (likely the more complex) concerns
- In the interim capacity will be increased to robustly support improvement of the proactive listening and follow-up culture in the organisation to profit from the intelligence gained from those that are speaking up
- There has been an aligned increased focus on the wider speaking up environment, e.g., through the We Do Not Accept focus, and anecdotally increased reporting of issues to Divisions and support partners

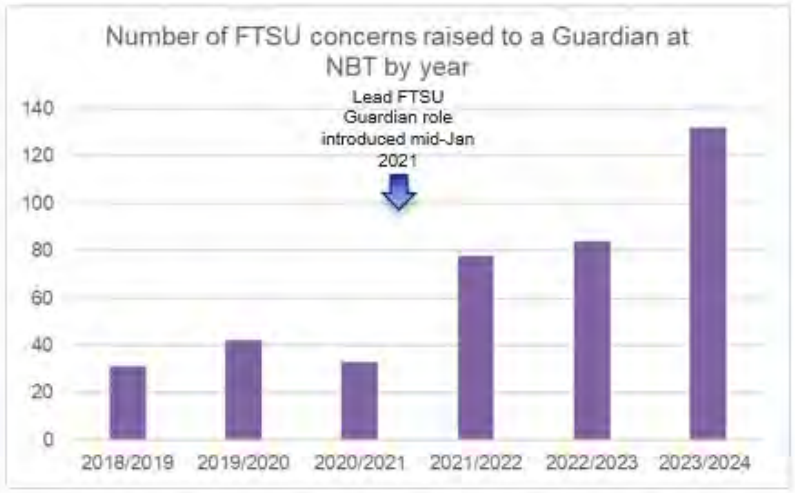
Triangulation:

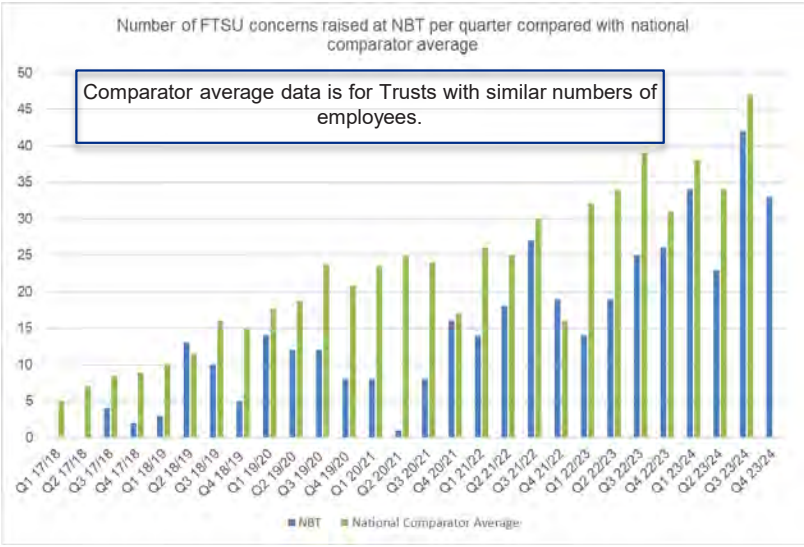
- A brief overview summary of triangulation through the People and Quality Triangulation group is provided in this report
- Improved scores have been obtained overall for the 2023 National Staff Survey (NSS) 'Raising Concerns' questions (Appendix 2)
    - Senior leaders are reminded that the scores reflect speaking up in the organisation generally, rather than to FTSU specifically
    - There are further high-level actions needed to reach the highest performing organisations; a deeper-dive may contribute to the refresh FTSU strategy/action plan
    - Divisional/Directorate/service NSS Raising concerns scores are available and could be considered by senior leadership for further action

Actions:

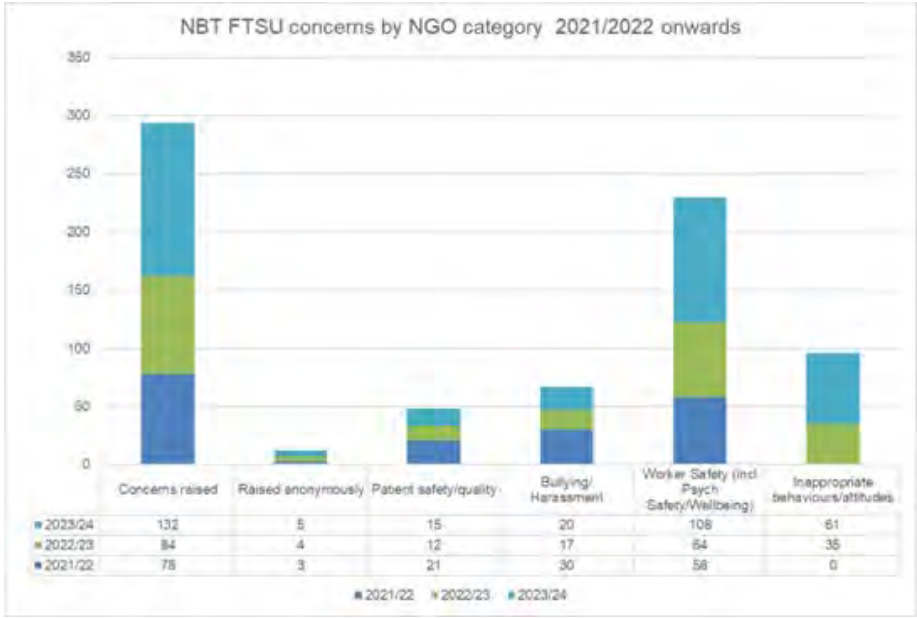
- An update on the high-level organisational self-review actions is available in Appendix 1
- One of the key known contributors to improvement of speaking up, listening up, follow up culture is proactive, visible role-modelling of speaking up, and intentional curiosity, by senior leadership to read the signals and maximise prevention and learning

FTSU Board report May 2024: Part 1: Assessment of NBT FTSU 'cases'





N.B. Nationally and at NBT Q3 concerns levels tend to be higher in Q3 due to Speak Up Month focus



NGO: Inappropriate attitudes/behaviours category added from 2022/23

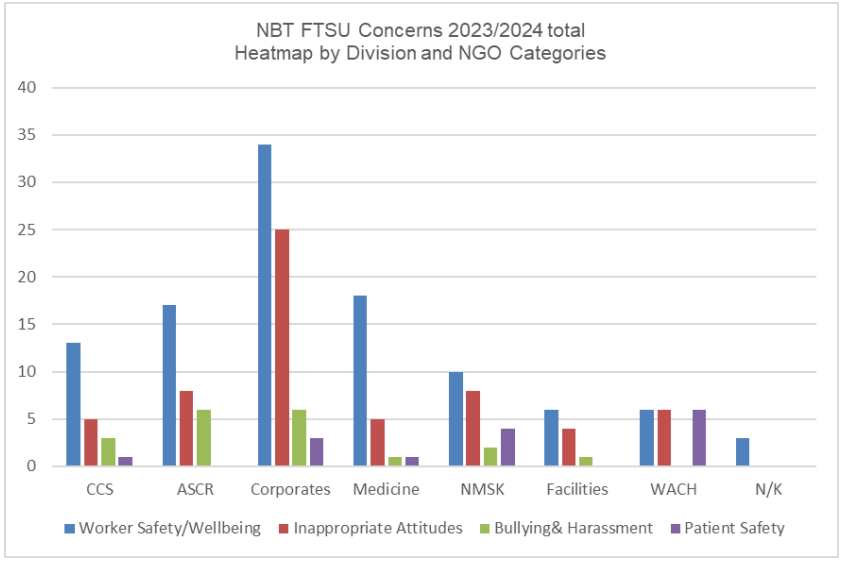
NB:
NGO guidance:
- Concerns can be reported in more than one category.
- Focus is on the perceptions of the person raising the concern.

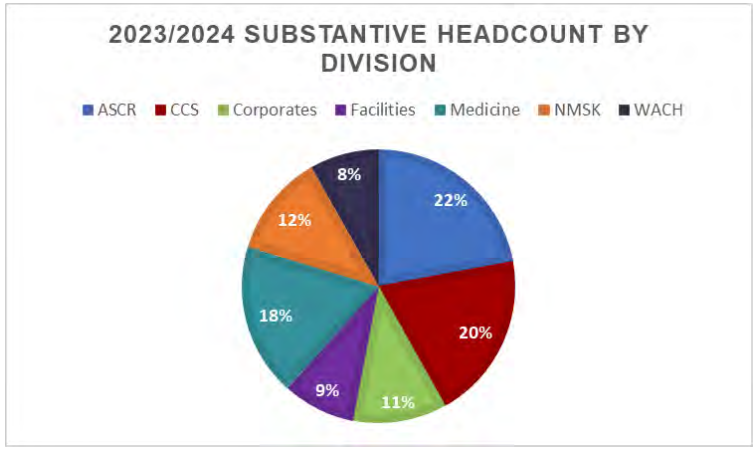
What do the data tell us?

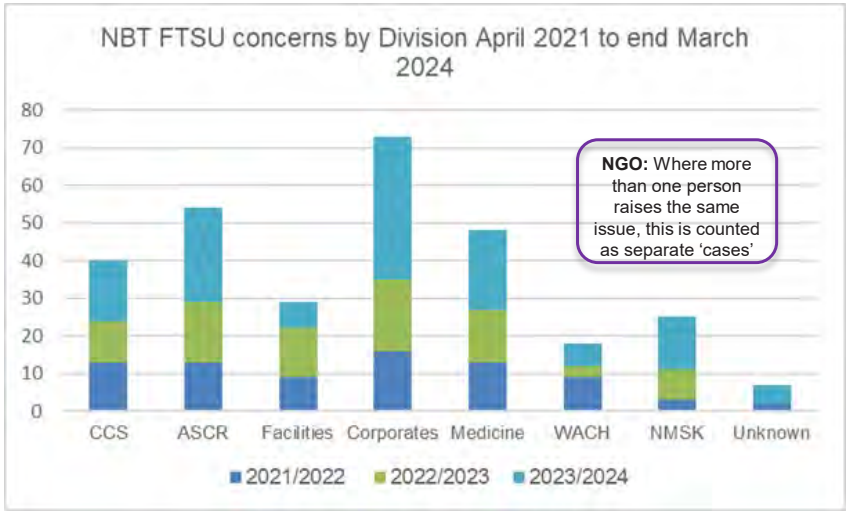
- The number of FTSU concerns raised at NBT has continued to increase
- The numbers of concerns raised has increased significantly in 2023/2024
- Relatively few concerns are directly about patient safety or quality of care
- The highest number of concerns fall into the category of 'inappropriate behaviours and attitudes'
- A high level of concerns also fall into the worker safety/wellbeing category – the majority are around emotional/psychological wellbeing impact related to other aspects spoken up about
- This pattern is consistent in the last 2-3 years since National Guardian Office categories were updated to include Inappropriate behaviours or attitudes.
- 2023/2024 national data summary is awaited; this pattern appears to be consistent with national 2022/2023 reporting levels

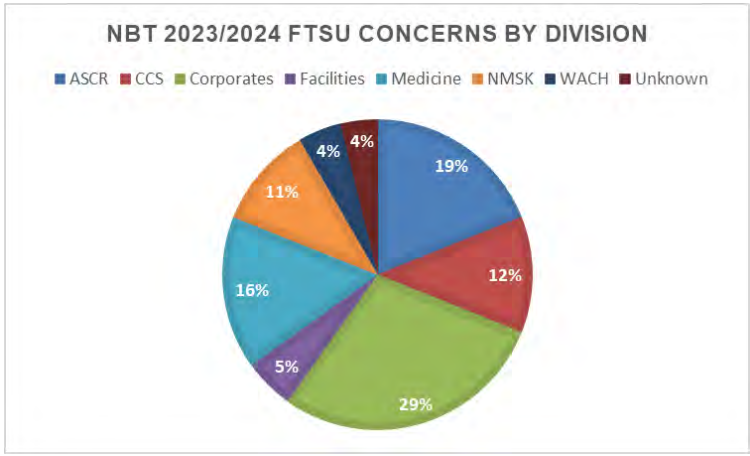
9.1

FTSU Board report May 2024: Part 1: Assessment of NBT FTSU 'cases'







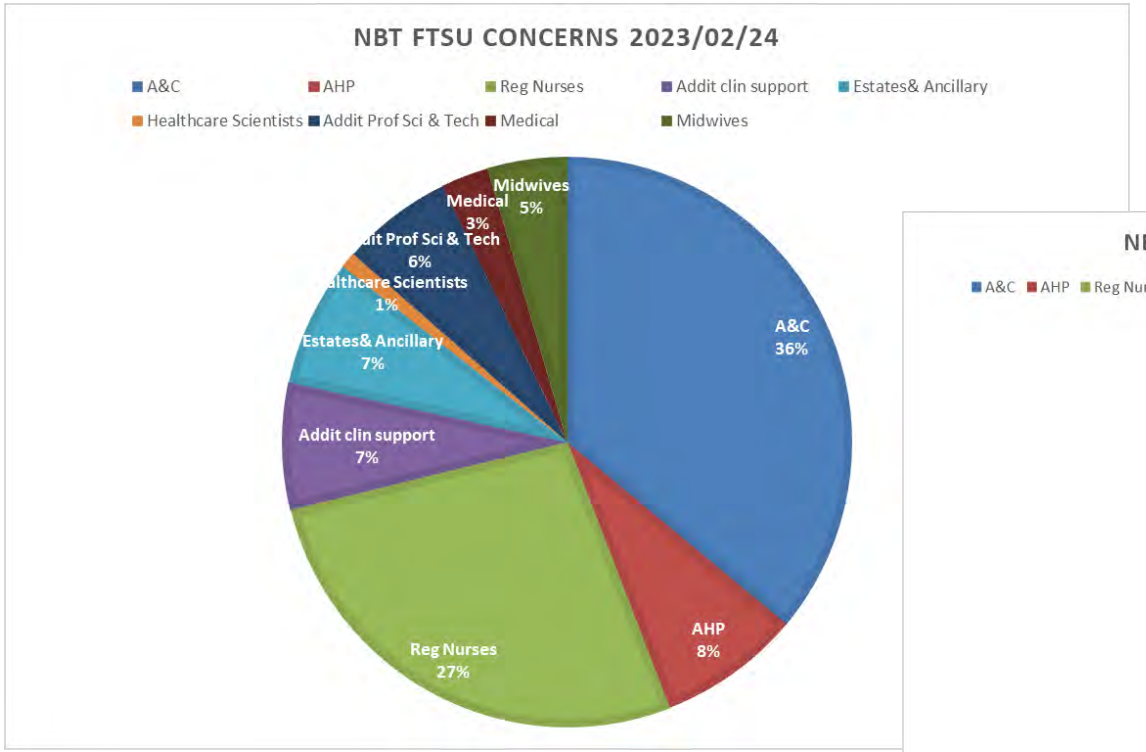


What do the data tell us?

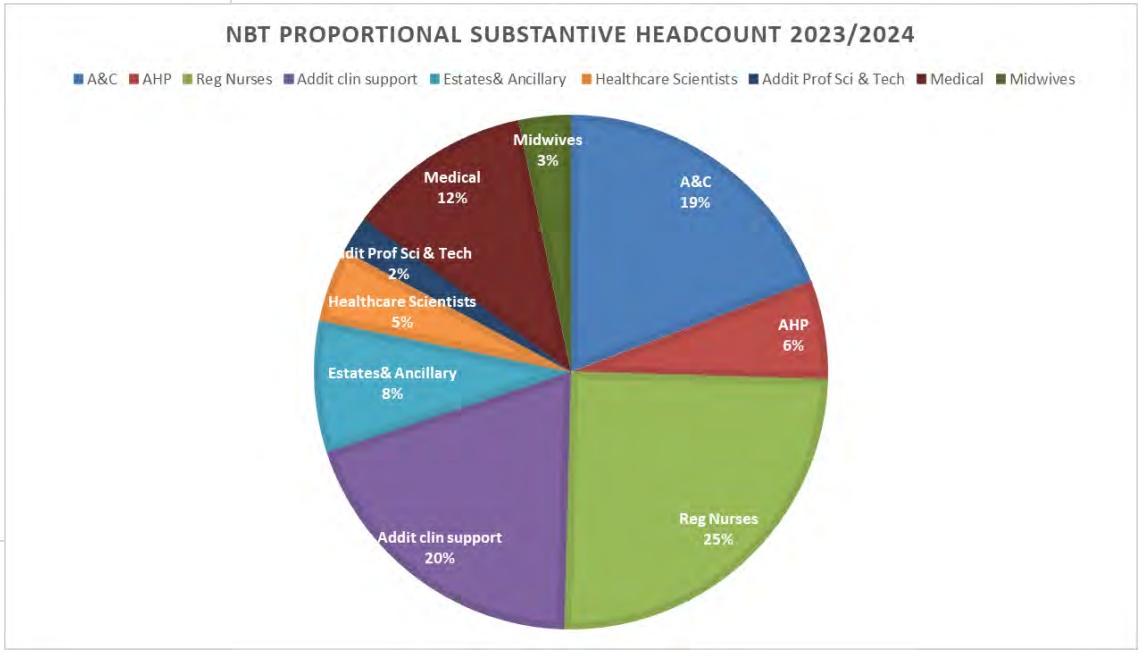
- For ASCR, Medicine and NMSK the numbers of concerns were proportional to headcount
- A relatively high proportion of concerns have been raised through Corporate areas – this appears to reflect increased pressures and behaviour and relationship issues between team members
- A higher number of concerns were raised in WACH this year than last, although these collectively focussed on one area
- Fewer concerns were raised in CCS and Facilities proportional to headcount

9.1

FTSU Board report May 2024: Part 1: Assessment of NBT FTSU 'cases' update



N.B: The NGO worker group categories are based on NHS Digital's National Workforce Data Set, e.g., Admin & Clerical: Non-clinical staff, including non-clinical managers, without patient contact



What do the data tell us?

Higher proportional concerns level:

- Admin & Clerical
- Relatively: Additional Prof Sci &Tech

Lower proportional concerns level:

- Additional clinical support
- Medical
- Healthcare Scientists

9.1

FTSU Board report May 2024: Part 1: Assessment of NBT FTSU 'cases' (continued)

NBT FTSU Themes 2023/24 Q3 and Q4

(**Rider:** concerns can be challenging to theme/group together and discuss in an informative/meaningful/sufficiently accurate manner while dealing with these sensitively and confidentially, and not creating unintended 'false narrative')

Patient safety/quality of care:

- Discrete clinical practice issues
- Patient care and staffing levels in relation to increased acuity levels – also impact on staff wellbeing
- Patient experience: clarity/updating of signs and letters
- Implementation of no-smoking policy (also impact on workers)

Attitudes and behaviours:

- Behaviours/attitudes between colleagues and/or managers
- Impact of communication style/demeanour of managers or lack of, or inconsistent, communication
- Clarity or effectiveness of dealing with behaviours between team members
- Manager responses felt to be lacking compassion/not understanding systemic factors and pressures
- Manager or leadership style including micro-management and feelings of disempowerment, impacting confidence and wellbeing
- Multi-or inter-professional interactions
- Fairness in processes and progression opportunity

Process/System-related

- Impact of process issues or organisational change on wellbeing (some historical)
- Support around reasonable adjustments
- Resourcing

Worker wellbeing

- Impact of the other categories of concerns on wellbeing/morale
- Physical and verbal abuse from relatives of patients
- Specific issue: Lone working and staff safety

FTSU Board report May 2024: Part 1: Assessment of NBT FTSU 'cases' (continued)

North Bristol NHS Trust

FTSU process timeframes:

(To provide assurance that matters spoken up about are acknowledged, evaluated, escalated and responded to in a timely manner)

Q3 and Q4 data	Average	Range
Time taken for initial acknowledgement by a FTSU Guardian	1 working day.	1-2 working days 100% acknowledged within the specified 2 working days
Time to closure (calendar):	1.3 months	2 days to 3 months (depending on the situation)

- Number of cases from 2023/2024 remaining open as of 09/05/24: six (these are either relatively complex issues needing robust consideration, or the more recent concerns raised, needing time to action/close robustly)
- Factors in protracted length to closure: sickness/leave of worker, challenges with time/workload for the manager in organising meeting, responsiveness of manager/leader, Guardian leave/capacity, FTSU workload balancing multiple cases, nuance, reflection and appropriate escalation/action/follow-up.
- Time from escalation to effective response by a manager that assures of appropriate action that issues are addressed (where appropriate): currently manual, improvement of analysis aimed for as part of new case management system development
- Typical actions taken by FTSU Guardians: Depending on the situation (following active listening), action can range from: logging the issue and informing themes and organisational triangulation action, supporting the staff member to speak up to a more senior manager themselves, or escalation with, or on behalf, of the staff member to a manager, senior manager or senior leader.
- Learning from concerns in Q3 and Q4 has included: consideration of staffing level review and increased acuity, impact of process and change, consideration of how to robustly address inter-personal and team or inter-team/professional communication aspects e.g., behaviours, civility and management thereof, communication/management style, feedback timeliness and effectiveness, confidentiality, disability adjustments, impact on morale of perceived lack of progression opportunity, updating of information for service users.

Additional assurance: The Guardian checks in subsequently with those speaking up, to ensure that workers feel that they have not suffered any disadvantageous treatment, which also serves as opportunity to discuss whether improvement has occurred, from worker perspective, as a result, and re-occurrence prevented.

NBTCARES

9.1

FTSU Board report May 2024: Part 1: Assessment of NBT FTSU 'cases' (continued)

FTSU Service User feedback included:

- Thank you for the opportunity to further have concerns considered and responded to with assurance that appropriate action was being taken in a challenging situation for all.
- I feel better for speaking up and ensuring the manager knows how staff are feeling about the issues raised
- I really appreciate the help and support from Freedom to Speak Up
- Thank you for the support; it is really appreciated
- Thank you for the prompt response to my concern and listening to me
- Thank you for supporting me, and the issue raised, being heard
- Many thanks for all your help
- I was grateful to get support through FTSU when this was not forthcoming directly initially through management

- Several workers during the last six months used the clear term of feeling 'unsafe at work' psychologically and wanting to be able to 'just get on with' the job that they loved rather than experiencing the issues that brought them to contact FTSU.
- Several had felt unheard previously or were raising issues wanting some learning to be taken from their experience in the workplace, to prevent other people experiencing similar.

One recent report of disadvantageous treatment/detriment has been reported to the FTSU Guardian(s) in 2023/24:

- This is currently being reviewed as a discrete concern (following protocol) for appropriate action

9.1

FTSU Board report May 2024: Part 2: Triangulation

Triangulation

(NHSE guidance: *How speaking up matters fit into a wider patient safety and worker experience context to help build a broader picture of speaking up culture and opportunities to learn and improve. What has been learnt and what improvements have been made as a result of workers speaking up.)*

Trust-wide triangulation:

(*Freedom to Speak Up, People/Workforce/Culture, Staff Psychology, Patient Safety, Patient Experience, Nursing, Health and Safety)

The quarterly People and Quality Triangulation Group* shares respective high-level information around thematic concerns/issues, and any hotspots, identified to ensure that Trust-wide joined up action is being taken to tackle and ultimately prevent these. Partners* are charged with taking the information into their respective areas to inform actions **or** highlight, through upward report, any thematic action felt not to currently being taken in the organisation.

Over-arching themes from FTSU concerns were supported by intelligence presented from other partners, including a high number of referrals to the Staff Wellbeing Psychology team, particularly around difficulties in working relationships and team support requests.

Common themes:

- Relationships, interpersonal behaviours, attitude issues between teams/team factors, individuals and colleagues/managers, 'brusque'/poor communication between colleagues
- Team dynamics and conflicts
- Communication between teams and managers, including lack of feedback loops on issues raised.
- People feeling dismissed/unheard by managers when raising issues
- Staffing levels, skill mix, retention, workforce gaps and workload pressures – impact on clinical practice/quality of care.
- Burnout
- Waiting time impact on patient experience and pressure from re-arranging clinics
- Process issues/design and clarity
- Communication with patients in busy services

A key area to be addressed is a robust, integrated approach to improving aspects of organisational culture (e.g., behaviours, inter-personal, team dynamics, and communication, and alignment with wider strategies and OD plans): In the last Triangulation group (April 2024) consideration of a potential paper setting out cross-function culture strategy and actions was suggested, including required resource, while acknowledging financial and other pressures.

Triangulation with National Staff Survey Results 2023: See Appendix 2

FTSU Board report May 2024: Part 2: Actions taken to improve speaking up culture:

(How speaking up matters fit into a wider patient safety and worker experience context to help build a broader picture of speaking up culture and opportunities to learn and improve.)

NHS North Bristol NHS Trust

Promotion of all speaking-up channels:

- Coverage of speaking up routes and FTSU by the Lead Guardian at fortnightly corporate induction sessions
- Through the 'We Do Not Accept' focus – Lead FTSU Guardian included in the focus planning work, 'Pop Up event' and as part of walkarounds at Southmead, Frenchay, Bristol Centre for Enablement, and planned visit to Cossham
- The Lead Guardian is supporting work of NBT's sexual safety at work group, including listening events in January and April 2024
- Internal communications through the operational bulletin and social media
- Divisions have been reminded to consider 'speaking up' posters (via a supplied template) to support local speaking Up

Engagement and training:

- Regular tailored sessions for new Student nurses and midwives, Trainee Nurse Associates, Preceptors, Internationally Educated Nurse 'Adapt' sessions, and GMC in-person sessions for International Medical Graduates, Accelerate programme. N.B. The NETs survey indicated 79% know the FTSU Guardian.
- Team engagement: updates and discussion, e.g., Pharmacy, BCE, R&D clinical team
- **NBT E-learning compliance for national FTSU Senior Leadership Module:** Board: 100%, SLG 76% (Organisational compliance data (currently not included in Statutory and Mandatory training): Speak Up module compliance 56%, Listen Up module compliance 28%, Follow Up module (all leaders) 42%)

FTSU network visibility: Walkarounds have involved the Executive Lead or Non-Executive Lead for FTSU, Lead Guardian or been supported by each of the Deputy Chief Nursing Officers. Future work will include further promotion of individual FTSU network Champion profiles.

9.1

Actions taken to support workers who may be unaware of speaking up processes or who find it difficult to speak up:

- Pan-Bristol FTSU Guardian letter for students as part of training sessions, including more recently NHSE SLEC Raising Concerns poster
- Addition of further FTSU Champions: four new Champions introduced with a focus for NMSK representation

NBTCARES

FTSU Board report May 2024: Part 2: Actions taken to improve speaking up culture (continued):

(How speaking up matters fit into a wider patient safety and worker experience context to help build a broader picture of speaking up culture and opportunities to learn and improve.)

NHS North Bristol NHS Trust

Assurance that FTSU arrangements are continually evaluated, and improvement identified:

- Organisational FTSU self-review high-level action progress **updated** – see Appendix 1
- 'Barriers to speaking up' engagement work carried out by the Lead Guardian through various training sessions, walk-arounds, etc – this, along with National Staff Survey data, will provide the basis of information for a UWE Masters (Human Resource Management) project to test/confirm this intelligence, and further information actions, in summer 2024
- A South-West FTSU network (Champions and Guardians) conference day is in planning for late October 2024, supporting the development of the network

Ongoing as routine:

- Feedback is requested from workers speaking up to Freedom to Speak Up (FTSU)
- The Lead Guardian attends the annual NGO conference and considers any NGO case reviews for learning and action
- The Lead Guardian attends quarterly SW Guardian network meetings for peer learning and support
- Peer-discussion with Bristol Lead Guardians (UHBW, AWP, Sirona, Spire)
- FTSU Guardians complete annual online refresher training – the focus for 2024 is Equality Diversity and Inclusion
- Gap analysis (2022/2023) did not identify any significant gaps; learning from any further speak up reviews would be incorporated

FTSU Board report May 2024: Part 3: Recommendations

Next steps:

High level actions are covered in Appendix 2:

- These include a refresh of the FTSU Strategy/plan aligned to other strategies including culture and organisational development plans

Trust Board members are requested to:

- Consider and discuss further ways to continue to action improvement of the broader speak up, listen up, follow up environment, including within respective Directorates
- Role-model the behaviours that support speaking up for safety, learning and improvement
- Provide an intentional, visible, proactive listening up environment, and support managers to do so
- Communicate the value to their respective services of colleagues speaking up
- Support communication of learning and change made as a result of speaking up
- Encourage colleagues to complete the respective National FTSU e-learning modules (mandatory though not currently contributing to statutory mandatory metrics at NBT)
- Consider the themes from the People and Triangulation Group and related action required by the Trust

9.1

Trust Board FTSU Report May 2024; Appendix 2

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner	Action Status	Update on actions
1. Evolve the People & Quality Triangulation Group as a forum for: • triangulation of concerns/issues data and themes across the organisation, and • exploring barriers to speaking up Review effectiveness after 12-months.	31/08/2024	Xavier Bell, Director of Corporate Governance	In progress	Has now met five times. Generally good attendance, and a good range of data available. Further consideration to be given to whether this group is afforded additional resource to underpin analysis and reporting. To be considered as part of 12-month review in August 2024. UWE Masters project to look at barriers to speaking up – Summer 2024.
2. Ensure that the HELM Programme covers leadership and management responsibilities for responding to concerns and creating a culture of “speak up, listen up, follow up”	31/01/2024	Sarah Margetts, Deputy Chief People Officer	In progress	The Lead FTSU Guardian is actively meeting with the leadership and management development team to consider how to effectively weave elements into HELM and other programmes

3. Ensure appropriate links between the FTSU function and the wider organisational development and cultural functions within the organisation, by including the Lead FTSU Guardian as a key partner and participant in relevant OD programmes and forums.	28/02/2024	Caroline Hartley, Associate Director of Culture and OD	Achieved	We are working more collaboratively with FTSU on key programmes of work, e.g., 'We do not accept' campaign, Sexual Safety working group and listening events, Retention and Staff Experience working group and Long-term Retention plan
4. Develop a co-created Communications Plan for speaking up, aligned with wider OD and cultural work, focused on "speak up, listen up, follow up", with single point of contact Communications support.	30/04/2024	Elliot Nichols, Director of Communications & Engagement	In progress (delayed)	Specific Communications capacity has been allocated to support the development of a Communications Plan, initially for FTSU. Alignment with wider OD and cultural work to be explored through the Triangulation Group, with the aim of a single comms plan supporting an aligned Just Culture/Speaking Up strategy (or similar).
5. Monitor the ring-fenced time for the FTSU Guardian and ensure recurrent funding available.	Ongoing – review in Jan 2024 as part of planning	Glyn Howells, Chief Finance Officer	On track	Recurrent funding for Lead FTSU Guardian is now secured. Non-recurrent funding secured for 2024/25 to pilot an Associate FTSU Guardian to provide resilience (and diversity) to the FTSU service. To remain under review throughout 2024/25.

6. Use the new People function governance (People Oversight Group) to oversee organisational response to staff survey results, particularly the speaking up questions, and monitor changes in responses in 2023 and future years.	31/07/2024	Sarah Margetts, Deputy Chief People Officer	On track	People governance structure being reviewed and updated in April 2024. Includes dedicated group on staff experience/culture and EDI Operational Delivery Group. Staff survey results for 2023 being analysed.
7. Refresh the FTSU Strategy in 2023/24, aligned to wider People, Quality, and OD strategies and plans.	30/04/2024	Hilary Sawyer, Lead FTSU Guardian	Delayed	This piece of work is being looked at alongside the need to have an aligned culture and OD plan/strategy that includes Speaking Up as a component part. This will be progressed during 2024/25.
Development areas to address in the next 12–24 months	**Target date**	**Action owner**		
1. Deliver the speaking up elements of the new 3-year Equality, Diversity and Inclusion Plan, one aim of which is to address cultural issues and barriers to speaking up through a 'top down and bottom up' approach.	31.3.2025	Associate Director of Culture, Leadership and Development	On track	Lead Guardian is engaged in EDI work and plan. Academic research commissioned on barriers to speaking up, utilising a final year MSc student from UWE (May – Sept 2024)

2. Deliver a campaign of work on zero acceptance of discrimination, harassment, bullying and violence, with a specific focus on key protected characteristics	31.3.2025	Associate Director of Culture, Leadership and Development	In progress	Campaign started in February 2024, with full engagement and involvement of Lead Guardian
3. Review and relaunch and improve our 'Red Card to Racism' campaign, to support those speaking up about racist behaviour or actions towards them or their colleagues, with resulting improved outcomes	1.12.2024	Head of Equality, Diversity and Inclusion	Not yet due	Plans in place to review, aligned to our EDI action plan and a focussed programme of work due to commence on anti-racism.
4. Develop policies and processes to support staff affected by domestic abuse and sexual violence (DASV) and evaluate effectiveness	31.3.2025	Associate Director of Culture, Leadership and Development	In progress	These are currently in development, linking in with DASV specialists in the Trust and safeguarding leads
5. Ensure staff are able to speak up against and about sexual violence and misconduct at work by implementing the ten commitments described within the NHS England 'Sexual Safety in Healthcare Organisational Charter', which NBT has signed up to.	31.7.2024	Chief People Officer	On track	Sexual Safety Working group established and new processes and resources in development, to be aligned with new NHSE national guidance and resources which are due to be released imminently

6. Further develop our psychological support services for staff and build on existing interventions which support psychological safety (e.g., Compassionate Conversations, Me and My Team, Start Well, End Well)	31.12.25	Associate Director of Culture, Leadership and Development	In progress	Plans to 'map' our psychological interventions for staff and develop a clear OD plan and priorities linked to relevant workforce strategies
7. Refresh and rebrand our existing cultural/behavioural training and interventions under the strategic theme of 'Proud to Belong', with an emphasis on kindness, civility and respect and inclusion.	31.3.2025	Associate Director of Culture, Leadership and Development	On track	This is one of the 4 priorities of our long-term Retention Plan, effective from 1.4.24. Actions aligned to this work are underway.
8 Double our number of Cultural Ambassadors and ensure they operate as an additional and effective form of support for staff who may be raising concerns or going through a formal HR process.	31.3.2024	Head of Equality, Diversity and Inclusion	Achieved	Training for 10 new Cultural Ambassadors occurred in January 2024. They are now fully operational at NBT

May 2024 Trust Board: Appendix 2: National Staff Survey (NSS) Results from 2023:

What do these show?:

- Results for the organisation for the four questions on Raising concerns have improved, particularly for non-clinical concerns.
- Further improvement through concerted, aligned action across the organisation would be needed to shift this further toward the best scoring organisations.
- Divisions could consider deep-dive around actions that may be improve scores in specific service areas

Divisional results:

- NMSK results continue to be better overall and continue to improve (other than for raising clinical concerns)
- WACH, Medicine, CCS, ASCR results improved generally
- Facilities results downturn and some scores below organisation average
- Corporate scores generally improved but some areas below organisation average

Service level:

- Underlying the above, there are some areas with 'red RAG results' that indicate areas that could be focussed on and triangulated by Divisional teams for action
- Results for occupational groups to be considered further to inform action – specific groups indicate action may be needed, whereas there has been improvement for others, e.g., midwives

Breakdown by characteristic: results can be viewed by various characteristics

For example:

- Results for non-White staff and staff recruited from outside the UK indicate improvement
- Results for staff with long-term health conditions remain lower

These results could be considered further as part of an organisation strategy on speaking up

FTSU Trust Board report May 2024: Triangulation

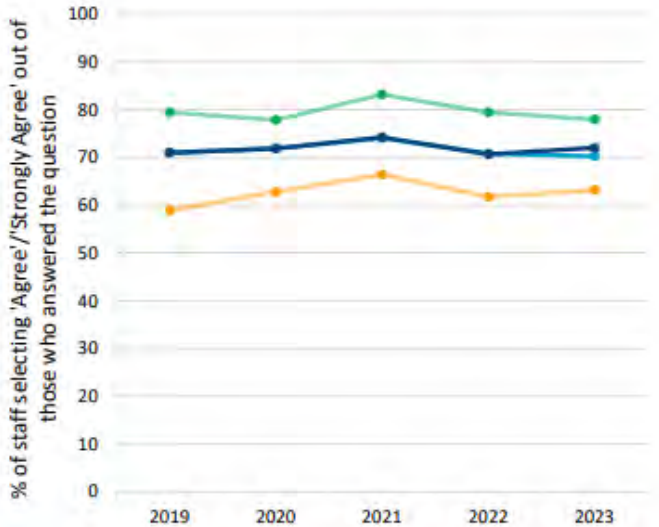
National Staff Survey 2023 results: Raising Concerns questions: Raising of clinical concerns and confidence in those being addressed

North Bristol NHS Trust

People Promise elements and theme results – We each have a voice that counts: Raising concerns

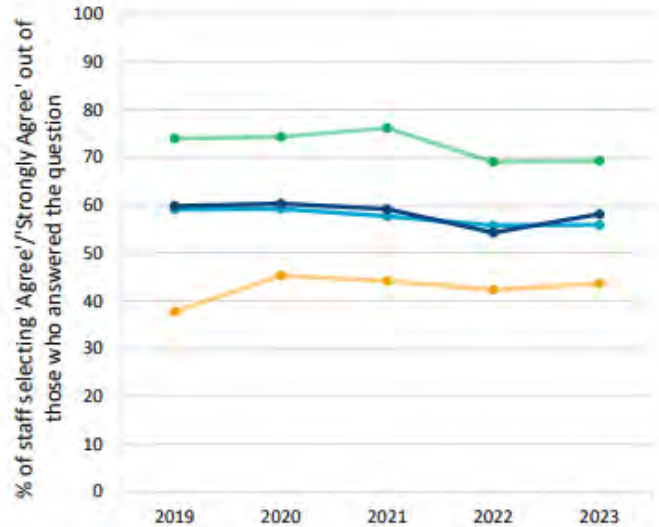
Survey Coordination Centre

Q20a I would feel secure raising concerns about unsafe clinical practice.



	2019	2020	2021	2022	2023
Your org	70.99%	71.89%	74.23%	70.68%	72.02%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	4052	4461	4444	4705	5716

Q20b I am confident that my organisation would address my concern.



	2019	2020	2021	2022	2023
Your org	59.82%	60.35%	59.18%	54.25%	58.12%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	4051	4459	4440	4695	5694

North Bristol NHS Trust Benchmark report

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NBTCARES

9.3

FTSU Trust Board report May 2024:Triangulation

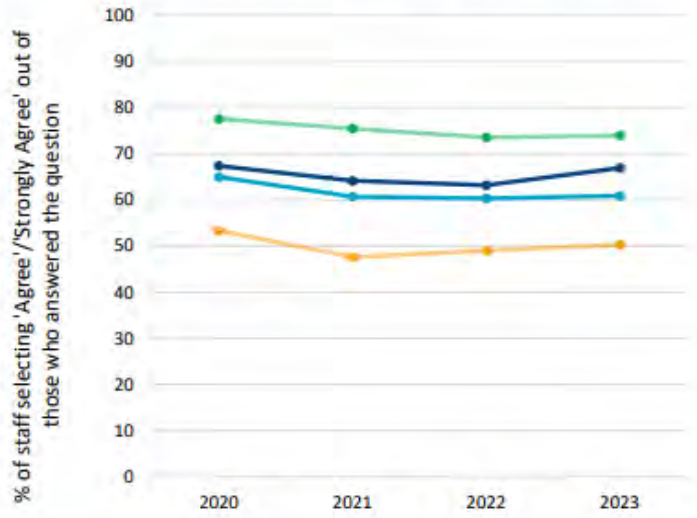
National Staff Survey 2023 results: Raising Concerns questions: Raising of anything of concern and confidence in that being addressed

North Bristol NHS Trust

People Promise elements and theme results – We each have a voice that counts: Raising concerns

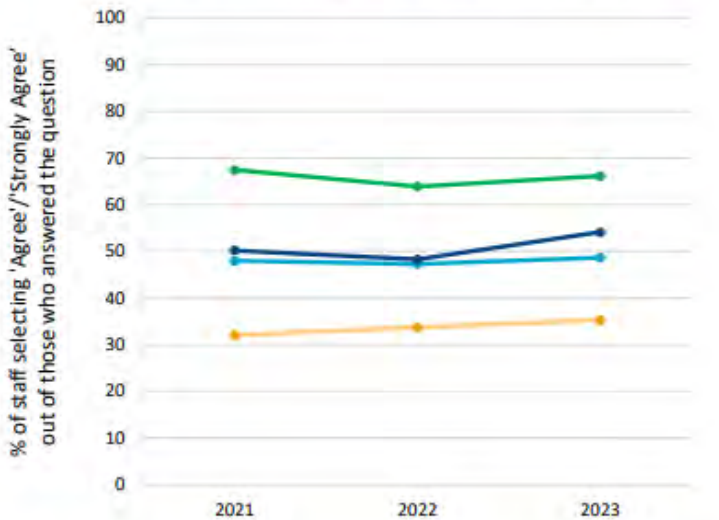
Survey Coordination Centre

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022	2023
Your org	67.41%	64.16%	63.19%	66.94%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	4468	4431	4713	5782

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023
Your org	50.17%	48.26%	54.12%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	4429	4698	5777

North Bristol NHS Trust Benchmark report

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NBTCARES

9.3

FTSU Trust Board report May 2024:Triangulation

NSS Raising Concerns Divisional scores 2023 vs 2022 (RAG comparison to NBT average for each year)

KEY

- Positive score of 100%
- Score > 3% better than Organisation average
- Score > 3% worse than Organisation average
- Scores in between

2023

	Question	NBT 2023	ASCR 2023	CCS 2023	Corporate 2023	Facilities 2023	Medicine 2023	NMSK 2023	WACH 2023
Q20a	I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	71.6%	74.3%	76.2%	62.0%	59.8%	74.5%	73.7%	78.0%
Q20b	I am confident that my organisation would address my concern (Agree/Strongly agree).	58.0%	57.6%	59.1%	53.2%	55.3%	58.9%	62.8%	59.9%
Q25e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	66.6%	64.7%	69.1%	66.7%	63.1%	64.8%	71.1%	66.4%
Q25f	If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	53.9%	50.9%	53.7%	51.1%	51.7%	55.0%	64.4%	51.1%

2022

	Question	Average Comparator score	NBT	ASCR	CCS	Corporates	Facilities	Medicine	NMSK	WACH
Q19a	I would feel secure raising concerns about unsafe clinical practice	70.80%	70.3%	74.0%	76.1%	59.4%	62.7%	70.8%	75.1%	72.7%
Q19b	I am confident that my organisation would address my concern	55.70%	54.8%	55.0%	57.6%	49.8%	59.9%	52.3%	57.8%	50.0%
Q23e	I feel safe to speak up about anything that concerns me in this organisation	60.30%	63.1%	62.3%	66.9%	61.1%	63.5%	61.2%	65.8%	58.8%
Q23f	If I spoke up about something that concerned me I am confident my organisation would address my concern	47.20%	48.9%	47.8%	50.8%	47.1%	54.6%	44.2%	53.6%	43.5%

Compared to 2022 scores, most corresponding scores have improved, although all scores for Facilities showed at least some downturn

NBTCARES

National Staff Survey Questions – related to Raising Concerns

The National Guardian Office (NGO) suggests other associated questions are particularly relevant around speaking up:

- **Ideas for Improvement:** anything that gets in the way of doing a good job – speaking up for improvement, feeling able to make suggestions as a result of psychological safety
- **Support from managers: The line manager has a strong influence on speaking up**
- **Worker wellbeing:** Reporting violence, harassment, bullying or abuse at work
- **Patient/worker safety:** Errors, near misses, and if reporting is encouraged and staff treated well, with action taken.

Results of these questions could potentially be considered in a further deeper dive by Directorate, Divisional or service leadership teams

I am able to make suggestions to improve the work of my team / department
I am able to make improvements happen in my area of work
My immediate manager works together with me to come to an understanding of problems
My immediate manager is interested in listening to me when I describe challenges I face
My immediate manager cares about my concerns
The last time you experienced physical violence at work, did you or a colleague report it.
The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it.
In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?
My organisation treats staff who are involved in an error, near miss or incident fairly
My organisation encourages us to report errors, near misses or incidents
When errors, near misses or incidents are reported, my organisation takes action to ensure they do not happen again
We are given feedback about changes made in response to reported errors, near misses and incidents

Report To:	Public Trust Board			
Date of Meeting:	30 May 2024			
Report Title:	Quality Committee Upward Report			
Report Author:	Richard Gwinnell, Deputy Trust Secretary			
Report Sponsor:	Sarah Purdy, Non-Executive Director and Chair of Quality Committee			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	That the Trust Board receives the report for assurance and notes the activities the Quality Committee has undertaken on behalf of the Board.			
Report History:	The report is a standing item to the Trust Board following each Quality Committee meeting.			
Next Steps:	The next report will be received at Trust Board in June 2024.			

Executive Summary		
The report provides a summary of the assurances received and items discussed and debated at the Quality Committee (QC) meeting held on 7 May 2024.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	✓
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	None specific.	
Financial implications:	No financial implications identified in the report.	
Does this paper require an EIA?	No as this is not a strategy or policy or change proposal	
Appendices:	Terms of reference of the Quality Committee with tracked changes. Quality Priorities report	

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1. Purpose

1.1 To provide a highlight of the key assurances received, items discussed, and items for the attention of the Trust Board arising from the Quality Committee (QC) meeting held on 7 May 2024.

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.

3. Meeting on 7 May 2024

3.1 Patient Safety Quarter 4 report

The Committee received this report, informing members of NBT's progress against the national safety priorities, the plans in place for their achievement, progress against the Trust's local safety priorities, and the patient safety service plan for 2024-25.

The Committee was informed that the Trust was on track to deliver the 2023-24 Patient Safety Strategy and to continue to embed the Patient Safety Incident Response Plan adopted in November 2023. NBT was working closely with partners including the Coroner's Service and was ahead of target in respect of sharing information with the Medical Examiner Service. A great deal of positive work was being done on patient safety and training in particular and the results of the staff survey relating to patient safety were encouraging. Work was also progressing well on local patient safety priorities, including inpatient falls, medicine management, responding well to clinically changing conditions and clinical flow (where a thematic review was in preparation). Almost all areas of the Patient Safety Plan for 2024-25 were rated green. The Trust was well ahead of target against national standards and working well against the local priorities.

The Committee welcomed and was assured by the progress reported.

3.2 Red Identification Bands: Visual Alert to Drug Alergy

The Committee received a report and presentation, outlining the options relating to red identification bands (RIBs), which could act as a visual alert that a patient had allergies to certain drugs. The Committee was advised that a great deal of research had been undertaken nationally and internationally and that some Trusts used RIBs (previously known as red wrist bands), whilst others did not, as their effectiveness was unproven. Given that NBT was in the process of implementing the electronic prescribing and medication administration (EPMA) system, the safeguards this would involve, the costs, hardware and disruption of introducing RIBs at the same time as EPMA and the risks associated with RIBs, the proposal was that RIBs should not be introduced at NBT at this stage, and that the options should be reconsidered when the EPMA system had been fully implemented.

The Chief Medical Officer and the Deputy Medical Director explained that EPMA was more likely to reduce medication errors (than RIBs) and that there was now a timeline in place to improve data exchange between NHS Digital and Careflow, so that patient

allergy information would be more readily accessible. There was a national shortage of RIBs, so they would be difficult and costly to source, and, by the time this had been done and additional staff training had been delivered, the EPMA system would be in place. Trying to do too many things at once was likely to backfire.

The Committee was uncomfortable making a decision not to use RIBs, given that the EPMA system was not yet fully in place, that the evidence of RIB effectiveness was mixed, and that UHBW was using RIBs. The Committee asked for a further detailed report to its June meeting, containing risk assessments, mitigations, pros, cons and timelines for each of the four options listed in the report.

3.3 Deteriorating Patient Update

The Committee received a report on the Deteriorating Patient Group and the work being undertaken to ensure a safer hospital for acutely unwell patients. The Committee was informed that NBT's aim was to be one of the safest Trusts in the UK and that work was progressing to that end, with a project manager in place, funding secured and clinical colleagues working well together. Key to improvement was having the right information in the right place at the right time and having all staff appropriately trained.

Recognition that a patient was deteriorating and having robust data available to help with that recognition were key ingredients and observations were now being done on time in more than 70% of cases (compared to 40% in August 2023). Effective response and escalation guidelines were also key and these were increasingly in place, with a close to pan-city approach to Sepsis. Plans were also in place to develop a 24/7 Rapid Response Service (building on the Hospital at Night Service) when other measures such as improved recognition, guidelines and training were sufficiently advanced.

The Committee questioned progress with developing the Rapid Response Service and were given details of progress with staff recruitment. The Committee was assured that many staff and former staff wanted more specialist and advanced nursing roles and that confidence around recruitment to the new service was high.

The Committee welcomed progress and looked forward to further updates.

3.4 Psychological Safety in Theatres

The Committee received details of the Theatres Civility Project, which was established in response to evidence (gathered during staff surveys and interviews) of uncivil behaviours displayed in some theatres. More recent staff feedback and a reduction in incidents reported had led to the re-classification of the risk as a workforce risk and the risk being downgraded, given positive news of improvement.

The Committee asked questions and were assured of the processes in place and the progress made on reducing incivility, including start-well-end-well conversations at the start and end of each shift and hot and cold debriefs after procedures were performed. There was now clear evidence of poor behaviour being tackled when it happened, and not therefore building into a problem, and of the number of incidents decreasing.

The Committee was assured by the reported progress and was content for the risk to be reduced and civility to be dealt with in divisions as part of "business as usual".

3.5 Women and Children's Health: Perinatal Quality Surveillance Matrix (PQSM) Quarter 4 report (including Perinatal Mortality Review Tool (PMRT) Q4 report and Avoiding Term Admissions into NICU (ATAIN) Q4 report)

The Committee received a report and presentation on the above, hearing about data against relevant maternity services measures and that PMRT had remained compliant with the Maternity Incentive Scheme (MIS) requirements throughout quarter 4. No new MNSI referrals had been accepted, no maternal deaths, and no admissions to ICU had occurred in quarter 4. The number of avoidable admissions to the neonatal unit had decreased significantly and staff and service user feedback had improved.

Maternity Service staff responded to questions from NEDs, commenting on improving workforce numbers, the importance of close monitoring of data, progress with reducing backlogs of data held off-site and aligning different methods of calculating workforce numbers. NBT had downgraded itself in respect of the telephone triage service, with ambitions to recruit more experienced and specialist staff in that area, and good progress was being made. Psychological support and scan follow-ups were also being progressed, with recent good news on additional funding for increased bereavement counselling.

NEDs welcomed the progress reported and the very few incidents of poor patient experience reported, given the numbers of mothers and babies involved. Further assurance was sought about the efficacy of the BadgerNet system, the documentation issues reported and the training given to staff. The Chief Nursing Officer reported that BadgerNet was the "best in class" system and that the pace of adoption and extent of training on the new system were normal, when measured against other systems. He nevertheless agreed to report back to the Committee on BadgerNet specifically.

The Committee heard that the new MIS Year 6 requirements included a PQSM report to every Board or Committee meeting, presented by a member of the Maternity Service senior leadership team. The Committee agreed that PQSM reports should continue to be submitted to the Committee every quarter, given that the data also went to every Board meeting as part of the Integrated Performance Report. The Committee noted and was assured by the reported position.

3.6 Quality and Safety: Changes to Quality Governance Structures

The Committee received a report and presentation on changes to quality governance structures, in which the terms of reference, names and memberships of some groups were proposed for change, to improve governance and address areas of weakness previously identified. The new structure was outlined in detail, along with the background to and rationale for the changes. The changes had been proposed following extensive self-assessment and alignment with the findings of the AuditOne well-led development review undertaken in 2023 and the KPMG audit in March 2024.

The Committee discussed the complexity of the governance structures and the need for work to align NBT and UHBW structures. Caution was expressed about losing the line of sight to patients and about too much bureaucracy leading to a loss of agility and responsiveness. The Committee was assured that the structure was about ensuring the right information was available to the right people at the right time, as close to the patient as possible, and that the changes would help achieve greater alignment with UHBW in due course.

The Committee approved the revised structure, approved the revised terms of reference for the Patient Safety Group (formerly named the Patient Safety Committee) and noted that the terms of reference for the Clinical Effectiveness and Outcomes Group (formerly named the Clinical Effectiveness and Audit Committee) would be reviewed at that Group's May meeting and subsequently presented to the Quality Committee for approval.

3.7 Draft Quality Account 2023/24

The Committee received a report and presentation on the Trust's Draft Quality Account for 2023/24. The Quality Account would be published for external consultation prior to its submission to the Board for approval in June. It was prepared in line with the statutory requirements to publish information about the quality of services provided by 30 June each year and reflected a real team effort and outstanding work being done across the Trust to improve service quality (i.e., patient safety, clinical effectiveness and patient experience).

The Committee welcomed the draft Quality Account, agreed with its contents and welcomed its clarity and presentation, noting the timescales for further feedback and approval. Members asked for more information to be inserted in the Quality Account about the relationship between quality assurance and Patient First; specifically about how Patient First could bring decision makers closer to patients and hence improve patient empowerment. The Director of Quality Governance undertook to do so.

3.8 CQUINS – Improving Quality 2023-24 Q3 and Q4

The Committee received an update on performance against the Commissioning for Quality and Innovation (CQUIN) framework schemes, with almost all schemes rated green. The Committee heard that CQUINS were no longer part of the national financial and contractual framework for 2024/25 and trusts could continue with existing CQUIN schemes if they wished, but they would no longer be externally monitored or funded. Two schemes would continue to be dealt with as CQUIN schemes (identification and response to frailty in emergency departments and achievement of revascularisation standards for lower limb Ischaemia) but all other schemes would be subsumed in the new Quality Priorities (QPs) and monitored and reported on in that context. Quarterly reports on the QPs would be submitted to the Quality Committee.

The Committee welcomed the report and was assured by the good progress reported.

3.9 **Other items:**

The Committee also received the following items for information:

- Sub-Committee upward reports from:
  - The Patient Safety Committee: the Quality Committee welcomed the progress reported, noting that all workstreams were rated green.
  - The Drugs and Therapeutics Committee: the Quality Committee noted the progress reported and discussed the lack of staff in antimicrobial stewardship and the increased reports relating to the safe and secure handling of medicines. Tim Whittlestone reiterated comments he had made to the Board recently, that some of the medication error reports arose because of additional pre-inspection testing. The Committee looked forward to further progress.

- The Control of Infection Committee: the Quality Committee discussed issues relating to the types of cannulas being used, which were the main source of infection, and work being undertaken with staff and the South Wales Ambulance Service Trust to reduce unnecessary pre-hospitalisation cannulation. They also discussed the national cleaning standards and efforts to increase cleaning in some patient areas, whilst reducing the cleaning of offices for example.

- The Quality Committee (and sub-committees') forward work-plans: further reports were requested on Red Identification Bands in June and from the Deteriorating Patient Group in July.

4. Identification of new risks & items for escalation

4.1 The Committee noted that the Quality Account would be submitted to the Board for approval at the appropriate time.

5. Summary and Recommendations

5.1 The Trust Board is recommended to receive the report for assurance and note the activities the Quality Committee has undertaken on behalf of the Board.

NHS North Bristol NHS Trust

Report To:	Public Trust Board			
Date of Meeting:	30 May 2024			
Report Title:	People & EDI Committee Upward Report			
Report Author:	Tomasz Pawlicki, Corporate Governance Officer			
Report Sponsor:	Kelvin Blake, Non-Executive Director, and Chair of People Committee			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	That the Trust Board receive the report for assurance and note the activities the People & EDI Committee has undertaken on behalf of the Board.			
Report History:	The report is a standing item to the Trust Board following each Committee meeting.			
Next Steps:	The next report will be received at the Trust Board in July 2024.			

Executive Summary		
The report provides a summary of the assurances received and items discussed and debated at the People, Equality, Diversity and Inclusion (EDI) Committee meeting held on 16 May 2024.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	✓
	Commitment to our Community - *In and for our community*	✓
Link to BAF or Trust Level Risks:	Reports received support the mitigation of various BAF risks.	
Financial implications:	No financial implications as a consequence of this report.	
Does this paper require an EIA?	No, as this is not a strategy or policy or change proposal	
Appendices:	Appendix 1 – Safe Staffing Nursing and Midwifery Appendix 2 - Draft Integrated Performance Report (IPR) format change for 2024/25	

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1. Purpose

1.1 To provide a highlight of the key assurances received, items discussed, and items for the attention of the Trust Board from the People & EDI Committee meeting held on 16 May 2024.

2. Background

2.1 The People & EDI Committee is a sub-Committee of the Trust Board. It meets bimonthly and reports to the Board after each meeting. The Committee was established to provide strategic direction and board assurance in relation to all workforce issues.

3. Meeting on 16 May 2024

Chief People Officer Update

The Committee received the Chief People Officer update which focused on the following key areas:

- The positive reduction in staff turnover within the organisation which at the end of March 2024 was at 12.3%, below our target of 16.5%. April data shows a further reduction and we have already exceeded our target for 2023/24 so will be adjusting this in collaboration with divisions/services.
- Ongoing collaborative work with University Hospitals Bristol and Weston (UHBW) on aligning Human Resources (HR) processes and policies as we move into the Group model. In particular, progress was noted around the Acute Provider Collaborative work to align our recruitment services and develop a collaborative bank.
- An update on industrial action and any potential future action.
- The ongoing work to address the backlog of job evaluation within the Trust, and support from an external third party as well as enhancing our own pool of internally trained evaluators.
- The analysis of the 2023 Staff Attitudes Survey results and the ongoing improvement work to reduce race discrimination. As a result of this the following objectives have been developed:
    - Increase Black, Asian and Minority Ethnic (BAME) staff in higher banded roles.
    - Develop and roll-out training on race awareness for all staff.
    - A focus on ensuring BAME staff have high-quality appraisals.
- The new online appraisal system which was launched in April 2024 and has received positive feedback from staff.
- The Ofsted inspection the Apprenticeship Centre in March 2024. This assessed the Centre against the Ofsted Further Education and Skills Education Handbooks for its Apprenticeship Provision for the Customer Service, Business Administration and Team Leader Apprenticeships with an overall Good rating.
- The reduction of agency expenditure, and ongoing work to continue to reduce this in line with regional and system wide interventions and reductions.

3.1 Safe Staffing Nursing and Midwifery

The Committee received the Safe Staffing Nursing and Midwifery report which set out the six-monthly review of safe nurse staffing at North Bristol NHS Trust (NBT) undertaken in November 2023, and discharges the duties expected of the Chief

Nursing Officer by the NHS England National Quality Board (NQB). The Committee noted that the Safer Nursing Care Tool (SNCT) aims to support the nursing and care workforce plans, as part of the workforce strategy that was approved by the Trust Board in 2023. The SNCT is a validated Tool, and endorsed by NHS England that categorises patients on the basis of their acuity and dependency using seven levels of nursing and care need. The SNCT was updated in November 2023 following extensive national research by the Shelford Group of hospital, which added additional levels of nursing and care need to reflect the increasing acuity and dependency of hospital patients. The review focused on adult inpatient areas at Southmead Hospital, examining workforce planning and nursing care. The review excludes the Emergency Department, urgent care assessment areas, Intensive Care Unit, theatres, Neonatal Intensive Care Unit, maternity services, Day Case Renal Dialysis Services, Outpatient Services and midwifery services.

The Chief Nursing Officer reflected on the overall encouraging position of the inpatient nursing workforce, most notably the reduction in turnover, reduction in vacancies, development of new roles, improved 2023 staff survey results, reduction in temporary workforce usage, and that NBT compares favourably alongside other providers in the South West with a mean of 9.1 Care Hours per Patient Day, peer average of 8.6 and national average of 8.4.

The Committee discussed the SNCT outputs and noted the changes to the tool for hospitals with >75% single rooms and the additional multiplier which has significantly increased the whole time equivalent requirements. The Committee noted this was the first use of the tool and there is a plan for a further assessment in June 2024.

The overall acuity and dependency of our patients has increased, the SNCT assessment identified an increase in the proportion of patients at levels 0 and 2 with a decrease in the proportion of patients at levels 1a and 1b. The changes in ward-based acuity and dependency could reflect the increasing complexity of care at level 2 (traditionally patients requiring level 2 care would be cared for in an intensive care unit environment). The increasing number of level 0 patients (requiring the least level of care) corresponding with the deteriorating no criteria to reside position, in that patients no longer require ‘acute’ hospital care and therefore their acuity and dependency needs are significantly lower.

The Committee noted the work undertaken by each of the clinical divisions to validate their SNCT outputs alongside professional judgement. Based on this professional judgement, an additional 22.28 WTE registered nurses would be requested to support ‘safer’ staffing, this would predominantly support additional registered nurses at night and give consideration for the safety profile of the wards requiring additional registered nurses. The Committee noted this request and endorsed the requirement, acknowledging that the Chief Nursing Officer was working closely with the Chief Finance Officer to establish a funding source.

The Committee noted the associated nursing workforce risks.

The Committee received assurance that that there is a clear validated process in place for monitoring and ensuring safe staffing in line with current national recommendations.

3.2 Operational Workforce

The Committee received an update on the ongoing work on the Long Term Retention Plan and action log against the Trust's one-year Retention Plan improvements.

The Committee was also updated on the Commitment to Our Community targets such as:

- Disparity Ratio - reduce the disparity ratio to our target of 1.25 by the end of March 2025.
- Employed staff from the 30 most challenged communities - set a target to achieve 38.5% of employed staff from 30 most socio-economically challenged communities.

The Committee welcomed the actions undertaken on Apprenticeship and Work Experience such as the number of roles being advertised externally as apprenticeships and the encouragement of apprenticeships as career progression opportunities to attract more applicants. The progress of the Commitment to our Community Plan was noted, and key milestones/achievements acknowledged by the Committee.

The Committee also received the Resourcing Performance Report which highlighted:

- The increased number of applications that the Trust received in March 2024
- The increase in vacancy rates across the Trust and Nursing and Midwifery and Additional Clinical services vacancies continue to fall.
- The successful increase in retention of Healthcare Support Workers and increase in candidates applying.
- The decrease in overall new starters numbers in March which is a seasonal norm.
- The decrease in overall recruitment time by three working days.

The Committee welcomed the update and received assurance on the positive outcomes regarding staff turnover and retention.

3.3 Apprenticeship Centre Bi-Annual Report

The Committee were joined by the Head of Apprenticeships & Early Years who presented the report which set out a high-level overview of the apprenticeship centre's activity over the past six months and reported on the achievement rate for the Academic year 2023-24, against the Education and Skills Funding Agency (ESFA) Accountability Framework.

The Committee discussed the opportunity for the apprenticeship team to visit schools to encourage young people to join apprenticeships and received reassurance that the apprenticeship team were actively involved in career days in many schools and colleges within the community. The team were praised by the Committee for their great work and for achieving the Good Ofsted rating.

3.4 Workforce Plan Update

The Committee received an update on the Long-Term Workforce plan. The Deputy Chief People Officer highlighted the refreshed plan has been aligned with Operational Plan and noted that the update would be presented to the Trust Board in May 2024 as a separate agenda item.

The Committee discussed the implementation of the Long-Term Workforce plan within the divisions and the ongoing work to develop collaborative workforce planning with University Hospitals Bristol and Weston (UHBW).

3.5 Allied Healthcare Professional (AHP) Development Plan

The Committee received an update on the AHP development plan that was launched in May 2023. The report outlined the progress achieved in the first year of implementing the "AHP development plan 2023-26" and summarised the achievements and impact, spotlighting significant discoveries, comparing performance with the preceding year, and outlining aspirations for delivery for the coming year.

The Committee received reassurance on the robust AHP infrastructure in the organisation and in collaborative arrangements with UHBW. Additionally, the Committee noted the ongoing work to improve the workforce modelling tools to ensure effective staffing levels and the aims to enhance the delivery of care and target improvements. The plan is available in the Diligent Reading Room for Trust Board members to view.

3.6 NHS Staff Attitude Survey (NSS) Results – Key Follow-up Actions

The Committee received the 2023 Staff Attitude Survey results which highlighted positive engagement from the staff and identified areas of improvement within the divisions such as:

- Race discrimination
- Burnout
- Improving the quality and outcomes of the appraisal process
- Sexual safety at work

The Committee received reassurance on the ongoing "We Do Not Accept" campaign and welcomed the future anti-racist training..

The Committee sought assurance on the sexual safety work within the organisation and it was agreed that additional information would be provided at a future meeting. Additionally, the Committee received reassurance that the EDI training sessions would be interactive and innovative to ensure a successful message and the embedment of the Trust values in Staff.

The Committee received assurance that overall, the Trust scored positively when compared against other Trusts in the South-West region. The Committee welcomed the results and thanked the People Team for all their hard work.

3.7 EDI Action Plan and Staff Network Update

The Committee received an update from the Associate Director of Culture, Leadership & Development on the EDI Action Plan and Staff Network Update which included the ongoing work with Freedom To Speak Up (FTSU) team and campaigns against bullying and harassment. Progress again the EDI plan was noted, and it was confirmed that many of the actions have now been completed or are in progress.

The Committee discussed the positive improvements within the staff groups and the ownership of the actions by Divisions and Services and how this is a significant step forward. The Chief People Officer noted his visits with different staff groups and the importance of aligning the different interventions that we currently have in place.

3.8 Draft Integrated Performance Report (IPR) format change for 2024/25

The Committee was asked to approve the revised IPR structure which is being aligned to the patient-first organisational priorities and with the work of the Divisional Performance Reviews (DPRs).

The Committee noted the proposed new changes to IPR structure for workforce metrics included:

- Focus on Patient First Metrics
  - Changes to People Priority Metrics:
    - Stability of Healthcare Support Workers with less than 12 Month Services
  - Commitment to Our Community Metrics
    - Disparity Ratio
    - Increase of Staff from 30 Most Challenged Communities
  - Actions derived from Long-Term Retention Plan and Commitment to our Community Plan delivery

- Focus on Temporary Staffing
  - Reaching the NHS England set a target for Agency expenditure
  - The NHS England productivity and temporary staffing reduction in 2024/25
  - Actions derived from the Temporary Staffing Oversight group and subgroups

- Focus on "Watch Metrics"

  Additional core indicators some of which we submit trajectories and actual performance to NHS England metrics.
  - Mandatory and Statutory training
  - Appraisal Completion in Window
  - Sickness Absence Rate (NHS England metrics – trajectory submitted as part of 2024/25 operational plan)
  - Vacancy Rate

The Committee discussed changes in depth and endorsed the changes subject to them being reviewed by the Trust Chair and Trust Secretary.

3.9 Health & Safety Committee Upward Report

The Committee received an update on the management of Health and Safety across the Trust sites and the issues identified and proposed next steps.

The Committee discussed Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) Incidents and received reassurance that mitigations are in place such as replacement of equipment and floor fixtures.

The Committee received confirmation that all non-conformances identified during the Central Sterile Services Department (CSSD) and British Standard Instructions (BSI) audit have either been closed or have an action plan in place. Additionally, the Committee acknowledged the internal audit conducted by the Fire Department, which took place from January 2023 to December 2023 and noted the actions identified in the action tracker.

4. Other items:

The Committee also received the following items for information:

- Trust-Level Risks (TLR) and Board Assurance Framework (BAF)
- Committee Self-Assessment Results
- Sub-Committee Upward Reports: People Oversight Group

5. Identification of new risks & items for escalation

5.1 No specific new risks were identified.

6. Summary and Recommendations

6.1 The Trust Board is asked to receive the report for assurance and note the activities the People & EDI Committee has undertaken on behalf of the Board.

NHS North Bristol NHS Trust

Report To:	People and Equality, Diversity, and Inclusion Committee			
Date of Meeting:	16 May 2024			
Report Title:	Bi-Annual Nursing, Midwifery and Allied Health Professionals Safe Staffing Report			
Report Author:	Dominique Duma, Deputy Chief Nurse (Workforce & Education) Mel Murrell, Associate Director, Nursing Workforce Recovery			
Report Sponsor:	Professor Steve Hams, Chief Nursing Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
	X	**X**		**X**
Recommendations:	The Committee is asked to. 1. Note the completion of the winter 2023 SNCT review of adult inpatient areas, thus complying with the National Quality Board requirements for safe staffing. 2. Note the impact on safer staffing due to the current funded position of 21% headroom for adult in-patient wards compared to the national minimum standard of 22%. There will be further work to review and agree our headroom position across all nursing and midwifery positions. 3. Note reviews of the emergency department, intensive care unit and neonatal intensive care unit are to be completed throughout 2024/25. 4. Note that the October 2023 SNCT has been updated to reflect changes to unavailability, acuity levels, 75%+ side rooms and additional patients, which has generated a substantial increased WTE requirement. 5. Note the detailed four stage process used to 'check and challenge' additional workforce requirements, including an external review by the Chief Nursing Officer for the Bristol, North Somerset, and South Gloucestershire ICB. 6. Note the safety impact of having to few RNs at night, most notably within the ASCR division. 7. Support the requirement for an additional 22.28 WTE RNs to support 'safer' staffing, focusing this additional WTE requirement in ensuring a 'safer' night nursing service. 8. Note the requirement to undertake a further SNCT assessment in June 2024. 9. Support the review of statutory and mandatory training requirements so as to potentially reduce unavailability.			

Report History:	Executive Team Meeting 24th April 2024
Next Steps:	Part of a bi-annual process for safer staffing Board Reporting.

Executive Summary

The purpose of this paper is to provide assurance to the Committee (which assures on behalf of the Board) that there is 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 nurse staffing at North Bristol NHS Trust (NBT) undertaken in November 2023 using the Safer Nursing Care Tool (SNCT) with recommendations to be supported by workforce business plans, as part of the workforce strategy approved by the Board in 2023.

Six-monthly reviews have taken place for a number of years, this is the third review undertaken by Professor Steve Hams, Chief Nursing Officer. The review has been conducted by Dominique Duma, Deputy Chief Nursing Officer with support from each of the five Divisional Directors of Nursing and their respective teams. Workforce data was provided by Ben Pope, Head of Strategic Workforce Planning.

The review includes adult inpatient areas at the Southmead Hospital site, the review excludes, the emergency department and urgent care assessment areas, the intensive care unit, theatres, the neonatal intensive care unit, maternity services, day case renal dialysis services and outpatient services. In October 2023, NHS England, via the Shelford Group published a revised SNCT. The revised Tool has been updated based on research and now provides specific multipliers for organisations with 75% or more of their bed base as single side rooms, additional acuity levels of 1c and 1d to reflect the increasing complexity of patient care and a mandated 22% 'headroom' (unavailability) factor which accounts for the additional requirements of annual leave, sickness, and training.

Our ability to provide outstanding patient experience depends on having a well-resourced, engaged, stable, agile, and motivated nursing and midwifery workforce. There are 3,948 WTE funded nurses, midwives, enhanced and advanced practitioners, and healthcare and midwifery support workers delivering patient care. This paper focuses specifically on nursing workforce delivering direct patient care on the in-patient wards.

The cost per Weighted Activity Unit metric is the primary productivity measure used within the Model Hospital. It shows how an organisation's costs compare to the amount of output (WAUs produced). A higher-than-average nursing staff cost per WAU suggest the organisation spends more on this staff group per unit of activity than a typical organisation. A lower-than-average nursing staff cost per WAU suggests the organisations spends less on this staff group per unit of activity than a typical organisation.

Data from the most recently reported data from August 2023 notes that NBT is in the lowest quartile compared with other NHS acute providers in the South West suggesting a more productive nursing service compared with others.

CHpPD is a measure of workforce deployment that can be used at ward level and service level or be aggregated to trust level. NBT compares favourably alongside other providers in the South West with a mean of 9.1 CHpPD, peer average of 8.6 and national average of 8.4.

The Safer Nursing Care Tool (SNCT) uses a baseline amount of care and nursing time in every 24-hour period, each patient is categorised based on their acuity and dependency, each of the categories has a WTE multiplier associated with it used to determine the overall number of hours of care and nursing time required to care for that patient in every 24-hour period. The categories are described as 'levels' of care ascending from to the lowest care requirement at level 0, through 1a, 1b, 1c, 1d, 2 and the highest level of care requirement level 3, each level has a descriptor, which can be found in Appendix 1.

Implementation of the new SNCT recognised the productivity impact of single side rooms, a minimum of 22% headroom (unavailability) and patients with enhanced care needs. The November 2023 census also demonstrated changes in the number of patients, the acuity and dependency of the patients in the census and this has resulted in a significant variance between our current funded establishment and the required establishment the tool calculated. To support our understanding of the impact of these drivers and respond to them, a top-down analysis was carried out using Trust level patient numbers and patient mix. The drivers have been grouped under four headings:

1) Additional patients
2) Acuity and dependency changes
3) Multiplier updates
4) Headroom

WTE summary impact of the above drivers:

Driver	Required WTE
Additional Patients	33.2
Acuity and Dependency Changes	51.3
Multiplier Updates	254.3
Headroom to 22%	13.7
Total (excluding additional patients)	**319.3**

Overall, by comparison to February 2023, the November 2023 SNCT assessment identified an increase in the proportion of patients at levels 0 and 2 with a decrease in the proportion of patients at levels 1a and 1b. Comparisons with previous assessments cannot be made for levels 1c and 1d as they are new levels introduced. The changes in ward-based acuity and dependency could reflect the increasing complexity of care at level 2 (traditionally patients requiring level 2 care would be cared for in an intensive care unit environment). The increasing number of level 0 patients (requiring the least level of care) corresponding with the deteriorating no criteria to reside position, in that patients no longer require 'acute' hospital care and therefore their acuity and dependency needs are significantly lower.

The Divisional Directors of Nursing and Divisional Director of Midwifery and Nursing have reviewed their respective requirements for safe staffing, triangulating this with professional judgement, patient experience, staff experience and patient outcomes of care.

Overall, the nursing and midwifery workforce is more stable compared to 12 months ago, this is reflected in lower vacancies, lower turnover, improved staff satisfaction, improved fill of temporary shifts and an increasingly productive workforce. However, unavailability continues to be 6% higher than funded establishment, which drives lower productivity and less time available to deliver direct care. Unavailability is driven by a number of factors, not least the increasing statutory and mandatory training requirements added in the last 24 months. The number of times an RN or HCSW is moved during their shift has reduced by over 80% in the past 12 months, a further sign that the workforce is more stable.

The average CHpPD is 9.1, which in the top quartile when compared with other hospital organisations across the South West. NBT is in the lowest quartile of nursing staff cost per Weighted Activity Unit (WAU compared with other NHS acute providers in the South West suggesting a more productive nursing service compared with others. Unavailability is currently funded at 21%, however overall unavailability is 6% higher and reflects the increasing number of statutory and mandatory training topics required.

Our rapid on boarding of IENs during 2023/24 has enabled us to rapidly close the RN vacancy gap, however the length of time for IENs to successfully complete their Objective Structured Clinical Examination to obtain Nursing and Midwifery Council registration has been longer than expected which has driven a higher-than-expected temporary workforce demand, this will settle during 2024/25 as the remaining IENs become RNs.

Apprenticeship will become a dominate approach to supporting the delivery of a highly skilled nursing and midwifery workforce as we proceed through the next five years, traditional domestic opportunities for education are becoming increasingly expensive and the apprenticeship route to RN is an important sustainable approach to developing our future workforce. Further, as we progress over the coming months, we will publish our strategy on enhanced and advanced practice and develop opportunities in all specialities for RNs and RMs to progress their clinical careers.

The banding changes to band 3 HCSW during 2023/24 had made a considerable difference to turnover, this intervention alone has seen an 8% reduction in turnover and has been responsible for an improvement in staff survey results and NBT being an employer of choice.

The revised SNCT has presented a number of challenges, not least the significant increase in the number of WTE equivalents required, this assessment will be completed on two further occasions (summer 2024 and winter 2024/25) to test the methodology and develop expertise in the new levels and descriptors. That said, there continues to be a small underlying deficit, and it is possible this deficit goes back over a decade when the Brunel Building was opened, at this time ward establishments were simply shifted without correction for a greater number of single side rooms.

Overall skill mix, the number of RNs to HCSWs is lower than the recommendations from the Royal College of Nursing, whilst a lower RN: HCSW may be appropriate for the less acute specialities, such as reablement, however a higher RN: HCSW ratio is needed in the higher acuity clinical areas, this will be corrected over the next 18 months.

A four-step review process has been initiated, initially starting with divisional reviews of the data, and subsequent increasing scrutiny, including an external review by the Chief Nursing Officer for

the Bristol, North Somerset, and South Gloucestershire Integrated Care Board. The second review completed by the Divisional Directors of Nursing and the Deputy Chief Nursing Officer identified an additional requirement of 78.72 WTE, 31.92 WTE RN and 46.80 WTE HCSW. Given the financial context we are operating during 2024/25, the Chief Nursing Officer undertook a further review (3rd Review) at which it was agreed that 22.28 WTE RNs would be requested to support 'safer' staffing, this would predominantly support additional RNs at night and give consideration for the safety profile of the wards requiring additional RNs.

The insufficient numbers of RNs are having an impact on the safety of care largely within ASCR, for example completion of 'observations on time' are 15% lower in ASCR wards, with the average delay of 80 minutes compared to an organisational average of 40 minutes. Completion of the four nursing assessments to reduce harm i.e., falls, pressure injuries, infection control and nutrition (MUST) within 6 hours of admission is 20% lower in ASCR wards when compared to the rest of the organisation, further the ASCR wards account for 40% of complaints for ASCR. The number of falls within ASCR wards with only 4 RNs available at night account for 86% of the falls within the division and account for 55% of medication errors within the division.

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	X
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	X
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	• **Risk 1179 (Workforce):** The lack of robust and fully established neonatal nursing workforce risks in a failure to deliver key objectives with respect to a safe service provision (Score 20). • **Risk 1459 (Workforce):** Due to reduction of experience within nursing workforce associated with rapid recruitment of IEN's, there is a risk to the quality of patient care and to the wellbeing, recruitment, and retention of staff (Score 15). • **(Risk 1283) Workforce:** There is a risk of increased staff burnout/sickness/turnover resulting in increased vacancy and use of (premium rate) temporary staffing if the division does not have a full establishment of Nursing staff in line with that indicated by SNCT data collection (score 15). • **(Risk 1284) Patient Safety**: There is a risk that patients could come to harm, as a result of sub-optimal care, if the funded establishment does not represent Safer Nursing Care Tool indicated numbers on the ASCR in-patient wards (score 15). • **Risk 1881:** There is a risk that caring for and treating patients in areas outside of the planned Medical Division bed base will present multifactorial risks for both patients and the trust (score 10). • **Risk 1565 / 1469:** Risk to workforce has moved from vacancy to skills gap AMU / SDEC and wider Division (score 9). • **Risk 1455** - Workforce risk due to continued operational pressures (score 9).	

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Please refer to the 'Equality Impact Assessment Form' at the following link: https://link.nbt.nhs.uk/Interact/Pages/Content/Document.aspx?id=9760</td></tr>
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11.1

NHS North Bristol NHS Trust

Safe nurse staffing – six monthly review
May 2024

People and Equality, Diversity, and Inclusion Committee

1. Introduction

The purpose of this paper is to provide assurance to the Committee (which assures on behalf of the Board) that there is 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 nurse staffing at North Bristol NHS Trust (NBT) undertaken in November 2023 using the Safer Nursing Care Tool (SNCT) (Appendix 1) with recommendations to be supported by workforce business plans, as part of the workforce strategy approved by the Board in 2023.

Six-monthly reviews have taken place for a number of years, this is the third review undertaken by Professor Steve Hams, Chief Nursing Officer. The review has been conducted by Dominique Duma, Deputy Chief Nursing Officer with support from each of the five Divisional Directors of Nursing and their respective teams. Workforce data was provided by Ben Pope, Head of Strategic Workforce Planning.

The review includes adult inpatient areas at the Southmead Hospital site, the review excludes, the emergency department and urgent care assessment areas, the intensive care unit, theatres, the neonatal intensive care unit, maternity services, day case renal dialysis services and outpatient services.

In October 2023, NHS England, via the Shelford Group published a revised SNCT. The revised Tool has been updated based on research and now provides specific multipliers for organisations with 75% or more of their bed base as single side rooms, additional acuity levels of 1c and 1d to reflect the increasing complexity of patient care and a mandated 22% 'headroom' (unavailability) factor which accounts for the additional requirements of annual leave, sickness, and training.

This report will provide a summary of the patient acuity and dependency data collected in November 2023 across the adult inpatient areas. Divisional Directors of Nursing and Head of Midwifery have reviewed the results and triangulated the findings with professional judgement in reaching conclusions and making recommendations.

The Divisional Director of Midwifery and Nursing has conducted a systematic, evidence-based process to calculate midwifery establishment using Birthrate Plus® tool which is endorsed by the Royal College of Midwives. Staffing levels, such as one-to-one midwifery care in labour and supernumerary status of the midwifery coordinator in charge of labour ward are reviewed monthly through the Perinatal Quality Surveillance Matrix (PQSM). A further assessment using Birthrate Plus® tool will be completed towards the end of 2024.

2. Background

The statutory reporting requirements as outlined in the 'Right Skills Right Place Right Time', published by the National Quality Board (2016), and 'Developing Workforce Safeguards' published by NHS England and Improvement (2018) sought to provide the framework of expectations for NHS provider organisations in ensuring they provided safe nurse staffing.

The Developing Workforce Standards document was developed to support organisations to utilise effective staff deployment by adopting a "triangulated approach" using evidenced based tools, professional judgement, and patient outcomes to manage common workforce issues and comply with the Care Quality Commission (CQC) well-led framework (2018). 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 is applied to increase confidence in recommended staffing levels and provide assurance.

In addition to national safe staffing standards, at NBT the process for managing safe nurse staffing daily is set out in a Safe Staffing Standard Operating Procedure. This is 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 National Quality Board require and ensures robust decision making for all staff around the safe care of our patients.

Twice daily safe staffing meetings occur between Divisions, overseen by a Divisional Director of Nursing or Deputy, 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 use of temporary staffing is also reviewed at these meetings.

The multi-professional workforce group, now reformed as the Nursing and Midwifery Workforce Group, historically met bi-monthly but the frequency of this meeting has been increased to monthly from January 2024. This meeting is chaired by the Deputy Chief Nursing Officer and is focused specifically on nursing and midwifery, with allied healthcare professionals forming a mirror group.

The Trust Board receives monthly assurance from the Integrated Performance Report on the UNIFY data return related to 'care hours per patient day' (CHpPD). Workforce risks are presented at the Nursing and Midwifery Workforce Group, Risk Management Group and People Oversight Group.

The Board received a deep dive presentation on safe nurse staff levels at its Board meeting in April 2023 provided by the Chief Nursing Officer, this covered the policy context, the evidence for safe staffing, how staffing levels are assessed in different nursing specialties, a review of the previous SNCT assessment and how safe staffing is managed on a day-to-day basis. The People and Equality, Diversity, and Inclusion Committee received a safe nurse staffing review at its meeting in May 2023 following an SNCT assessment in February 2023, this noted a gap of 65.9 Whole Time Equivalents (WTEs) Registered Nurses (RNs) and 70.4 WTE Healthcare Support Workers (HCSWs) between 'funded' establishment and acuity and dependency requirements of patients reviewed in the assessment, the most significant gap was in the Anaesthesia, Surgery, Critical Care and Renal (ASCR) division, with a deficit of 39.6 WTE RNs

and 34.1 WTE HCSWs. Due to the financial position additional recurrent establishment increases were not approved.

3. The nursing workforce at NBT

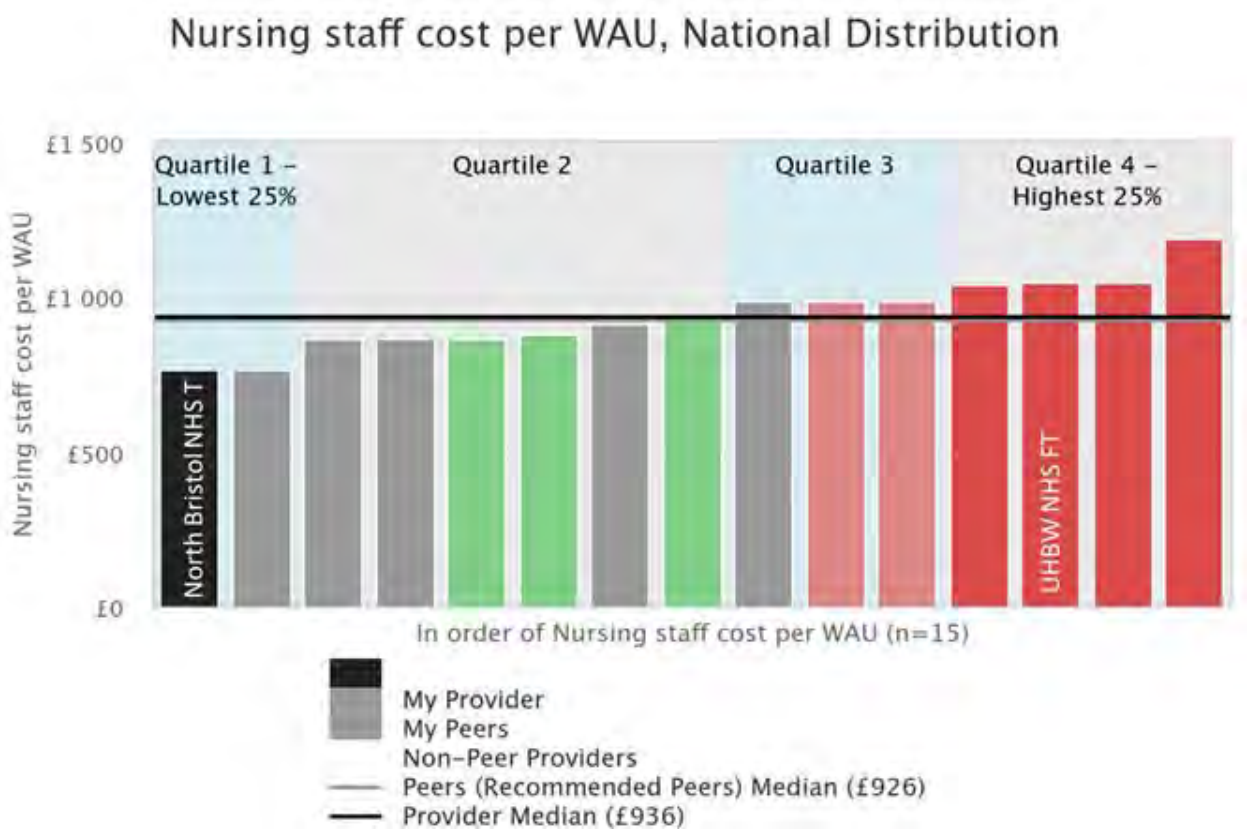
Our ability to provide outstanding patient experience depends on having a well-resourced, engaged, stable, agile, and motivated nursing and midwifery workforce. There are 3,948 WTE funded nurses, midwives, enhanced and advanced practitioners, and healthcare and midwifery support workers delivering patient care. This paper focuses specifically on nursing workforce delivering direct patient care on the in-patient wards.

Nursing staff cost per Weighted Activity Unit (WAU)

The cost per WAU metric is the primary productivity measure used within the Model Hospital. It shows how an organisation's costs compare to the amount of output (WAUs produced). It is possible to break the cost per WAU down into the various cost components (e.g., pay vs non-pay, or medicines cost per WAU) to provide a more detailed indication of where an organisation appears to be more, or less productive than its peers. This information can help organisations identify those areas of expenditure where they differ most from their peers and help determine which interventions or activities are most likely to lead to improvements in productivity.

A higher-than-average nursing staff cost per WAU suggest the organisation spends more on this staff group per unit of activity than a typical organisation. A lower-than-average nursing staff cost per WAU suggests the organisations spends less on this staff group per unit of activity than a typical organisation.

Data from the most recently reported data from August 2023 notes that NBT is in the lowest quartile compared with other NHS acute providers in the South West suggesting a more productive nursing service compared with others.



Recruitment

We have made significant progress over the last year with recruitment and closing our vacancy position for both registered and un-registered roles. Overall, the Trust has seen a 79.22% reduction in Band 5 vacancies (including RNAs and Internationally Educated Nurses at Band 4) and 89.95% reduction in Band 2/3 vacancies (Healthcare Support Worker and Trainee Nursing Associates) between November 2022 and January 2024.

NICU, Ward 34B and 34A saw improvements in band 5 vacancy position from December to January (-8.94, -3.92 and -2.92 WTE respectively). While Ward 26B (+2.39wte) and 27B (+1.92wte) saw slight deterioration in their vacancy position. NICU, Mendip birthing suite, plastics/ breast demonstrated the largest improvements in their band 2/3 vacancy positions (-3.6, -3.6, and -1.8 WTE respectively). While emergency/ vascular theatre, transitional Care, 26B & outpatients nursing saw the largest deteriorations (+5.4, +4.5 +3.6 and +3.5 WTE).

The vacancy position has been supported by a focused recruitment programme for both domestic and internationally educated nurses. NBT remains a popular employer of choice with an average of 70 domestic applications being received from May to December 2023. Average applications from October to December rose to 100 per month. Between May 2023 and December 2023 Divisions made 323.77 offers to RNs and RMs. During the same period, we welcomed 180.05 WTE new starters breaking down into 142.87 RNs and 37.18 RMs. The Trust ran continuous centralised recruitment for Band 2 and 3 HCSWs from May 23 to Dec-23, with 218.18 offers made during this time.

Internationally educated nurses make a vital contribution to our workforce at NBT. As of January 2024, we have welcomed 542 IENs, allocated to all clinical divisions. In 2023, we recruited the highest number of IENs and 246 were welcomed to NBT. We have supported a first cohort of internationally educated midwives, so far 3 midwives have arrived and 2 have successfully gained their NMC midwifery registration. There are plans for 2024/25 to reduce the IEN recruitment, in line with our system partners and national direction. We have a strong focus on the commitment to our community and will be implementing our HCSW apprenticeship programme working closely with local colleges.

Attendance

There has been a continual and sustained improvement to the sickness rate over the last 12 months from 7% to 5.5%. Absence reports are generated for reporting by the Divisions at the monthly nursing and midwifery workforce group. The departments/wards with the highest sickness levels in November 2023 are renal, theatres, vascular wards, Medirooms, and the surgical ward Gate 33a.

Retention/Turnover

The most noticeable improvement to turnover is the un-registered nursing and midwifery position. Registered nursing and midwifery 12-month turnover has improved from 17.5% January 2023 to 13.1% January 2024. A priority focus for retention is, 'supporting our new starters' and specifically HCSWs where turnover has historically been high. There are four key actions we are taking to address HCSW retention which have all been implemented. Additionally, in January 2023, band 2 HCSWs were given the opportunity to up-band to band 3 and this has contributed to the reduction in turnover. There has been a reduction in turnover from 25.1% (November 2022) to 16.98% (January 2024) for HCSWs.

Training Posts

There are a number of key training posts which are supporting the Trust's commitment to improving retention.

- **Trainee Nursing Associates (TNA) & Registered Nurse Degree Apprenticeship (RNDA)**
  There are currently 90 TNAs on programme and 116 NAs have been qualified since 2019. NBT has 10 Registered Nursing Degree Apprentices (RNDAs) who have just completed their training programme. There is a commitment to support a further 40 candidates in 2024 for the RNDA programme with procurement processes in process, and 40 TNA places for 2024.

- **Advanced and enhanced practice**
  A Trust lead for advanced and enhanced practice was appointed in August 2023 to progress the advanced and enhanced agenda. Advanced practice at NBT is supporting the care delivered to our communities through the provision of expert clinical care, informed inquiry, educational development, and effective leadership. We have 24 advanced clinical practitioners (ACPs), eight of whom have full accreditation, we have 16 advanced nurse practitioners (ANPs) and five ACPs in training, during 2024 an additional seven trainee advanced practitioners will commence their apprenticeship training. Our approach to advanced practice is aligned with current local, regional, and national policy and guidance in conjunction with NBTs Patient First Strategy 2023 and the Centre for Advancing Practice

multi-professional framework for advancing practice in England (2017), to achieve robust, governed, and sustainable advanced practice workforce delivery and expansion. The last six months has seen significant progress in developing the advanced and enhanced practice agenda at NBT.

- **Student Placement Experience**
  From March – August 2023 NBT had 288 student nurses on placement. The evaluation feedback demonstrated an overall satisfaction rate of 87% (response rate 61%).

- **Staff Survey 2023**
  Overall, the staff survey results are positive for nursing with some focused work needed for midwives. The response rate for registered nurses and midwives was 58.1% and ranked 5th out of 7th in the occupational group "people promise" comparison.

  The highest scoring themes were "we have a voice that counts" and "staff engagement"; with additional focus required on "we are safe and healthy". Particularly around burnout, adequate staffing, finding work emotionally exhausting and feeling tired. We are proud to find many scores above the NBT average, especially, being enthusiastic about going to work, opportunities to contribute and show initiative, making a difference to patients and service users, shared team objectives and sense of value within the team.

  There were also positive indicators relating to a safety culture, raising, and addressing concerns. The scores for midwifery and trainee/nursing associates were generally lower, with stronger scores from health care support workers, nurse managers and specialist nurse practitioners.

4. Our nursing workforce: meeting the needs of adult in-patients

Care Hours per Patient Day (CHpPD)

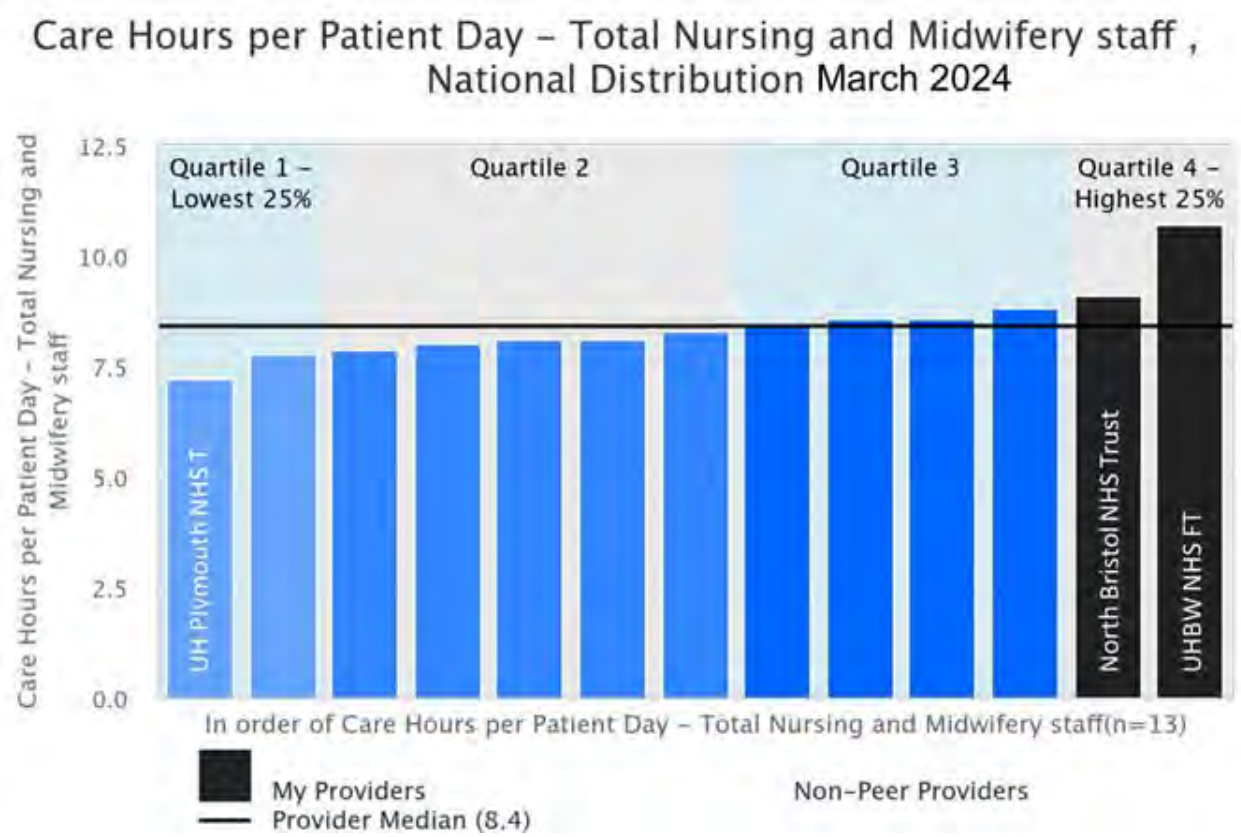
CHpPD is a measure of workforce deployment that can be used at ward level and service level or be aggregated to trust level.

It provides a view of all professions that deliver care in a ward-based setting and differentiates registered clinical staff from non-registered clinical staff. This ensures skill-mix is well-described and the nurse-to-patient ratio is considered when deploying the clinical professionals to provide the planned care, reflected alongside an aggregated overall actual CHpPD.

CHpPD is formally the principal measure of workforce deployment in ward-based settings and increasingly forms an integral part of a ward/unit/trust review and oversight of quality and performance indicators to inform quality of care, patient outcomes, people productivity and financial sustainability.

Monthly CHpPD data is routinely collected, recorded, and reported through the Model Health System, available down to ward level for inpatient areas in each acute trust. The Model Health System retrospectively shows CHpPD data obtained from the NHS Strategic Data Collection Service and safe-staffing monthly returns.

NBT compares favourably alongside other providers in the South West with a mean of 9.1 CHpPD, peer average of 8.6 and national average of 8.4.



Nurse to patient ratio

The Royal College of Nursing (RCN) 'Mandatory Nurse Staffing Levels' (2012) and NICE 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014) suggest acute wards must have a planned Registered Nurse (RN) to patient ratio of no more than 1:8 during the day. NBT safe staffing Standard Operating Procedure (approved in April 2023) and Red, Amber, Green (RAG) rates for safe staffing are set to the above national levels.

Skill mix

The skill mix was evaluated as part of the safer staffing review process. There are three key drivers which are influencing the current skill mix position:

- **RN:HCSW ratio**

The overall average skill mix % of the in-patient wards at NBT is 53% registered nurse vs 47% HCSW. There is some variation in skill mix depending on the speciality, we should ideally be aiming for a 65/35% split for each ward with higher acuity.

- **% of non-domestically trained RNs**

The large proportion of newly appointed IENs has impacted on the skill mix. To mitigate, the Divisions have increased the practice educators to support more ward- based training, but this is at a cost pressure. IENs account for approximately one third of the nursing workforce with some wards having 50-73% IENs.

- **Current position stability (LoS >12 months)**

All in-patient clinical Divisions have seen a decrease in the staff numbers with a length of service of >12months which also impacts on the skill mix.

Temporary Staffing

The demand for registered nurse and midwifery saw expected seasonal peaks during July 2023, October, and November 2023. Bank fill rates have steadily increased across the year from 47% to its highest position of 60%. Agency usage has seen fill from Tier 1 increase and reduce across Tiers 3 and Tier 4 remaining static at < 1% of total shifts filled in December 2023 (compared to May 23) with use limited to specialist areas including Critical Care, ED, Stroke, NICU and registered mental health nurse shifts. Unfilled shifts have reduced from 22% to 17% (May 2023 compared to December 2023) NBT eXtra will be launching a recruitment campaign specifically to increase the Bank resource for Registered Mental Health Nurses and Engagement Support Workers and reduce the reliance of agency further.

Unregistered shift demand has reduced by 18% when comparing May 2023 to December 2023. Bank fill rate has increased by 10% during the same period based on hours requested and filled.

NBT eXtra have embarked on a programme of transformation both in the service delivered and with a focus on the experience of workers. This programme will support retention together with sustaining and then increasing Bank fill rates further as the programme develops. This programme of work is aligned to the agency reduction programme and system led, Acute Provider Collaborative programme.

There is a newly formed nursing and midwifery temporary staffing task group which is responsible for the monthly review of temporary staffing expenditure and implementing temporary staffing reduction controls. This is seeing positive results in medicine and NMSK.

5. SNCT

The SNCT is a National Institute for Health and Care Excellence (NICE) endorsed evidence-based tool which supports organisations in determining optimal staffing levels through a measurement of patient acuity and dependency to inform decision-making on staffing and workforce. The Tool was designed and developed by the Shelford Group and is provided under licence from Imperial College London. The Trust undertakes a bi-annual SNCT census staffing review. The general adult ward nursing staffing levels and skill mixes are reviewed annually for budget setting.

The Safer Nursing Care Tool (SNCT) uses a baseline amount of care and nursing time in every 24-hour period, each patient is categorised based on their acuity and dependency, each of the categories has a WTE multiplier associated with it used to determine the overall number of hours of care and nursing time required to care for that patient in every 24-hour period. The categories

are described as 'levels' of care ascending from to the lowest care requirement at level 0, through 1a, 1b, 1c, 1d, 2 and the highest level of care requirement level 3, each level has a descriptor, which can be found in Appendix 1.

In late 2023 the Shelford Group released a revised version of the Tool, and endorsed by NHS England, it was updated to reflect the increasing acuity and dependency requirements of patients, they also released a version of the Tool specifically designed for organisations that have 75% or more side rooms (as is the case for the Southmead Hospital). In addition to updating the Tool, two additional levels of care have been introduced, these are levels 1c and 1d, these levels reflect patients with a higher acuity and dependency requiring more than one care professional at any given time.

The chart below provides a summary of the multipliers for each level, demonstrating the difference between the previous Tool (old multiplier) and the new version (new multiplier).

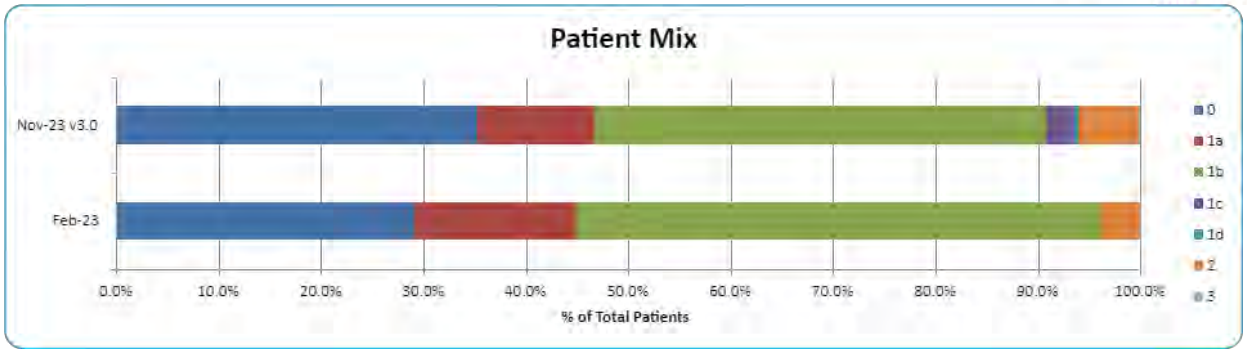
Adult Inpatient			
Level	Old Multiplier	New Multplier	Increase
Level 0	0.99	1.27	28.7%
Level 1a	1.38	1.75	26.5%
Level 1b	1.72	2.34	36.3%
Level 1c	N/A	4.20	N/A
Level 1d	N/A	8.38	N/A
Level 2	1.97	3.95	100.9%
Level 3	5.96	6.04	1.2%
Total	**12.02**	**15.35**	**27.7%**

Assessment Unit			
Level	Old Multiplier	New Multplier	Increase
Level 0	1.27	1.27	0.3%
Level 1a	1.66	1.75	5.5%
Level 1b	2.08	2.34	12.7%
Level 1c	N/A	4.20	N/A
Level 1d	N/A	8.38	N/A
Level 2	2.26	3.95	74.9%
Level 3	5.96	6.04	1.2%
Total	**13.22**	**15.35**	**16.1%**

SNCT - November 2023

During November 2023 all adult in-patient wards were open. There was variable use of extra patients on some wards, including double occupancy, boarding patients, and extra patients in the four bedded bays, during this time each ward consistently had five extra patients, making each ward 37 bedded rather than 32. As previously noted, the SNCT has been updated to reflect organisations with 75% or more side rooms, additional levels of 1c and 1d have been added and has a mandated inbuilt 'time out' factor of 22% (current funded time-out (headroom) at NBT is 21%).

Overall, by comparison to February 2023, the November 2023 SNCT assessment identified an increase in the proportion of patients at levels 0 and 2 with a decrease in the proportion of patients at levels 1a and 1b. Comparisons with previous assessments cannot be made for levels 1c and 1d as they are new levels introduced. The changes in ward-based acuity and dependency could reflect the increasing complexity of care at level 2 (traditionally patients requiring level 2 care would be cared for in an intensive care unit environment). The increasing number of level 0 patients (requiring the least level of care) corresponding with the deteriorating no criteria to reside position, in that patients no longer require 'acute' hospital care and therefore their acuity and dependency needs are significantly lower.



Based on the patient mix of patients (as outlined above) the required number of WTEs are detailed in the table below.

		Based on SNCT Data			Funded		
Division		Required Registered	Required Unregistered	Required Total.	Registered Establishment	Unregistered Establishment	Establishment Total
339 Anaesthesia, Surgery, Critical & Renal Division		266.7	178.2	444.9	169.6	120.9	290.5
339 Neurosciences & Musculoskeletal Division		185.5	181.7	367.2	150.8	146.9	299.1
339 Women and Childrens Division		7.8	6.3	14.1	14.9	12	26.9
339 Medicine Division		422.3	420.4	842.6	368.8	359.8	728.7
Grand Total	**704.2**	**882.3**	**786.6**	**1668.9**	**704.1**	**639.6**	**1345.2**

*Note Elgar, renal demonstrated a significant increase in Level 2 patients due to the increased number of transplants – this will require further validation by the tool again - the DDON has undertaken a "work-back" establishment review; stroke was excluded from the census due to non-compliance with the correct tool)

Variation Analysis – Trust wide

Implementation of the new SNCT recognised the productivity impact of single side rooms, a minimum of 22% headroom (unavailability) and patients with enhanced care needs. The November 2023 census also demonstrated changes in the number of patients, the acuity and dependency of the patients in the census and this has resulted in a significant variance between our current funded establishment and the required establishment the tool calculated. To support our understanding of the impact of these drivers and respond to them, a top-down analysis was carried out using Trust level patient numbers and patient mix. The drivers have been grouped under four headings:

5) Additional patients
6) Acuity and dependency changes
7) Multiplier updates
8) Headroom

WTE summary impact of the above drivers:

Driver	Required WTE
Additional Patients	33.2
Acuity and Dependency Changes	51.3
Multiplier Updates	254.3
Headroom to 22%	13.7
Total (excluding additional patients)	**319.3**

Additional Patients (33.2 WTE)

In November 2023 the average patients per day in the census were 833, compared to 817 in February 2023, a net increase of 16 patients, the additional patients were predominantly driven by Ward 10a (there were also small movements in a number of wards when comparing the two census periods). In February 2023 10a had on average 11 patients per day reflecting its status as partially open at that time and in November 2023 this had risen to 31.3 patient per day. The table below shows the additional patients with the Trust level patient mix in November 2023 and new multipliers applied to obtain an indicative impact.

Patient Number 16.1	Additional Patients						
Month	0	1a	1b	1c	1d	2	
November 2023 Patient Mix	35.2%	11.5%	44.1%	2.7%	0.4%	5.9%	
November 2023 Patient Numbers	5.7	1.9	7.1	0.4	0.1	1.0	
New Multipliers	1.27	1.75	2.34	4.20	8.38	3.95	Total Required
Required WTE - New Multipliers	7.2	3.2	16.6	1.8	0.5	3.8	**33.2**

Acuity and Dependency Changes (51.3 WTE)

In the November 2023 census the Trust saw three main shifts in acuity and dependency across inpatient wards:

1. Level 1b --> Level 0/1a - reduction in required hours
2. Level 1b --> Level 2 - increase in required hours
3. Level 1b --> Level 1c/1d - increase in required hours

The table below shows the net impact of changes to acuity and dependency by using November 2023 (minus additional patients), new multipliers applied to February 2023 patient mix and November 2023 patient mix. The outcome is a comparison of only the changes, 7.1% fewer 1b patients, 1.9% more level 0 and 1a, 2% more level 2 and 2.7 % 1c and 0.4% 1d patients. Overall, this change in patient mix represents a greater proportion of patients with higher acuity and more dependency.

Patient Number -817.1	Acuity and Dependency					
Month	0	1a	1b	1c	1d	2
February 2023 Patient Mix	29.1%	15.8%	51.3%	0.0%	0.0%	3.9%
February 2023 Patient Numbers	237.6	128.8	419.1	0.0	0.0	31.9
November 2023 Patient Mix	35.2%	11.5%	44.1%	2.7%	0.4%	5.9%
November 2023 Patient Numbers	288.0	94.1	360.0	22.3	3.2	48.5
New Multipliers Used	1.27	1.75	2.34	4.20	8.38	3.95

	0	1a	1b	1c	1d	2	Total Required	
Required WTE Feb-23 Patient Mix	302.2	225.0	981.7	0.0	0.0	125.8	1634.7	Variance
Required WTE Nov-23 Patient Mix	366.4	164.4	843.2	93.7	26.7	191.6	1686.0	**51.3**

New Multipliers (254.3 WTE)

The table below shows the impact of the new multipliers by using the Nov-23 patient mix, applying both the old and the new multipliers and calculating the variance. For level 1c and 1d multipliers which did not exist in the old tool level 1b multipliers have been used.

Patient Number 817.1	New Multipliers					
Month	0	1a	1b	1c	1d	2
November 2023 Patient Mix	35.2%	11.5%	44.1%	2.7%	0.4%	5.9%
November 2023 Patient Numbers	288.0	94.1	360.0	22.3	3.2	48.5
Old Multipliers	1.27	1.66	2.08	2.08	2.08	2.26
New Multipliers	1.27	1.75	2.34	4.20	8.38	3.95

	0	1a	1b	1c	1d	2	Total Required	
Required WTE - Old Multipliers	365.5	155.8	747.9	46.4	6.6	109.6	**1431.7**	Variance
Required WTE - New Multipliers	366.4	164.4	843.2	93.7	26.7	191.6	**1686.0**	**254.3**

Headroom (Unavailability) (13.7 WTE)

The SNCT tool has 22% headroom built in, 1% higher than NBT funds for adult inpatient wards. National standard recommends a minimum of 22%. The table below shows the overall SNCT required WTE based on the November 2023 census (stroke wards and the additional patients removed to avoid duplicating impact).

The table below shows the impact of isolating 1% headroom. To do this the values in the above table were divided by 122% and multiplied by 1%.

SNCT Required for November 2023 (stroke wards removed as did not comply with new tool):

Division	1% Headroom Registered	1% Headroom Unregistered	1% Headroom Total
339 Anaesthesia, Surgery, Critical & Renal Division	2.2	1.5	3.6
339 Neurosciences & Musculoskeletal Division	1.5	1.5	3.0
339 Women and Childrens Division	0.1	0.1	0.1
339 Medicine Division	3.5	3.4	6.9
Grand Total	**7.2**	**6.4**	**13.7**

There are key drivers contributing to the variance between worked and funded WTE resulting in the unavailability exceeding the funded headroom of 21% - vacancies, poor skill mix resulting in higher supernumerary time, acuity resulting in increased enhanced care, and leave. It is a complex and dynamic position, but the impact of the above factors has been illustrated below:

Current funded headroom by availability group (21% allocation):

Unavailability Group	Headroom Uplift
Annual Leave	14.9%
Sickness	3.8%
Study	1.8%
Other Leave	0.5%
Working Day (non-clinical duties)	0%
Total	**21%**

Review of the unavailability groups identified on the Healthroster shows the actual unavailability to be at 27%.

Registered	**Current 21%**	**WTE Uplift**	**Cost**	**Actual %'s**	**WTE**	**Cost**
Annual Leave	**14.9%**	93.3	£4,697,228	**15.0%**	94.08	£4,738,357
Sickness	**3.8%**	23.8	£1,197,951	**7.1%**	44.61	£2,246,777
Study Leave	**1.8%**	11.3	£567,450	**2.4%**	14.98	£754,483
Other Leave	**0.5%**	3.1	£157,625	**2.0%**	12.20	£614,511
Total	**21.0%**	**131.4**	**£6,620,254**	**26.5%**	**165.87**	**£8,354,130**
Unregistered	**Current 21%**	**WTE Uplift**	**Cost**	**Actual %'s**	**WTE**	**Cost**
Annual Leave	**14.9%**	86.6	£3,229,637	**13.9%**	80.70	£3,008,603
Sickness	**3.8%**	22.1	£823,666	**8.2%**	47.92	£1,786,490
Study Leave	**1.8%**	10.5	£390,157	**4.0%**	23.40	£872,314
Other Leave	**0.5%**	2.9	£108,377	**1.6%**	9.03	£336,683
Total	**21.0%**	**122.1**	**£4,551,837**	**27.7%**	**161.05**	**£6,004,090**

Annual leave: the variance is driven by variable length of service and is variable across teams.

Sickness: levels have exceeded the 3.7% since before the pandemic and although there is an improving trend with attendance, sickness absence continues to exceed the funded uplift. The year-to-date position shows double the amount of absence compared to the funded uplift, an average of 46 WTE.

Study leave: exceeds the funded uplift by an average of 17 WTE per month. This is driven by several factors. We continue to support the “grow your own” approach to domestic recruitment and support apprenticeship models, such as the Trainee Nursing Associate, Registered Nurse Degree Apprenticeship and later this year we will be launching our apprenticeship programme for HCSWs in line with our commitment to the community. The increase of apprenticeship models, additional study requirements for clinical staff and the adapt programme for the IENs has not been recognised in a funded uplift to the headroom.

Other leave: constituted of a range of unavailability reasons with the main drivers being Wellbeing Day, Unpaid Time Off, Emergency Leave and Bereavement Leave. The well-being day having the largest impact on the roster availability, but recognition of the value to individuals. Working Day reflects worked time where the individual is not carrying out their primary clinical function, e.g., Trust induction, teaching, management, and audit. This unavailability type is not included within the headroom but accounts for 27 WTE of unavailable time per month.

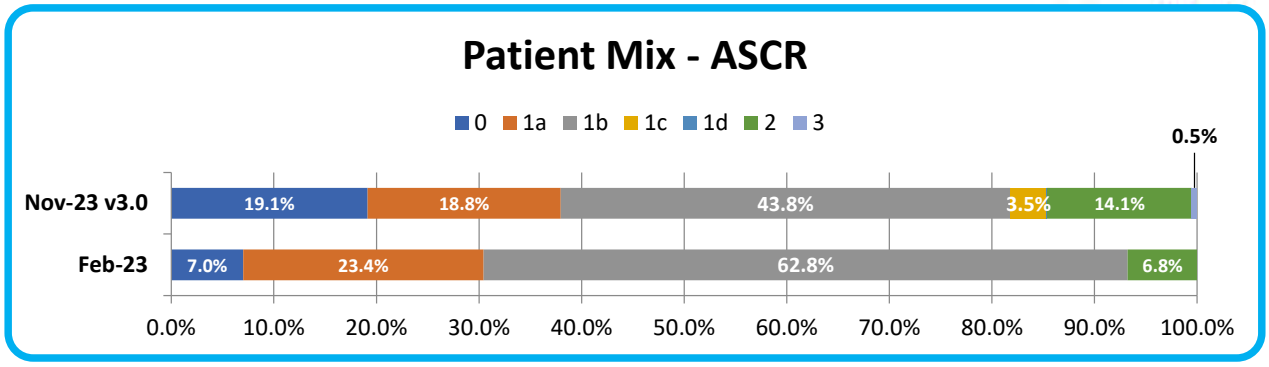
Variation Analysis - Divisions

SNCT - ASCR Division

Following the February 2023 SNCT review, the Division implemented an uplift to the roster templates and increased the nursing establishments 24/7 on wards 8b (renal), 32b (surgical assessment unit), and 33a (emergency burns and plastics), this was enacted due to an increase in acuity and dependency; increasing number of patients requiring enhanced care; additional patients on wards; and to maintain safe care. The uplift is an unfunded cost pressure to the Division and drives temporary staffing demand on each ward by an average of 5-8 WTE RNs (this total WTE includes all temporary staffing for all booking reasons and will not be isolated to the uplift).

The November 2023 SNCT for ASCR has illustrated a variance of required vs funded of 97.1 WTE for RNs and 57.3 WTE HCSWs: total of 154.4 WTE. Data collection for ASCR has demonstrated a significant increase to acuity (level 2) which is driven predominantly by an increase in complex renal patients, including patients receiving renal transplantation. Further, due to the successful implementation of the Same Day Emergency Care (SDEC) model, this has resulted in higher acuity patients being admitted to the ward than was seen previously.

The Division has seen an increase in level 2 patients from 6.8% to 14.1% from the previous SNCT census. Additionally, there has been a growth in the requirement of enhanced care due to the rise in patient acuity managed by the Division and this includes the impact of medical outliers required by the hospital flow model. The changes to the patient acuity data are demonstrated on the figure below.



ASCR SNCT required vs funded establishment

		Based on SNCT Data			Funded Establishment		
Specialty	Cost Centre	Required Registered	Required Unregistered	Required Total.	Registered Establishment	Unregistered Establishment	Total Establishment
General Surgery Services	339 14104 Ward 32B	38.1	33.1	71.2	28.6	24.8	53.4
	339 14222 Ward 26A Surgery	39.9	40.1	80.0	23.4	23.5	46.9
General Surgery Services Total		**78.0**	**73.2**	**151.2**	**52.0**	**48.3**	**100.3**
Surgical Wards	339 14221 Ward 33A Surgical	45.5	17.7	63.2	24.8	9.6	34.4
	339 14324 Ward 33B Urology	36.6	25.8	62.4	26.0	18.3	44.3
Surgical Wards Total		**82.1**	**43.5**	**125.6**	**50.8**	**27.9**	**78.7**
Urology Services	339 14325 Ward 26B	26.3	31.7	58.1	23.7	28.6	52.3
Urology Services Total		**26.3**	**31.7**	**58.1**	**23.7**	**28.6**	**52.3**
Renal Services	339 14411 Ward 8B (Renal - 38 Bed)	80.3	29.8	110.0	43.2	16.0	59.3
Renal Services Total		**80.3**	**29.8**	**110.0**	**43.2**	**16.0**	**59.3**
Grand Total		**266.7**	**178.2**	**444.9**	**169.6**	**120.9**	**290.5**

The Divisional Director of Nursing for ASCR has also completed a forward-facing review of the safe staffing for the Intensive Care Unit in the context of changing capacity and Guidelines for the Provision of Intensive Care Services (GPIC's). This has been undertaken in collaboration with the South West Critical Care Network (SWCCN) and the outcomes are presented in this paper.

The Network has recommended the following:

We would encourage the unit and the organisation to review an uplift in the nursing establishment compared to other units in the SWCCN, NBT has a low WTE nurses per bed.

In response to this recommendation, the Division has increased investment into the service over the past financial year reflecting the enhanced supernumerary period required for new starting staff. The unit is appropriately staffed according to acuity with increased requirements for staff escalated through the trust wide staffing process; the ICU has retained automatic agency escalation for the unit to maximise opportunities for shift cover with appropriately skilled staff.

The Division recognise that acuity on the unit has had significant spikes in activity in year and that overall acuity looks to be increasing and are gathering the data to support this assumption and have highlighted it in discussion with commissioners and as part of the trust business

planning process. Additionally, the Division is reviewing the impact of the system stroke reconfiguration which occurred in May 2023 in relation to the number of admissions to the ICU.

We would encourage the unit and the organisation to review the relative split of band 5/6/7s. A unit the size of NBT, particularly given the complexity of some of the patients, would benefit from an uplift in the proportion of band 6 nurses.

In response to this recommendation, the division is supportive of ensuring the right balance of experienced staffing on the unit and is fortunate to have very low vacancy rates for the last three years. Quality metrics also remain at a very high standard for the unit. The division has recently started a review of comparator organisations and will review the outcomes of their data.

Divisional Staffing Risks

There are two risks related to nursing workforce within the ASCR Divisional risk register rated above 10. The number of workforce risks is unchanged from the previous May 2023 census.

- **(Risk 1283) Workforce:** There is a risk of increased staff burnout/sickness/turnover resulting in increased vacancy and use of (premium rate) temporary staffing if the division does not have a full establishment of Nursing staff in line with that indicated by SNCT data collection (score 15).
- **(Risk 1284) Patient Safety**: There is a risk that patients could come to harm, as a result of sub-optimal care, if the funded establishment does not represent Safer Nursing Care Tool indicated numbers on the ASCR in-patient wards (score 15).

Recommendation

The data collection for ASCR has consistently demonstrated increases to acuity and dependency over the past six years. The Divisional Director of Nursing has raised concerns through the risk register reflecting that the funded position does not align to the indicated position by SNCT. The temporary uplift in roster templates for wards 8b, 33a and 32b following the May 2023 census were unfunded and has driven an increase demand for temporary staffing.

The most recent safer staffing review has identified a continued shortfall in required versus funded hours. This has been driven primarily by an increased acuity on renal, due to the higher number of renal transplants and the enhanced care requirements of the surgical patients and the impact of the high multiplier accounting for the care needs of these patients in single rooms.

The Third Review recommendations (Hots spots) are designated areas of safety priority to support an additional RN at night.

NHS North Bristol NHS Trust

Ward	Final DDON & FBP submission (2nd review) – Core Nursing Only	Safer Staffing Cost per Ward	3rd Review Hotspots WTE	3rd Review Hotspots Cost (£)
32b	- 2.6 WTE RN	£137,768	2.6 WTE RN	£137,768
26a	- 5.2 WTE HCSW	£194,039		
26b	- 2.6 WTE RN	£137,768	2.6 WTE RN	£137,768
8b & ADT	- 5.94 WTE RN	£291,500	5.94 WTE RN	£291,500
33a	- 5.20 WTE HCSW - 3.34 WTE RN	£403,453 – Just RN's	3.34 WTE RN	£209,414
33b (Urology)	- 2.6 WTE HCSW	£87,609		
Total	- **27.48 WTE**	**£1,252,137**	**14.48 WTE**	**£776,450**

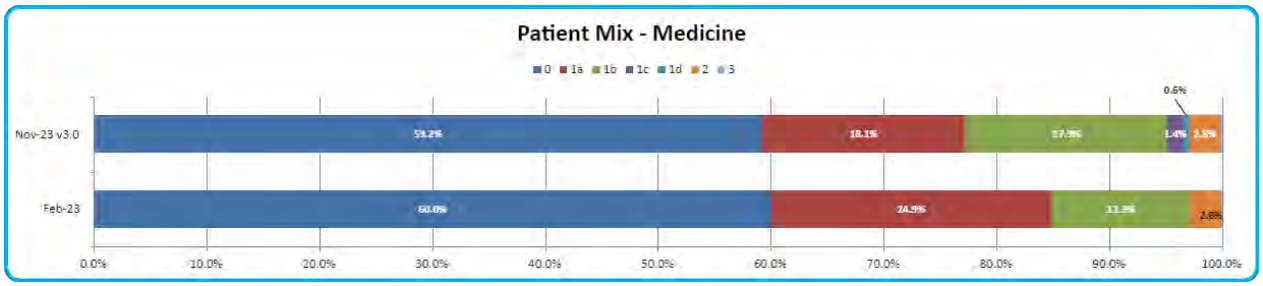
SNCT - Medicine Division

Following the February 2023 SNCT review, the Division introduced a new role to address concerns raised around nutrition and an under establishment of healthcare support workers. Following a successful pilot of the new role the Division implemented this role as a cost pressure of 3 WTE on wards 9a/9b (complex care) and EEU (enablement unit). Additionally, to address ongoing nursing and HCSW training needs the Division employs 4 WTE additional practice educators which is unfunded as a cost pressure.

The November 2023 SNCT for Medicine has illustrated a variance of required vs funded of 53.4 WTE for RNs and 60.6 WTE HCSWs: total of 114 WTE. Data collection for medicine has demonstrated an increase to level 1b and 1c which is driven predominantly by an increase in enhanced care. It is worth noting that this is supported by the average level of staffing worked during the year. The changes to the patient acuity data are demonstrated on the figure below.

11.1

Medicine SNCT patient acuity data Nov 23 and Feb 24



Medicine SNCT required vs funded establishment

Specialty	Cost Centre	Required Registered	Required Unregistered	Required Total.	Registered Establishment	Unregistered Establishment	Establishment Total
Medicine Cluster 3	339 14410 Ward 8A (Flex Capacity)	34.1	27.9	61.9	28.6	23.4	51.9
Medicine Cluster 3 Total		**34.1**	**27.9**	**61.9**	**28.6**	**23.4**	**51.9**
Medicine Cluster 2	339 14103 Ward 32A	32.8	41.7	74.5	28.6	36.4	64.9
	339 14503 Ward 9A	33.1	44.2	77.3	23.4	31.2	54.6
	339 14501 Ward 9B Flex Capacity	29.7	39.6	69.3	23.4	31.2	54.6
	339 14502 Ward 28B (Complex)	26.7	36.7	63.4	23.4	32.2	55.5
	339 17003 EEU	49.3	79.7	128.9	43.0	69.5	112.5
	339 14509 Ward 10A	26.1	33.4	59.5	23.4	30.0	53.4
Medicine Cluster 2 Total		**197.6**	**275.3**	**472.9**	**165.1**	**230.4**	**395.5**
Medicine Cluster 4	339 14402 Ward 27A	39.1	23.4	62.5	30.4	18.2	48.6
	339 14520 Ward 27B	38.0	26.9	64.9	33.8	23.9	57.7
	339 14403 Ward 28A Respiratory	41.5	31.5	72.9	35.0	26.5	61.5
Medicine Cluster 4 Total		**118.6**	**81.7**	**200.3**	**99.2**	**68.6**	**167.8**
Medicine Cluster 1	339 14031 Acute Medical Unit Gate 31A&B	72.0	35.5	107.5	76.0	37.4	113.5
Medicine Cluster 1 Total		**72.0**	**35.5**	**107.5**	**76.0**	**37.4**	**113.5**
Grand Total		**422.3**	**420.4**	**842.6**	**368.9**	**359.8**	**728.7**

Divisional priorities have been focussed on practice development staff through supporting international and new starters; enhanced care; co-pilots supporting flow; and some specific registered nurse support.

Further, additional one RN and 1 HCSW resource has been required to manage patients within Acute Medical Unit corridor (4 – 6 patients), and one RN and one HCSW to support the Acute Frailty corridor (3 – 4 patients). Going forward a cost centre separating escalation capacity will be online from April 2024. The care of patients in escalation areas has been reviewed and risk assessments completed February 2024.

Divisional Staffing Risks

There are 4 risks related to nursing workforce within the medicine Divisional risk register. This is an increase from the May 2023 report.

- **Risk 1881:** There is a risk that caring for and treating patients in areas outside of the planned Medical Division bed base will present multifactorial risks for both patients and the trust (score 10).
- **Risk 1565 / 1469:** Risk to workforce has moved from vacancy to skills gap – AMU / SDEC and wider Division (score 9).
- **Risk 1455** - Workforce risk due to continued operational pressures (score 9).

Recommendation

The conclusion from the May 2023 safer staffing review was the medicine wards funded establishments are generally appropriate to meet the requirements across the Division.

The November 2023 safer staffing census demonstrated an increase in enhanced care and escalation patients. Temporary staffing demands have been driven by the high operational pressures and the requirement to staff multiple escalation cohorts. Despite these challenges the Division have implemented a number of successful agency reduction controls.

Ward	Final DDON & FBP submission (2nd review) – Core Nursing Only	Safer Staffing Cost per Ward	3rd Review Hotspots WTE	3rd Review Hotspots Cost (£)
AFU	- 2.6 WTE RN	£137,768		
27a	- 2.6 WTE RN	£137,768	2.6 WTE RN	£137,768
27b	- None	-		
28a	- None	-		
28b	- 1.8 WTE RN	£92,784		
8a	- 2.6 WTE HCSW	£106,430		
9a/9b/10a	- 10.4 WTE HCSW	£388,078		
EEU	- None			
Total	- **20.0 WTE**	**£862,827**	**2.6 WTE**	**£137,768**

SNCT - NMSK Division

Following the February 2023 SNCT review, the Division implemented a skill mix review for the ward 25a (Major Trauma), by increasing the number of RNs on the night shift and decreasing the health care assistant funded establishment. This was a temporary solution to address the recommendations from the May 2023 safe staffing review and in the absence of available resource to address immediate safety concerns.

A key focus of the Division has been to educationally support the registered nurses. The Division has appointed a high volume of Internationally Educated Nurses (IENs) in the last year as a result of the service growth for the system reconfiguration of stroke services, and as a consequence of high turnover following a significant patient safety case on 25a. The Division has substantively appointed an additional 1.48 WTE practice education facilitator roles to support the education and training needs of the new starters, however this is in part, carried as a cost pressure to the Division. Furthermore, 2 fixed term posts have also been supported to provide targeted support for staff development, again at a cost pressure to the Division.

In May 2023 the BNSSG system stroke reconfiguration went live and NBT became the main system provider for all acute stroke services. Due to the initial shortfall in staffing and high volume of IENs who were subsequently recruited to meet the required increase to the funded establishment, a significant requirement for temporary staffing was seen, although is rapidly reducing as IEN's gain UK registrations. The staffing for the stroke ward on 34b, is aligned to current national guidelines however, previous SNCT outcomes for 34a have demonstrated a variance between the funded and required establishment. More specifically, annual SNCT reviews for the 3 years preceding the system reconfiguration, demonstrated year on year

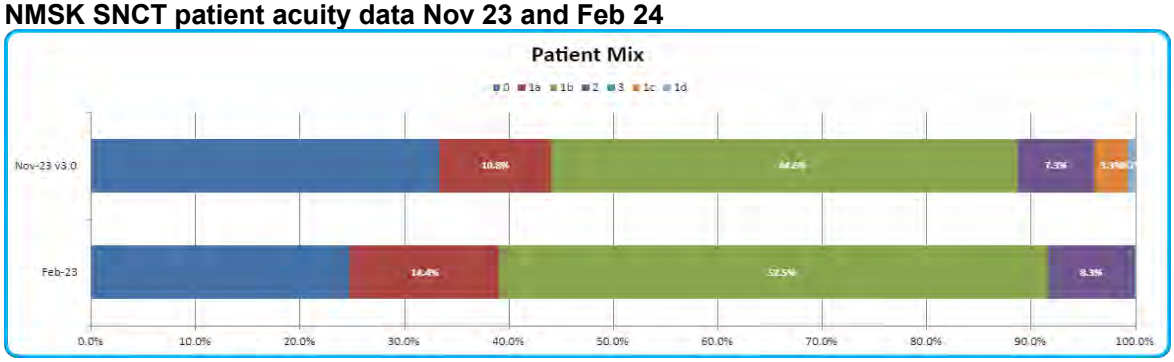
increases in required establishment, with the view to hold any investment requests in May 2023 until the reconfiguration had been completed and the impact on 34a staff requirements accurately assessed.

Since reconfiguration, the average requirement for stroke beds on 34a has consistently doubled, accordingly, as these patients, who have suffered large strokes, carry a significantly higher nursing dependency that the planned neurology cohort, Gate 34a carries the single greatest Divisional cost pressure for nursing staffing of 11.2 WTE HCSWs.

For the November 2023 census both 34a and 34b did not use the new SNCT template but assessed acuity using a 'beta' version of a stroke specific SNCT staffing tool, also developed by the Shelford Group. The Division retrospectively re-validated all the data, but the methodology did not provide sufficient robustness to be reliably applied in this report. The Division will undertake full compliance with the new SNCT for the next census audit. As a result, wards 34a and 34b have been removed from the November 2023 SNCT, although, based on consistent historical SNCT data supporting increasing nursing establishment, alongside robust Trust data detailing the impact of the system reconfiguration, an investment request for 34a was included as a Divisional priority.

NMSK has illustrated a variance of required vs funded of 32.9 WTE for RNs and 34.8 WTE for HCSWs: total of 67.7 WTE. Data collection for NMSK has demonstrated an increased requirement for enhanced care as demonstrated on the figure below.

NMSK SNCT patient acuity data Nov 23 and Feb 24



NMSK SNCT required vs funded establishment.

Specialty	Cost Centre	Required Registered	Required Unregistered	Required Total.	Registered Establishment	Unregistered Establishment	Establishment Total
Cluster 1 - Neurosurgery, Spines & Pain	339 14211 Ward 7A	34.7	34.6	69.3	31.2	31.2	62.3
	339 14241 Ward 6B	48.6	41.7	90.3	36.4	31.2	67.5
Cluster 1 - Neurosurgery, Spines & Pain Total		**83.3**	**76.3**	**159.6**	**67.5**	**62.3**	**129.9**
Cluster 2 - Trauma & Orthopaedics	339 14242 Ward 25B	35.2	41.5	76.6	23.4	27.5	50.9
	339 14311 Ward 7B	26.9	23.9	50.8	23.4	20.8	44.2
	339 14312 Ward 25A	30.5	36.1	66.6	26.3	31.2	57.5
Cluster 2 - Trauma & Orthopaedics Total		**92.6**	**101.5**	**194.0**	**73.1**	**79.5**	**152.6**
Cluster 3	339 25000 Rosa Burden Ward	9.6	3.9	13.5	10.2	5.1	16.7
Cluster 3 Total		**9.6**	**3.9**	**13.5**	**10.2**	**5.1**	**16.7**
Grand Total		**185.5**	**181.7**	**367.2**	**150.8**	**146.9**	**299.1**

Divisional Staffing Risks
There is 1 risk related to workforce within the NMSK Divisional risk register rated above 10.

- **Risk 1459 (Workforce):** Due to reduction of experience within nursing workforce associated with rapid recruitment of IEN's, there is a risk to the quality of patient care and to the wellbeing, recruitment, and retention of staff *[Score 15: Extreme Risk].*

Recommendation

The conclusion from the May 2023 safer staffing review was the NMSK wards funded establishments are generally appropriate to meet the requirements across the Division. An exception to this is the emergency trauma ward (25a) which has complex and high acuity patients. A skill mix review resulted in an investment to increase the number of RNs on the night shift by 1 per shift. The majority of the wards in NMSK are tertiary services and acuity fluctuates due to the unpredictable admission pattern. It also receives the highest proportion of ICU step downs predominantly to neurosurgery and trauma.

The November 2023 safer staffing census and outcomes have been reviewed by the Divisional Director of Nursing. The Division has made significant progress over the past 12 months stabilising the nursing workforce following the system reconfiguration of the acute stroke service. This necessitated a higher agency demand due to a high number of IENs and an initial higher volume of hyper acute stroke patients. The Division has implemented financial controls for temporary staffing.

The Divisional Director of Nursing has reviewed the census outcome and applied professional judgement and is requesting an establishment uplift of 31.2 WTE.

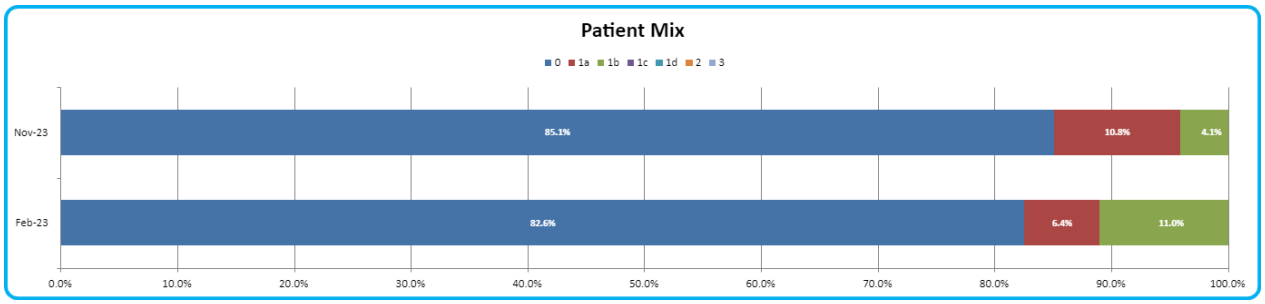
Ward	Final DDON & FBP submission (2nd review) – Core Nursing Only	Safer Staffing Cost per Ward	3rd Review Hotspots WTE	3rd Review Hotspots Cost (£)
25b	- 10.4 WTE HCSW	£388,078		
25a	- 5.2 WTE RN	£253,765	5.2 WTE RN	£253,765
34a	- 5.2 WTE RN - 10.4 WTE HCSW	£641,843		
34b	- Not included in request due to reperforming data collection	-		
Total	- **31.2 WTE**	**£1,283,687**	**5.2 WTE**	**£253,765**

SNCT – W & C Division (Cotswolds Ward- gynaecology)

Following the February 2023 SNCT review, the Division concluded that the ward is adequately staffed for general gynaecology work and fluctuations in capacity can be met by temporary staffing.

The November 2023 SNCT for W&C Division has illustrated a variance of required vs funded of an over establishment of 7.1 WTE RNs and 5.7 WTE HCSW: total over funded establishment of 12.8 WTE. The previous census identified a required RN establishment of 10.9 WTE against a funded establishment of 14.9 WTE. The SNCT census only captures in-patient activity and there is also a day-case unit and a dynamic workstream through emergency clinic.

Data collection for W&C has demonstrated a reduced number of in-patients during the November 2023 census period compared to the February 2023 census period (268 vs 327) and this will be driving some of the establishment variance. The patient acuity data is demonstrated on the figure below and is reflective of the cohort of patients expected in gynaecology.



The Divisional Director of Nursing and Midwifery has undertaken a review of the Neonatal Intensive Care Unit safer staffing through analysis of workforce metrics and professional judgement. The neonatal service is a speciality, which covers a whole pathway of care for newborn babies, ranging from intensive care through to community outreach and transport. The neonatal nursing workforce faces several key challenges, including meeting national (BAPM) standards for nurse to baby ratios due to a national shortage of nursing staff. A sufficient number and appropriate mix of qualified registered nurses is required to deliver safe and effective care to NICU patients. As vulnerable infants, it is difficult to calculate the nurse staffing requirements in advance, as infant care needs can quickly change from one shift to the next, necessitating flexible staffing plans. Understaffing is a substantial problem, one that puts patients at increased risk of missed or rationed care, medical incidents, disparities of care, and morbidity and mortality.

Following the Neonatal Critical Care Review (NCCR), NICUs' nursing establishment was expanded during 2023/24, further exacerbating the challenge of recruiting to establishment, and increasing the reliance on temporary staffing. Despite this, significant progress has been made in terms of recruiting band 5 nurses, culminating in a vacancy position of 14.35 WTE (March 2024). Attracting and retaining skilled neonatal nurses remains a challenge and is crucial to ensuring an adequate skill mix of newly qualified and experienced staff, as well as registered and non-registered staff that is required for safe, effective care.

A further challenge is the need to ensure 70% of nurses receive the training in speciality (QIS). A minimum of two qualified nurses/midwives should always be on duty (one of whom must be QIS). Our ability to support the required numbers of staff to attend the QIS training has been negatively impacted by the high proportion of newly qualified nurses recruited. Whilst non-registered nurses support clinical care and help to ensure adequate total establishments and rotas, they should be appropriately trained and work under the supervision of registered QIS nurses.

We have a specialist team of Advanced Neonatal Nurse Practitioners (ANNPs) who can provide a flexible solution to many of the workforce challenges facing neonatal services. However, they require appropriate job plans, agreed accountability pathways and indemnity outside their routine nursing roles and work. There are also particular demands on workforce requirements in relation to ANNPs, which are being worked through.

To meet these gaps, there is a requirement to match these pressures with robust recruitment strategies and to develop nurses within the neonatal speciality.

Sickness levels (7.9% for band 5s -March 24), with stress, anxiety, and depression as the predominant reason for absence and turnover rates (17.65% for band 5s – March 24) remain high and are compounding the staffing challenges.

As a result of the above and the need to reduce the reliance on temporary staffing, there is an increasing need to focus on retention strategies going forward.

Divisional Staffing Risks
There is 1 risk related to NICU workforce within the W&C Divisional risk register rated above 10.

- **Risk 1179 (Workforce):** The lack of robust and fully established neonatal nursing workforce risks in a failure to deliver key objectives with respect to a safe service provision *[Score 20: Extreme Risk].*

Recommendation

For gynaecology, there are no funding requests or changes to the establishment. However, it is recommended that to capture the complexities and variations of the patient demand and flow, a more in-depth review of the nursing workload is required. It is also recommended that the Division start to scope the SDEC model with a view to utilise the current nursing workforce in gynaecology to support this model. The Director of Midwifery will be repeating the Birthrate Plus® tool in due course which may lead to establishment adjustments for midwifery.

6. Summary

The Divisional Directors of Nursing and Divisional Director of Midwifery and Nursing have reviewed their respective requirements for safe staffing, triangulating this with professional judgement, patient experience, staff experience and patient outcomes of care.

Overall, the nursing and midwifery workforce is more stable compared to 12 months ago, this is reflected in lower vacancies, lower turnover, improved staff satisfaction, improved fill of temporary shifts and an increasingly productive workforce. However, unavailability continues to be 6% higher than funded establishment, which drives lower productivity and less time available to deliver direct care. Unavailability is driven by a number of factors, not least the increasing statutory and mandatory training requirements added in the last 24 months. The number of times an RN or HCSW is moved during their shift has reduced by over 80% in the past 12 months, a further sign that the workforce is more stable.

The average CHpPD is 9.1, which in the top quartile when compared with other hospital organisations across the South West. NBT is in the lowest quartile of nursing staff cost per

Weighted Activity Unit (WAU compared with other NHS acute providers in the South West suggesting a more productive nursing service compared with others. Unavailability is currently funded at 21%, however overall unavailability is 6% higher and reflects the increasing number of statutory and mandatory training topics required.

Our rapid on boarding of IENs during 2023/24 has enabled us to rapidly close the RN vacancy gap, however the length of time for IENs to successfully complete their Objective Structured Clinical Examination to obtain Nursing and Midwifery Council registration has been longer than expected which has driven a higher-than-expected temporary workforce demand, this will settle during 2024/25 as the remaining IENs become RNs.

Apprenticeship will become a dominate approach to supporting the delivery of a highly skilled nursing and midwifery workforce as we proceed through the next five years, traditional domestic opportunities for education are becoming increasingly expensive and the apprenticeship route to RN is an important sustainable approach to developing our future workforce. Further, as we progress over the coming months, we will publish our strategy on enhanced and advanced practice and develop opportunities in all specialities for RNs and RMs to progress their clinical careers.

The banding changes to band 3 HCSW during 2023/24 had made a considerable difference to turnover, this intervention alone has seen an 8% reduction in turnover and has been responsible for an improvement in staff survey results and NBT being an employer of choice.

The revised SNCT has presented a number of challenges, not least the significant increase in the number of WTE equivalents required, this assessment will be completed on two further occasions (summer 2024 and winter 2024/25) to test the methodology and develop expertise in the new levels and descriptors. That said, there continues to be a small underlying deficit, and it is possible this deficit goes back over a decade when the Brunel Building was opened, at this time ward establishments were simply shifted without correction for a greater number of single side rooms.

Overall skill mix, the number of RNs to HCSWs is lower than the recommendations from the Royal College of Nursing, whilst a lower RN: HCSW may be appropriate for the less acute specialities, such as reablement, however a higher RN: HCSW ratio is needed in the higher acuity clinical areas, this will be corrected over the next 18 months.

A four-step review process has been initiated, initially starting with divisional reviews of the data, and subsequent increasing scrutiny, including an external review by the Chief Nursing Officer for the Bristol, North Somerset, and South Gloucestershire Integrated Care Board. The second review completed by the Divisional Directors of Nursing and the Deputy Chief Nursing Officer identified an additional requirement of 78.72 WTE, 31.92 WTE RN and 46.80 WTE HCSW. Given the financial context we are operating during 2024/25, the Chief Nursing Officer undertook a further review (3rd Review) at which it was agreed that 22.28 WTE RNs would be requested to support 'safer' staffing, this would predominantly support additional RNs at night and give consideration for the safety profile of the wards requiring additional RNs.

The insufficient numbers of RNs are having an impact on the safety of care, for example completion of 'observations on time' are 15% lower in ASCR wards, with the average delay of 80 minutes compared to an organisational average of 40 minutes. Completion of the four

nursing assessments to reduce harm i.e., falls, pressure injuries, infection control and nutrition (MUST) within 6 hours of admission is 20% lower in ASCR wards when compared to the rest of the organisation, further the ASCR wards account for 40% of complaints for ASCR. The number of falls within ASCR wards with only 4 RNs available at night account for 86% of the falls within the division and account for 55% of medication errors within the division.

7. Recommendations

- Note the completion of the winter 2023 SNCT review of adult inpatient areas, thus complying with the National Quality Board requirements for safe staffing.
- Note the impact on safer staffing due to the current funded position of 21% headroom for adult in-patient wards compared to the national minimum standard of 22%. There will be further work to review and agree our headroom position across all nursing and midwifery positions.
- Note reviews of the emergency department, intensive care unit and neonatal intensive care unit are to be completed throughout 2024/25.
- Note that the October 2023 SNCT has been updated to reflect changes to unavailability, acuity levels, 75%+ side rooms and additional patients, which has generated a substantial increased WTE requirement.
- Note the detailed four stage process used to 'check and challenge' additional workforce requirements, including an external review by the Chief Nursing Officer for the Bristol, North Somerset, and South Gloucestershire ICB.
- Note the safety impact of having to few RNs at night, most notably within the ASCR division.
- Support the requirement for an additional 22.28 WTE RNs to support 'safer' staffing, focusing this additional WTE requirement in ensuring a 'safer' night nursing service.
- Note the requirement to undertake a further SNCT assessment in June 2024.
- Support the review of statutory and mandatory training requirements so as to potentially reduce unavailability.

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NHS North Bristol NHS Trust

Appendix 1

SNCT Descriptors October 2023

the SHELFORD GROUP

Safer Nursing Care Tool (SNCT)

Safer Nursing Care Tool

Care level	Descriptor *Care requirements may include the following:*
Level 0 Hospital inpatient. Needs met by provision of normal ward cares.	• Underlying medical condition requiring on-going treatment. • Post-operative / post-procedure care - observations recorded as per local policy. • National Early Warning Score (NEWS) is within normal threshold. • Patients requiring oxygen therapy. • Patients not requiring enhanced therapeutic observations (according to local policy). • Patients requiring assistance of one with some activities of daily living.
Level 1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	• Step down from Level 2 care. • Requiring continual observation / invasive monitoring/physiological assessment. • NEWS local trigger point reached and requiring intervention/action/review. • Pre-operative optimisation/post-operative care for complex surgery. • Requiring additional monitoring/clinical interventions/clinical input including: – Patients at risk of a compromised airway. – Oxygen therapy greater than 35% + / - chest physiotherapy 2-6 hourly or intermittent arterial blood gas analysis. – Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest drains. – Severe infection or sepsis. – New spinal injury/cord compression.
Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.	• Complex wound management requiring more than one nurse or takes more than one hour to complete. • Patients with stable Spinal/Spinal Cord Injury. • Patients who consistently require the assistance of two or more people with mobility or repositioning. • Requires assistance with most or all care needs. • Complex Intravenous Drug Regimes – (including those requiring prolonged preparatory/administration/post-administration care). • Patient and/or carer's requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. • Patients requiring intermittent or within eyesight observations according to local policy. • Facilitating a complex discharge where this is the responsibility of the ward-based nurse.
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety.	• Patients requiring arm's length or continuous observation as per local policy.
Level 1d Patient's who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety.	• Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.
Level 2 Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels surgeons can may require transfer to or be cared for in a dedicated Level 2 facility/unit.	• Deteriorating / compromised single organ system. • Step down from Level 3 care or step up from Level 1a. • Post-operative optimisation/ extended post-op care. • Cardiovascular, renal or respiratory optimization requiring invasive monitoring. • Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure. • First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction. • CNS depression of airway and protective reflexes. • Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes. • Requires a range of therapeutic interventions which may include: – Greater than 50% oxygen continuously. – Requiring close observation due to acute deterioration and needing advanced organ support. – Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium. – CNS depression of airway and protective reflexes. – Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains.
Level 3 Patients needing advanced respiratory support and/ or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems. • Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/ sepsis or neuro protection.

11.1

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Workforce Metrics:
Integrated Performance Report 2024/25

Ben Pope, Head of Strategic Workforce Planning

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2024/25 Integrated Performance Report Proposed Changes

- Currently 14 slides in the Well Led section with focus on core traditional workforce metrics
- In 2024/25 there is an opportunity to tighten the focus, so we consider the priorities we have set as a Trust through Patient First and where NHS England are focussing and have set targets
- The approach would move towards a deeper view on fewer metrics with other metrics being presented as 'Watch Metrics' where we would exception report if performance became adverse according to the Statistical Process Control method (NHS England best practice ad Trust standard)
- The aim is to reduce the content to ensure we are keeping track of what is important and can provide focussed assurance on the
- In accordance with the Trust Accountability Framework guidance, we should aim for a 'Golden Thread' from Board to individual level. In this instance we are proposing that the changes to the IPR are reflected in the Accountability Framework used by divisions and the Executive at monthly Divisional Reviews – with two points of difference:
  - The Integrated Performance Report will include additional metrics which provide context for cross cutting Corporate work, e.g. % of Healthcare Support Workers with <12 Months Service (People priority = retention), or Agency Expenditure (Temporary Staffing Oversight)
  - Division can include additional metrics aligned to their Patient First priorities
- The Operational Workforce Report, a People Directorate derived report, will also include a number of these metrics and more, providing more insight as an assurance mechanism specifically for the People and EDI committee – the purpose of this report is described on the following slide

Metrics Overview IPR

AIM: Cover progress against national performance standards/requirements, delivery of People agenda

Driver	Slide	Metric	Executive	Narrative	Target 24/25
Patient First Trust Priorities	Retention	Turnover	CPO	24/25 Long-Term Retention Plan Actions	11.90%
		Healthcare Support Worker Stability	CPO		TBC
	Commitment to our Community	Disparity Ratio	CPO	24/25 Commitment to our Community Actions	1.25
		Employed population from our communities	CPO		38.50%
Accountability Framework	Temporary Staffing Oversight and Join Resourcing Steering Group	Agency WTE	TBC	24/25 Temporary Staffing Oversight and Join Resourcing Steering Group	N/A
		Agency Spend	TBC		N/A
		Agency spend as a % of pay spend	TBC		3.20%
	Watch Metrics	Sickness	CPO	High Level Actions by Exception	4.40%
		Non-Medical Appraisal	CPO		90%
		MaST	CPO		85%
		Vacancy Factor	CPO		TBC
Safe Staffing		Safe Staffing Fill	CNO	Under Review with CNO	>120%, <80%
		Required vs Rostered Hours	CNO		N/A
		Care Hours Per Patient Day	CNO		N/A
Medical Appraisal and Revalidation		Appraisal Compliance	CMO	CMO Team	90%
		Non-Compliant Doctors	CMO		N/A

Metrics Overview – Divisional Review

Driver	Slide	Metric
Patient First	People - Retention	Turnover
Patient First	Commitment to our Community	Disparity Ratio
		Employed population from our communities
Accountability Framework	Exception Report	Turnover
		Sickness
		Non-Medical Appraisal
		Medical Appraisal
		MaST
		Agency spend as a % of pay spend
		Vacancy Factor

- Divisional Review metrics will align with the IPR metrics except for any additional metrics divisions have identified as part of their Patient First priorities
- People Partners and Workforce Team working to finalise divisional targets and trajectories (where required)

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Proposed New IPR Structure

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IPR Update Proposal

NHS North Bristol NHS Trust

Focus on Patient First metrics – Executive Lead – CPO

- People Priority – Metrics
  - Turnover Rate (also NHS England metrics – trajectory submitted as part of 2024/25 operational plan)
  - % of Healthcare Support Workers with <12 Months Service (Stability)
- Commitment to our Community Priority - Metrics
  - Disparity Ratio
  - % of Staff from 30 Most Challenged Communities
- Actions derived from Long-Term Retention Plan and Commitment to our Community Plan delivery

Focus on Temporary Staffing – Executive Lead – CPO

- NHS England set target – Agency Spend as a % of Pay Spend = 3.2% (for BNSSG)
- NHS England focus on productivity and temporary staffing reduction in 2024/25
- Actions derived from Temporary Staffing Oversight group and subgroups (to be progressed through proposed Temporary Staffing Oversight and Join Resourcing Steering Group)

Focus on 'Watch Metrics' - Executive Lead – CPO

Additional core indicators some of which we submit trajectories and actual performance to NHS England – Metrics

- Mandatory and Statutory training
- Appraisal Completion in Window
- Sickness Absence Rate (NHS England metrics – trajectory submitted as part of 2024/25 operational plan)
- Vacancy Rate

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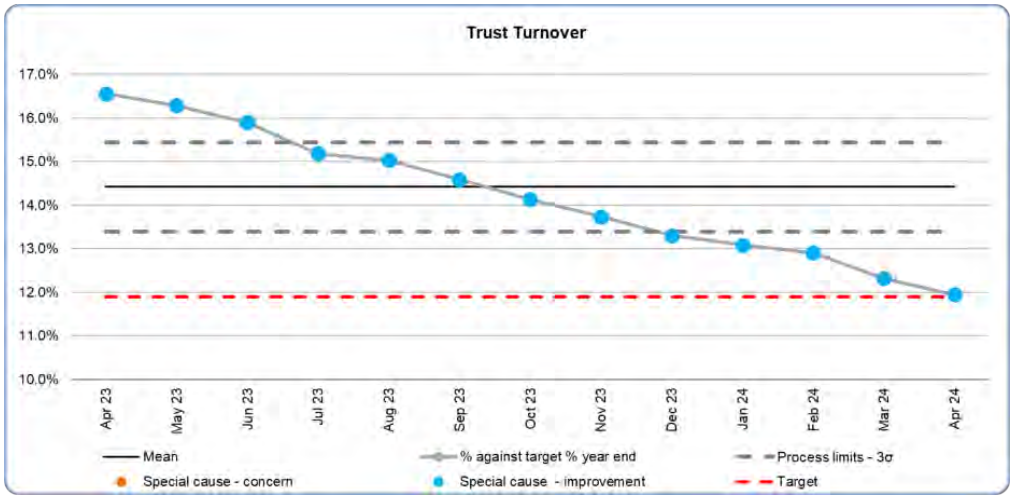
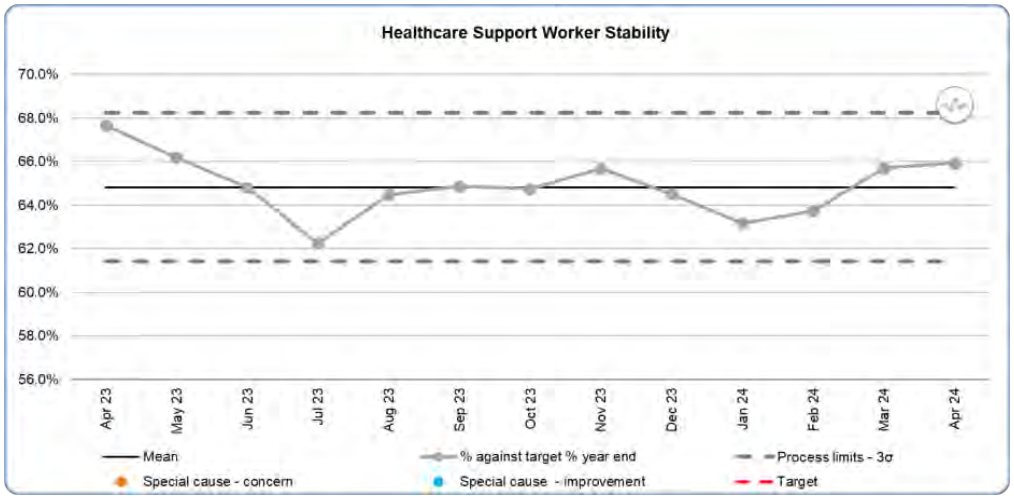
Retention (CPO)

Patient First Priority People





Narrative Basis

- Insight into current position against targets/SPC limits
- Insights into drivers of performance including other metrics in narrative for context
- Actions completed and actions planned including recognition of being off track

Driver/Area	Action and Impact	Owner	Due

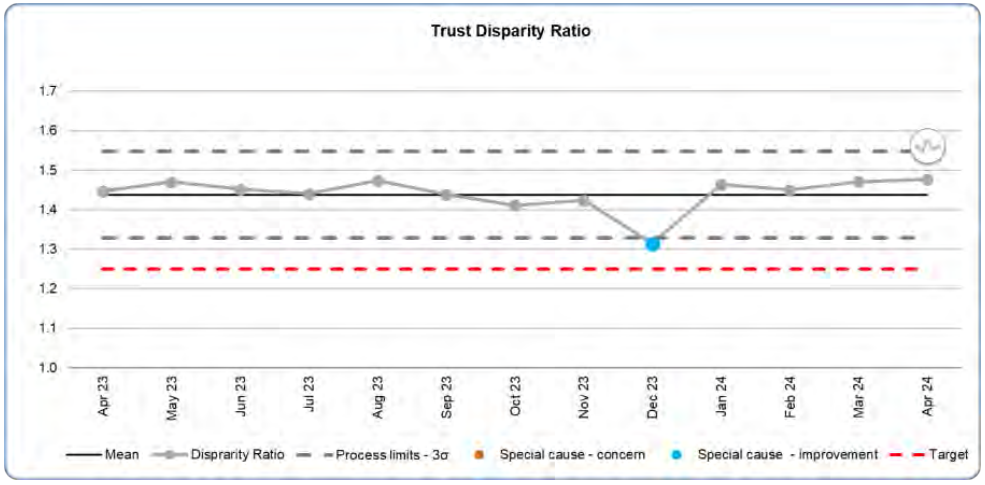
Responsible Owners

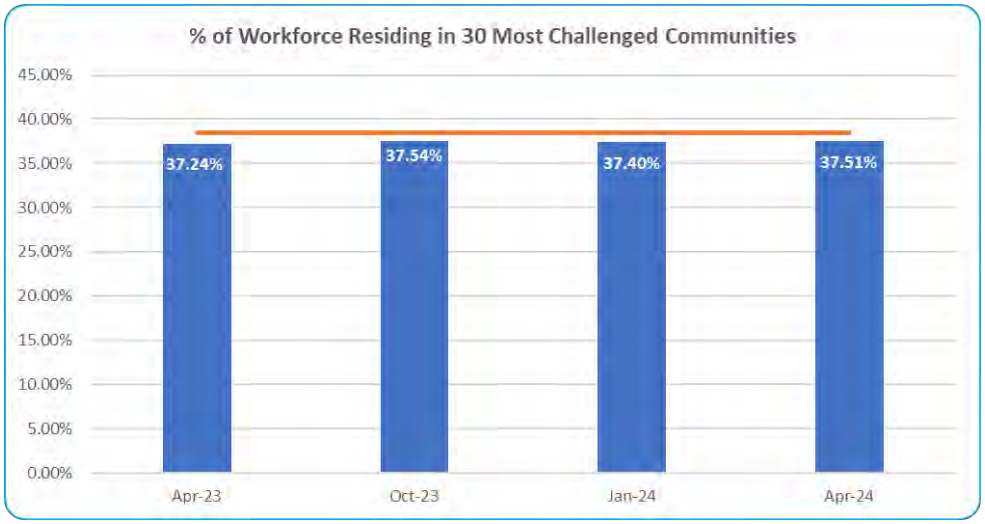
Associate Director for Culture Leadership and Development

People Promise Manager

Commitment to our Community (CPO)

Patient First Priority – Commitment to our Community





Narrative Basis

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Driver/Area	Action and Impact	Owner	Due

Responsible Owners

Associate Director for Culture Leadership and Development

Head of Talent Acquisition

Community and Education Project Manager

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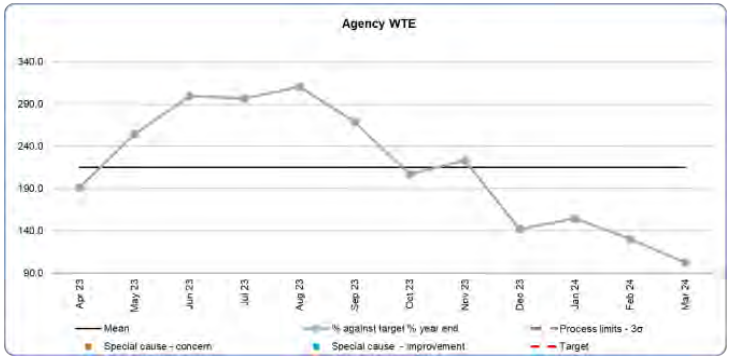
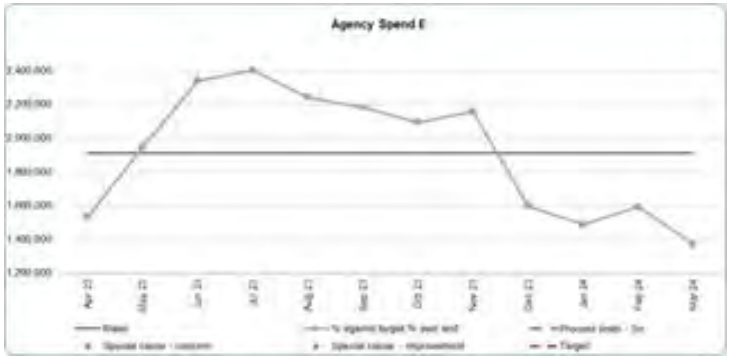
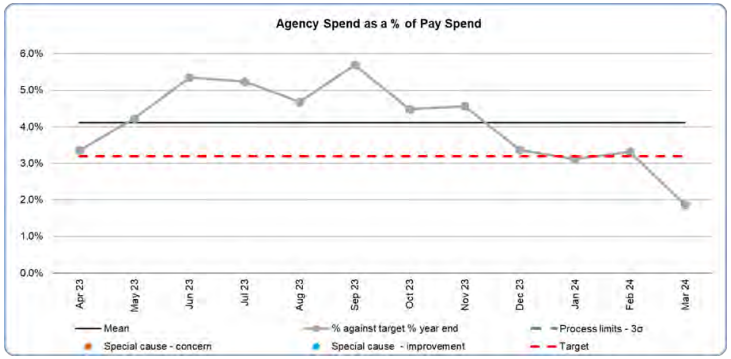






Temporary Staffing (CPO)

Narrative Basis

- Insight into current position against targets/SPC limits
- Insights into drivers of performance including other metrics in narrative for context
- Actions completed and actions planned including recognition of being off track

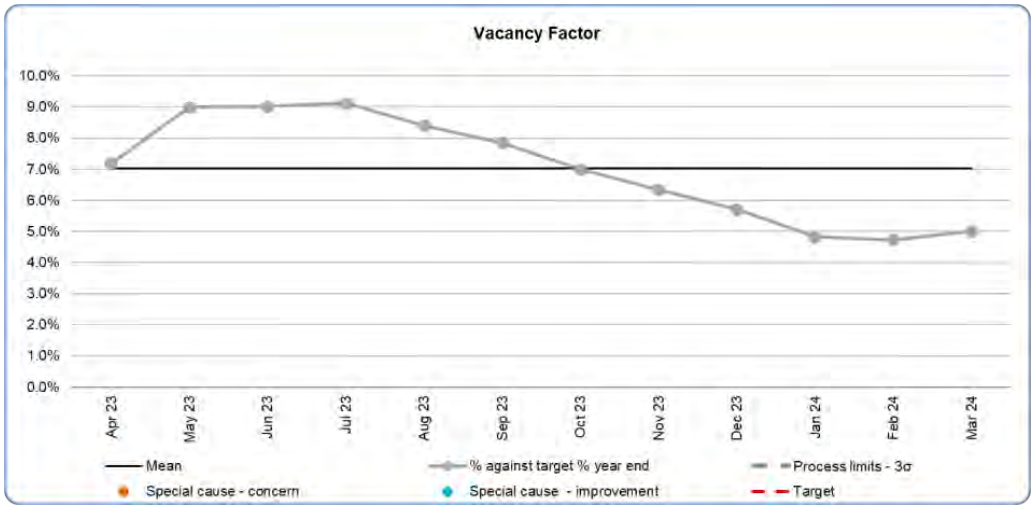
Driver/Area	Action and Impact	Owner	Due

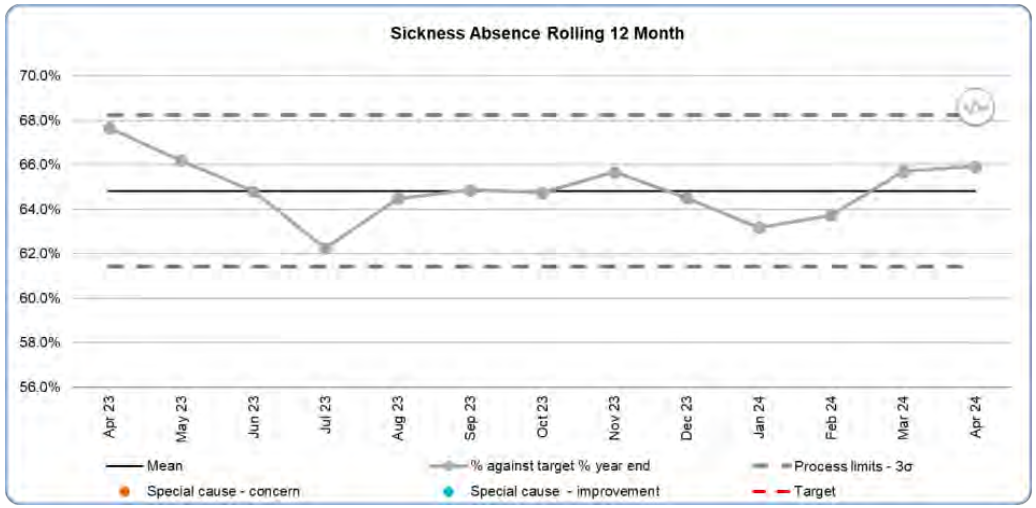
Responsible Owners

Deputy Chief Nursing Officer

Associate Director of Medical Workforce

Watch Measures (CPO)

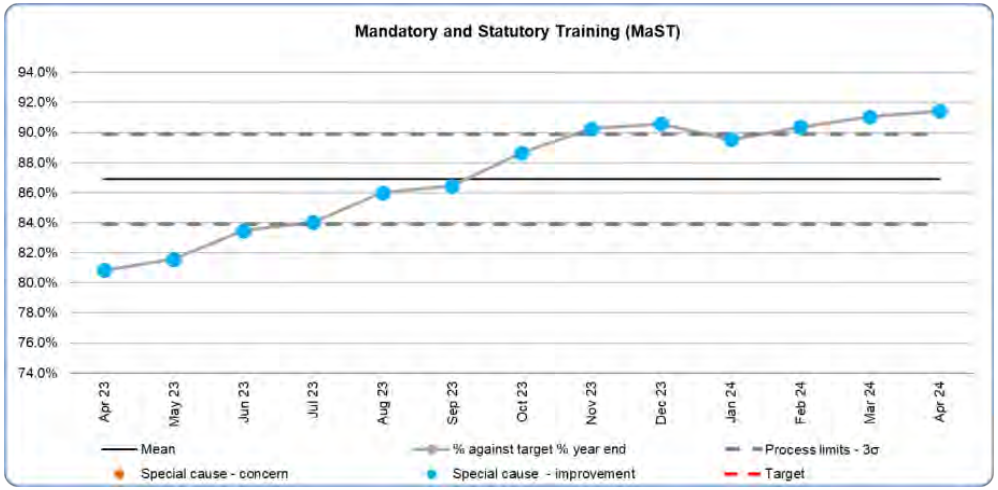


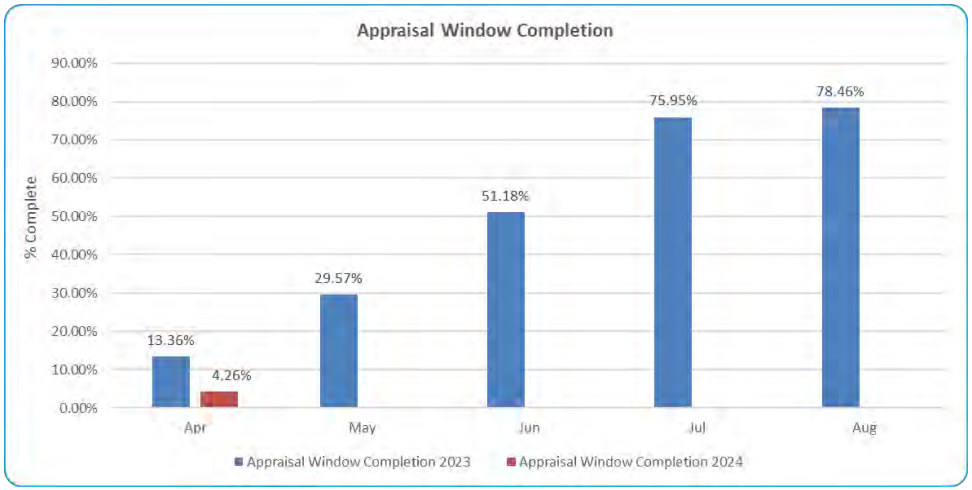


Deterioration – hotspots and mitigating actions

Improvement – celebrate success and any learning

Watch Measures (CPO)





Deterioration – hotspots and mitigating actions

Improvement – celebrate success and any learning

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Current IPR Structure

May 2024

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Executive Summary is still required but content would change to focus on priorities and watch measures where performance adverse or improved.

Quality

Within Maternity, the term admission rate to NICU rose to 6.4% against a national target of 5% and 2 PMRT cases rated the care following the death of a baby as D. Perinatal services reported 2 moderate harm incidents in February but there were no new MNSI cases reported. Medication incidents have increased this financial year, but harm incidents remain low. The Medicines Governance Team have launched the 'Medicines Safety Forum' which is multidisciplinary meeting to review data and agree actions – the 2nd meeting was held in April. Infection control data for March showed an increase in C-Difficile, with a slight breach of annual trajectory, E-Coli cases were below annual trajectory and there were no new MRSA cases. Improvement work continues for the sustained increase in MSSA rates, which reflects regional/national trends. The reducing trend in falls rates continued. The number of grade 2 pressure ulcers reduced, with a 15% annual reduction achieved. WHO Safety Checklist compliance remains strong and will now become a 'watch' metric.. The year-1 workplan for Patient & Carer Experience has been successfully delivered and the focus for 2024-25 is now being finalised for approval in line with the Trust's Quality priorities aligned to Patient first. 92.24% of patients gave the Trust a FFT positive rating, which remains within the expected range of performance. Complaint response compliance has greatly improved to 85% in March, particularly reflecting improved performance in ASCR. All complaints are acknowledged within 3 working days as required.

Workforce

The Trust vacancy factor was 5.02% (480.79wte) in March up from 4.82% (459.66wte) in February. The rise was driven by an increase in funded establishment (+38.28wte), as NBT's staff in post figure also grew from February to March (+17.15wte). NBT's Rolling 12-month staff turnover rate decreased from 12.91% in February to 12.32% in March, continuing the improvement trend since November 2022. The Trust rolling 12-month sickness absence rate decreased slightly to 4.65% in March from 4.67% in February. Overall temporary staffing demand increased by 4.61% (+45.10wte) from February to March, driven by increased demand for estates and ancillary staff (+22.28wte, +16.61%) and registered nursing and midwifery staff (+32.60, +9.92%). There was a decrease in unfilled shifts (-8.58%, -15.07wte), driven by an increase in bank shift utilisation (+8.93%, +62.71wte). Total unfilled shifts as a proportion of temporary staffing demand deceased from 17.34% in February to 14.68% in March.

Finance

The financial plan for 2023/24 in Month 12 (March) was a surplus of £1.0m. The Trust has delivered a £3.7m surplus, which is £2.7m better than plan. The year end position is breakeven. In-month, the Trust has fully recognised ERF income and undertaken a full review of accruals and provisions, as a result there is a net benefit of £3.7m. Temporary staffing costs in the year-to-date position are creating a £10.5m adverse variance to plan. Unidentified savings within the in-year position are creating a £10.1m adverse variance, the impact of which is offset by delays in investments and vacancies. The Trust cash position at Month 12 is £62.7m, a reduction of £41.3m from Month 1. This is driven by the Trust underlying deficit and capital spend. The Trust has delivered on plan against its full year capital funding of £48.9m. The Trust has delivered £18.0m of completed cost improvement programme (CIP) schemes at month 12.

Proposal to remove slide in place of focussed narrative on priority metrics or areas where performance changed

Well Led Introduction

Vacancies

The Trust vacancy factor was 5.02% (480.79wte) in March up from 4.82% (459.66wte) in February. The rise was driven by an increase in funded establishment (+38.28wte), as NBT's staff in post figure also grew from February to March (+17.15wte). The growth in funded establishment, was predominantly seen in medical and dental (+15.44wte), administrative and clerical (+9.20wte) and additional clinical services (+5.03) staff groups. Vacancy reductions were seen in registered nursing and midwifery (-15.11wte) and health care scientists (-2.74wte). The improvements for both staff groups were driven by increased staff in post; with Maternity Services, Surgery Management Services and Medicine Cluster 2 seeing the biggest improvements for registered nursing and midwifery staff. Estates and ancillary staff saw an increase in vacancy level (+10.22wte, +1.23%), driven by reduced staff in post.

Turnover

NBT's Rolling 12-month staff turnover rate decreased from 12.91% in February to 12.32% in March continuing the improvement trend since November 2022. The biggest improvements for March were seen in additional clinical services, registered nursing and midwifery, and administrative and clerical staff.

Patient First target for 2023/24: 16.5% or below

Prioritise the wellbeing of our staff

The Trust rolling 12-month sickness absence rate decreased slightly to 4.65% in March from 4.67% in February.

Trust Target for 2023/24 (based on moving from 3rd to 2nd quartile of all national acutes): 5.2%

Temporary Staffing

In March 74.96% of temporary staffing demand was filled by bank, 9.54% by agency and 15.71% was unfilled. This is an improved position compared to February which saw 71.79% of demand filled by bank, 10.24% by agency and 17.97% unfilled. Overall temporary staffing demand increased by 4.61% (+45.10wte) from February to March, driven by increased demand for estates and ancillary staff (+16.61%, +22.28wte) and registered nursing and midwifery staff (+9.92%, +32.60wte). There was a decrease in unfilled shifts (-8.58%, -15.07wte), driven by an increase in bank shift utilisation (+8.93%, +62.71wte), and March also saw a small decrease in agency usage (-2.55%, 2.55wte). The decrease in unfilled shifts was mostly seen amongst additional clinical services staff (-25.67%, -19.28wte). In terms of temporary staffing request reasons, annual leave saw a 2.50% increase from February to March, and Increased Dependency/High Acuity a 1.20% increase.

wte = whole time equivalent

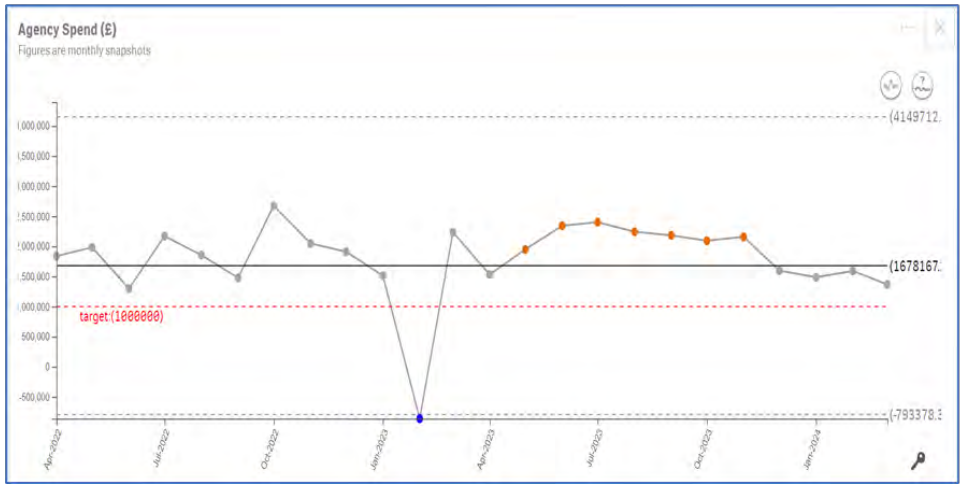
Well Led Introduction – Actions

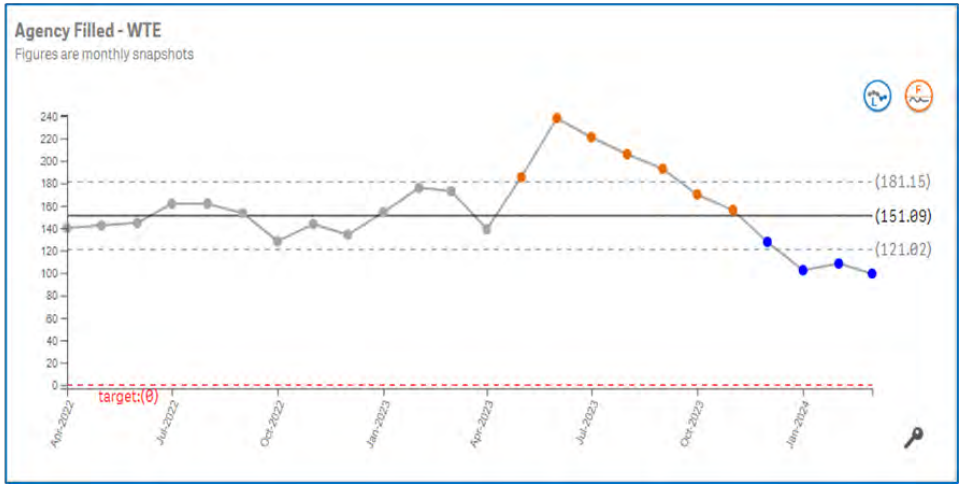
Proposal to remove slide in place of focussed narrative on priority metrics or areas where performance changed

Theme	Action	Owner	By When
Vacancies	eForms have now been extended to Medical Recruitment. Furthermore, in our efforts to streamline processes, the medical recruitment process is now aligned to AfC hiring. The AfC recruitment operations team have been successful in achieving 15 days to complete onboarding checks for the second consecutive month which was the Trust target.	Deputy Chief People Officer	Apr-24
Turnover	Immediate retention actions commenced linked to HCA turnover in first 12 months of employment in hotspot areas, with additional interventions being implemented aligned to NBT's 2023-24 Retention Plan	Associate Director Culture, Leadership & Development	Jul-24
Staff Development	Implementing the Kallidus Perform Online Appraisal system across the Trust. System will go live 1 Apr 24	Associate Director Culture, Leadership & Development	Jun-24
Wellbeing	Review of the role and scope of Wellbeing Champions underway. Avon Partnership Occupational Health Service (APOHS) Stakeholder event to support effective review of occupational health services. Initial meeting with Chief Medical Officer team to develop project charter for staff health and wellbeing strategy to be developed.	Associate Director Culture, Leadership & Development	Jun-24
Temporary Staffing	SW Pan regional agency rate reductions on track to implement 8th April for Nursing agency (inc RMN and Theatres) Intention letters to reduce the rates and new rate cards issued to suppliers. Financial profiling of potential impact of reduced rates underway. Medical Locum work continues with draft rate card to be prepared by end of March. Bank attraction campaign and week of promotional activities underway with planned go-live week 8th April.	Deputy Chief People Officer and Associate Director of Nursing Workforce Recovery	Apr-24

Temporary Staffing

Proposal to remove slide in place of focussed narrative on priority metrics and action





What Does the Data Tell Us
Agency use saw a decrease of 2.55wte overall, despite an increase of 5.61wte in registered nursing and midwifery. The increased registered nursing and midwifery agency use was most notable in Critical Care (ICU) (+6.45wte), and Ward 28A (+2.31).

Ward 9b (-1.14wte), Ward 33A (-0.94wte) and Acute Medical Unit Gate 31A&B (-0.73wte) saw the largest decreases in agency use for registered nursing staff in March.

Agency registered mental health nurse (RMN) use decreased by 0.48wte from February to March, driven by decreased usage in Wards 9B, 33A, Acute Medical Unit Gate 31A&B and ICU.

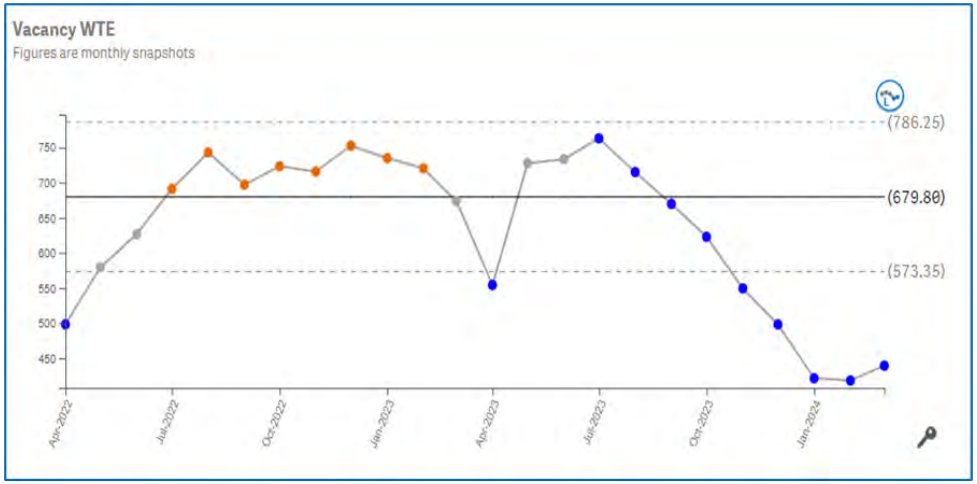
Actions

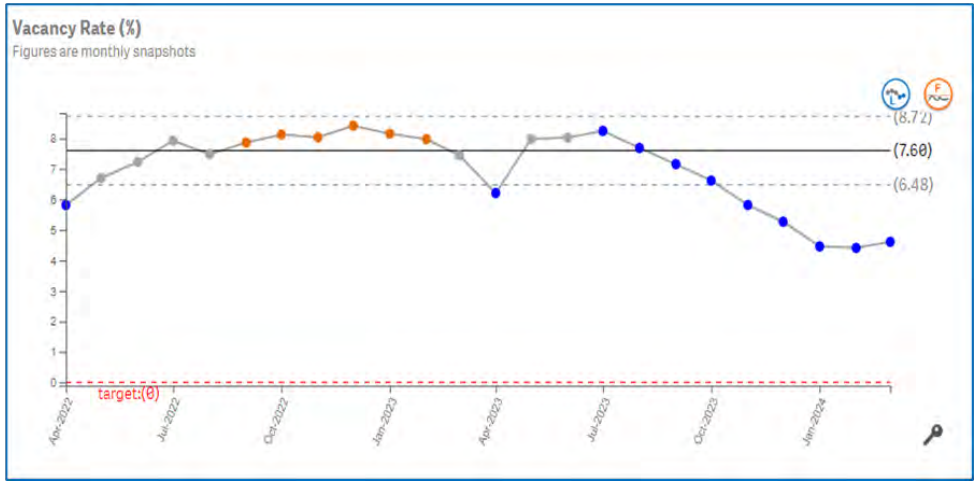
1. SW Regional agency rate card confirmed with first reduction for nursing on 8th April with monthly rate reductions to achieve full NHSE cap compliance general (July) specialist (Oct)
2. Ongoing conversation on planned collaboration with University Hospitals Bristol and Weston (UHBW) on Bank rate alignment in preparation for the collaborative Bank pilot launching summer.
3. Final planning and preparation for the "Shine a spotlight on Bank" week of attraction and promotional activities wc 22nd April
4. Bank Staff Survey results being published April 2024
5. Continued focus and planning of agency removal opportunities

Agency Reduction: Agency is typically limited to specialist staff types, Theatres, Critical Care and ED. Focus on removal options for general locations under discussion. Close monitoring of the impact of the SW regional rate reductions will be monitored locally and within the wider SW regional groups being held 2 – weekly.
Bank Optimisation: Workstream picking up real traction. The first Bank Forum taking place on Tuesday 10th April further to full week of activities and publication of Bank Staff Survey results by end of April 2024.

Vacancy Position

Proposal to remove dedicated slide and focus place on 'Watch Measures'





Talent Acquisition Recruitment Activity
Unregistered Nursing and Midwifery
1.Offers: 10.22wte of offers for Health Care Support Worker (HCSW) roles were made in March: 1.61wte for band 2 and 8.61wte for band 3
2.Pipeline: 32.60wte of candidates with offers being processed. Current withdrawal rates have dropped to 5% for HCSW roles which suggest that 30.97wte will join over next three months (between April and June) which is lower than last year where 100.29wte joined, however there are 131.44wte more staff in post this year compared with last year.

Registered Nursing and Midwifery
1.Offers: 38.78wte of offers to band 5 experienced and newly qualifying nurses across the Trust
2.Pipeline: Domestic 167.76wte band 5 candidates with offers being processed. Current withdrawal rate is at 8% which suggests 154.33wte will join the Trust.
3.Pipeline International: International recruitment is currently paused for the next few months.

Recruitment Activity
1.TA attended three Nursing careers events this month including UWE's Meet the employer's event for Healthcare students
2.International Recruitment: We welcomed 13wte Internationally educated Nurses to the Trust in March

Current actions being taken to mitigate withdrawal rates:
1.Midwifery incentivisation programme in place – Withdrawal rates have increased slightly to 9%
2.Pipeline Engagement Open Days now running monthly with attending candidates receiving site visit and tour with Divisional representation.

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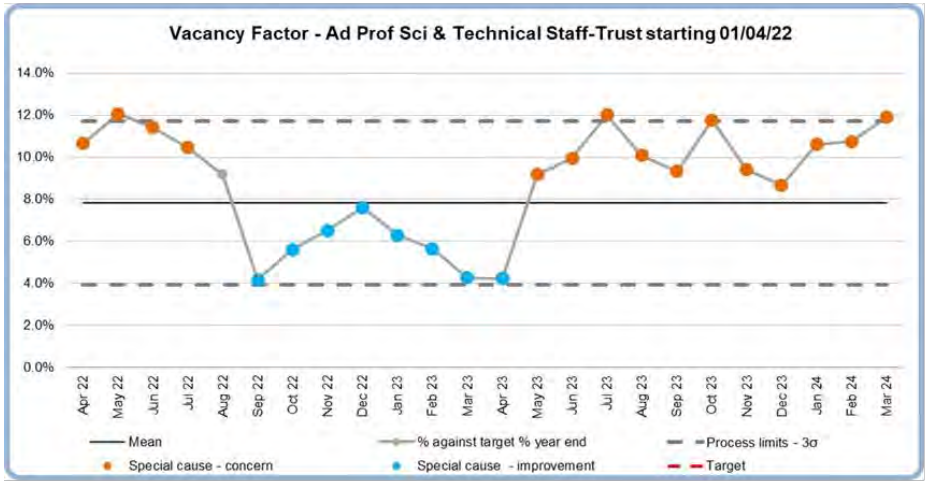
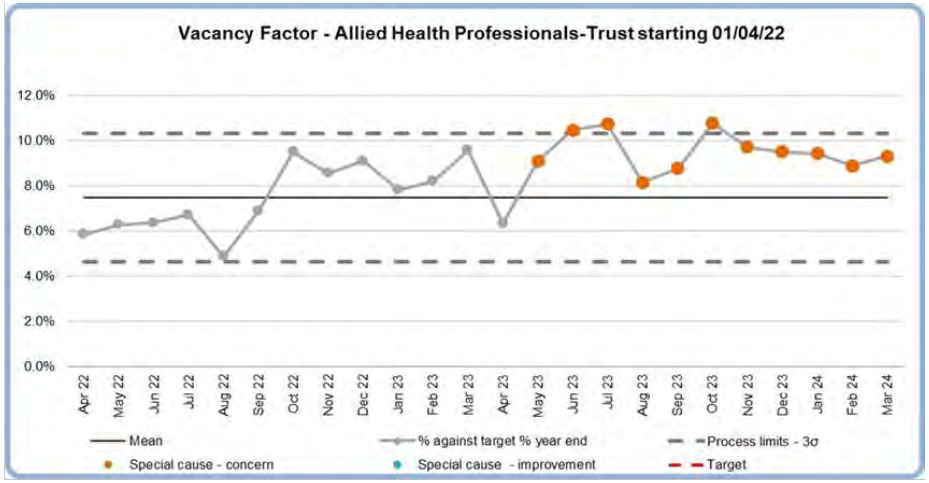
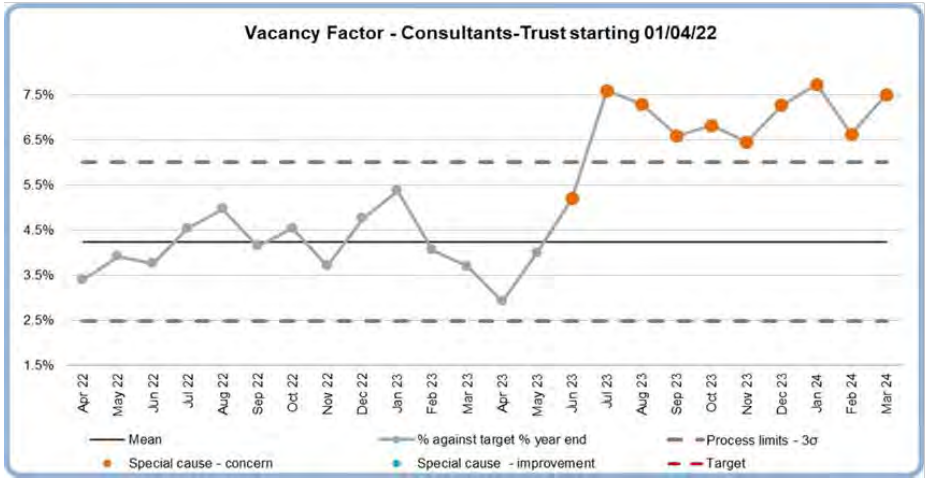
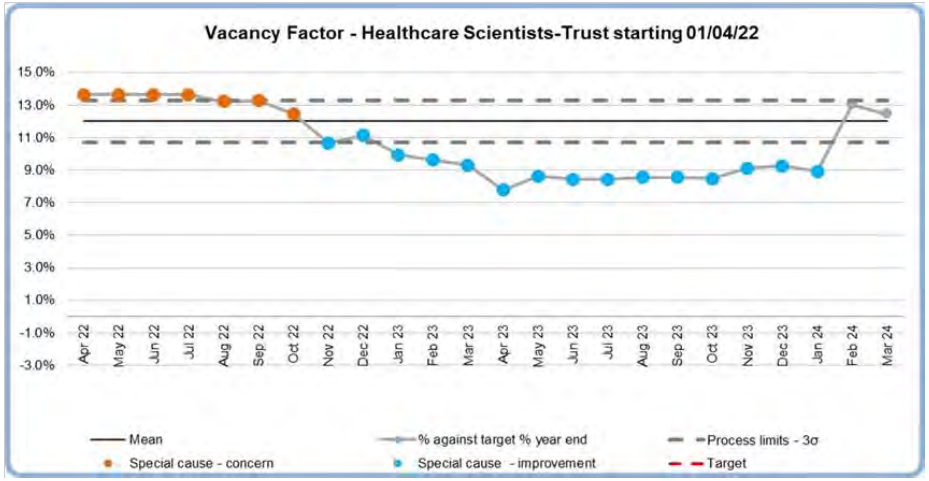
Vacancy

Proposal to remove slide in place of focussed narrative on priority metrics or areas where performance changed









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Vacancy

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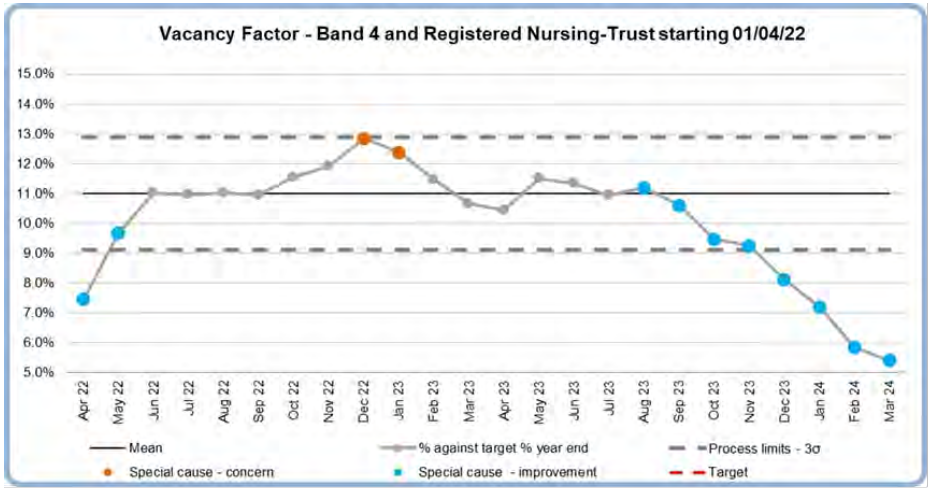
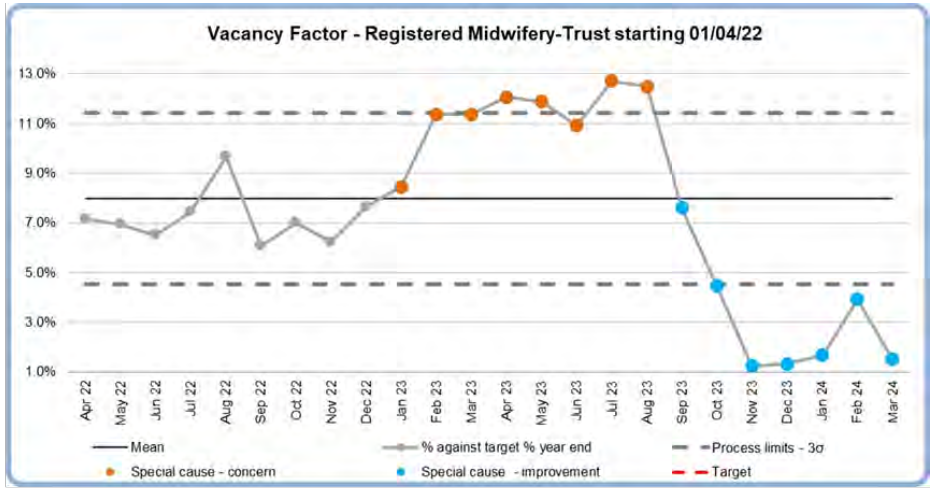
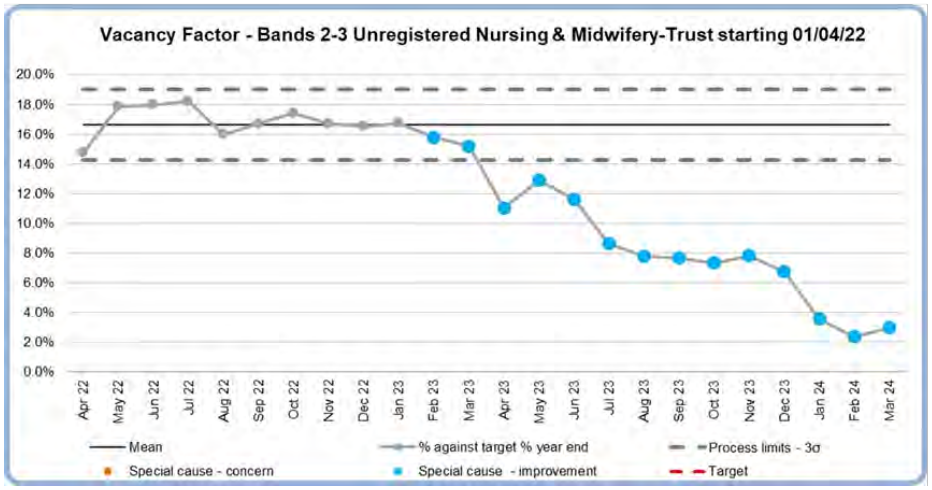
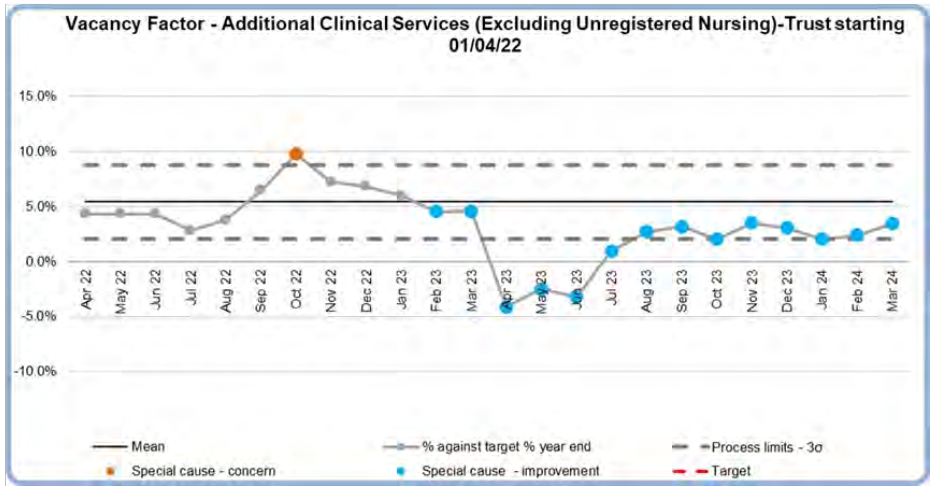


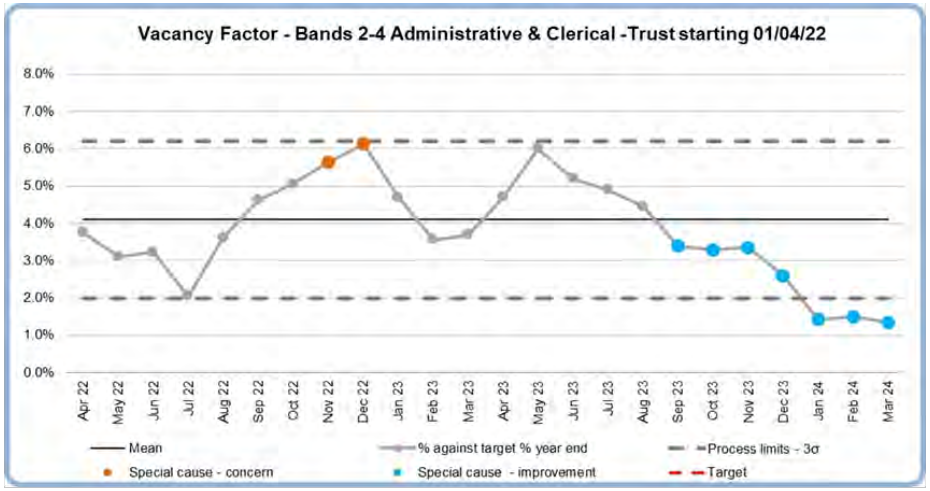


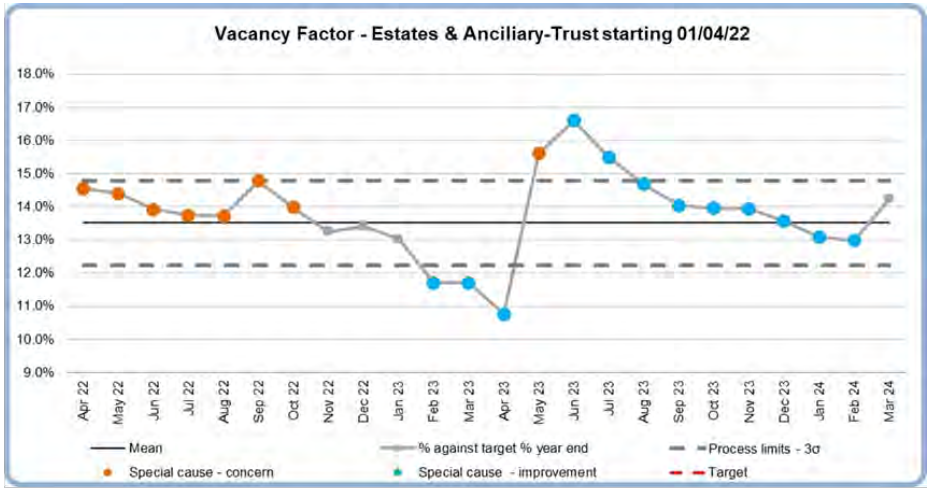


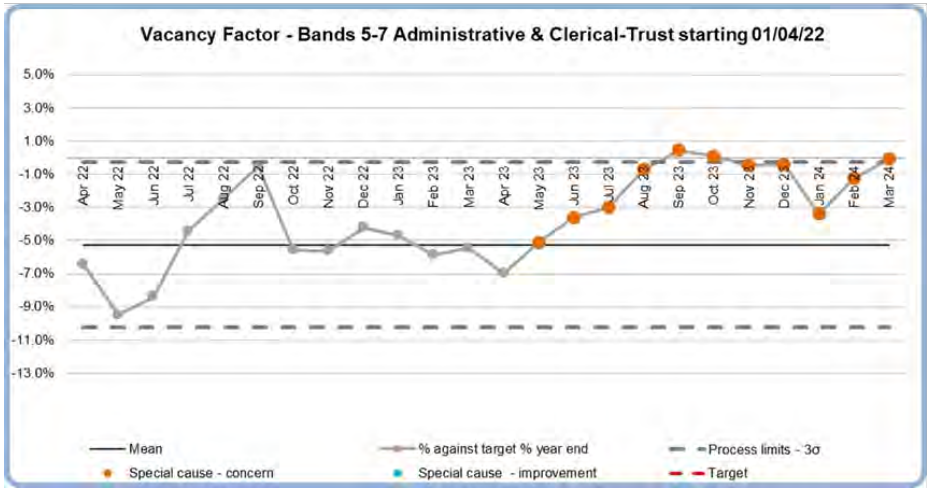


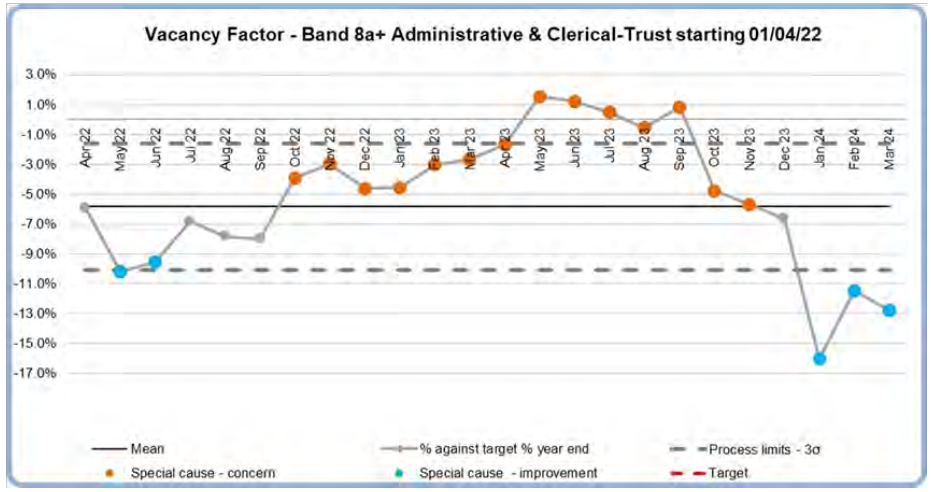
Vacancy

Proposal to remove slide in place of focussed narrative on priority metrics or areas where performance changed





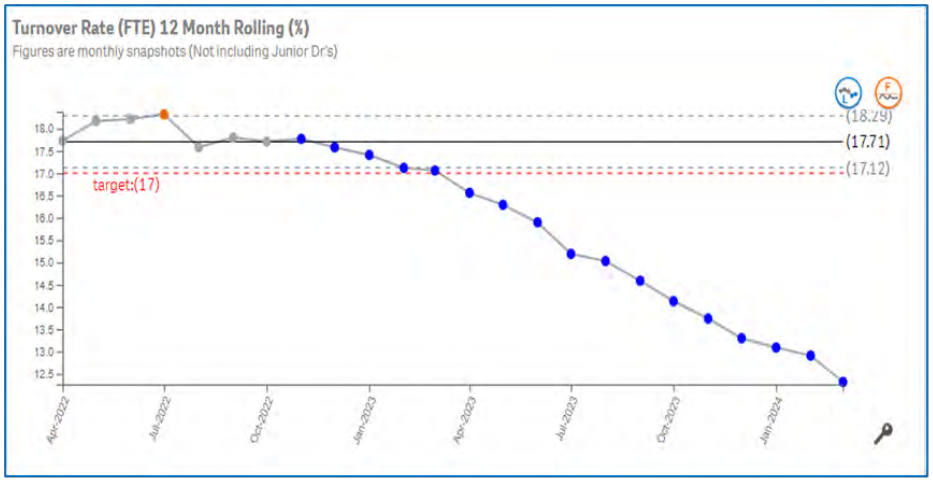


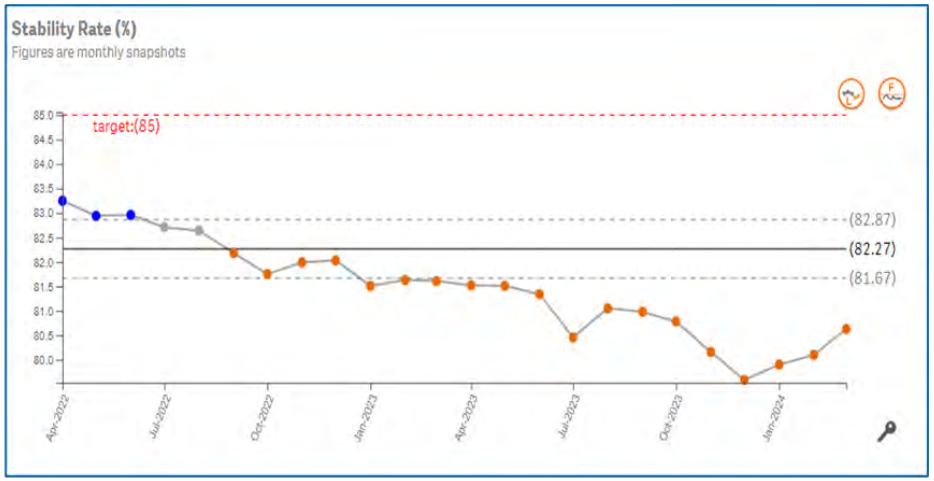


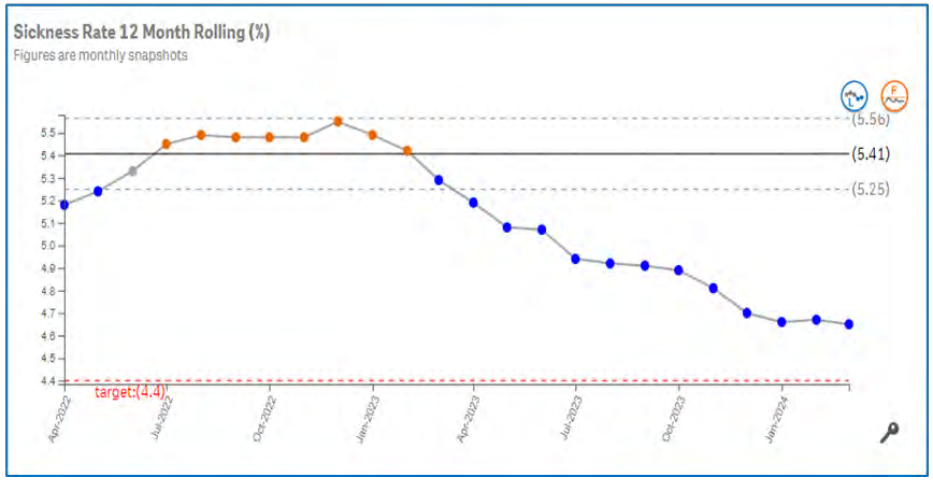
11.2

Engagement and Wellbeing

Proposal to move Turnover and Stability onto Patient First Retention Slide and Sickness onto 'Watch Metrics' slide







11.2

Proposal to remove slide in place of focussed narrative on priority metrics or areas where performance changed

People support and engagement

Actions delivered: (Associate Director of People)
- Disciplinary behavioural framework agreed
- Agreed policies on disciplinary, appeals, job evaluation
- New leave policy including provisions for baby loss/miscarriage and fertility treatment
- Complex investigations service – 6 internal IOs trained, 4 bank only investigators appointed.
- New casework system implemented

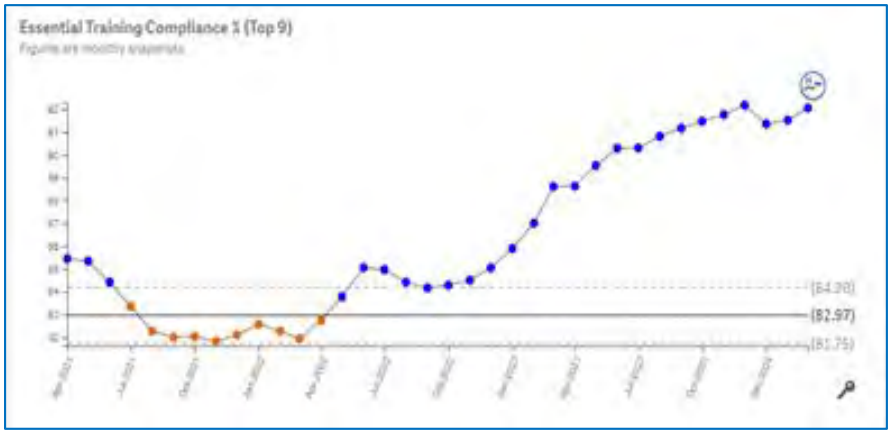
Actions in Progress:
- Launch of complex investigations service (**June**)
- Data triangulation, in respect of staff allegations and zero acceptance campaign (**June)**
- Development of restorative just culture training (**June – July)**
- Collaboration with recruitment services on staff contracts (fixed term contracts, international recruitment, ex-offenders) **(June – July)**

Retention and Staff Experience (including Health and Wellbeing)
Actions Delivered: (Associate Director Culture, Leadership & Development)
- Diverse Recruitment Panels launched on 1st April
- Sexual Safety planning workshop occurred and output shared with the working group – to be incorporated into the '*We do not accept*' campaign in May
- Occupational Health joint NBT/APOHS stakeholder event occurred
- Staff survey general free text comments analysed and shared with Divisions
- Citizen Advice sessions formally agreed for a further 12 months
- First Operational EDI Group took place
- New on-line appraisal system went live 1st April
- In February, the Library and Knowledge Service hosted a visit from NHS England to assess the quality of the Library and Knowledge Service. Final report pending but we met all the essential quality criteria set by NHS England. NHS England also identified several areas of good practice

Actions in Progress: (Associate Director of Culture, Leadership & Development)/Associate Director of People)
- Track progress of the new My Appraisal system **April – July 24**
- Development of tools and resources by the 'Sexual Safety in Healthcare' Group **(December 2023 – July 2024)**
- Development of Staff Survey follow-up actions **(April – end May 2024)**
- Develop an NBT-wide Health and Wellbeing Strategy and underpinning Staff Experience Plan **(March – June 2024)**
- Trust-wide implementation of the recommendations of the *'Too Hot to Handle*' paper into racism in the NHS **(April – October 2024)**
- Market review of alternative EAP / counselling providers, leading up to contract renewal/expiry of our current EAP contract with Health Assured in July or possible extension to September if additional time is required.
- International Women's Day event with a focus on female health and wellbeing delivered. Expert led sessions included: Breast screening, Breastfeeding and RTW, Financial resilience, Pelvic Health and Mental Health. **March 2024**

Essential Training

Proposal to remove slide in place of focussed narrative on priority metrics or areas where performance changed



Essential Training (Head of Learning and Development)

What Does the Data Tell Us - Essential Training (Head of Learning and Development)

- SPC Chart indicates a special cause variation – improvement (Indicator where high is good).
- QLIK (1 May 24) compliance compared with same time in the previous year (12 months):
  - All staff 91.4% (↑ from 88.7%).
  - Permanent Staff 94% (↑ from 91%).
  - Fixed Term Temp 87% (↑ from 79%).
  - Other 82%.
    - NBT eXtra 87% (↑ from 49.5%).
    - Honorary 41% (↑ from 30.5%).
  - Note: Medical & Dental staff group 79% compliant (Fixed Term, Bank and Honorary below 85% target).
- Training Compliance By Training Title (Top 9) indicates Information Governance is 87% (Trust compliance target 95%).
- The most significant training expirations in the next three months are Information Governance 1-year, Fire 1-year, and Equality and Diversity 3-year.
- Oliver McGowan's mandatory e-learning is at 75%. All staff must complete it. Oliver McGowan Mandatory Level 2 - Face to Face – dates available on Link.

Actions

- Working up an action plan to improve compliance of honorary, medical and dental staff.
- Information Governance added to induction for all new starters.

Leadership & Management Learning (Leadership Development Manager)

- **Mastering Management:** Cohort 1, have completed, celebration event scheduled for 22.05.24. We're considering offering Leadership Circles for Mastering Management alumni to support continued learning. Cohorts 2-5 are full and in progress. Cohort 6 started 03.04.24 20/24 places filled. Cohort 7 is now open, starting 08.05.24. We have allocated 140/ 240 participant places, 215 completed expressions of interest. Feedback from participants is excellent. Rating 4.38/5' (1 = Poor; 5 = Excellent) to the question 'Overall, how would you rate the learning impact from this module? Modules improved based on qualitative and qualitative feedback. UWE have begun impact evaluation. We have begun planning to bring Mastering Management in house in April 2025 once the contract with UWE has been completed.
- Coaching and Mentoring: contracting for procurement of PLD platform in partnership with UHBW has been successfully completed. Target go-live date 01.05.24. A successful NBT Coaching Community CPD event was held on 07.03.24. The fourth joint mentoring scheme with our neighbors at the Defense Equipment & Support (DE&S) launched on 03.04.24, places are available to support the project management skills of NBT staff, Band 5 and above
- **Excellence in Management:** Cohort 3 successfully launched on 27th March 24 – confirmed cohort of 24 delegates bringing the total of managers on programme to 71. Representation of Race; Disability & Sexual Orientation protected characteristics is 33%. Gender spilt 71% female:29% Male. 23 people have successfully completed and Cohort 2 will complete on 15th May. Applications are open for cohort 4 which launches end August.
- **Accelerate update**: Cohort 2 has completed all 3 sessions and will have their celebration event on the 23rd of April. Cohort 3 is now promoted, Application deadline is on the 30th of April. I**LM Leadership and Team Skills**—1ILM cohort 1, which has 20 delegates scheduled to attend the first session on Thursday 11th April 2024. We also have 19/20 places filled for Cohort 2 (starting in June 2024) and are now filling cohort 3, commencing in September 2024.

Trust Apprenticeships and Widening Engagement (Head of Apprenticeships and Early Careers)

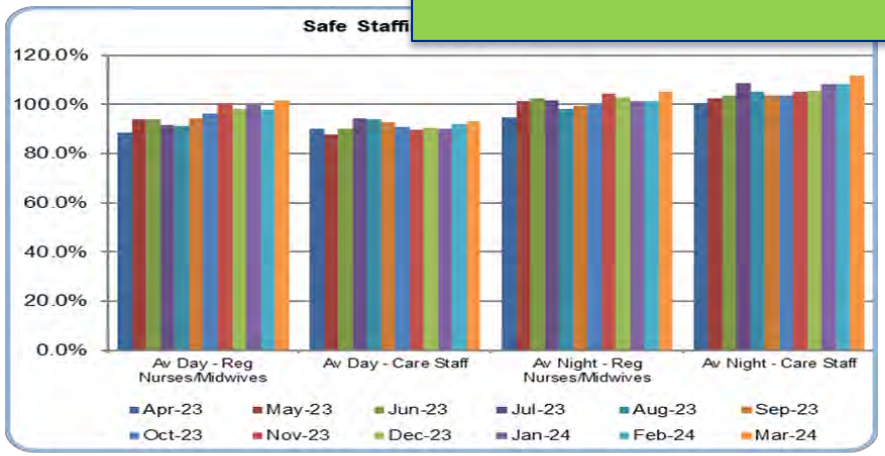
- March levy – Expired funds - £36,289, Transferred levy - £8744, Levy utilisation 65%
- 433 apprentices currently on programmes from level 2 to 7. Apprenticeship vacancies are increasing slowly, particularly in admin and Clerical roles and Saplings. Working with TA to boost apprenticeship recruitment and the benefits they bring.
- Successful bid for NHSE Grants has secured 11x £10,400 grants to support Healthcare Science apprentice starts this year.
- MPSF roles are already making a good impact and the final roles starts 16/04 with activities already planned within the areas of the Commitment to Community plan.

Apprenticeship Centre

- Ofsted inspection took place 12-14 March. We await formal notification of the inspection result.
- Current Learners enrolled non direct 96, direct 61. Working group with clinical colleagues discussing recruitment drive for Senior Healthcare Support Worker Apprentices in discussion to start this year.
- Recruitment for the May cohorts of non-clinical apprenticeships is progressing and we have been working with line managers to get feedback for programme improvements.

Safe Staffing

Under review with CNO



Mar-24	Day shift		Night Shift	
	RN/RM Fill rate	CA Fill rate	RN/RM Fill rate	CA Fill rate
Southmead	101.71%	93.03%	105.11%	111.69%

Ward Name	Registered nurses/ midwives Day	Care staff day	Registered nurses/ midwives Night	Care staff Night
AMU 31 A&B 14031				
Cotswold Ward 01269				
Elgar Wards - Elgar 1 17003				
Ward 25B 14242				
Ward 26A 14311				
Ward 27A 14402				
Ward 28A 14502				
Ward 32A CAU 14103				
Ward 32B SAU 14104				
Ward 33A 14221				
Ward 33B 14222				
Ward 34A 14325				
Ward 6B (mainly Neuro) 14211				
Ward 8B (Renal - 38 Bed) 14411				
Ward 9B Flex Capacity 14501				
		Below 80%		Over 120%

Safe Staffing Shift Fill Rates:
Ward staffing levels are determined as safe, if the shift fill rate falls between 80-120% , this is a National Quality Board (NQB) target.

What does the data tell us?
For March 2024, the combined shift fill rates for days for RNs across the 28 wards was 101.71% and 105.11% respectively for days nights for RNs. This is reflected through a higher acuity and number of escalation patients in month. The combined shift fill for HCSWs was 93.03% for the day and 111.69% for the night. Therefore, the Trust as a collective set of wards is within the safe limits for March.

March *registered nursing* fill rates:
- 3.57% of wards had daytime fill rates of less than 80%
- 0.00 % of wards had night-time fill rates of less than 80%
- 3.57% of wards had daytime fill rates of greater than 120%
- 10.71 % of wards had night-time fill rates of greater than 120%

February *care staff* fill rates:
- 14.29% of wards had daytime fill rates of less than 80%
- 3.57% of wards had night-time fill rates of less than 80%
- 10.71% of wards had daytime fill rates of greater than 120%
- 32.14% of wards had night-time fill rates of greater than 120%

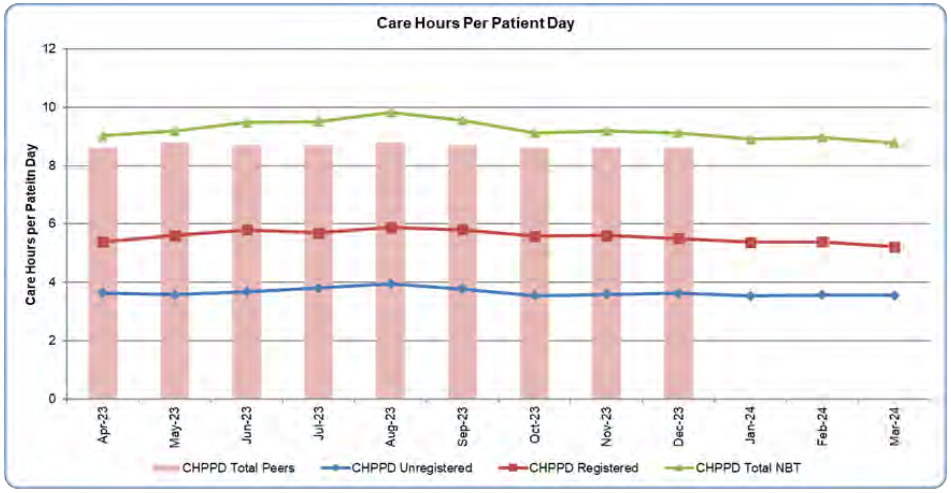
The “hot spots” as detailed on the heatmap which did not achieve the fill rate of 80% or >120% fill rate for both RNs and HCSWs have been reviewed. The fill rate <80% for care staff on the medical wards (AMU, Elgar, 9b) is due to shortage of HCSWs due to higher number of patients requiring enhanced care and driven by headroom.

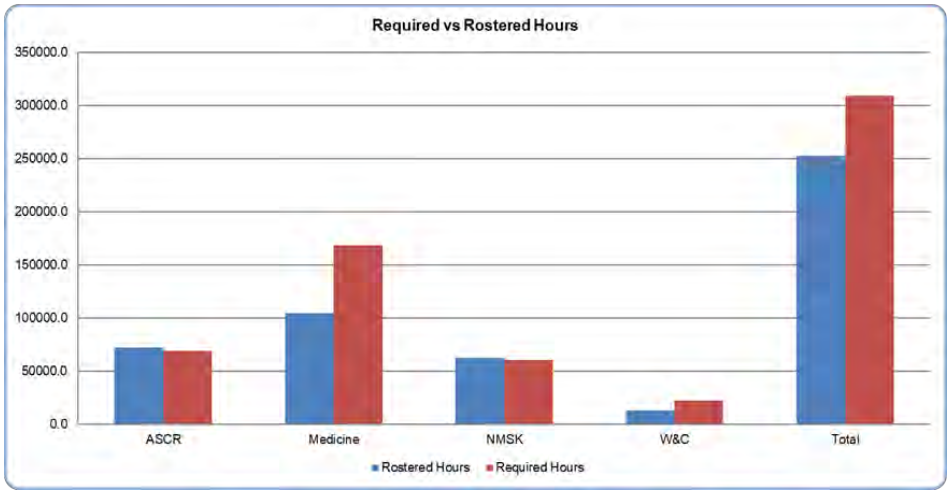
The areas above 120% for RNs are driven by winter high acuity and escalation areas in medicine and this is aligned to the recent safer staffing report findings for medicine. It is also driven by some wards who have a high proportion of IENs (6b). The increased fill rates for the percentage of HCSWs at night reflects the deployment of additional staff in response increased levels of therapeutic observation (enhanced care) to maintain patient safety – medicine and NMSK have seen high numbers of enhanced care patients.

Compliance:
The Safe Care Census regularity has been reduced to twice daily to more closely align with shift patterns. The average compliance is 55% and there are plans to improve compliance through robust monitoring at the daily staffing meetings.

Care Hours

Under review with CNO





Care Hours per Patient Day (CHPPD)
The chart shows CHPPD for the Model Hospital peers (all data from Model Hospital). CHPPD data provides a picture of how staff are deployed and how productively. It provides a measure of total staff time spent on direct care and other activities such as preparing medications and patient records. This measure should be used alongside clinical quality and safety metrics to understand and reduce unwanted variation and support delivery of high quality and efficient patient care.

What does the data tell us?
Compared to national levels the acuity of patients at NBT has increased and exceeded the national position.

Required vs Roster Hours
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 are redeployed between clinical areas and Divisions following daily staffing meetings involving all Divisions, to ensure safety is maintained in wards/areas where a significant shortfall in required hours is identified, to maintain patient safety.

What does the data tell us
The required hours have been augmented using the completion rate for SafeCare patient census data. Where the census completion was less than 100% the required hours have been supplemented by an assumption that for the census periods not completed the patient mix would have been the same on average. The data demonstrates that the total number of required hours has exceeded the available rostered hours.

To review with CMO

Medical Appraisal

What does the data tell us?

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

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

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.

11.2

NHS North Bristol NHS Trust

Report To:	Public Trust Board			
Date of Meeting:	30 May 2024			
Report Title:	Long-Term Workforce Plan Update			
Report Author:	Ben Pope, Head of Strategic Workforce Planning			
Report Sponsor:	Peter Mitchell, Interim Chief People Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
	No	**No**	**Yes**	**No**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
		X	**X**	**X**
Recommendations:	The Trust Board is asked to note the update on the progress against the actions described in the October 2023 Long-Term Workforce			
Report History:	Development of a Long-Term Workforce Plan for NBT was identified as a priority as part of our Trust strategy and in support of our new Clinical Strategy. Work was commissioned to develop this plan using Carnall Farrar as consultancy support, with an agreement that this would come to the Board for approval in October 2023. A commitment was made to bring an update back to the Trust Board in line with Operational Planning.			
Next Steps:	Further update to be provided to October 2024 Trust Board.			

Executive Summary

The ongoing aim of our Long-Term Workforce Plan is to respond to the workforce challenges facing the NHS and NBT, to ensure we have the right people with the right skills at the right time and at the right cost. It will also help us to align with the national, regional and system context and direction of travel, by identifying the workforce we require to meet the demand for our services in the longer-term (5 years).

This update to the Long-Term Workforce Plan that was submitted to the Trust Board in October focuses on the commitments made in the initial plan. In the October 2023 plan we made the following commitments:

1. Link this Long-Term Workforce Plan and workforce modelling with our 24/25 operational planning process.
   Update: *The modelling and assumptions developed during the 2024/25 planning process are being built into our Long-Term Workforce Plan with our updated forecast and 'Waterfall' charts to be presented to the People Oversight Group and People and EDI Committee.*

2. Refresh this Long-Term Workforce Plan and workforce modelling in March 2024, aligned to our proposed governance process.
   Update*: Updated actions and progress are contained within this Board update.*

3. Agree our implementation plan for the next 6 to 18 months, and high-level implementation plan for the next 5 years.
   Update: *Progress has been made, our Long-Term Retention and Commitment to our Community plans signed off with clear 2024/25 actions, other key actions have been taken, e.g., implementation of nurse degree apprenticeships new college apprenticeship route for Healthcare Support Workers.*

4. Fully quantify the cost/benefit analysis of the interventions described in this plan.
   Update: *Nationally financial challenges have delayed financial decisions for 2024/25 and thus longer term. We are agreeing an approach for demand forecasting aligned with the medium-term financial plan.*

5. Engage further within the Trust to share this Long-Term Workforce Plan and ensure stakeholders understand its implications for their area of the organisation.
   Update: *Initial engagement across divisions sharing of the first iteration of the plan and modelling via workshops and engagement through GMs away day. Focus on 2024/25 Work will continue and focus on context of KPMG internal audit recommendation to provide greater support and training to our divisional and professional stakeholders and embedding oversight of deliverables into our People Governance structure.*

The plan remains focussed on the six interventions themes proposed in the initial plan and builds in updates based on our developed assumptions, e.g., through our Long-Term Retention Plan, Commitment to our Community Plan and Operational Plan for 2024/25.

Our Long-Term Workforce Plan is 'live' and needs to respond to the changing local, regional, and national and international landscape balancing the needs of our internal stakeholders, e.g., divisions and professions, with our system partners through collaborative work such as the ICS People and Culture plan and working towards a Hospital Group model with University Hospitals Bristol and Weston. This ongoing need for evolution and improvement has been reflected in the next steps.

Next Steps

Approach, Support and Training

1. Continue to embed long-Term workforce planning and workforce data literacy across the Trust, responding to recommendations in the internal KPMG Workforce Planning audit – with a particular focus on training and support for divisional and professional stakeholders and developing a clear, coordinated and documented approach to workforce planning.

2. Develop the capacity and capability required to deliver this support to the Trust.

Workforce Modelling

3. Develop our workforce modelling to enhance how our existing tool is used, how it complements other more focused tools we already use (GooRoo, Safer Nursing Care Tool, Theatre Model), meets the need of all divisions and staff groups and considers how other tools can be utilised for maximum benefit, e.g., NHS England Optioneering tools.

4. Develop our workforce demand modelling to ensure we have a long-term view that can be used to underpin decision making including financial decisions. Align our workforce demand modelling to medium-term financial modelling and productivity work to ensure we

have the best approach to forecasting demand to underpin our supply plans. Aim to answer the question 'Broad', 'Narrow and Deep' or both?

Alignment

5. Develop our alignment with system partners via ICS People and Culture Plan, Joint Clinical Strategy, Acute Provider Collaborative and working towards our Hospital Group, in terms of our approach to planning, the tools we use and assumptions we develop. This must include working collaboratively with ICS and UHBW colleagues to work towards a singular approach to developing assumptions, modelling methodology and decision making.

Intervention Themes

6. Continue to develop our intervention themes and track the progress and impact of our actions within the Long-Term Workforce Plan.

7. Expand our theme around Growing Apprenticeships to encompass a wider learning, development, and education component to robustly respond to the requirements of the NHS England Long-Term Workforce Plan and Educator Workforce Strategy.

8. Combine Transform Teams and Implement New and Extended roles focused on the Clinical Strategy 'Blended Workforce' commitment. Seek to establish a multi-professional group to develop and deliver a systematic approach to deliver this commitment and embed this within the People Governance structure.

9. Develop the Productivity theme in line with ICS work on workforce productivity, including definitions and measurement approach and ensure we at NBT have accessed best practice to identify workforce productivity opportunities.

The next update of the plan is due to be provided to the Trust Board in October 2024.

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	X
	Innovate to Improve – *Unlocking a better future*	X
	Sustainability – *Making best use of limited resources*	X
	People – *Proud to belong*	X
	Commitment to our Community - *In and for our community*	X
Link to BAF or Trust Level Risks:	Trust Level Risk - 763	
Financial implications:	Financial implications of delivering the interventions and actions described in the Long-Term Workforce Plan will be assessed prior to initiating delivery and will follow the Trust business case approval process where required.	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	As detailed delivery plans are finalised for the actions described in the Long-Term Workforce Plan equality impact assessments will be completed.	
Appendices:	Appendix 1 - Action and Impact Progress Update Appendix 2 – Long-Term Workforce Plan Update Summary Slides	

NHS North Bristol NHS Trust

1 Purpose

1.1 The purpose of this paper is to provide the Trust Board with an update on the progress against actions that were committed to in the October 2023 version of the Trust Long-Term Workforce Plan and to outline the next steps towards the next Board update in October 2024.

2 Introduction

2.1 The ongoing aim of our Long-Term Workforce Plan is to respond to the workforce challenges facing the NHS and NBT, to ensure we have the right people with the right skills at the right time and at the right cost. It will also help us to align with the national, regional and system context and direction of travel, by identifying the workforce we require to meet the demand for our services in the longer-term (currently 5 years).

2.2 This paper represents an update to the Long-Term Workforce Plan that was submitted to the Trust Board in October 2023 and focuses on the commitments made in the initial plan, updating our assumptions as the have developed including through the delivery of our operational plan for 2024/25. In the October plan we made the following primary commitments:

2.2.1 **'Link this Long-Term Workforce Plan and workforce modelling with our 24/25 operational planning process'.**
The modelling and assumptions developed during the 2024/25 planning process are being built into our Long-Term Workforce Plan with our updated forecast and 'Waterfall' charts to be presented to the People Oversight Group and People and EDI Committee

2.2.2 **'Refresh this Long-Term Workforce Plan and workforce modelling in March 2024, aligned to our proposed governance process'.**
Updated actions and progress are contained within this Board update.

2.2.3 **'Agree our implementation plan for the next six to 18 months, and high-level implementation plan for the next 5 years'.**
Progress has been made, our Long-Term Retention and Commitment to our Community plans are signed off with clear 2024/25 actions, other key actions have been taken and are described throughout ensuring we have provided an update on our progress. As we look forward our plans must be aligned with

2.2.4 **'Fully quantify the cost/benefit analysis of the interventions described in this plan.'**
Nationally financial challenges have delayed financial decisions for 2024/25 and thus longer term. Following the submission of our Trust operational plan for 2024/25 in May-2024 we will now move to align our Long-Term Workforce Plan with the refresh of the medium-term financial model ensuring our forecast demand for workforce enables us to agree and cost supply interventions.

2.2.5 **'Engage further within the Trust to share this Long-Term Workforce Plan and ensure stakeholders understand its implications for their area.'**
Initial engagement across divisions sharing the first iteration of the plan and modelling via workshops and engagement through a General Manager's away day. Engagement in specific parts of the plan, e.g., retention, commitment to our community, apprenticeships and nursing resourcing have also taken place and the impact of that work is reflected in this plan. Engagement work will continue and focus on context of

KPMG internal audit recommendation to provide greater support and training to our divisional and professional stakeholders and embedding oversight of deliverables into our People Governance structure.

2.3 The plan remains focussed on the six interventions themes proposed in the initial plan and builds in updates based on our developed assumptions, e.g., through our Long-Term Retention Plan, Commitment to our Community Plan and Operational Plan for 2024/25.

2.4 Our Long-Term Workforce Plan is 'live' and needs to respond to the changing local, regional, and national and international landscape balancing the needs of our internal stakeholders, e.g., divisions and professions, with our system partners through collaborative work such as the ICS People and Culture plan and working towards a Hospital Group model with University Hospitals Bristol and Weston. This ongoing need for evolution and improvement has been reflected in the next steps.

3 Context

3.1 The NHS England 2024/25 operational planning process highlighted productivity challenges in our services and our workforce with significant financial constraints in place for 2024/25. This has meant our planning process since October 2023 has focused predominantly on 2024/25. However, national priorities have been defined for workforce and these focus on ongoing and longer-term interventions where action must be started or continued in 2024/25. The priorities focus on the People Promise and retention, improving the working lives of Postgraduate Doctors, and implementing the clinical expansion in the NHS Long-Term Workforce Plan through our educator workforce and placement capacity.

3.2 As part of the launch of the NHS England Long-Term Workforce Plan, we have participated in implementation planning workshops through Southwest regional NHS England teams and await the outcome which is anticipated to be a finalised implementation plan and funding arrangements. We anticipate delivery of actions to meet the aims of the national plan will be coordinated through Bristol, North Somerset, South Gloucestershire Integrated Care System's (ICS) 'People and Culture' plan which will be delivered through the establishment of a People Academy with the aim of developing and supporting the existing and future workforce to deliver the agreed priorities of the ICS.

3.3 Working with University Hospitals Bristol and Weston colleagues we will develop our plan, approach, and tools to support our Joint Clinical Strategy, Acute Provider Collaborative, and work towards a Hospital Group. Impact of closer partnership and collaborative working will be at the core of our ongoing Long-Term Workforce Plan development during 2024/25.

3.4 The plan will continue to inform and reflect our Patient First improvement priorities, our Long-Term Retention and Commitment to our Community plans. Work will be ongoing to develop how our plan can support our Clinical Strategy, Reset and Recovery and Long-Term Sustainability plans. Developing an agreed set of long-term demand assumptions across activity, workforce and finance and participation in focused workforce productivity planning with the ICS (which will be monitored through the ICS Strategic Oversight Group) will be key to ensuring our modelling and ultimately decision making is successful and our plans meaningful.

4 Actions to Deliver this Update

4.1 To develop our Long-Term Workforce Plan further, in October 2023 we committed to take the following overarching actions shown in table one, which contains an update on progress.

Table one, Actions to Deliver this Update

Intervention	Action	Date	Progress
Complete action plan and cost benefit analysis	Engage SROs and action owners to finalise the Workforce Programme Plan, including quantification of the cost benefit analysis of the interventions described in the plan.	Nov 2023	An updated proposal to embed each intervention theme into the People Governance Structure with oversight through the People Oversight Group is in progress. Intervention themes all have elements that will require cost benefit analysis and this proposal to embed delivery of actions into the People Governance structure will mean the analysis will be developed and owned by subject matter experts. Any cost benefit analysis will need to be incorporated in a single view in this plan but must be underpinned by an agreed and costed view of workforce demand which forms a key next step with finance partners.
	Embed monitoring of operational delivery in the Strategic Workforce Planning and Resourcing Group and oversight within the People Oversight Group.	Nov 2023	
Key stakeholder engagement in the ongoing process	Draft underpinning workforce planning approach guidance documents, to ensure consistent repetition and development of our Long-term Workforce Planning process including roles, responsibilities, key stakeholder activities and technical information on our planning approach.	Nov 2023	Initial guidance has been drafted with focus on divisions' roles and responsibilities and operational planning requirements. This draft will be finalised and include our long-term workforce planning approach by Q2 of 2024/25 taking account of alignment work with the Medium-Term Financial plan, Joint Clinical Strategy, Hospital Group work and the ICS (Integrated Care System) People and Culture plan development. Finalising and communicating this guidance also form part of the internal KPMG audit on workforce planning, with the following agreed management actions identified: **1** Document the workforce planning process including the review mechanism and roles and responsibilities of individuals involved in the process **2** Develop a clear business planning timetable set out with defined deadlines for submitting business
	Share definitions and planning approach with all relevant stakeholders to ensure consistency as we move into development of the next iteration of the plan.	Nov 2023	

			plans, meetings to support check and challenge and final sign-off at the relevant committee level. **3** Disseminate awareness among staff via regular communications on the workforce planning being done in the Trust and communicate the workforce plan and related policies.
Wider engagement within the Trust	Engage further within the Trust to share this Long-term Workforce Plan and ensure stakeholders understand its implications for their area of the organisations and the further work require for the next iteration to March 2024.	Nov 2023 to Mar 2024	The modelling approach was presented at the Operational Planning launch in November 2023 and at the General Managers away day and through individual divisions' stakeholder workshops in December 2023. How the plan will continue to be communicated and developed will require focussed work over the summer as we aim to develop our aligned approach both internally and with system partners.
Alignment with 2024/25 operational planning	Link this Long-term Workforce Plan and workforce modelling with our 24/25 operational planning process through engagement with our planning team and the planning team in our ICS.	Oct 2023 Feb 2024	Key assumptions developed in the Operational Planning process have been used to inform this update of the Long-Term Workforce Plan
Further iterate the plan	Refresh this Long-term Workforce Plan and workforce modelling to March 2024, ensuring the key actions in this plan relating to further alignment with other work, expansion of concepts, diving deeper into the data and modelling and, moving data quality improvement actions forward.	Nov 2023 - Mar 2024	Each intervention theme's impact has been modelled where possible and is being updated into a refreshed model to be presented to the People and EDI Committee in July 2024. The required focus on 2024/25 operational planning has meant capacity to focus on long-term planning assumptions and modelling has been limited. The next six months provides an opportunity to focus on the longer-term view, developing our thinking with system partners, and internally with clinical, finance and operational colleagues.

4.2 Our Long-Term Plan Interventions

4.2.1 Introduction

4.2.1.1 Our plan remains focussed on the six interventions themes proposed in the initial plan and builds in updates based on the development of our assumptions, e.g., through delivery of our Long-Term Retention Plan, Commitment to our Community Plan and Operational Plan for 2024/25.

4.2.1.2 Our plan is 'live' and needs to respond to the changing local, regional, national, and international landscape balancing the needs of our internal stakeholders, e.g., divisions and professions, with our system partners through collaborative work such as the ICS People and Culture plan and working towards a Hospital Group model with University Hospitals Bristol and Weston. This ongoing need for evolution and improvement has been reflected in the next steps.

4.2.1.3 In this update our intervention themes reflect where we are in our work across several workforce areas and we have highlighted where ongoing work is in place that will inform future updates to this plan and where further action is required to develop our intervention themes, e.g., a proposal to broaden 'Grow Apprenticeships' to encompass wider education and development, including work with Accredited Education Institutions and delivery of the NHS England Educator Workforce Strategy.

4.2.2 Enhance Recruitment

4.2.2.1 Recruitment is a strategic function that goes beyond filling vacancies. Having a considered and comprehensive recruitment strategy and approach plays a crucial role in shaping our performance, culture, and future capability as an organisation. The importance of recruitment and the teams, processes and systems that underpin it forms a key part of our Acute Provider Collaborative work, underpinning our workforce plans is ensuring that we can provide an attractive, modern, seamless, and efficient recruitment and employment offer. We know that Bristol is a highly desirable place to live and work, but the Southwest has the third highest house prices and the third lowest salaries in the country, and in Bristol the lowest house prices are ten times higher than the annual earnings of lower income households.

4.2.2.2 With a collective workforce of more than 24,000 staff, we are committed to working across UHBW and NBT to tackle these challenges together, working in collaboration to attract staff, ensuring that we truly make Bristol a great place to work, and that we offer opportunities for people to grow and develop their careers across the breadth of our health and care system. We know that working together will enable us to improve quality, efficiency, resilience and offer greater opportunities for the growth and development of our collective workforce, contributing to outstanding patient care. We aim to create a centre of excellence and recruitment expertise across our two Trusts. We believe that in doing so, we will enable opportunities for people to flourish and develop, and for them to have fulfilled roles and meaningful careers with us now and in the future.

4.2.2.3 Within NBT we have an ambition that everyone feels proud to belong, and in UHBW we strive to be the best place to work. This case for change outlines how we intend to bring together these ambitions as part of a shared vision, outlining how we propose to get there, and the investment needed to make this become a reality. We are

excited by this opportunity to work together and are committed to making this a success for the benefit of our teams, staff, and patients.

4.2.3 **Grow Apprenticeships**

4.2.3.1 Apprenticeships can be transformative for both the individual apprentice and the organisation they work for and are a key tool to help us to maintain and develop our workforce, expanding apprenticeship opportunities across NBT can help address workforce shortages, build supply in hard to recruit areas, and provide development opportunities for existing staff. Apprenticeships are a useful recruitment attraction tool; it is equally important to recognise their potential in developing capability and providing opportunities for existing staff.

4.2.3.2 The National Long-term Workforce Plan states that "apprentices are less likely to leave training compared to those in traditional undergraduate training programmes" and cite the example that "attrition rates for all current cohorts of Registered Nurse Degree Apprenticeship programmes are 4% compared to over 15% for traditional nursing undergraduate and postgraduate courses".

4.2.3.3 Expanding apprenticeships is a priority of the National Long-term Workforce Plan. NHS England has committed to supporting ICSs to develop local apprenticeship strategies and to create a funding approach that better supports employers, together with the government, a complete view of this arrangement from NHS England remains outstanding but pockets of funding and prioritisation have emerged since October 2023.

4.2.3.4 We have continued to embed our commitment to apprenticeships by recruiting three new staff members for the Mayoral Priorities Skills fund project, these roles are funded until 31st March 2025. One to work on apprenticeships (recruitment and retention/support), one on additional skills delivery (e.g., ICT, skills taster sessions, employability) and one on community engagement and mentorship and we aim to engage 302 people over the 13-month period 172 from community and 130 apprentices.

4.2.3.5 We aim to support 99 of our current apprentices who are facing barriers to their achievement through this work, and enrol 31 new apprentices who are BAME, disabled or under 21. Of the 172 community engagements, we aim to hire 50 new staff from underrepresented groups or areas.

4.2.4 **Improve Retention**

4.2.4.1 Improving retention helps us to maintain skills, experience and institutional knowledge within the Trust. It can also have significant benefits in supporting continuity of patient care.

4.2.4.2 Improving retention is one of our People Improvement Priorities, linked to Patient First and Our one-year retention plan launched in 2023/24 focussing on the three priority areas below. Turnover has improved from 17.1% in Mar-23 to 12.0% in Apr-24 (0.1% above our target of 11.9% by March 2025), we have delivered our one-year retention plan but maintain focus on improvements made and those improvements that still need to be monitored. Long-term target to 2028/29 has been re-baselined to 10% following positive

performance in 2023/24. Delivery of target has been applied to divisions and staff groups based on opportunity and an assessment of where interventions will be applied to have greatest impact.

4.2.4.3 NBT will continue to focus on these areas to sustain improvement:

- Flexible working
- Supporting new starters
- Staff wellbeing and support

4.2.4.4 Our Long-Term Retention plan will now build on these 2023/24 actions. The plan proposes several targeted interventions for different career stages: early career, experience at work and later career. These respond to the different risk points related to job satisfaction and retention at these stages. Our four themes are:

- Ensure a good work life balance
- Build a culture of kindness and belonging
- Supporting our leaders and managers
- Supporting career development and progression

4.2.4.5 Improved Retention through Delivery of the People Promise

4.2.4.6 As part of the 2025/25 national planning guidance NHS England set three workforce objectives with the 1st focussing on retention: ***'Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions'***

4.2.4.7 We recognise that 'When excellent staff experience is achieved, staff become inspired to be the best people they can be, which in turn delivers the best patient care. To achieve excellent staff experience NBT must create an environment where staff can feel valued, supported, encouraged, and ultimately succeed as outlined in the NHS People Promise

4.2.4.8 In early 2023 we were selected to be one of 116 NHS organisations from across England to take part in the People Promise Exemplar Programme in collaboration with NHSE national retention team

4.2.4.9 The purpose of the People Promise Exemplar Programme is: ***"To test the assumption that optimum delivery of all NHS People Promise interventions delivered in one place simultaneously can deliver improved staff experience and retention outcomes - beyond the sum of the individual components".***

4.2.4.10 To test the assumption exemplar sites have been asked to:

- Undertake an initial analysis of retention and staff survey data highlighting any key themes
- Complete a People Promise self-assessment in collaboration with key organisational stakeholders
- Develop retention improvement plans and key actions
- Deliver the retention improvement plans across the organisation

- Measure impact of retention improvement interventions
- Embed activity as business as usual

4.2.4.11 The People Promise project plan supports the delivery of our one and five year and retention plans, our Equality, Diversity and Inclusion Plan, our Commitment to our Community plan, our Long-Term Workforce Plan, and our People Strategy

4.2.5 **Transform Teams**

4.2.5.1 The National Long-term Workforce Plan has a priority around working differently to enable innovative ways of working. We must continue to explore opportunities to develop the ways we work. During the development of this plan, we explored the opportunity for us to re-profile adult inpatient ward nursing demand and change the shape of the nursing workforce

4.2.5.2 The impacts associated with the actions from this intervention theme in October 2023 have not been monitored or included in Appendix 1 as the proposed skill mix change between band 5 and 6 nurses on adult wards did not take place.

4.2.6 **Implement New and Extended Roles**

4.2.6.1 The National Long-term Workforce Plan seeks to expand using new roles as part of multidisciplinary teams. We have an opportunity to move activity (task shifting) to different professional groups through redesigning the composition of teams to make full use of enhanced and advanced practice roles in nursing allied health professions, healthcare science and pharmacy, and of Medical Associated Professions ("MAPs"). These roles are easier to recruit to, but unlike the intervention to transform teams, may necessitate an increase in overall WTE. Table 2 below shows the anticipated growth in these roles described in the National Long-term Workforce Plan

4.2.6.2 Expanding these roles can offer modernised, attractive career pathways contributing to improved recruitment and retention. These roles bring new skills into teams, which creates opportunities to improve patient care and experience. Considering the skills development of the healthcare workforce is a key component of the National Long-term Workforce Plan to meet the growing complexity of need for healthcare services.

4.2.6.3 Future of intervention theme - proposed integration with ‘Transform Teams’ aligned to Clinical Strategy ‘Blended Workforce’ people commitment. Acknowledge that this must take broadest possible view rather than focus on medical teams

4.2.6.4 The impacts below were described in the October 2023 plan with point 1 embedded within the Trust Clinical Strategy. Delivery of the actions above and impacts below must be underpinned by a clinically led multi-professional group with the focus of delivering the Clinical Strategy ‘Blended Workforce’ commitment.

- Double number of Physician Associates to 38 WTE in the next 2 years
- Increased % of staff in new roles as part of multidisciplinary teams

- Improved retention of staff
- Reduction in workforce shortfalls and in temporary staffing spend
- Improved staff experience
- Improved quality of care and experience for patients

4.2.7 **Productivity**

4.2.7.1 Improvements in productivity will be enabled by multiple work programmes (Reset and Recovery plan, Clinical Strategy, Long Term Sustainability Plan), some of which are already in progress and are already part of our existing strategy, e.g., theatre 10-hour day and outpatient optimisation within our Reset and Recovery plan.

4.2.7.2 Productivity forms one of the Trust's Patient First Corporate Projects under the pillar of Sustainability. The project seeks to provide data and insight at a speciality level of areas of opportunity where Productivity has decreased since 2019/20. This will use the Engagement Value Outcome (EVO) methodology with the support from the Sustainability team, with initial information being shared with the largest opportunity for improvement. Outside of this project divisions and corporate directorates will continue to identify cost improvement programmes that are driven by productivity improvement.

4.2.7.3 Taking this targeted approach is contrary to the current modelling where the NHS England Long-Term workforce plan assumption of a 0.8% improvement in labour productivity in the clinical workforce is applied form 2025/26 onwards by constraining the base case clinical workforce demand growth. Determining what will change because of productivity improvement is key to developing our modelling assumptions.

4.2.7.4 In addition to the clinical service development work that is aimed at improving productivity at NBT there is also productivity driven directly by workforce improvements may mean more staff in work or fewer staff having to be replaced, e.g., improvement in sickness absence and turnover – the Trust is targeting a reduction in sickness and turnover which is anticipated to have an impact on productivity. Achieving target sickness of 4.4% would mean a 12% reduction in sickness which would mean approximately 40 wte back at work. Improving turnover to 11.9% would mean 70 wte fewer staff leaving the organisation (based on current staff in post) than in 23/24, with less recruitment required and less productivity lost through new starters, new to the Trust or to the NHS or new to registration.

4.2.7.5 Developing our short and long-term labour productivity assumptions will need to consider anything with a workforce impact, to support this NHS England have a developed a labour productivity toolkit which will be used by our ICS to work with providers and develop a view of productivity that can be developed and implemented, and we will work collaboratively with the ICS using NHS England best practice to develop this intervention further.

4.2.8 **Our Intervention Theme Summary**

4.2.8.1 Work is ongoing to refine some of our underlying assumptions and actions in line with NHS England operational planning priorities for 2024/25 and our interpretation and application of them.

4.2.8.2 In addition, refinement of the current interventions and any newly identified interventions in the next iteration to March 2024. Where possible, the impact of some initiatives on our workforce gap has been quantified. There is more work to be done to establish potential scale and impact. Each will require further work to refine the investment, focused effort and resource required for their delivery.

5 Next Steps

5.1 Approach, Support and Training

5.1.1 Continue to embed long-Term workforce planning and workforce data literacy across the Trust, responding to recommendations in the internal KPMG Workforce Planning audit – with a particular focus on training and support for divisional and professional stakeholders and developing a clear, coordinated, and documented approach to workforce planning.

5.1.2 Develop the capacity and capability required to deliver this support to the Trust

5.2 Workforce Modelling

5.2.1 Refresh our workforce modelling with the updated assumptions and actions and present the 'Waterfall' outputs to the People Oversight Group and People and EDI Committee for assurance

5.2.2 Develop our workforce modelling to enhance how our existing tool is used, how it compliments other more focussed tools we already use (GooRoo, Safer Nursing Care Tool, Theatre Model), meets the need of all divisions and staff groups and consider how other tools can be utilised for maximum benefit, e.g., NHS England Optioneering tools.

5.2.3 Develop our workforce demand modelling to ensure we have a long-term view that can be sued to underpin decision making including financial decisions. Align our workforce demand modelling to medium-term financial modelling and productivity work to ensure we have the best approach to forecasting demand to underpin our supply plans. Aim to answer the question 'Broad', 'Narrow and Deep' or both?

5.3 Alignment

5.3.1 Develop out alignment with system partners via ICS People and Culture Plan, Joint Clinical Strategy, Acute Provider Collaborative and working towards our Hospital Group, in terms of our approach to planning, the tools we use and assumptions we develop. This must include working collaboratively with ICS and UHBW colleagues to work towards a singular approach to developing assumptions, modelling methodology and decision making.

5.4 Intervention Themes

5.4.1 Continue to develop our intervention themes and track the progress and impact of our actions within the Long-Term Workforce Plan.

5.4.2 Expand Grow Apprenticeships to encompass a wider learning, development, and education component to robustly respond to the requirements of the NHS England Long-Term Workforce Plan and Educator Workforce Strategy.

5.4.3 Combine Transform Teams and Implement New and Extended roles focussed on the Clinical Strategy 'Blended Workforce' commitment. Seek to establish a multi-professional group to develop and deliver a systematic approach to deliver this commitment and embed this within the People Governance structure.

5.4.4 Develop the Productivity theme in line with ICS work on workforce productivity, including definitions and measurement approach and ensure we at NBT have accessed best practice to identify workforce productivity opportunities.

5.4.5 **We must continue to embed and collectively own our Long-Term Workforce Plan and its development ensuring it continues to develop into meaningful process for decision making and assurance.**

Appendix 1 – Action and Impact Progress Update

The key below is for interpretation of the **specific action** tables. Where the 'progress' section is highlighted green the original status of 'Discovery', 'Development', or 'Delivery' has been maintained, where an action has moved from one status to another since October 2023 this is demonstrated with original tick mark turner amber, and the new tick mark is green.

Enhance Recruitment

Table one below shows the overarching actions for the intervention theme.

Table one, Overarching Actions Enhance Recruitment

Description	Action/Impact	Progress
Deliver the objectives of our Recruitment Services Reconfiguration	Action	Ongoing improvement work will now be delivered through the Acute Provider Collaborative. This work is in the process of determining its metrics and their anticipated impact. **Key Metric: Vacancy rates reduced 7.9% (Sep-23) → 5% (Mar-24)**
Continue improvement to reduce our overall withdrawal rate from 14% to 10% by 2028/29	Impact	Currently our withdrawal rate is 7.6% - further improvements will be developed through the Acute Provide Collaborative.
Complete Employer Brand and EVP business case	Action	Current investment request in our 2024/25 operational plan.
Develop our outreach plan - broadening our recruitment pools	Action	Through our Commitment to our Community plan, we have developed an outreach plan and recruited specialist resource into our Talent Acquisition team to support the delivery of this work.

Table two below shows the specific actions for the intervention theme.

Table two Specific Actions Enhance Recruitment

Intervention	Action				Original Completion Date	Progress
Improve our recruitment service delivery	Complete a pilot of Robotic Process Automation within the recruitment function by Jan 2024		✓ ← ✓		Jan 2024	Pilot paused awaiting alignment with wider digital strategy and current process improvement via Acute Provider Collaborative programme.
	Implement digital forms for candidates by Jan 2024, to reduce interview to offer to 12 days by Apr 2024			✓	Jan 2024	**Digital forms have been implemented.**
	Reconfigure the NBT recruitment service by the end of Q2 2024, through a review of role profiles and structures to better align with organisational need		✓ → ✓		Sept 2024	Through the People Directorate consultation, the initial review and restructure is in progress. The work of the Acute Provider Collaborative will then continue to transform and improve our team and their processes.
Develop a compelling Trust-wide Employer Brand and corresponding Employee Value Proposition ("EVP")	Complete Business Case for EVP (Employee Volume Proposition), with the first draft ready for BCRG approval for Jan 2024		✓ → ✓		Jan 2024	Current investment request in our 2024/25 operational plan – awaiting approval to proceed with business case.

Broaden our recruitment pools	Develop full outreach action plan under Commitment to our Community		✓ → ✓		Dec 2023	**Forms key part of agreed Commitment to our Community plan.**
	Redevelop JDs to improve inclusive language and emphasise on skills not qualifications		✓ → ✓		Dec 2023	Job Banding project lead in place and project in delivery to improve standardisation of job descriptions and incorporate more inclusive language.
	Develop Specialist Skills Recruitment cell to target advertising and international reach		✓ → ✓		Feb 2024	Talent Acquisition team expanded to offer a wider range of resourcing skills to the organsiation with outreach work with divisions in progress.

Grow Apprenticeships

Table three below shows the overarching actions associated the intervention theme

Table three, Overarching Actions Grow Apprenticeships

Description	Action/Impact	Progress
Finalise apprenticeships cost benefit analysis	Action	Work is in progress to develop a 'complete' approach to apprenticeship demand forecasting and cost impact assessment. A tool to capture current apprentices, apprenticeship completion and new apprenticeship demand and associated backfill requirements is in development. The aim of this tool is to ensure decision making on apprenticeship expansion is made in the round. National funding arrangements associated with delivering the aspirations in the NHS England Long-Term Workforce Plan.

12.1

Explore growing apprenticeships in other areas, which are not yet quantified	Action	Work has been ongoing develop apprentices in new areas, e.g., New college route for Healthcare Support Workers implemented in 2024/25 with 60 targeted in the 1st year, 13 Advanced Practitioners to be supported to accreditation through apprenticeship in line with the new Trust approach to Advanced Practice, NHS England funding for 11 Healthcare Scientist apprentices bid for and won to start in 2024/25, Midwifery apprenticeships scoped for 2025 academic year, new Medical apprenticeship pilot scoping in progress for 2025 start.
Grow our registered degree Nursing (+120) and AHP apprenticeships (+6) and Nursing Associate apprenticeships (+55 to get to cohort of 80 per year) by 181 apprenticeship starters per year (from internal and external recruitment) – from 2024/25 onwards	Impact	Registered Degree apprenticeships for nursing have been established for 2024/25 with two cohorts of 20 planned and the 1st cohort starting in May successfully recruited to. Funding has been agreed for these 40 only and a recurrent funded position is being sought, however the cost of backfill is a limiting step and the national position suggests apprenticeship expansion funding will not be to cover backfill. In order to fund this position a reduction in Nursing Associate apprenticeships for 2024/25 had to be implemented (from a cohort of 80 in total to 30). AHP degree apprenticeships plans have been developed and are being implemented, however a plan to increase apprenticeships to the levels described in the NHS England Long-Term Workforce plan have been limited by backfill costs.
Expand our entry level apprenticeships, with an additional 52 WTE additional starters per year recruited from outside the Trust – from 2024/25 onwards	Impact	External recruitment to apprenticeships remains a focus for the Trust, promoting certain role to always be advertised as apprentices and using a national 'Find an Apprenticeship' platform to promote adverts. The original assumptions related to externally recruiting to apprenticeship growth on top of base case – this has been adjusted to show impact of growing apprenticeships but with the assumption that this will be through internal movement and within existing starter volumes rather than in addition to.

6% of staff in post will be apprentices by 2028/29	Impact	Target has been set based on current profile of apprenticeships and thus apprenticeship levy utilisation, as our workforce profile and apprenticeship requirements change this % may be reviewed and change accordingly.

Table four below shows the specific actions and progress associated with the intervention theme.

Table four, Specific Actions Grow Apprenticeships

Intervention	Action				Date	Progress
Increase Registered Degree Nursing Apprenticeships	Have 20 Registered Nurse Degree Apprenticeships in post by Jan 2024 and 40 more in the pipeline by Mar 2024			✓	Mar 2024	**Nurse degree apprenticeships – 2 cohorts of 20 in 24/25 with 20 started in May and a further 20 in October.**
Increase Registered Degree Apprenticeships	Identify additional professional groups for increased numbers of apprenticeships and develop appropriate business cases to quantify and outline the cost benefit analysis for the next tranche of work.		✓ ⇒ ✓		Mar 2024	This process will be ongoing as we develop the overarching case to support degree apprenticeships through long-term demand and supply forecasting.

Increase external hires to low-level apprenticeships	Review opportunities required and developed an action plan for next steps	✓	✓		Jan 2024	Targeted actions have been taken to promote external recruitment to apprenticeships, and this action is embedded within our Commitment to our Community plan.

Improve Retention

Table five below describes the overarching actions and progress associated with the intervention theme.

Table five, Overarching Actions Improve Retention

Description	Action/Impact	Progress
Deliver objectives of our Retention Plan and champion our flexible working offer	Action	Our one-year retention plan has been delivered with key elements continuing in our long-term retention plan which has been signed off and is in delivery. Flexible working remains one of the core elements of our retention offer.
Assess impact on retirement rates of changes to NHS pension scheme in Oct 2023.	Action	NHS pensions workshop for People colleagues took place in 2024. Retire and Return policy re-write in progress to make our offer clearer for staff.
Develop our Employer Brand and Employee Value Proposition (EVP) Impact across all professional groups.	Action	Our EVP business case forms part of our investment request for 2024/25 operational planning – awaiting investment decision.
Achieve our Trust Retention Plan target for retention of 13% by March 2028.	Impact	Our target has been re-baselined to 10% by 2028/29 as we have achieved below 13% by the start of 2024/25.
Where sectors are already hitting target or over-performing, set a further improvement trajectory based on the planned Trust improvement trajectory.	Impact	Our re-baseline turnover target takes account of division and professions level improvement.

By 2028/29, improved retention will mean 383 fewer wte leave NBT each year.	Impact	Our re-baselined target of 10% will deliver 225 wte per year.

Table six below shows the specific actions associated with the intervention theme

Table six, Specific Actions Improve Retention

Intervention	Action				Date	Progress
Flexible working	Relaunch flexible working policy to reduce staff self-selecting workforce life balance as reason for leaving Trust by Mar 2024		✓		Mar 2024	**We have delivered this action.** **2022/23 - 21% of staff's top reason for leaving was 'work life balance' 2023/24 – target met as this reduced to 18%**
	Deliver Autumn Retention Drive - Let's Talk Flexible Engagement to achieve: - a 10% improvement for the National staff survey 2023 question: 'I can approach my immediate line manager to talk openly about flexible working' - A minimum 80% approval rate of formal Flexible working requests (period 1.9.23 – 31.3.24)			✓	Mar 2024	**We have delivered this action.** **We are tracking at 90% overall positive delegate feedback for the HELM programme**

12.1

Supporting new starters	Ensure business cases for fixed term roles include process to assess if permanent role is offered at contract end, to reduce multiple recruitment activity for the same role		✓		**Dec 2023**	This work is in progress.
Staff well-being and support	Implement improved and extended induction for HCSW to ensure: - all have 1/3/6-month new starter check-ins by Mar 2024 - first new additional support sessions in place by Jan 2024 - Increase itchy feet contacts by a minimum of 25% in the period 23/24 compared to 22/23		✓ →	✓	Mar 2024	This action remains in progress with ongoing work to promote and ensure consistency of regular check-ins during HCSWs' first 12 months in post We have matured the additional support session into a celebration event to take place in July 2024
	Deliver Autumn Retention Drive – Retention Wellbeing Conversations, Staff Health Checked and Vaccinations to achieve: - 10% reduction in staff selecting 'work life balance as a reason for leaving' (6 months Sept 2023 – Mar 2024 compared with the same period 22/23) - 60 health check slots per week for staff by Jan 2024			✓	Mar 2024	**We have achieved this action.** **2022/23 - 21% of staff's top reason for leaving was 'work life balance' 2023/24 – target met as this reduced to 18%**

12.1

Transform Teams

Table seven below shows the overarching actions and progress associated with this intervention theme.

Table seven, Overarching Actions Transform Teams

Description	Action/Impact	Progress
Conduct cost benefit analysis, gather external feedback and take decision whether to pursue	Action	In developing this action, the concept of the adult ward nursing skill mix was not pursued prior to the stage where a cost benefit analysis was required.
In addition to this potential reprofiling there is a need for a systematic review of adult inpatient ward responses to recent establishment reviews	Action	This action has been superseded by the implementation and ongoing focus and validation of the new Safer Nursing Care tool.

Table eight below shows the specific actions and progress associated with Transform Teams.

Table eight, Specific Actions Transform Teams

Intervention	Action				Date	Progress
Re-profiling of nursing roles	Map skillsets across Nursing, starting with areas with largest Nurse band 5 shortfall to review if skills activity can be reconfigured to other roles			✓ → ✓	Mar 2024	In Nov 2023 a new validated Safer Nursing Care tool was implemented for adult ward nursing, implementing this tool and analysing and understanding its impact and how to further embed the tool in our establishment review process became the priority action to underpin this action. The tool and analysis

						took place, but further iterations are required to determine impact – a second application of the tool is in progress in May-2023
	Validate impact on activity-to-WTE ratios and outputs of first modelling iteration.	✓	→	✓	Dec 2023	Review is in progress for ward nursing initially. Impact of the new Safer Nursing care Tool has meant that validation of its impact must be considered vs population driven demand growth of model vs a constrained bed base
Increased use of enhanced, advanced, and associate roles	Further Pilots and POD modelling to consider broader use of AHP roles within Divisions and define new AHP roles and career pathways by Feb 2024	✓			Feb 2024	Further scoping of this opportunity is required – initial driver has been instability in AHP teams but this position has begun to stabilise so timing of this action will be reviewed – currently paused.
	Appraise Clinical Fellow review to produce an activity plan that identifies how we better utilise 20% study time for Trust activity, and to manage the 20% output gap and consider QI incentives	✓	→	✓	Mar 2024	Less than full time working for Postgraduate Doctors increasing, coupled with Clinical Fellow workforce where 80% clinical + 20% study time contracts in place and for some clinical divisions has triggered the need for a review of all rota's – currently due to commence in August 2024.

Implement New and Extended Roles

Table nine below shows the overarching actions and progress associated with this intervention theme.

Table nine, Overarching Actions Implement New and Extended Roles

Description	Action/Impact	Progress
Consider additional professional groups to explore use of new and extended roles.	Action	This approach will require further effort to coordinate across professions initially through the People Governance structure.
Improve data quality for roles within this intervention to better enable workforce planning and workforce redesign.	Action	Since October 2023 a piece of work to map all Advanced Practitioners in partnership with the Trust Advanced Practice lead has delivered an analysis and recommendation to adopt new national coding available for our workforce systems and finance ledger for Advanced Practice – final validation in progress with sign off scheduled for July-2024

Table ten below shows the specific actions and progress associated with the intervention theme.

Table ten, Specific Actions Implement New and Extended Roles

Intervention	Action				Date	Progress
Systematically review and identify opportunities to expand Enhanced, Advanced and MAPs	Set up International Exchange partnership trial with Pune including nursing skills such as OH and Therapists as well as Clinical roles	✓	→	✓	Mar 2024	The pipeline with Pune has been initiated focussing initialling medical clinical observership.
	Map skillsets across medical workforce to underpin Clinical Strategy Implementation		✓		Mar 2024	Draft approach has been completed by role and finalisation will need to form part of the coordinated work planned through the clinical strategy 'Blended Workforce' work stream.

12.1

Continue to develop our five-year Advanced Practice Strategy	Complete work to map AHP staff, including numbers and skillsets and deliver an AHP Strategy by Mar 2024		✓ ⇒ ✓		Mar 2024	AHP staff are identifiable within the Trust and the Chief AHP owns the AHP Strategy. Recruitment of a deputy Chief AHP is in progress to provide ongoing support to the delivery of this work.

Productivity

Table eleven below shows the overarching actions and progress associated with the intervention theme.

Table eleven, Overarching Actions Productivity

Description	Action/Impact	Progress
Nuance the application of our assumption between different staff groups and roles	Action	Nuance encompasses definition and measurement of productivity – where the impact is seen, e.g., lower unit costs, reduced demand for workforce, increased output
Fully map how our Trust existing productivity programs realise workforce benefits	Action	Productivity forms one of the Trust's Patient First Corporate Projects under the pillar of Sustainability. Provides data/insight at a speciality level of areas of opportunity where Productivity has decreased since 2019/20 using Engagement Value Outcome (EVO) methodology no formal workforce component currently within this project. Other clinical programmes such as Theatres 10 Hour Day and Outpatient Transformation will identify any workforce impact, but this will happen based on existing project timelines. Workforce productivity mapping is beginning at NBT and aligned with system work via the ICS People and Culture plan. An NHS England framework developed in Northeast Yorkshire will be used and monitored through ICS Workforce Strategic Oversight group
Develop our improvement trajectory and monitor delivery over time	Action	This trajectory must be developed in line with the work described in the action above.

Table twelve below shows the specific actions and progress associated with the intervention theme.

Table twelve, Specific Actions Productivity

Intervention	Action				Date	Progress
Apply a productivity improvement assumption of 0.8% across our clinical workforce	Review application of productivity assumption of 0.8% to all clinical roles, to capture further nuance		✓		Mar 2024	Progress against these actions will be delivered as part of the ongoing work to develop a plan for labour productivity in partnership with the ICS and aligned to other system partners.
	Create an improvement trajectory to monitor achievement of the 0.8% yearly improvement target.					

12.1

NHS
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Improvement Priority: **Long-Term Workforce Plan**

May 2024

NBTCARES

Aim of our Long-Term Workforce Plan – A Reminder

- The **aim** of our Long-Term Workforce Plan is to ensure we have the **right people** with the **right skills** at the **right time** and at the **right cost**.

- It also helps us to **align with the national and regional context** and direction of travel.

  - We have developed a **new workforce modelling approach** for NBT to underpin our thinking which is **guided by the principles, best practice and methodology that underpins the national NHS Long-Term Workforce Plan**.

  - This helps us to **move from retrospective data** to workforce data literacy to ensure we plan for the **right workforce against activity for the future and mitigate supply shortages**.

    - We have **already put the groundwork** in to support this plan (for example engagement with divisions through our in-year workforce planning process)

    - We are now embedding this **strategic plan for our future** workforce supply to address our workforce gap.

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Introduction – What did we Commit to Last Time?

- Link this Long-Term Workforce Plan and workforce modelling with our **24/25 operational planning process**
  Update: The modelling and assumptions developed during the 2024/25 planning process are being built into our Long-Term Workforce Plan with our updated forecast and 'Waterfall' charts to be presented to the People Oversight Group and People and EDI Committee.
  - Refresh this Long-Term Workforce Plan and workforce modelling in **March 2024**, aligned to our proposed governance process
    Update: Updated actions and progress are contained within this Board update.
    - **Agree our implementation plan** for the next 6 to 18 months, and high-level implementation plan for the next 5 years *Update: Progress has been made, our Long-Term Retention and Commitment to our Community plans signed off with clear 2024/25 actions, other key actions have been taken, e.g., implementation of nurse degree apprenticeships new college apprenticeship route for Healthcare Support Workers.*
    - Fully quantify the **cost/benefit analysis** of the interventions described in this plan – *Nationally financial challenges have delayed financial decisions for 2024/25 and thus longer term. We are agreeing an approach for demand forecasting aligned with the medium-term financial plan.*
    - **Engage further** within the Trust to share this Long-Term Workforce Plan and ensure stakeholders understand its implications for their area of the organisation - *Initial engagement across divisions sharing of the first iteration of the plan and modelling via workshops and engagement through GMs away day. Focus on 2024/25 Work will continue and focus on context of KPMG internal audit recommendation to provide greater support and training to our divisional and professional stakeholders and embedding oversight of deliverables into our People Governance structure.*

Wider Context

- **NHS England 2024/25 operational planning process**. Operational planning priorities were not issued until 27th March 2024, for People there are three objectives for 2024/25, focus on the People Promise and Retention, Improve Postgraduate Doctors Working Lives, Implement the Clinical Expansions in the NHS Long-Term Workforce Plan

- **NHS England Long-Term Workforce Plan. We are participating in i**mplementation planning workshops through Southwest regional NHS England teams and awaiting outcome and finalised implementation plan and funding.

- **ICS People and Culture Plan. We are participating in the r**efresh of the ICS People Programme and development of the People and Culture plan in response to national long-term workforce plan.

- **Joint Clinical Strategy, Acute Provider Collaborative and Hospital Group.** Impact of closer partnership and collaborative working will be at the core of plan development during 2024/25.

- **Update on Patient First improvement priorities** Long-Term Retention Plan focussed on flexibility, long-term careers, Commitment to our Community, focussed on shifting where we recruit from, providing support to our most challenged local communities. Clinical Strategy - Long-Term Sustainability Plan – NBT will participate in focused workforce productivity planning with the ICS and this will be monitored through the ICS Strategic Oversight Group.

Interventions to Close the Gap

NHS North Bristol NHS Trust

The next slides provide a summary against each of the six intervention themes focusing on assumptions and next steps in the October 2023 plan, progress, proposed changes and new work.

ENHANCE RECRUITMENT

NHS North Bristol NHS Trust

Original Assumptions Demand / Supply

- Increase our hiring rate from 2024/25 onwards through a targeted reduction of offers ending in withdrawals to 10% by 2028/29
- Improved staff experience – with vacancies filled more quickly staff may feel less stretched.

Key Actions

- Deliver the objectives of our Recruitment Services Reconfiguration
- Complete Employer Brand and Employer Value Proposition business case
- Develop our outreach and Commitment to our Community plan
- Progressing a collaborative recruitment model with UHBW through the Acute Provider Collaborative.

Updated Assumptions and Progress

Recruitment Services Reconfiguration
- Delivered rapid improvement to recruitment processes
- Withdrawal rate progress 14% (Sep-23_ → 7.6% (Mar-24)
- Vacancy rates reduced 7.9% (Sep-23) → 5% (Mar-24)

Employer Value Proposition
- Current investment request in our 2024/25 operational plan

Outreach
- Forms key part of agreed Commitment to our Community plan
- Recruiting local staff can support the trust to connect more effectively with the community, facilitating community connections, engagement and outreach programmes – 50 roles in 2024/25
- Recruit a dedicated outreach role – complete

APC / Commitment to our Community
- Project initiated aimed at providing an attractive, modern, seamless, and efficient recruitment and employment offer. Improving quality, efficiency, resilience and offer greater opportunities for the growth and development of our collective workforce, contributing to outstanding patient care

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GROW APPRENTICESHIPS

NHS North Bristol NHS Trust

Original Assumptions

- Grow our registered degree Nursing (+120) and AHP apprenticeships (+6) and Nursing Associate apprenticeships (+55 to get to cohort of 80 per year) by 181 apprenticeship starters per year (from internal and external recruitment) – from 2024/25 onwards
- Expand our entry level apprenticeships, with an additional 52 WTE additional starters per year recruited from outside the Trust – from 2024/25 onwards
- 6% of staff in post will be apprentices by 2028/29

Key Actions

- Finalise apprenticeships cost benefit analysis
- Explore growing apprenticeships in other areas, which are not yet quantified (e.g., healthcare scientists, midwifery and a physician associate apprenticeship which is about to be launched)

Updated Assumptions and Progress

Finalise Apprenticeship Cost Benefit Analysis

- Five-year demand forecast tool in development to support planning, optimum use of levy and backfill assessment
- Business planning process for apprenticeship expansion and funding backfill in development, current national position is funding cannot be used for backfill despite apprenticeship expansion

Apprenticeship Expansion

- 40 (from original assumption of 120) registered degree apprenticeships have been funded in short term but required a reduction in Nursing Associate apprenticeships (planned 80 reduced to 30)
- Positive vacancy position requires re-assessment of volume of 'additional' external recruitment required – apprenticeship expansion will remain targeted
- Entry level apprenticeships being finalised – 60 targeted from new college route
- Commitment to our Community Plan focussing on specific areas of underrepresentation, includes a range of professions as well as a focus on apprenticeships and entry levels into the key staffing groups across the organisation through networking and promotion of career pathways

Apprenticeships in Other Areas

- Accessing Healthcare Science apprentice grants, Medical and Midwifery degree apprenticeships being scoped for start within 12 months

Broaden Intervention Theme

- Proposal to broaden to include wider education and development and include response NHS England - Educator Workforce Strategy

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INCREASE RETENTION

NHS North Bristol NHS Trust

Original Assumptions

- Impact across all professional groups.
- Achieve our Trust Retention Plan target for retention of 13% by March 2028.
- Where sectors are already hitting target or over-performing, set a further improvement trajectory based on the planned Trust improvement trajectory.
- By 2028/29, improved retention will mean 383 fewer WTE leave NBT each year.

Key Actions

- Deliver objectives of our Retention Plan Champion our flexible working offer
- Assess impact on retirement rates of changes to NHS pension scheme in Oct 2023.
- Develop our Employer Brand and Employee Value Proposition

Updated Assumptions and Progress

Deliver objectives of Retention Plans

- One-year retention plan delivered with ongoing focus on improvements made and five-year retention plan signed off and in delivery
- Long-term target re-baselined to 10% following positive performance in 2023/24 and engagement work with divisions
- Delivery of target has been applied to divisions and staff groups based on opportunity and an assessment of where interventions will be applied to have greatest impact

Impact on retirement post NHS pension scheme change.

- Voluntary early retirement rates have seen an increase since Oct-23 however the numbers are small and more time and further analysis is required
- Retention plans include pension related interventions

Develop our Employer Brand/Employee Value Proposition

- Current investment request in our 2024/25 operational plan

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TRANSFORM TEAMS

NHS North Bristol NHS Trust

Original Assumptions

- Impact on ward-based nursing teams (excluding ED, ITU, theatres and outpatients)
- Change the shape of our inpatient nursing teams. (Band 4: +75 WTE, Band 6: +133 WTE, Band 7: +25 WTE, Band 5: -233 WTE)
- Reduction in vacancies in band 5 nursing and in need for international recruitment
- Reduction in temporary staffing costs to cover gaps.

Key Actions

- Map skillsets across the nursing workforce and validate modelling quantification of impact.
- Conduct cost benefit analysis, gather external feedback and take decision whether to pursue.
- In addition to this potential reprofiling there is a need for a systematic review of adult inpatient ward responses to recent establishment reviews

Updated Assumptions and Progress

Conduct cost benefit analysis

- Further discussion relating to potential adverse impacts of the proposed changed to inpatient wards
- Upcoming role profile consultation for nursing and midwifery roles band 4 and above must also be considered
- Positive improvements in vacancies due to improved retention and successful recruitment has meant reduced reliance on international recruitment planned for 2024/25 and ongoing

Systematic review of adult inpatient establishment reviews / Map skillsets across the nursing workforce

- New national tool has demonstrated potential significant additional need – validation is ongoing and must be worked through using further iterations of the tool

Future of Intervention Theme

- Proposed integration with 'New and Extended Roles' aligned to Clinical Strategy 'Blended Workforce' people commitment

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IMPLEMENT NEW & EXTENDED ROLES

NHS North Bristol NHS Trust

Original Assumptions

- Double number of Physician Associates to 38 WTE in the next 2 years
- Increased % of staff in new roles as part of multidisciplinary teams
- Improved retention of staff
- Reduction in workforce shortfalls and in temporary staffing spend
- Improved staff experience
- Improved quality of care and experience for patients

Key Actions

- Map skillsets across the medical workforce, identify areas which would most benefit from new roles and quantify impact.
- Complete cost benefit analysis and take decision to pursue team redesign
- Develop AHP workforce models in line with our AHP Strategy.
- Consider additional professional groups to explore use of new and extended roles.
- Improve data quality for roles within this intervention to better enable workforce planning and workforce redesign

Updated Assumptions and Progress

Workforce Planning for New and Extended Roles

- Advanced Practice policy and approach to supporting advanced practice developed
- Initial data set developed to map skills (using role) across teams and align to workforce metrics to identify opportunity
- Focussed work happening in specialty teams but overarching approach to identifying opportunities and prioritise in systematic way required – scoping in progress
- Clinical Strategy People Commitment (and Joint Clinical Strategy) – Governance and Actions

Future of Intervention Theme

- Proposed integration with 'Transform Teams' aligned to Clinical Strategy 'Blended Workforce' people commitment. Acknowledge that this must take broadest possible view rather than focus on medical teams

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INCREASE PRODUCTIVITY

NHS North Bristol NHS Trust

Original Assumptions

- Impact on all clinical staff groups
- Assumption to improve productivity year on year by 0.8% from the national Long-Term Plan.
- Suppress growth in workforce demand for clinical staff by 219 WTE over 5 years, or around 44 WTE per year on average, starting from 2024/25.

Key Actions

- Nuance the application of our assumption between different staff groups and roles
- Fully map how our Trust existing productivity programmes realise workforce benefits
- Develop our improvement trajectory and monitor delivery over time

Updated Assumptions and Progress

Nuance application between different staff groups and roles

- This can be undertaken once the actions below have been implemented.
- Nuance also encompasses definition and measurement of productivity – where the impact is seen, e.g., lower unit costs, reduced demand for workforce, increased output

Map existing productivity programmes realise workforce benefits

- Productivity forms one of the Trust's Patient First Corporate Projects under the pillar of Sustainability. Provides data/insight at a speciality level of areas of opportunity where Productivity has decreased since 2019/20 using Engagement Value Outcome (EVO) methodology - no formal workforce component
- Other clinical programmes such as Theatres 10 Hour Day and Outpatient Transformation will identify any workforce impact
- Workforce productivity mapping is beginning at NBT and aligned with system work via the ICS People and Culture plan. An NHS England framework developed in Northeast Yorkshire will be used and monitored through ICS Workforce Strategic Oversight group

Develop improvement trajectory and monitor delivery

- We can do this once the definitions, measurement and assessment of opportunity has taken place as outlined above.

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Next Steps

NHS North Bristol NHS Trust

Approach, Support and Training

1. Continue to embed long-Term workforce planning and workforce data literacy across the Trust, responding to recommendations in the internal KPMG Workforce Planning audit – with a particular focus on training and support for divisional and professional stakeholders and developing a clear, coordinated and documented approach to workforce planning.

2. Develop the capacity and capability required to deliver this support to the Trust.

Workforce Modelling

1. Develop our workforce modelling to enhance how our existing tool is used, how it complements other more focused tools we already use (GooRoo, Safer Nursing Care Tool, Theatre Model), meets the need of all divisions and staff groups and considers how other tools can be utilised for maximum benefit, e.g., NHS England Optioneering tools.

2. Develop our workforce demand modelling to ensure we have a long-term view that can be used to underpin decision making including financial decisions. Align our workforce demand modelling to medium-term financial modelling and productivity work to ensure we have the best approach to forecasting demand to underpin our supply plans. Aim to answer the question ‘Broad’, ‘Narrow and Deep’ or both?

Next Steps

Alignment

1. Develop our alignment with system partners via ICS People and Culture Plan, Joint Clinical Strategy, Acute Provider Collaborative and working towards our Hospital Group, in terms of our approach to planning, the tools we use and assumptions we develop. This must include working collaboratively with ICS and UHBW colleagues to work towards a singular approach to developing assumptions, modelling methodology and decision making.

Intervention Themes

1. Continue to develop our intervention themes and track the progress and impact of our actions within the Long-Term Workforce Plan.

2. Expand our theme around Growing Apprenticeships to encompass a wider learning, development, and education component to robustly respond to the requirements of the NHS England Long-Term Workforce Plan and Educator Workforce Strategy.

3. Combine Transform Teams and Implement New and Extended roles focused on the Clinical Strategy 'Blended Workforce' commitment. Seek to establish a multi-professional group to develop and deliver a systematic approach to deliver this commitment and embed this within the People Governance structure.

4. Develop the Productivity theme in line with ICS work on workforce productivity, including definitions and measurement approach and ensure we at NBT have accessed best practice to identify workforce productivity opportunities.

NHS North Bristol NHS Trust

NBTCARES

Report To:	Public Trust Board			
Date of Meeting:	30 May 2024			
Report Title:	Integrated Performance Report			
Report Author:	Lisa Whitlow, Associate Director of Performance			
Report Sponsor:	Executive Team			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
	N/A	**N/A**	**N/A**	**N/A**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			✓	
Recommendations:	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 in the Integrated Performance Report.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	✓
	High Quality Care – *Better by design*	✓
	Innovate to Improve – *Unlocking a better future*	✓
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	✓
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	This report links to the following BAF risks: • BAF Significant Internal Risk (SIR) 1 "Patient Flow & Ambulance Handovers" • BAF Significant Internal Risk (SIR) 1.1 "Long Waits for Treatment" • BAF Significant Internal Risk (SIR) 2 " Workforce" • BAF Significant Internal Risk (SIR) 17 "Underlying Financial Position"	
Financial implications:	Whilst there is a section referring to the Trust's financial position, there are no financial implications within this paper.	
Does this paper require an EIA?	N/A	
Appendices:	Slides	

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North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

May 2024

(presenting April 2024 data)

NBTCARES

Contents

North Bristol Integrated Performance Report

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Trend	Benchmarking (in arrears except A&E & Cancer as per reporting month)	
																			Peer Performance	Rank
Responsiveness	A&E 4 Hour - Type 1 Performance	R	95.00%	68.00%	80.16%	70.74%	75.15%	71.49%	71.94%	64.33%	60.56%	63.37%	67.17%	63.30%	64.87%	63.77%	63.56%		54.11%	1/11
	A&E 12 Hour Trolley Breaches	R	0	-	2	39	10	12	17	23	223	213	269	318	168	260	324		5-2228	3/11
	Ambulance Handover < 15 mins (%)		65.00%	-	38.76%	33.96%	34.54%	32.21%	26.14%	25.74%	25.35%	30.54%	29.30%	34.33%	39.53%	37.39%	41.13%			
	Ambulance Handover < 30 mins (%)	R	95.00%	-	82.40%	73.03%	78.48%	74.86%	70.85%	64.84%	57.57%	66.56%	61.70%	64.15%	71.52%	68.29%	72.73%			
	Ambulance Handover > 60 mins		0	-	87	231	164	165	182	317	620	438	548	532	326	364	440			
	Average No. patients not meeting Criteria to Reside			202	208	190	198	200	198	195	218	228	243	245	233	211	233			
	Bed Occupancy Rate			100.00%	96.08%	97.14%	96.99%	95.81%	93.63%	95.59%	97.12%	96.84%	96.28%	97.81%	97.40%	97.48%	98.16%			
	Diagnostic 6 Week Wait Performance		5.00%	3.02%	17.44%	17.48%	18.64%	15.10%	14.18%	12.50%	11.40%	9.81%	10.11%	12.28%	5.19%	4.22%	3.10%		23.28%	2/10
	Diagnostic 13+ Week Breaches		0	0	740	593	595	300	124	59	17	14	7	4	5	0	0		0-2485	1/10
	RTT Incomplete 18 Week Performance		92.00%	-	62.66%	63.23%	61.02%	60.97%	60.50%	60.53%	61.52%	61.94%	60.14%	61.11%	61.58%	59.75%	60.36%		53.87%	8/10
	RTT 52+ Week Breaches	R	0	1427	2684	2798	2831	2689	2599	2306	2124	1858	1685	1393	1383	1498	1609		74-15824	2/10
	RTT 65+ Week Breaches			180	591	594	619	624	606	582	545	420	388	249	193	146	192		0-3658	2/10
	RTT 78+ Week Breaches	R		28	65	84	59	44	48	48	55	49	50	45	39	27	18		0-326	3/8
	Total Waiting List	R		47823	47861	47731	49899	50119	50168	48969	48595	47698	47245	46710	46394	46278	46441			
	Cancer 31 Day First Treatment		96.00%	95.63%	86.27%	90.77%	87.80%	81.59%	0.00%	0.00%	85.61%	88.14%	86.30%	77.12%	86.18%	83.07%	-		88.00%	9/10
	Cancer 62 Day Standard	R	85.00%	78.02%	53.20%	54.21%	52.15%	50.81%	0.00%	0.00%	55.74%	58.04%	55.74%	48.42%	45.14%	51.82%	-		55.43%	9/10
	Cancer 28 Day Faster Diagnosis	R	75.00%	75.64%	66.43%	65.14%	57.36%	54.96%	0.00%	0.00%	59.46%	71.42%	74.89%	70.88%	74.80%	73.79%	-		59.46%	8/10
	Urgent operations cancelled ≥2 times		0	-	0	0	0	0	0	0	0	1	1	0	0	0	-			

RAG ratings (Red/Green) are against Current Month Trajectory. For metrics with no trajectory, RAG rating is according to comparison with previous month, except for Urgent Operations Cancelled ≥ 2 times and Diagnostic 6 Week Wait Performance which is RAG rated against National Standard.

North Bristol Integrated Performance Report

Domain		Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Trend
Quality, Safety and Effectiveness	Trust Quality Metrics	Summary Hospital-Level Mortality Indicator (SHMI)				0.98	0.98	0.99	0.99	0.98	0.98	0.99	0.97	-	-	-	-	-	
		Never Event Occurrence by month		0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	
		Commissioned Patient Safety Incident Investigations				2	4	0	0	2	2	2	1	1	2	0	1	1	
		Healthcare Safety Investigation Branch Investigations				0	0	0	0	0	0	0	1	1	2	0	0	0	
		Total Incidents				1019	1120	1082	1042	1161	1135	1491	1547	1182	1251	1340	1291	1135	
		Total Incidents (Rate per 1000 Bed Days)				37	38	37	35	41	40	48	52	39	39	45	40	37	
		WHO checklist completion			95.00%	99.20%	96.97%	97.77%	99.01%	98.58%	97.68%	99.08%	99.36%	99.43%	99.52%	99.82%	99.71%	99.89%	
		VTE Risk Assessment completion	R		95.00%	95.61%	95.03%	94.97%	94.72%	94.33%	93.88%	92.96%	92.83%	91.63%	86.25%	85.21%	84.91%	-	
		Pressure Injuries Grade 2				20	15	18	17	12	14	11	10	12	11	18	10	14	
		Pressure Injuries Grade 3			0	0	0	0	0	2	1	0	0	1	1	0	0	0	
		Pressure Injuries Grade 4			0	0	0	0	0	1	0	0	1	0	0	1	0	0	
		Pressure Injuries rate per 1,000 bed days				0.63	0.45	0.55	0.47	0.46	0.46	0.26	0.34	0.33	0.35	0.47	0.28	0.36	
		Falls per 1,000 bed days				5.92	6.39	5.66	4.91	5.73	4.96	6.45	6.56	6.38	5.58	5.72	5.66	5.18	
		MRSA	R	0	0	0	0	1	1	0	0	1	1	0	0	0	0	1	
		E. Coli	R		4	8	4	7	4	2	7	5	11	5	6	5	2	6	
		C. Difficile	R		5	1	4	11	6	2	5	4	3	2	2	9	8	6	
		MSSA			2	1	2	6	9	5	2	4	3	6	3	3	2	2	
		Observations Complete				99.14%	99.05%	98.89%	99.22%	97.56%	96.48%	99.02%	98.83%	98.66%	98.73%	98.50%	98.60%	98.90%	
		Observations On Time				41.65%	42.49%	45.38%	48.37%	61.62%	69.58%	73.33%	75.00%	72.04%	72.85%	71.82%	72.94%	70.70%	
		Observations Not Breached				52.73%	53.66%	57.47%	58.21%	73.78%	80.83%	85.17%	88.39%	85.54%	85.57%	84.80%	84.52%	83.10%	
	Maternity	5 minute Apgar 7 rate at term			0.90%	0.79%	0.00%	0.72%	0.93%	0.45%	0.64%	0.68%	1.82%	0.78%	0.23%	1.22%	1.90%	1.00%	
		Caesarean Section Rate				36.41%	42.80%	44.37%	40.65%	46.33%	47.02%	42.89%	43.19%	41.26%	44.90%	47.50%	44.74%	45.88%	
		Still Birth rate			0.40%	0.24%	0.21%	0.44%	0.43%	0.21%	0.29%	0.21%	0.21%	0.72%	0.43%	0.00%	0.22%	0.00%	
		Induction of Labour Rate			32.10%	36.89%	35.91%	33.55%	38.04%	32.08%	30.65%	34.31%	30.21%	36.65%	31.67%	31.36%	34.45%	32.71%	
		PPH 1500 ml rate			8.60%	3.16%	4.09%	2.87%	4.13%	2.31%	2.68%	3.97%	2.96%	2.42%	2.38%	4.04%	2.68%	3.52%	
	Fragile Hip	Fragile Hip Best Practice Pass Rate				68.42%	55.00%	43.10%	62.00%	58.00%	55.77%	79.17%	70.59%	61.40%	60.00%	67.92%	71.43%	-	
		Admitted to Orthopaedic Ward within 4 Hours				47.37%	47.50%	27.59%	40.00%	48.00%	36.54%	33.33%	25.49%	21.05%	28.57%	9.43%	14.29%	-	
		Medically Fit to Have Surgery within 36 Hours				70.18%	67.50%	44.83%	62.00%	58.00%	55.77%	81.25%	72.55%	68.42%	64.29%	71.70%	73.47%	-	
		Assessed by Orthogeriatrician within 72 Hours				96.49%	85.00%	93.10%	96.00%	98.00%	96.15%	97.92%	96.08%	91.23%	88.57%	90.57%	95.92%	-	
	Stroke	Stroke - Patients Admitted				94	121	181	133	191	156	155	164	157	184	163	152	96	
		Stroke - 90% Stay on Stroke Ward			90.00%	86.36%	87.01%	85.71%	89.02%	80.91%	84.62%	82.22%	71.95%	77.42%	75.22%	76.47%	78.13%	-	
		Stroke - Thrombolysed <1 Hour			60.00%	56.25%	42.86%	73.33%	44.44%	68.18%	52.38%	75.00%	56.25%	37.50%	85.71%	60.00%	78.13%	-	
		Stroke - Directly Admitted to Stroke Unit <4 Hours			60.00%	73.24%	58.97%	61.86%	66.67%	58.93%	56.19%	59.78%	61.45%	70.97%	58.62%	63.92%	61.54%	-	
		Stroke - Seen by Stroke Consultant within 14 Hours			90.00%	93.59%	77.42%	84.11%	80.00%	86.89%	87.93%	89.80%	85.71%	92.23%	86.47%	95.50%	84.21%	-	

RAG ratings (Red/Green) are against Current Month Trajectory. For metrics with no trajectory, RAG rating is according to comparison with previous month, except for Urgent Operations Cancelled ≥ 2 times and Diagnostic 6 Week Wait Performance which is RAG rated against National Standard.

North Bristol Integrated Performance Report

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Trend
Quality & Caring Patient Experience	Friends & Family Positive Responses - Maternity				94.44%	93.50%	91.79%	88.81%	91.00%	89.49%	89.49%	89.29%	91.73%	92.73%	91.16%	93.93%	90.05%	
	Friends & Family Positive Responses - Emergency Department				86.07%	79.57%	81.95%	81.75%	83.58%	74.74%	72.80%	79.33%	80.94%	81.44%	81.12%	73.99%	77.89%	
	Friends & Family Positive Responses - Inpatients				92.85%	93.29%	91.62%	93.65%	93.70%	93.37%	91.96%	92.53%	91.30%	92.71%	91.98%	91.55%	92.73%	
	Friends & Family Positive Responses - Outpatients				95.53%	95.43%	94.67%	95.46%	95.13%	94.04%	94.65%	95.45%	96.01%	95.31%	94.58%	95.12%	95.33%	
	PALS - Count of concerns				120	141	141	145	123	135	139	152	103	191	133	157	137	
	Complaints - % Overall Response Compliance			90.00%	73.17%	79.49%	80.00%	79.63%	64.10%	71.11%	65.00%	60.00%	73.00%	79.00%	71.00%	84.62%	86.11%	
	Complaints - Overdue				3	1	6	5	4	5	9	10	3	5	6	4	2	
	Complaints - Written complaints				38	57	44	42	48	49	60	49	36	44	40	39	36	
Workforce	Agency Expenditure ('000s)				1533	1948	2342	2402	2242	2182	2093	2184	1610	1507	1592	1368	891	
	Month End Vacancy Factor				6.21%	7.96%	8.03%	8.25%	7.69%	7.16%	6.62%	6.42%	5.87%	4.87%	4.82%	5.02%	2.55%	
	Turnover (Rolling 12 Months)	R		-	16.56%	16.29%	15.90%	15.19%	15.03%	14.59%	14.13%	13.74%	13.30%	13.09%	12.91%	12.32%	12.01%	
	Sickness Absence (Rolling 12 month)	R		-	5.19%	5.08%	5.07%	4.94%	4.92%	4.91%	4.89%	4.81%	4.70%	4.66%	4.67%	4.65%	4.62%	
	Trust Mandatory Training Compliance				80.99%	82.00%	84.23%	84.73%	86.69%	87.04%	89.39%	90.69%	91.06%	90.14%	89.44%	91.16%	91.50%	

RAG ratings (Red/Green) are against Current Month Trajectory. For metrics with no trajectory, RAG rating is according to comparison with previous month, except for Urgent Operations Cancelled ≥ 2 times and Diagnostic 6 Week Wait Performance which is RAG rated against National Standard.

Executive Summary – May 2024

Urgent Care

Four-hour performance reported at 63.56% in April. NBT ranked first out of 11 AMTC providers but was not compliant with the national requirement of 76%. 12-hour trolley breaches reported at 324 last month, whilst there were 272 ambulance handover delays over one-hour. There were two primary drivers for the position; the first was a 13.02% increase in ED presentations compared to April 2023, and a rise in the NC2R position for the month leading to a commensurate increase in bed occupancy. Executive-level escalation at system-level continues. Discussions amongst System COOs have reached a position where a new NC2R level ambition is being set; to reduce the NC2R percentage within NBT to 15%. This is now a key contingent in the Trust committing to the 78% ED 4-hour performance requirement for March 2025. Community-led D2A programme remains central to ongoing improvement. Work also progresses around development of a “Transfer Of Care” Hub (TOC Hub) modelled on recommendations from the national UEC plan and aimed at reducing barriers to transfers of care through a single multi-disciplinary and multi-agency hub. In the meantime, internal hospital flow plans continue to be developed and implemented.

Elective Care

Having delivered the clearance of capacity related 65-week wait breaches at the end of 2023/24, the Trust has now submitted a plan which aims to clear all non-capacity related breaches by September 2024. While plans are in place for most specialties, there is an outstanding challenge (related to complex procedures and limited clinical capacity) in clearing the remaining backlog of some specialist breast reconstruction surgery. However, the position is constantly changing with new options being considered and implemented.

Diagnostics

Performance in April-24 continues to meet the requirements for 2024/25, reporting at 3.10% (against target of 5%). No patient is waiting longer than 13 weeks for diagnostic and greater than 95% are now receiving their diagnostic test within 6-weeks. The Trust is setting an ambition to go beyond national requirements and return to national constitutional standards of no more than 1% breaching 6-weeks in the coming year.

Cancer Wait Time Standards

Despite significant referral increases in tumour sites such as Gynaecology, Skin and Breast etc. – and in the face of significant activity losses due to industrial action, the Trust has met its requirement to reduce the 62-Day backlog to less than 6% of the total waiting list. The reported position for end of March was 174 patients – against a peak of nearly 1000 patients 18 months ago. The February FDS position reported at 74.80% and March reported 73.79%, just below the 75% requirement. This resulted from an unplanned loss of capacity in one of our high-volume tumour site specialties i.e. Skin cancer. Remedial actions are already in place to recover the loss, but fundamental clinical and pathway redesign is the route to sustainable performance.

Executive Summary – May 2024

Quality

Within Maternity, the term admission rate to NICU rose to 6.4% against a national target of 5% quarterly. PMRT has remained fully compliant with Maternity Incentive Scheme (MIS) requirements during Q4 and there have been no maternal admissions to ICU or new MNSI cases during March 2024. Training compliance remains on target to meet MIS requirements.. In April, the overall number of reported medication incidents reduced as has the ratio of all incidents to those causing harm. Infection control data for April showed an increase in C-Difficile, with a slight breach of annual trajectory, E-Coli cases were below annual trajectory and there was one new MRSA case. Improvement work continues for the sustained increase in MSSA rates, which reflects regional/national trends. The reducing trend in falls rates continued, which include a notable reduction in patients experiencing multiple falls. The number of Grade 2 pressure injuries remained stable, with no grade 3 or 4s in the past month and overall decreases seen for 2023/24. The 2023-24 CQUIN position was positive, with 6/8 national schemes fully achieved, one partially and one that fell short (flu vaccinations). The year-2 workplan for Patient & Carer Experience has been set, reflecting the Trust's approved Quality priorities. 92.87% of patients gave the Trust a FFT positive rating, which remains within the expected range of performance. Complaint response compliance further improved to 86% in April. All complaints are acknowledged within 3 working days and this month we have profiled the important work of our Complaints Lay review panel which provides objective feedback on the quality of investigations and responses to support continuous improvement in our approach

Workforce

NBT's Rolling 12-month staff turnover rate decreased from 12.32% in March to 11.95% in April, 0.05% above the target set for 2024/25; work is in progress to identify opportunities for further improvement. We remain focussed on monitoring the impact of our actions from the one-year retention plan through delivery of our five-year retention plan, particularly the proportion of our Healthcare Support Workers leaving within the 1st 12 months of service.
Following approval of our Commitment to our Community plan work is in progress across several areas to improve our disparity ratio and meet the Trust target of 1.25 by March 2025 and to grow our employment from our 30 most challenged communities, community outreach, mentorship, work experience, diverse recruitment panels and positive action to support underrepresented groups to apply for roles in the Trust are aim to support our aims.
Trust-wide agency spend and usage has seen a significant decrease between March and April, with the Trust below the 2024/25 target for agency spend in both months

Finance

The financial plan for 2024/25 in Month 1 (April) was a deficit of £2.0m. The Trust has delivered a £3.6m deficit, which is £1.6m worse than plan. In month 1 the Trust has seen the impact of temporary staffing costs above substantive staffing levels and unidentified CIP offset by the delays in investment and ERF funding. Unidentified savings within the in year position are creating a £1.4m adverse variance, the impact of which is offset by delays in investments and vacancies. The Trust cash position at Month 11 is £56.0m, a reduction of £6.7m from Month 1. This is driven by the Trust I&E deficit and capital spend. The Trust has delivered £0.4m of completed cost improvement programme (CIP) schemes at month 1. There are a further £7.1m of schemes in implementation and planning that need to be developed, and £23.5m in the pipeline.

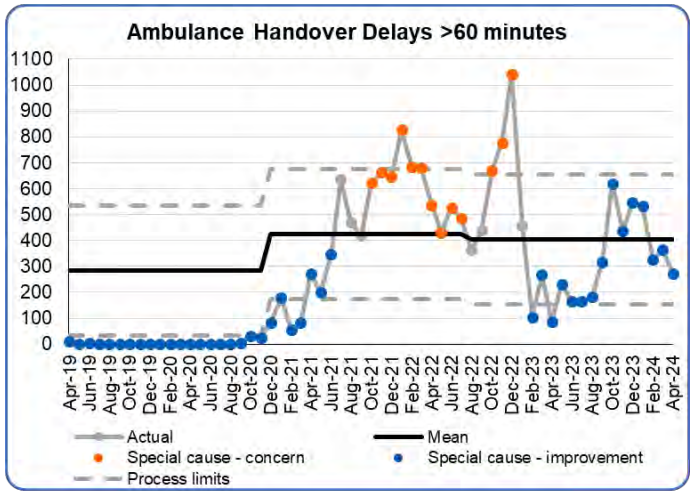
Responsiveness

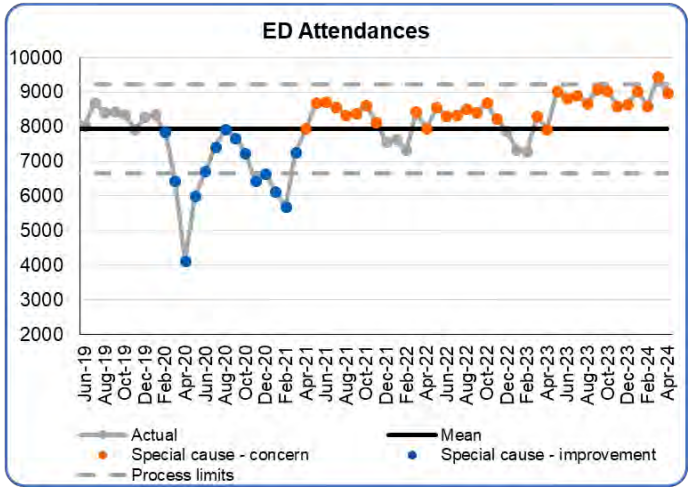
Board Sponsor: Chief Operating Officer
Steve Curry

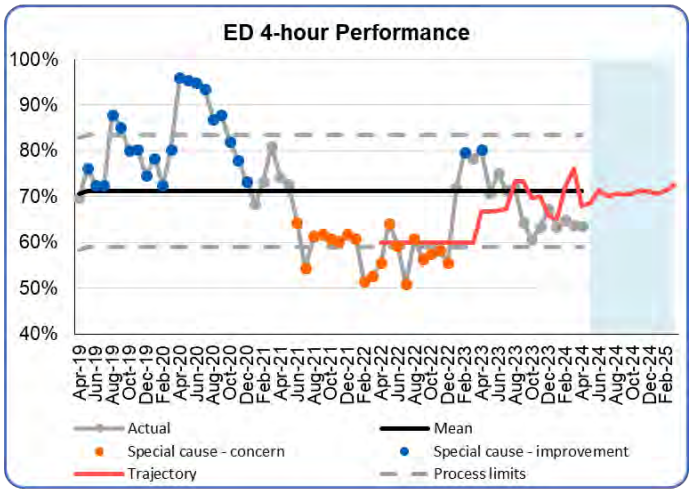
Responsiveness – Indicative Overview at April-2024

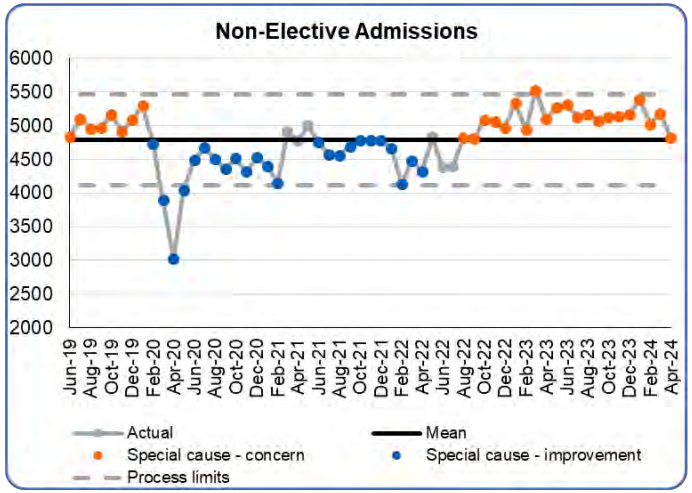
Delivery Theme	Delivery Indicator	Key Improvement /Delivery Action
Urgent & Emergency Care	UEC plan	Internal and partnership actions continue.
	NC2R/D2A	Secured NC2R reduction ambition from System. Aiming for 17% in Q1 and 15% in Q2.
RTT	65-week wait	Still a challenged position for a small number of specialist procedures
Diagnostics	5% 6-week target	Achieved
	CDC	Phase 1 (mobiles in place) Phase 2 (fixed build) by the 30/08/2024
Cancer	28-day FDS Standard	End of 2023/24 recovery impacted by unplanned loss of capacity and a 50% percentage point increase in Skin referrals compared to Apr-23. Sustainable delivery requiring System and clinically-led pathway changes. Despite this, the improved performance at NBT resulted in the organisation being removed from national tiering.
	62-Day Combined Standard	Stabilising operational plans and moving to clinical and System pathway change as a means of securing sustainable performance. The latest reported position is 64%, which is higher than the required 60% for national tiering.

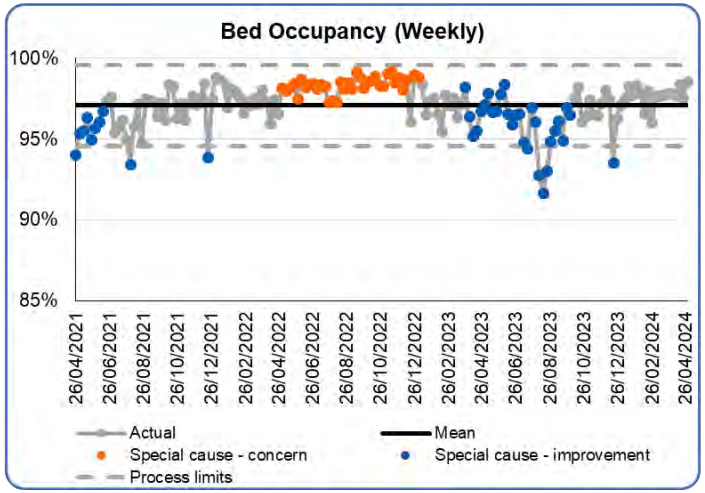
Urgent and Emergency Care

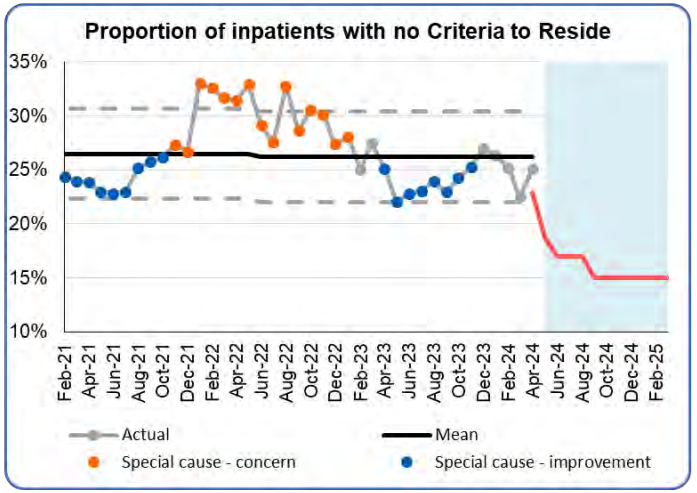












Urgent and Emergency Care

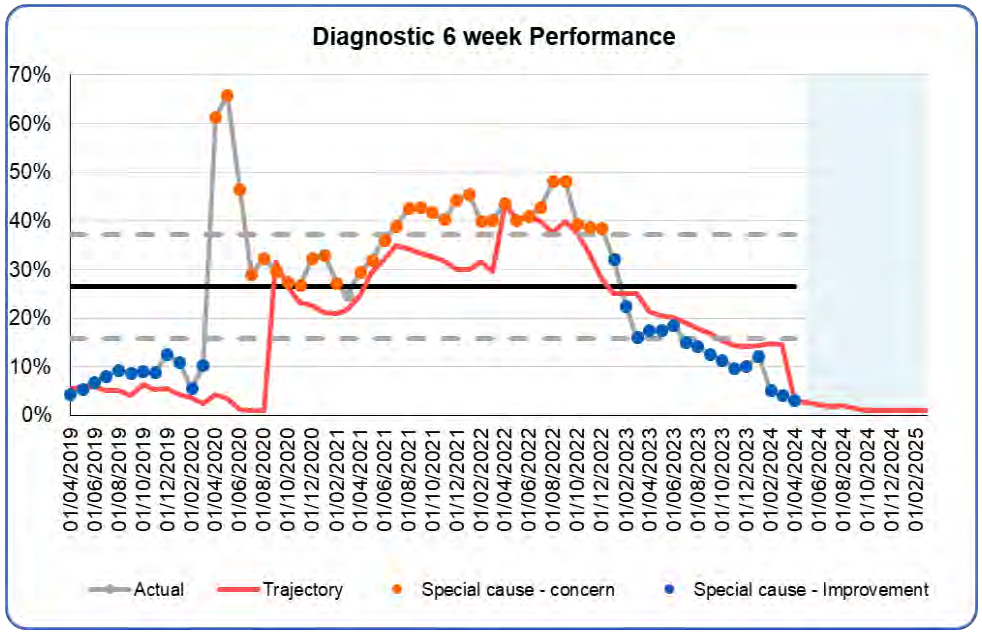
What are the main risks impacting performance?

- High volumes of NC2R continue to compound an already pressured UEC hospital pathway. As previously noted, the increase between October - December 2023 coincided with a period of planned bed reductions within community beds; a position which has been challenged at the point of planning by NBT.
- Year-on-year ED attendances have been increasing in previous months, but there was a marked increase yet again in April, showing attendances at 13.02% higher than April 2023.

What actions are being taken to improve?

- Executive and CEO-level escalation regarding NC2R impact - commitment secured from system partners to focussed work with revised reduction ambition.
- Ambulance handovers – the Chief Nursing Officer led a 'refresh' of the continuous flow model in response to December ambulance delays. Although the approach had continued over the summer, its scale of deployment was commensurate with a lower level of patient flow pressure. The approach has been reintroduced more rigorously with two-hourly monitoring in place. The normal risk mitigations which have been previously used continue to apply in using this 'balance of overall risk' approach.
- Ongoing introduction of the UEC plan for NBT; this includes key changes such as implementing a revised SDEC service, mapping patient flow processes to identify opportunities for improvement and implementing good practice ward level patient review and discharge processes (including actions recommended from the ECIST review).
- A revised bed plan for winter was designed, having used a previous summer reserve to compensate for community bed losses in the early autumn. The revised plan included the build-up of a new bed reserve based on higher levels of patient discharge in the pre-Christmas period. While the new reserve was significant, the pressures experienced in the post-Christmas period meant that much of this had been deployed earlier than planned.
- Development of a "Transfer Of Care" Hub (TOC Hub) modelled on recommendations from the national UEC plan and aimed at reducing barriers to transfers of care through a single multi-disciplinary and multi-agency hub.

Diagnostic Wait Times



What are the main risks impacting performance?

- The Trust continues to achieve target of no more than 5% patients waiting over 6-weeks; with performance reported at 3.10% for April 2024.
- The Trust is maintaining clearance of all >13-week breaches.
- Staffing gaps within the Sonography service and a surge in urgent demand means that the NOUS position remains vulnerable. Given the volume of this work, any deterioration can have a material impact on overall performance.
- Risks of imaging equipment downtime, staff absence and reliance on independent sector. Further industrial action remains the biggest risk to compliance.

What actions are being taken to improve?

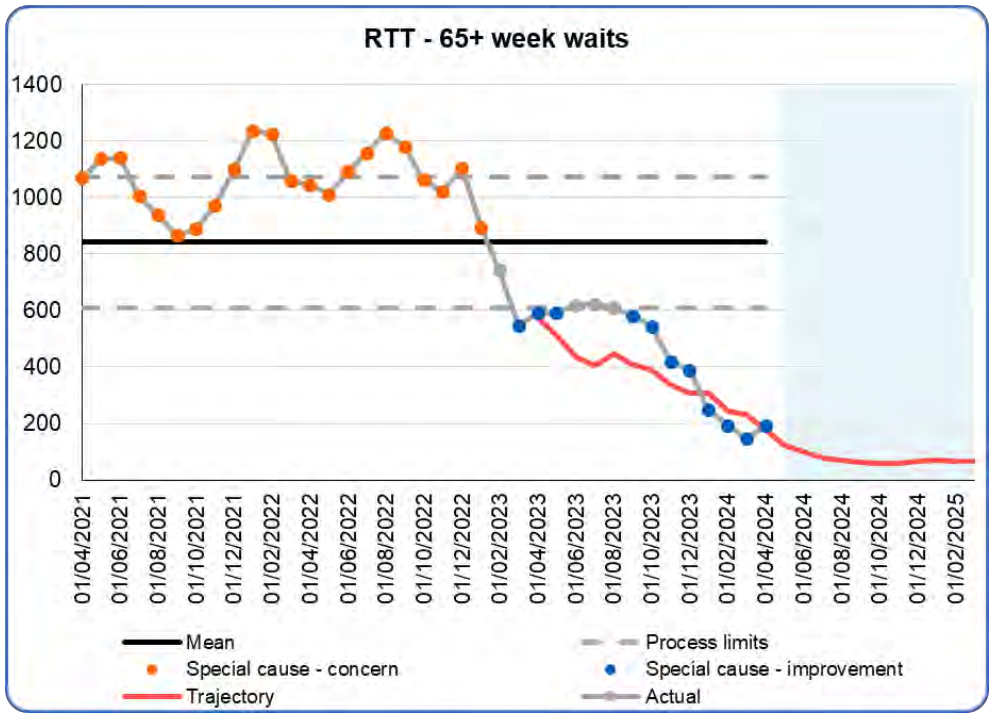
- The Trust has committed to actions that deliver the national constitutional standard of 1% in 2024/25.
- CDC commenced 01/04/2024 in temporary accommodation with phase 2 (fixed build) commencing from 30/08/2024.

Diagnostic Imaging Reporting Turnaround Times (TATs)

Standard	Maximum Target	Performance as at Apr-24	Commentary	Drivers of Performance	Actions
• ED – all patients • Inpatient – Acutely unwell and urgent (CT & MRI)	Within 12-hours	**94.2%**	Perform well in this area	Challenges driven by significant demand increases	• Dedicated Consultant in ED 08:00-21:00 • 2 x Radiology Registrars in ED
• Inpatient – non-urgent (CT, MRI & Plain Film)	Within 24-hours	**96.2%**	Perform well in this area	Challenges driven by significant demand increases – particularly CT and MRI ? Stroke expansion related	• Continuing to address recruitment challenges – see below
• Outpatient – non-urgent (CT, MRI & Plain Film)	Within 28-days	**78.4%**	Challenges in cross-sectional TATs e.g. CT and MRI	Challenges driven by significant ED and Inpatient demand competing with meeting GP access requirements – urgent and cancer referrals prioritised	• Recruitment initiatives to attract Consultant Radiologists including internationally • Increase Radiographer vetting and reporting • Increase volume of outsourcing cross-sectional imaging reporting
• GP Direct Access – non-urgent (CT, MRI & Plain Film)	Within 28-days	**97.3%**			

The new national imaging reporting turnaround times were released in August 2023. We will be required to report performance against these targets – awaiting reporting methodology from NHSE.

Referral To Treatment (RTT)



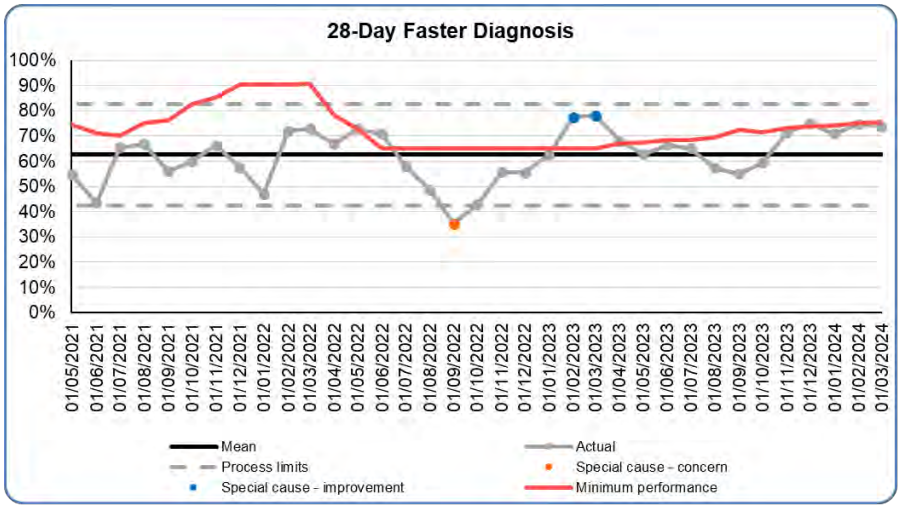
What are the main risks impacting performance?

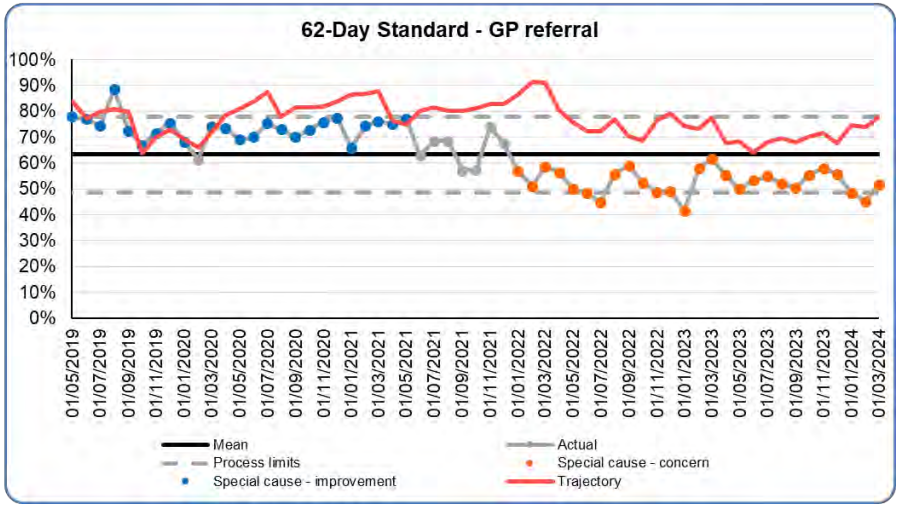
- Continued impact of repeated periods of industrial action.
- Rebooking of cancelled cancer and urgent patients is displacing the opportunity to book long-waiting patients.
- Continued reliance on third party activity in a number of areas.
- The potential impact of UEC activity on elective care.
- Challenges remain in a small number of specialist procedures.

What actions are being taken to improve?

- Trust has committed to zero 104-week breaches from the end of June 2024.
- Plans to eliminate 65-week and 78-week wait breaches for all specialties, with the exception of DIEPs, by Sept-24.
- Speciality level trajectories have been developed with targeted plans to deliver required capacity in most challenged areas; including outsourcing to the IS for a range of General Surgery procedures and smoothing the waits in T&O between Consultants.
- Options for Independent Sector (IS) transfer are limited to patients meeting IS treatment criteria. The Trust has transferred all suitable patients into available capacity across local IS Providers.
- The Trust is actively engaged with the Getting It Right First Time (GIRFT) programme of work and working with specialists in theatre utilisation improvements to ensure use of available capacity is maximised.

Cancer Performance





What are the main risks impacting performance?

- Last minute year-end capacity loss in Skin clinics impacting the end of year performance.
- Ongoing clinical pathway work reliant on system actions remains outstanding.
- Reliance on non-core capacity.
- Increased demand is now a significant driver – Skin referrals, Gynaecology referrals and Endoscopy referrals.
- Volume and complexity of Urology pathway remains challenging.
- March reported an increase in Breast 28-day breaches and whilst Breast remain compliant to the FDS standard at 90% this had an impact on the Trusts position. Skin also reported an increase in breached pathways against reduced overall informed activity.

What further actions are being taken to improve?

- Significant additional activity has been commissioned to recover industrial action related deteriorations in Skin and Gynaecology.
- Recovery actions can only be made sustainable through wider system actions. The CMO is involved in System workshops looking to reform cancer referral processes at a primary care level.
- Focus remains on sustaining the absolute >62-Day Cancer PTL volume and the percentage of >62-Day breaches as a proportion of the overall wait list. This has been challenged by recent high volume activity losses (industrial action related) within areas such as Skin.
- High volume Skin ‘poly-clinics’ enacted to recover cancer position. Having achieved the improved >62-Day cancer PTL target, the next phase will be to ensure the revised actions and processes are embedded to sustain this improvement. At the same time, design work has commenced to fundamentally improve patient pathways, which will improve overall Cancer wait time standards compliance.
- Moving from an operational improvement plan to a clinically-led pathway improvement plan for key tumour site pathways such as Skin and Urology (e.g. prostate pathway and implementation of Primary Care Tele-dermatology for the Skin care pathway).

Quality, Safety and Effectiveness

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

Maternity

Perinatal Quality Surveillance Monitoring (PQSM) Tool – March 24 data

	Jan-24	Feb-24	Mar-24	TREND
Activity				
Number of women who gave birth, all gestations from 22+0 gestation	453	442	448	
Number of babies born alive >=22+0 weeks to 26+6 weeks gestation (Regional Team Requirement)	0	3	1	
Number of women who gave birth (>=24 weeks or <24 weeks live)	451	440	447	
Number of babies born (>=24 weeks or <24 weeks live)	456	445	449	
Number of babies born alive >=24+0 - 36+6 weeks gestation (MBRRACE)	36	36	24	
No of livebirths <24 weeks gestation	0	1	1	
Induction of Labour rate %	31.7%	31.4%	34.5%	
Spontaneous vaginal birth rate %	45.6%	43.2%	43.6%	
Assisted vaginal birth rate %	9.1%	8.9%	11.2%	
Caesarean Birth rate (overall) %	44.9%	47.5%	44.7%	
Planned Caesarean birth rate %	20.6%	21.6%	19.9%	
Emergency Caesarean Birth rate %	24.3%	25.9%	24.8%	
NICU admission rate at term (excluding surgery and cardiac - target rate 5%)	4.2%	6.4%	5.20%	
Perinatal Morbidity and Mortality Inborn				
Total number of perinatal deaths (excluding late fetal losses)	2	1	3	
Number of stillbirths (>=24 weeks excl. TOP)	1	0	1	
Number of neonatal deaths : 0-6 Days	1	0	1	
Number of neonatal deaths : 7-28 Days	0	1	1	
PMRT grading C or D cases (themes in report)	1	2	1	
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (MNSI)	0	0	0	
Maternal Morbidity and Mortality				
Number of maternal deaths (MBRRACE)	0	0	0	
Direct	0	0	0	
Indirect	0	0	0	
Number of women recieving enhanced care on CDS	Data Not Available (DNA)			
Number of women who received level 3 care (ITU)	0	0	0	
Insight				
Number of datix incidents graded as moderate or above (total)	0	2	0	
Datix incident moderate harm (not SI, excludes MNSI)	0	2	0	
Datix incident PSII (excludes MNSI)	0	0	0	
New MNSI referrals accepted	0	0	0	
Outlier reports (eg: MNSI/NHSR/CQC/NMPA/CHKS or other organisation with a concern or request for action made directly with Trust)	0	0	0	
Coroner Reg 28 made directly to Trust	0	0	0	
Workforce				
Minimum safe staffing in maternity services: Obstetric cover (Resident Hours) on the delivery suite	83	83	83	
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps	2	0	0	
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps	2	2	2	
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	0	0	0	
Minimum safe staffing in maternity services: Neonatal Consultants workforce (rota gaps)	1	1	1	
Minimum safe staffing in maternity services: Neonatal Middle grade workforce (rota gaps)	1	1		
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled bank shifts).	5.4%	e (DNA)	8%	

		Jan-24	Feb-24	Mar-24	TREND
Vacancy rate for midwives		5.59%	8.04%	6.17%	
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained)		35%	52%	54%	
Vacancy rate for NICU nurses		26	11	10	
Datix related to workforce (service provision/staffing)		13	9	13	
Consultant led MDT ward rounds on CDS (Day to Night)		93%	96%	81%	
Consultant led MDT ward rounds on CDS (Day)		100%	100%	97%	
One to one care in labour (as a percentage)		99%	100%	97%	
Compliance with supernumerary status for the labour ward coordinator		100%	99%	100%	
Number of times maternity unit attempted to divert or on divert		0%	1	0	
In-utero transfers					
In-utero transfers accepted		1	1	5	
In-utero transfers declined		e (DNA)	0	0	
ex-utero transfers to NICU					
ex-utero transfers accepted		8	6	11	
ex-utero transfers declined		0	0	2	
NICU babies transferred to another unit due to capacity/staffing		0	0	0	
Number of consultant non-attendance to 'must attend' clinical situations		0	0	0	
Involvement					
Service User feedback: Number of Compliments (formal)		67	26	110	
Service User feedback: Number of Complaints (formal)		5	4	3	
Friends and Family Test Score % (good/very good) NICU		100	100	100	
Friends and Family Test Score % (good/very good) Maternity		92	91	93	
Staff feedback from frontline champions and walk-abouts (number of themes)		4	5	0	
Improvement					
Progress in achievement of MIS 10		10	10	10	
Training compliance in annual local BNLS (NICU)		100%	100%	98%	
Training compliance in maternity emergencies and multi-professional training (PROMPT) * note: includes BNLS	*Overall*	81%	84%	79%	
	Obstetric Consultants	95%	95%	89%	
	Other Obstetric Doctors	97%	69%	73%	
	Anaesthetic Consultants	75%	72%	62%	
	Other Anaesthetic Doctors	100%	74%	73%	
	Midwives	80%	89%	73%	
	Maternity Support Workers	71%	95%	90%	
	Theatre staff	Data Not Available			
	Neonatologists	Data Not Available (DNA)			
	NICU Nurses	Data Not Available			
Fetal Wellbeing and Surveillance	*Overall*	85%	86%	85%	
	Obstetric Consultants	89%	89%	89%	
	Other Obstetric Doctors	70%	71%	72%	
	Midwives	86%	91%	82%	
Trust Level Risks		7	4	3	

The ATAIN quarterly report shows that the term admission rate to NICU was 6.4% against a national target of 5%. The avoidable admission rate dropped significantly from the previous quarter; from 18.2% in Q3 to 6.3% in Q4. The report did not identify a definitive reason for this reduction. The recommendations from the report are not dissimilar to those from the previous quarter, with the addition of creating an optimisation bundle for babies born via caesarean between 37- and 39-weeks' gestation.

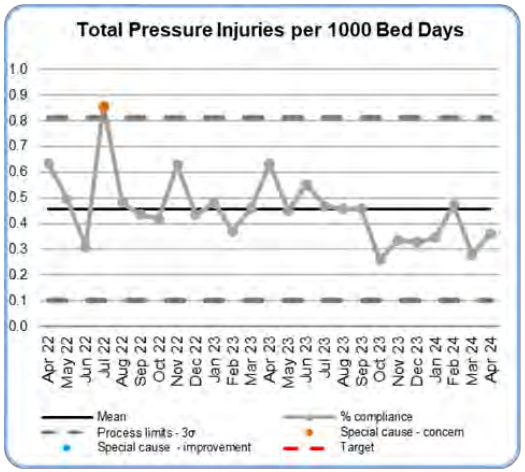
PMRT has remained fully compliant with MIS requirements during Q4

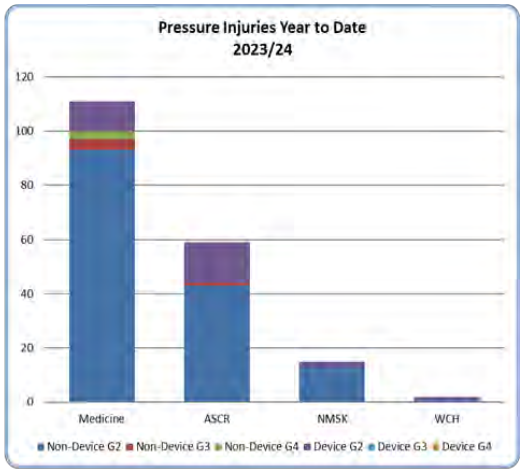
There have been no maternal admissions to ICU and no new MNSI cases during March 2024.

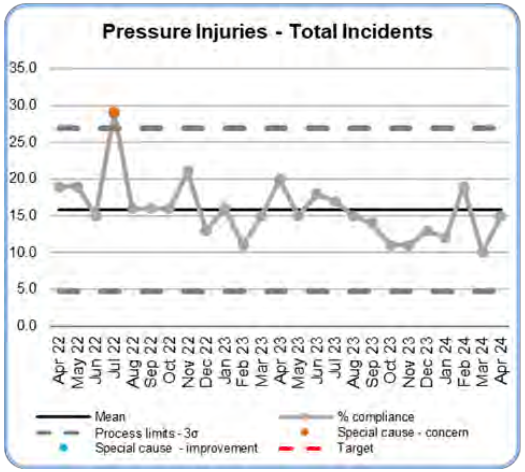
Training compliance remains on target to meet MIS requirements.

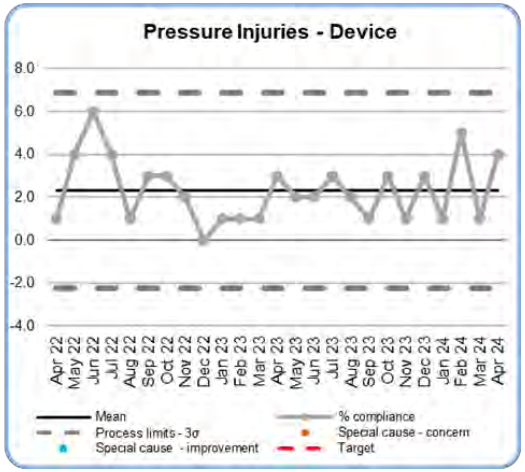
It is acknowledged that the data is reported a month in arrears however any immediate safety concerns would be presented to Divisional Quality Governance, Trust Board and the LMNS as appropriate.

The Perinatal Quality Surveillance Model is shared with Quality Committee and with the Local Maternity and Neonatal System









Pressure Injuries

What does the data tell us?

In April there was there was an increase in the number of grade 2 pressure ulcers. There were 15 grade 2 pressure ulcers, to which 4 were attributable to a medical device.

There was no grade 3 or 4 pressure ulcer. There were three unstageable pressure injuries to 27b.

There was also a decrease in DTI incidents from the previous month to 9 DTI's.

The targets for PU reduction in 2023/2024:

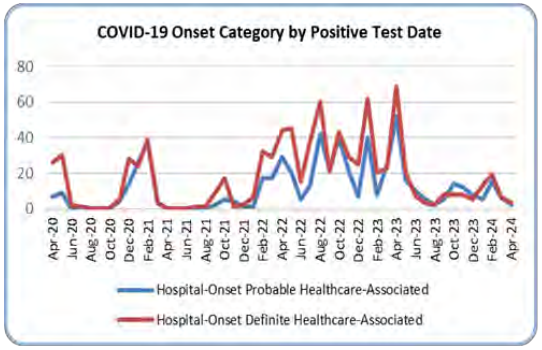
10% reduction on grade 2 pressure ulcers. **The Trust achieved a 15% reduction.**

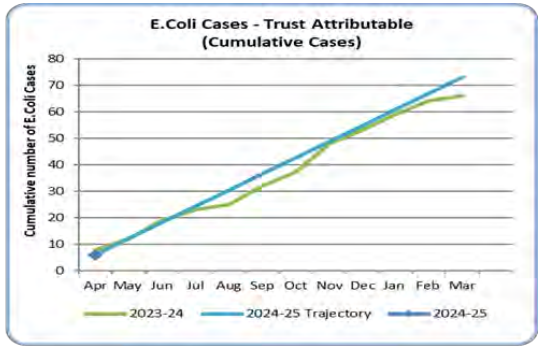
- Zero tolerance for grade 3 and grade 4 pressure ulcers with a 50% reduction from 2022/2023. **The Trust achieved the 50% reduction of Grade 3 but did not meet the Grade 4 target but did achieve a 25% reduction.**

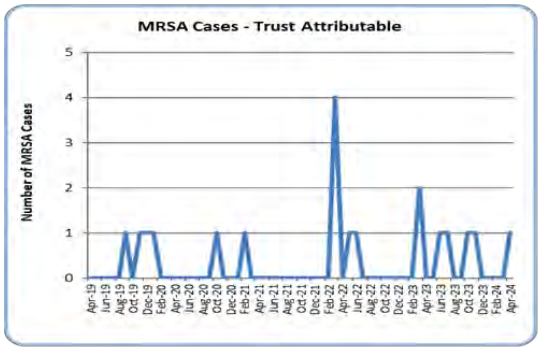
It is proposed that the targets for 2024/25 remain the same, which will continue to decrease the pressure ulcer incident rate at NBT. This will be ratified at the Pressure Ulcer Steering Group.

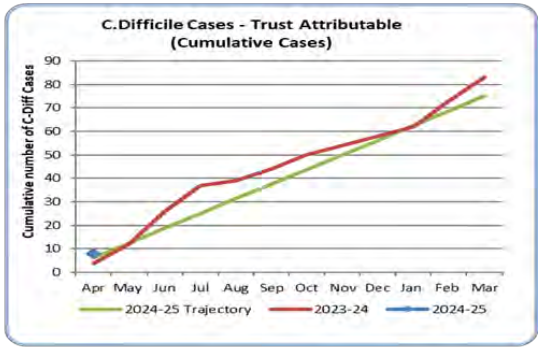
What actions are being taken to improve?

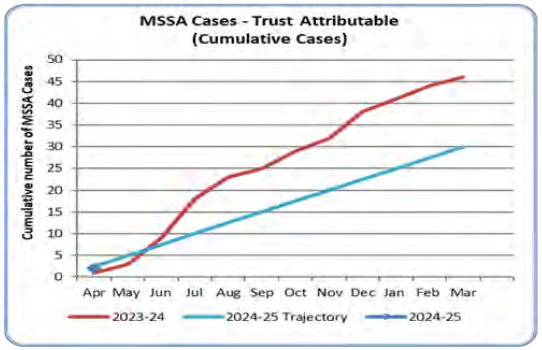
- The TVN team provide a responsive, supportive and educational service across NBT and work collaboratively and strategically within the ICB across the BNSSG system. The team actively seek to work in collaboration with patients, clinical teams and other stakeholders to reduce patient harm.
- The TVN team are working in collaboration with the IPC team to review wounds that have MSSA to address the increase in infection prevalence.
- A working group has been developed within the medicine division to focus strategies and support on reducing pressure ulcers incidents.
- The TVN team have met with the Molnlckye and have agreed a trial for Mepilex heel and sacrum. The research suggests that used prophylactically that they reduce pressure ulcer and deep tissue injury in injuries in high-risk patients. The TVN team have also engaged with the research team to support with a possible research project in the future.

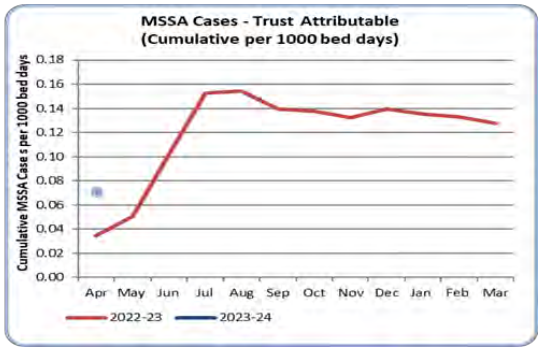












Infection Prevention and Control

What does the data tell us?

COVID-19 (Coronavirus) / Influenza - Case numbers continue to reduce

Winter D+V (Norovirus) - Small numbers of cases have continued – managed effectively

MRSA – 1 case during April

MSSA – New trajectories have been set to not exceed 36 cases and a 10% reduction in Line related infection .

C. Difficile – Awaiting trajectories from UKHSA . 9 cases in April have been reviewed with plans in place regarding education addressing sampling and documentation, this remains a recurring theme

Gram negative – Plans in place looking at hydration in continence group as well as following regional and national programmes

What actions are being taken to improve?.

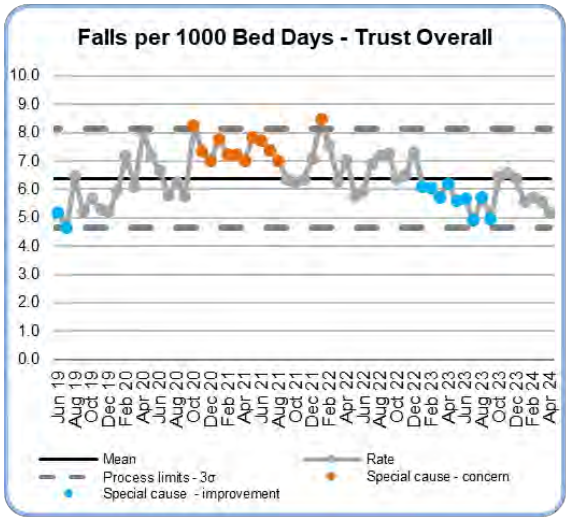
- Bacteriemia reduction plans are trust wide with work being undertaken with Medical , Nursing and AHP staff . An audit of prehospital cannulas is taking place with the aim to work with SWAST to reduce insertion of " Just in Case lines "
- MSSA reduction work is at the forefront as an action plan following an external report - coordination of this strategically via Dep Medical director and DIPC to investigate implementation of other vascular devises , comparison with local trusts to understand lessons learnt and themes and trends.
- Data for MSSA cases in NBT remain consistent with those locally, IPC teams are linking up to deliver regional reduction , this focusses on looking at the point of entry being iv devise or related to a chronic wound – linking with tissue viability.
- Recognising the rise of *C Diff* over Q4 and in Q1 increased education is being targeted in clinical areas focusing on sampling and documentation .
- Continence group has been working with the nutrition assistance to deliver hydration projects and we have increased education related to catheter management. Contributing to the ICB catheter passport

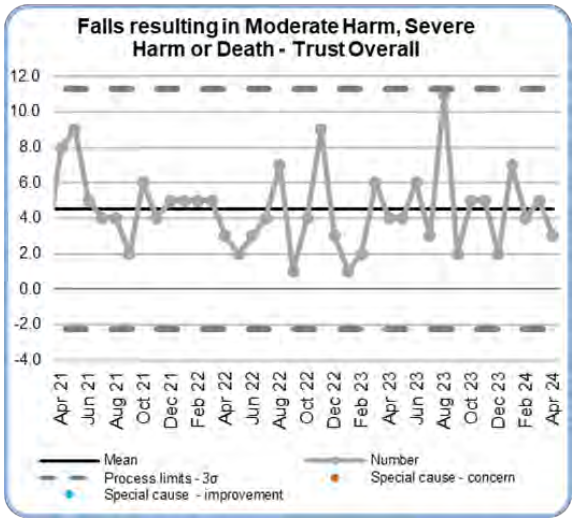
Other infections

Pertussis (Whooping Cough) – there has been a continued increase in cases all requiring contact tracing and risk management

Measles – NBT has had a case and contacted traced appropriately using DrDoctor technology to inform patient contacts and Occ health managing staff

TB - Contact tracing and co-ordination of case management continues





Falls

Falls incidents per 1000 bed days

NBT reported a rate of 5.18 falls incidents per 1000 bed days in April which is below the average of 6.39.

There were 159 falls reported in April. 1 moderate level harm and 2 severe.

Medicine division: 89 falls reported. This is their lowest number of falls this year.
NMSK division: 42 falls reported. This is the highest number of falls this year.
ASCR: 26 falls reported. This is middle range rate of falls.

Multiple falls accounted for only 4% of falls this months which is much lower than the average of around 25%. With no patients having more than two falls.

Older patients continue to be the highest proportion of patients who fall, with 78% of reports in the over 65's. All the patients who experienced moderate and above harm were aged over 65.

What actions are being taken to improve?

The falls prevention and management team have been extended until the end of July 2024 to continue to implement the delivery plan.

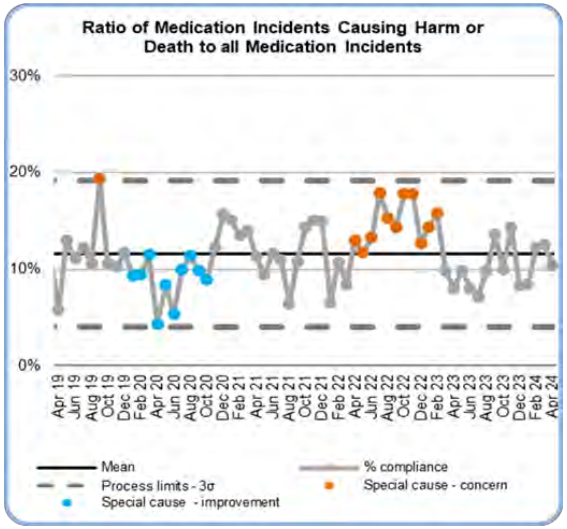
The bathroom activity analysis has been completed. Further works are required to consider how we address some of the hazards identified in the report. This includes considering a small-scale trial of pedal bins with handles. This is under discussion with infection control and waste management.

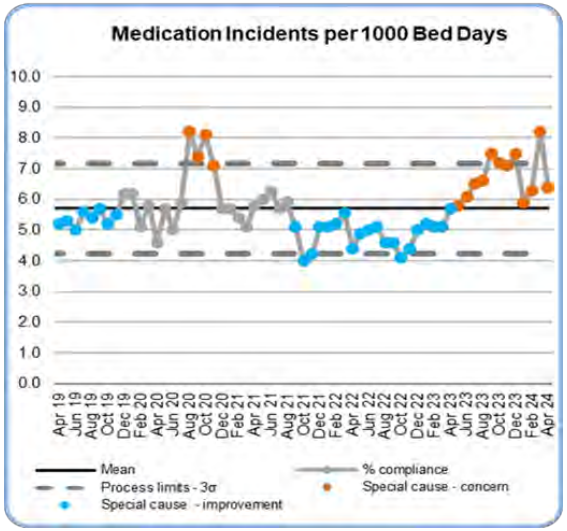
The patient information leaflet is in its final stages of review, working with the communications team to link to the Sirona based STEP program for chair-based exercises.

The eLearning package is just waiting on the creation of a LINK page to be able to have all referenced resources in one place.

Work will start this month within medicine division on improving the availability and storage of hoist slings to help with the quality improvement work for safe lifting following a fall.

N.B. The data presented only presents inpatient falls and does not include falls from hoist, stairs or in outpatient areas.





Medicines Management Report

What does the data tell us?
Medication Incidents per 1000 bed days
During April 24 NBT had a rate of 6.0 medication incidents per 1000 bed days. This is below the 6-month average of 6.7 for this measure.

Ratio of Medication Incidents Reported as Causing Harm or Death to all Medication incidents
During April 24, 10.4% of all medication incidents are reported to have caused a degree of harm
Low Harm – 16
Moderate Harm – 2
Death - 1
(This information has been included as an indicator of the composition of the 'harm' incidents. It is of note however that these categorisations are subject to change as incidents reviewed and closed)

Overall comment
In April, the overall number of reported incidents has reduced as has the ratio of all incidents to those causing harm.

Work to better understand this data underway through the Medicines Safety Forum (see below) and Medicines Governance Team as we are keen to better understand the likely causes of the fluctuations seen month on month. Work is also underway with the Patient Safety Team to improve the quality of data being captured through both the adoption of LFPSE and move to Radar. The hope is that more consistent coding and better links with staff will aid understanding of the picture that this data portrays.

What actions are being taken to improve?
The Medicines Governance Team have, with support from the Patient Safety Team, launched the 'Medicines Safety Forum' a multidisciplinary group whose aim is to focus on gaining a better understanding of medicines safety challenges and subsequently supporting staff to address these.

The 2nd meeting of the group was held in April – this was supported by the Trust's Head of Patient Safety and SEIPS methodology was adopted to gain a clearer understanding of the issues faced by staff around 'Medicines Administration'

A resource proposal detailing the Pharmacy staffing required to support medicines safety improvement work going forward will be discussed at the DTC in due course.

Patient Experience

Board Sponsor: Chief Nursing Officer
Steven Hams

Patient & Carer Experience – Strategy Delivery Overview March 2024

A	Amber - Progress on Track but known issues may impact on plan	C	Complete
G	Green - Progress on Track with no issues	R	Red - Progress is off Track and requires immediate action

Patient & Carer Experience Strategy Commitment	Commitments	Progress Status
Listening to what patients tell us	We will continue to share patient experiences at Board and through other governance committees, to ensure the voice of the patient is heard.	Patient story programme continues to Board and Patient and Carer Experience Committee. Patient Story Hub developed on Intranet
	We will build on our existing methods to collect patient feedback ensuring these are accessible to all. We will explore the use of new technologies to support this including how we capture social listening (social media comments).	We are in the process of exploring new technologies, including social listening and digital techniques for theming large narrative datasets. We have also recently recruited 3 new Patient Experience Feedback volunteers to undertake FFT, local surveys and patient conversations across the hospital, improving accessibility for all patients.
	We will continue to develop the Integrated Performance Report, so that the Board and other leaders can have oversight of the experience our patients receive.	IPR reporting has been refined to include an overview of progress against the Patient & Carer Experience Strategy. Further opportunity to hone these and develop further.
Working together to support and value the individual and promote inclusion	We will aim to increase the diversity of our volunteer teams to reflect our local community and the patients we serve, with a particular focus on Outpatient areas.	Aligns to KPMG action plan and VS Strategic Plan which both reference this objective. Work for this is scheduled for quarter 2 due to imminent team vacancies (leavers) and need to replace.
	We will meet the needs of patients with lived experience of Mental Health or Learning Disability and neurodivergent people in a person-centred way.	This has been identified as a Quality Priority. MH Strategy nearing finalisation, with significant system wide engagement in its development and supporting workstreams. We have a patient partner with LD who is actively involved in sharing her lived experience to improve services.
	The voice and the involvement of carers will be respected and integral in all we do.	We were one of three organisations to pledge commitment to Young Carers Covenant. We have an action plan for improvement following 15 step challenge undertaken by YCs. We are also in the process of updating our carers awareness training and are planning for Carers Week in June.
	Personalised care in various services by using tools such as 'This is Me' developed for patients with dementia, 'Shared Decision Making' and "Supported Decision Making"	This has been identified as a Quality Priority. Exploring use of 'Ask 3 Questions' as part of shared decision making.
	We will work together with health, care, and local authority partners to reduce health inequalities, by acting on the lived experiences of patients with a protected characteristic and/or who live in communities with a high health need.	Continued work with the GRT community and people experiencing homelessness, which is embedded within the wider programme of Health Inequalities which is one of the Trust's 2024/25 quality priorities.
Being responsive and striving for better	We will continue to sustain and grow our Complaints Lay Review Panel as part of our evaluation of the quality of our complaint investigations and responses	Due to recent launch of Radar, this work is not scheduled until Q2 but we have laid the foundations and there is appetite from our patient and carer partners to participate.
	We will continue to undertake the annual Patient Led Assessments of the Care Environment (PLACE) audits and respond to areas of improvement.	Development of physical access working group of patients who will participate in this year's PLACE assessments in November. Presentation on last year's PLACE results scheduled for sharing at PCEG in August.
	We will involve the volunteer voice within feedback to shape future volunteer roles and patient engagement opportunities.	We have recently developed a new volunteer role based on a complaint. Further work for this is scheduled for quarter 2 due to imminent team vacancies (leavers) and need to replace.
Putting the spotlight on patient and carer experience	We will refresh the patient experience portal on our website and staff intranet	Intranet pages recently updated for all PE teams.
	We will develop a Patient Experience e-learning module to support the ongoing need of staff for easy access to busy frontline staff.	E-learning module scoped with L&D team through NHS Elect. This is currently being tested with a small working group before roll out.

Patient & Carer Experience - Overview April 2024

Spotlight: Complaints Lay Review Panel

Our Complaints Lay Review Panel has been meeting for many years, taking a small break in 2019, and reconvening in 2020 online during the pandemic.

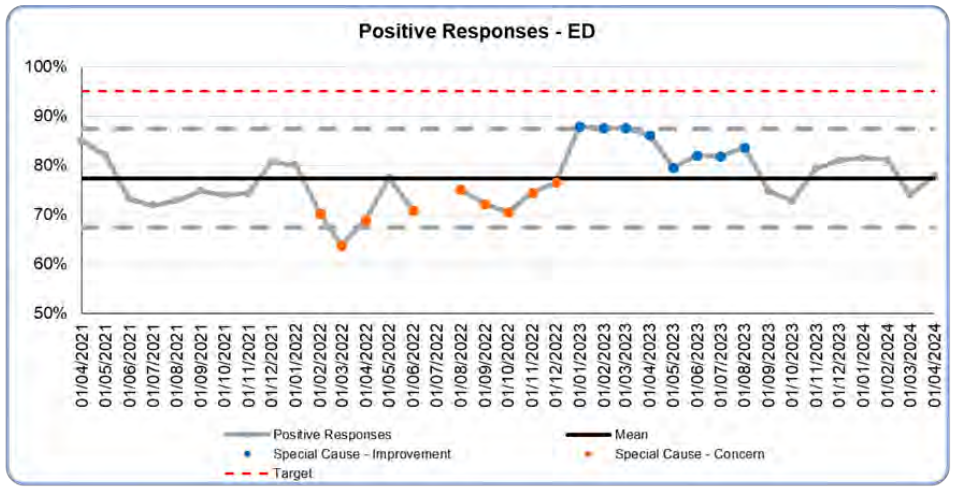
Our panel is made up of 7 members and they are recognised nationally as an exemplar best practice model. We've spoken at several national conferences sharing the model with other Trusts. We are very proud of them and their commitment to helping us review the quality of our complaints process from the patient's perspective.

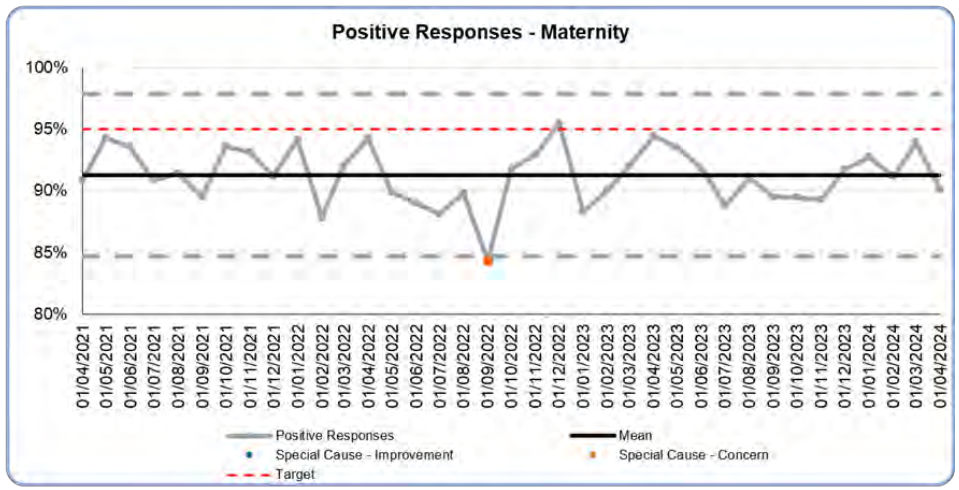
The panel meets quarterly and reviews 3 or 4 complaints. These are selected at random and anonymised. The panel looks at how we handled the case, providing a rating score, and noting areas of good practice and opportunities for improvement.

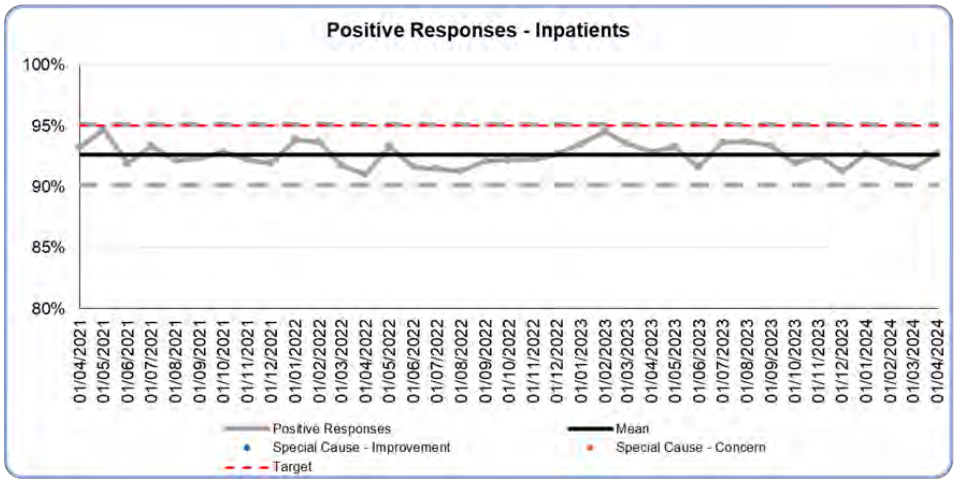
A panel member attends our Divisional Patient Experience Group meeting to give feedback directly to divisions on the panel's findings. The panel is now also following up on complaint actions to ensure that any actions identified in the complaint response have been completed.

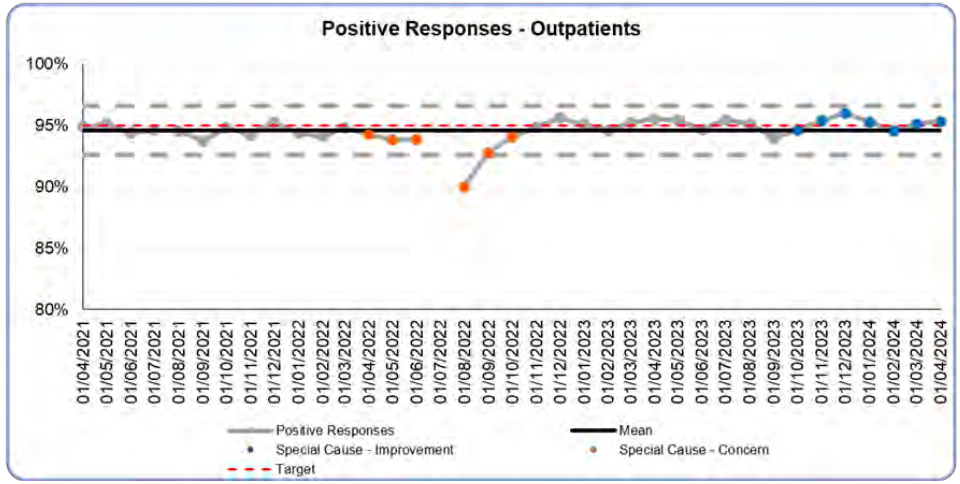
Whilst the panel gained two new members last year, it is one of our objectives in 2024/25 to grow and diversify the group further.

Patient Experience









N.B. no data available for the month of July for ED and Outpatients due to an issue with CareFlow implementation

Patient Experience

What does the data tell us – Trust wide?

- In April, 9536 patients responded to the Friends and Family Test question. 6841 patients chose to leave a comment with their rating.
- We had a Trust-wide response rate of 14%, which is the same as the previous month.
- 92.87% of patients gave the Trust a positive rating. This was in keeping with the previous month.
- The top positive themes from comments were: staff, waiting time and clinical treatment.
- The top negative themes from comments were: waiting time, communication and staff.

What does this data tell us – Maternity?

- Positive responses across Maternity are 89% in April. Negative responses are 6.6% in April.
- The response rate across Maternity is 18%.
- Top positive themes from comments are staff and clinical treatment.

> Every single member of staff was amazing, kind, caring and compassionate. Despite the pressures they are under I felt the care we received was second to none. Thank you to all the midwives and maternity staff

What does the data tell us - Emergency Department?

- Positive responses have increased from 73.9% in March to 77.8% in April. Negative responses have decreased from 16.5% in March to 14.3% in April.
- The response rate for ED was 20% in April.
- The top positive theme remains staff.
- The top negative theme remains waiting time.

> Staff were kind and polite. The waiting times were long, but this can't be the fault of the staff. I received excellent service when I was assessed and treated

What does the data tell us - Inpatients?

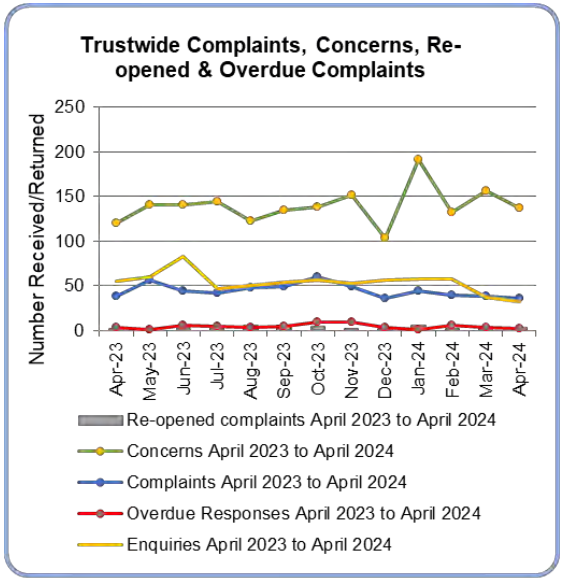
- Positive responses have increased from 88.1% in March to 90.5% in April. Negative responses increased from 4.9% in March to 5.7% in April.
- The response rate for inpatients in April has increased to 23%, from 22% in March.
- Top positive themes from comments are staff, clinical treatment and waiting time.
- Negative themes from comments are, communication, staff and environment.

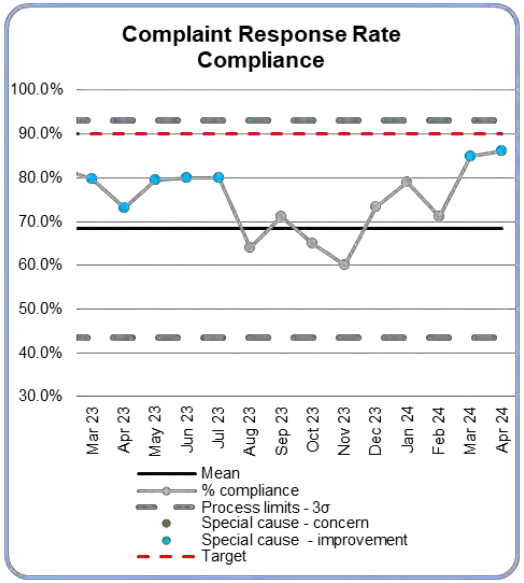
> Very quick to be seen as staff could see how much pain I was in, excellent care, felt well looked after and very reassured by all the staff that I saw.

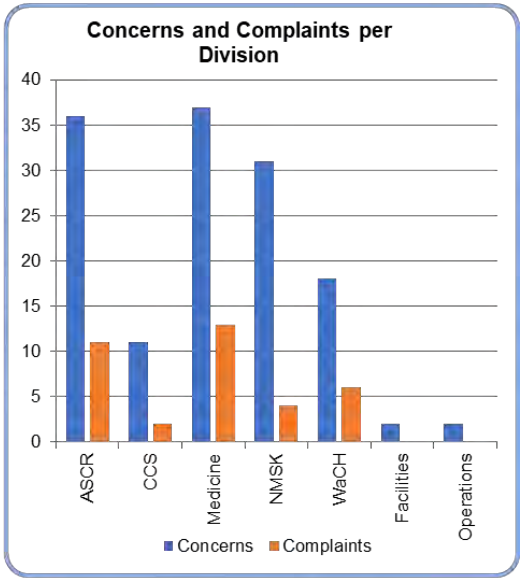
What does the data tell us – Outpatients?

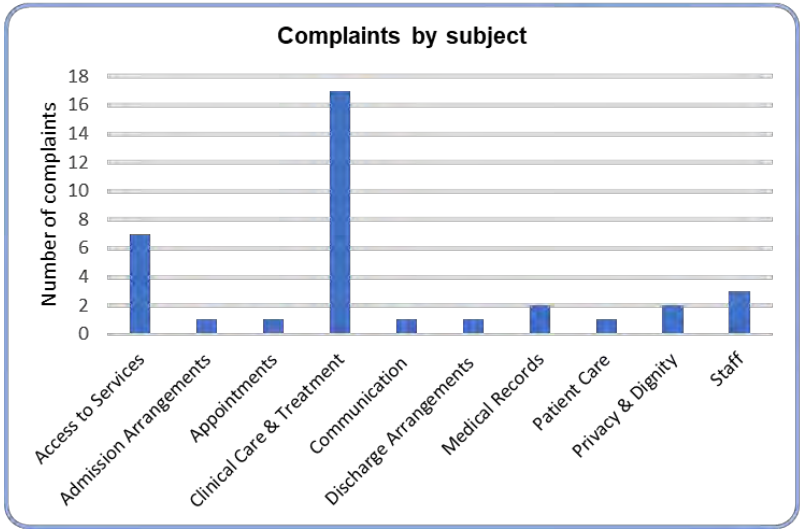
- Positive responses are 95.3% for April. Negative responses have slightly increased to 2% from 1.9% in March
- The response rate for outpatients remained the same in April, 12%.
- Most of the positive feedback relates to staff and waiting time.
- The negative feedback relates to waiting time and communication.

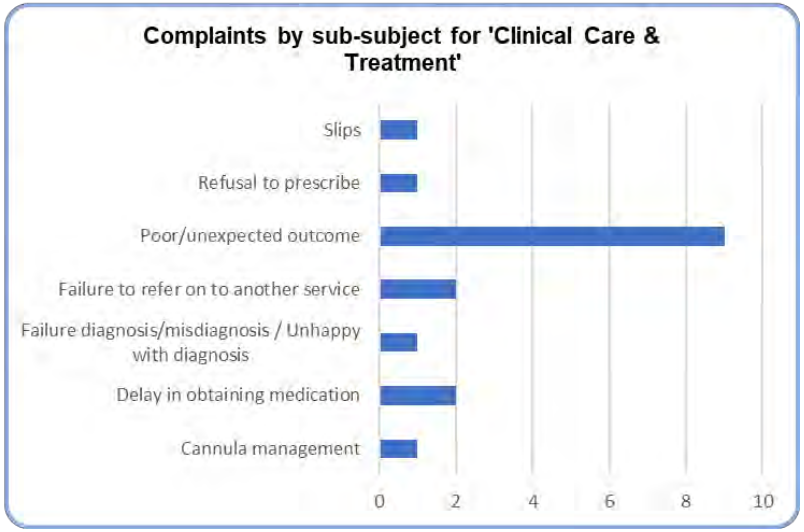
> Just very easy to check in and find the right gate etc. And the medical staff were really clear, helpful, explained what they were doing and what I needed to do. Just an all round good experience











Complaints and Concerns

What does the data tell us?

In April 2024, the Trust received 36 formal complaints. This is 3 less than in March and 2 fewer than the same period last year.

The most common subject for complaints is 'Clinical Care and Treatment' (17). A chart to break down the sub-subjects for 'Clinical Care and Treatment' is included.

Of the 36 complaints, the largest proportion was received by Medicine (13).

There were 3 re-opened complaints in April (1 NMSK, 1 MED, 1 WaCH), the same number as the previous month.

The number of overdue complaints at the time of reporting has decreased from 4 in March to 2 in April and are with Medicine and ASCR.

The response rate compliance for complaints has increased slightly from 85% in March to 86% in April . A breakdown of compliance by clinical division is below:

ASCR – 83% NMSK- 86% Medicine – 71%

WaCH – 100% CCS – 100%

The overall number of PALS concerns received has decreased from 157 in March to 137 in April. However, activity is up on the same period last year when 121 were received.

In April 100% of complaints were acknowledged within 3 working days and 100% of PALS concerns were acknowledged within 1 working day.

Commissioning for Quality and Innovation (CQUIN)

Board Sponsor: Chief Nursing Officer
Steven Hams

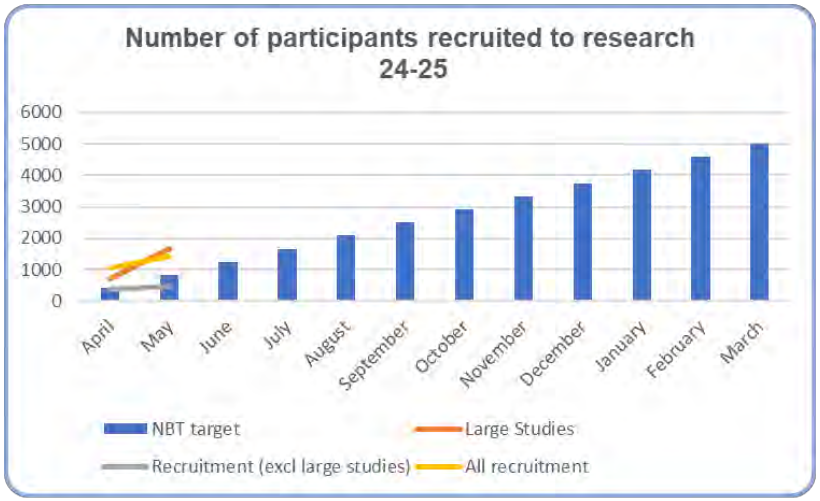
Commissioning for Quality and Innovation (CQUIN) Schemes – 2023/24

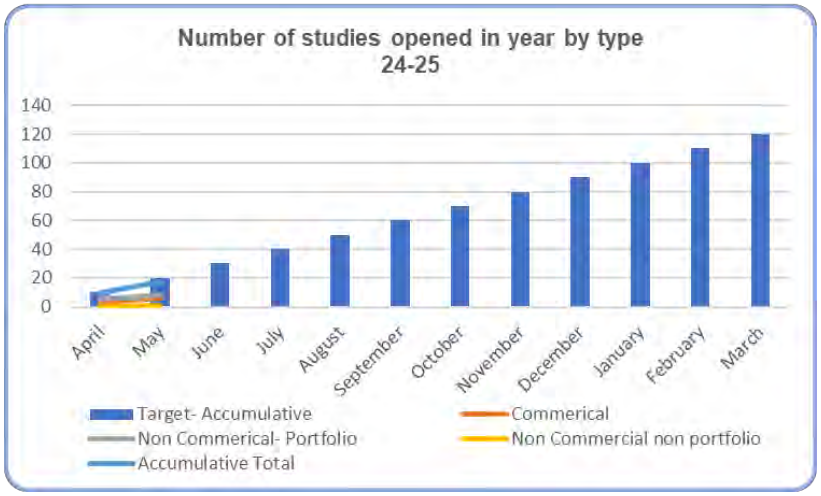
CQUIN Scheme Ref. / Title	Description	Lead Division	Q1	Q2	Q3	Q4	Comment (*forecasts are % of £ CQUIN value*)
CQUIN01: Flu vaccinations for frontline healthcare workers	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact.	Operations, Trustwide	N/A	N/A	🔴	🔴	***Target range 75%-80%. National target not achieved***
CQUIN02: Supporting patients to drink, eat and mobilise (DrEaM) after surgery	Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending	ASCR	🟢	🟢	🟢	🟢	***Target range 70%-80%.* Full achievement**
CQUIN03: Prompt switching of intravenous to oral antibiotic	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria (Please note that for this indicator, a LOWER % = better performance)	CCS	🟢	🟢	🟢	🟢	***Target range 60%-40%* Full achievement**
CQUIN05: Identification and response to frailty in emergency departments	Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up	Medicine	🟢	🟢	🟢	🟢	***Target range 10%-30%.* Full achievement**
CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions	Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes	Trustwide	🟢	🟢	🟢	🟢	***Target range 10%-30%.* Full achievement**
CQUIN08 - Achievement of revascularisation standards	Achievement of revascularisation standards for lower limb Ischaemia (within 5 days for unplanned inpatient admission)	ASCR	🟡	🔴	🟢	🟡	***Target range 45%-65%.* *Full achievement only in Q3***
CQUIN10: Treatment of non small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-2) referred for treatment with curative intent.	Medicine	🟢	🟢	🟢	🟢	***Target range 80%-85%.* Full achievement**
CQUIN11: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	Achieving high quality shared decision (SDM) making conversations to support patients to make informed decisions based on available evidence and their personal values and preferences and knowledge of the risks, benefits and consequences of the options available to them.	NMSK ASCR Clinical Governance	N/A	🟢	N/A	🟢	***Target range 65%-75%.* Full achievement**

🟢 **Full: ≥ max target %** | 🟡 **Partial: ≥ min target % and < max target %** | 🔴 **Not met: < min target %**

Research and Innovation

Board Sponsor: Chief Medical Officer
Tim Whittlestone





Research and Development

Our Research activity

We strive to offer a broad range of research opportunities to our NBT patients and local communities whilst delivering high-quality care combined with a positive research experience.

Graph 1 shows our activities in relation to research participation. Year to date 834 participants have enrolled in research @NBT with an annual target of 5000 (excluding our 2 large studies). The NBT research portfolio remains strong, we have 221 NIHR Portfolio studies open to recruitment . We have opened 17 new portfolio studies year to date, as shown in graph 2. We are pleased to see steady growth in the number of studies collaborating with commercial partners and a subsequent increase in recruitment to these studies; these collaborations enable us to offer our patients access to new clinical trial therapies and generate income to support reinvestment and growth in research across the trust.

Our grants

The level of grant development activity across NBT remains consistently healthy, with 75 research grant submissions supported by R&D, in 2023. Congratulations to Claire Lanfear (staff nurse in cancer services), who was recently awarded NIHR Pre-Application funding to support their clinical academic career development. Also, congratulations to Dr Pippa Bailey on her recent intent to fund for an NIHR HSDR grant, £1.8m, to undertake hybrid-effectiveness-implementation trial of outreach service to improve access to living donor kidney transplantation and Miss Shelley Potter for her recent NIHR HTA intent to fund, £2.6m, to lead a phase III randomized controlled trial comparing Targeted Axillary Dissection vs axillary node clearance. Finally, congratulations to Ronelle Mouton on her recently awarded, prestigious, NIHR Senior Clinical Research Practitioner award, which will provide protected time to further Ronelle's development as an academic leader

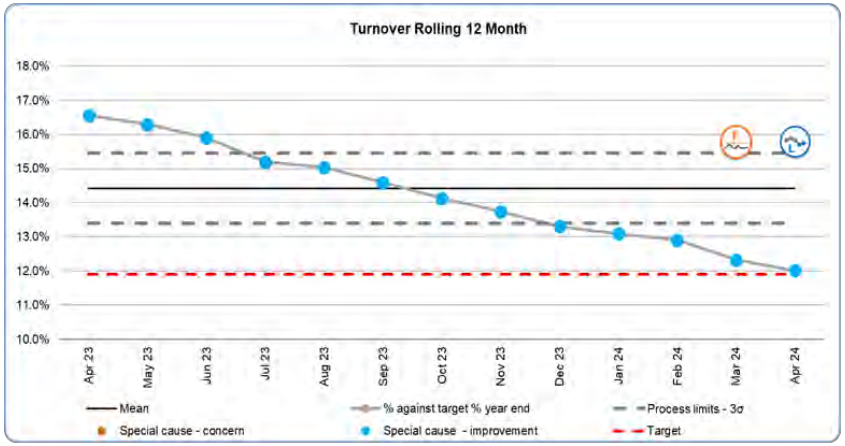
The active research grant portfolio at NBT has increased by £5m from this point last year, to a total of £50m, due to both a high level of NIHR grant success 2021-2023 as well as some older grants being extended due to Covid disruption. NBT was awarded £1.1m Research Capability Funding for 2023/34, a 53% increase on the previous year's allocation. This allocation put NBT in 9th position, out of 248 NHS Trusts in England, our first time in the top 10. RCF is allocated in direct proportion to the level of NIHR grant income received by an NHS Trust in the previous calendar year. The level of NIHR grant income received by NBT in 2023 was higher than the previous years and the 2024 forecast NIHR grant income is looking to be higher still. This is an amazing achievement and reflects the size of NBT's NIHR research grant portfolio; the level and quality of NIHR grants being submitted across NBT and the high success rates

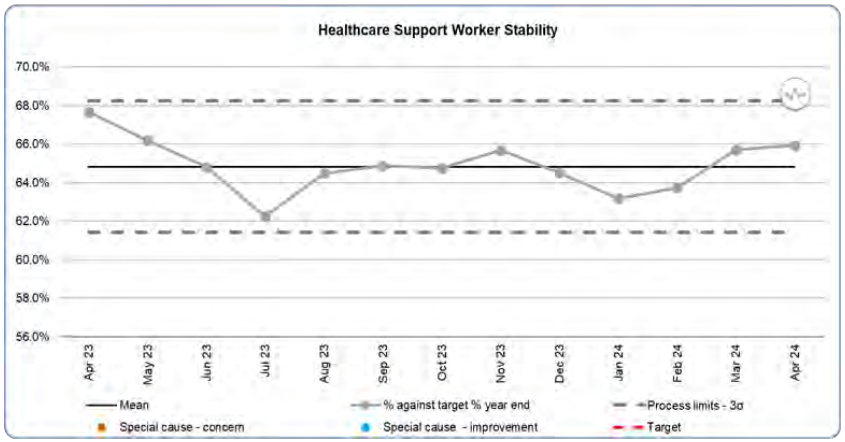
R&D has a focus on supporting non-medics, including nurses, midwives and allied health professionals to develop research ideas, projects and academic careers. R&D operates a rolling call for applications from non-medics to receive mentorship and funding for early-stage research. In addition, with thanks to the Southmead Hospital Charity, R&D has launched a call for applications to our SHC Springboard scheme, seeking applications from NBT staff to undertake small research projects up to £25k, deadline 3rd July. Anyone who is interested in applying to either of these schemes will receive full support from our research development team to prepare an application, previous research experience is not required, early engagement with R&D is encouraged ResearchGrants@nbt.nhs.uk .

Workforce

Board Sponsors: Chief Medical Officer, Chief People Officer
Tim Whittlestone and Peter Mitchell

Retention Patient First Priority People



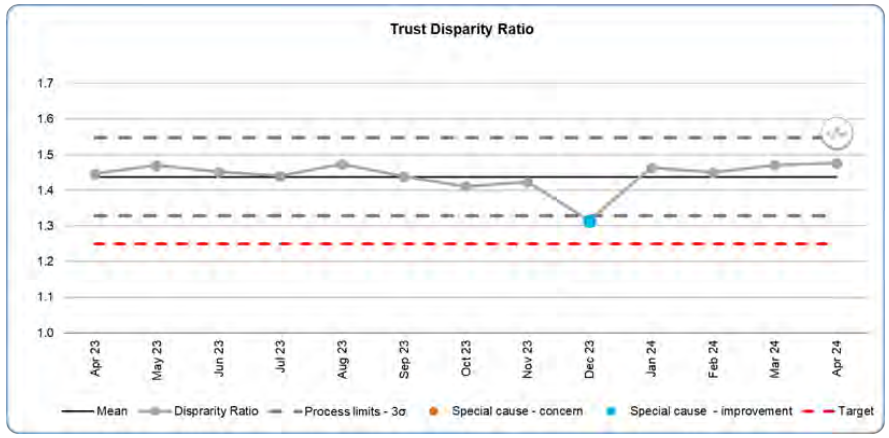


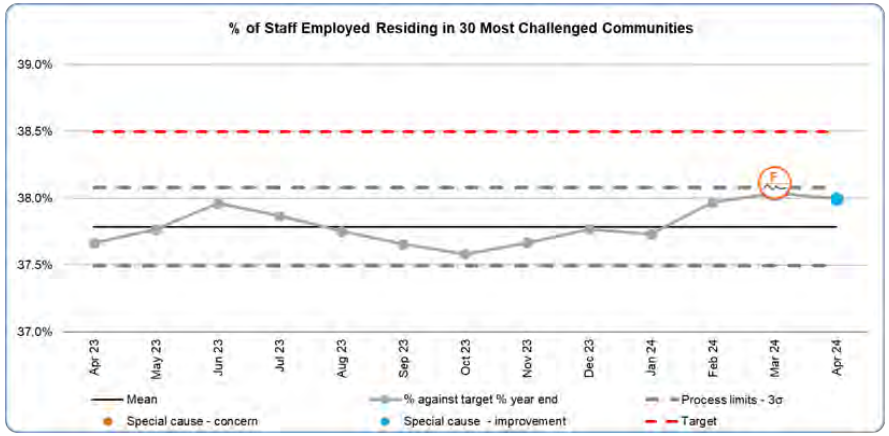
- Turnover is at 12% in April 2024, 0.05% above the target set for 2024/25. Work is in progress with divisions to build more stretching targets given current improvement
- Healthcare Support Worker (HCSW) stability (% of staff in post with >12 months service) shows no statistically significant deterioration or improvement. Retention plan priority is 'Supporting New Starters' - specifically HCSWs where turnover in the first 12 months has been historically high. Impact of actions to support HCSW in their 1st 12 months will continue be monitored in 2024/25 as starters in 2023/24 will remain in their 1st 12 months of service throughout the year
- 9 out 13 actions in our one-year plan are complete with 4 are in progress and are continuing to being monitored through delivery of our five-year retention plan. The table below shows our priority actions in the next four

Driver	Action and Impact	Owner	Due
HCSWs	Embed induction and onboarding improvements to reduce early turnover	Nursing Leaders / Staff Induction Team	Jun-24
Work Life Balance	Share new tools for teams to work flexibly to increase successful flexible working applications and reduce number of staff leaving due to 'work life balance'	People Promise Manager	Jul-24
Culture	Launch a Civility and Respect framework teams can use to improve their culture and reduce occasions of incivility.	Associate Director of Culture	Aug 24

Commitment to our Community

Patient First Priority – Commitment to our Community

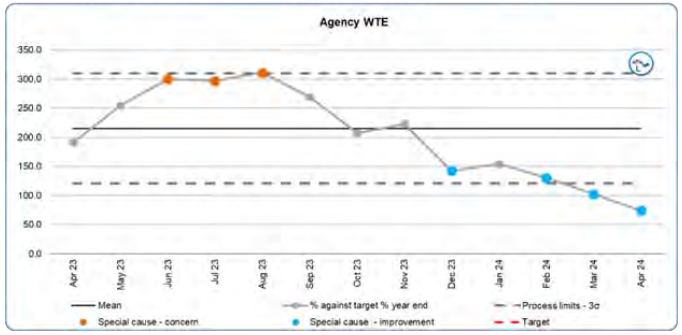




- **Disparity Ratio** (likelihood of B.A.ME applicants being appointed over white applicants from shortlisting – Workforce Race Equality Standard metric) has shown no statistically significant deterioration or improvement in the last 13 months
- **Diverse Recruitment Panels** – work to address unconscious bias in interview selection process with current focus on senior roles initiated on 1st April 2024
- **Positive Action Programme –** work initiated to encouraging staff from underrepresented groups to apply focussed on both internal and external applicants
- **% of Employed Staff from 30 Most Challenged Communities** – small growth in employed staff since April 23. From June 2024 this will be measured through an SPC format. Our Community and Education Project Manager and Outreach Lead are leading:
- **Community Outreach** - Setting up partnerships have been set up with many local groups and drop-ins/sessions delivered.
- **Mentoring Programme** - Provide Mentoring for up to 170 people seeking work locally - Internal and External – Currently on track to achieve this through community partnerships
- **Work Experience** - Review of local Schools / colleges in targeted locations. Career ambassadors launched to support. Career roadmaps in development.

Driver	Action and Impact	Owner	Due
Community Outreach	Career Hub re brand in Brunel Atrium - due to be completed and launched by end of June	Head of Talent Acquisition	May-24
Community Outreach	Engage with community groups and deliver sessions to engage residents in job searching - 10 community organisations engaged and visited in April and May.	Head of Talent Acquisition	Jun-24

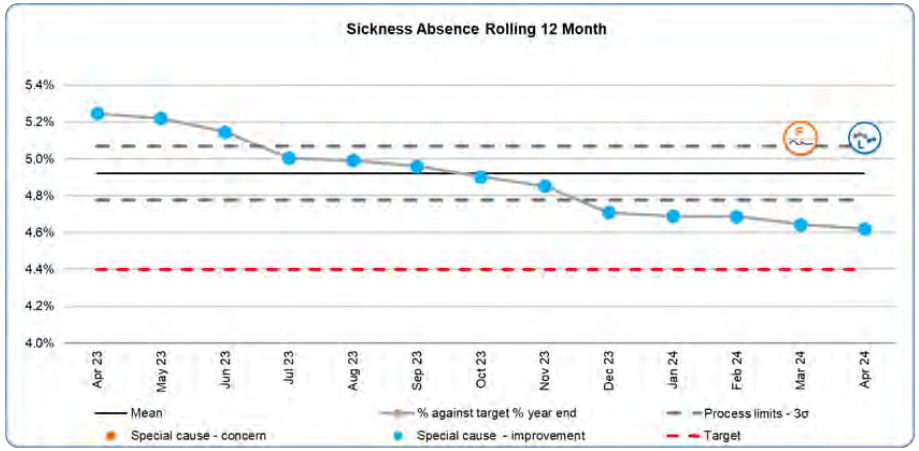
Temporary Staffing

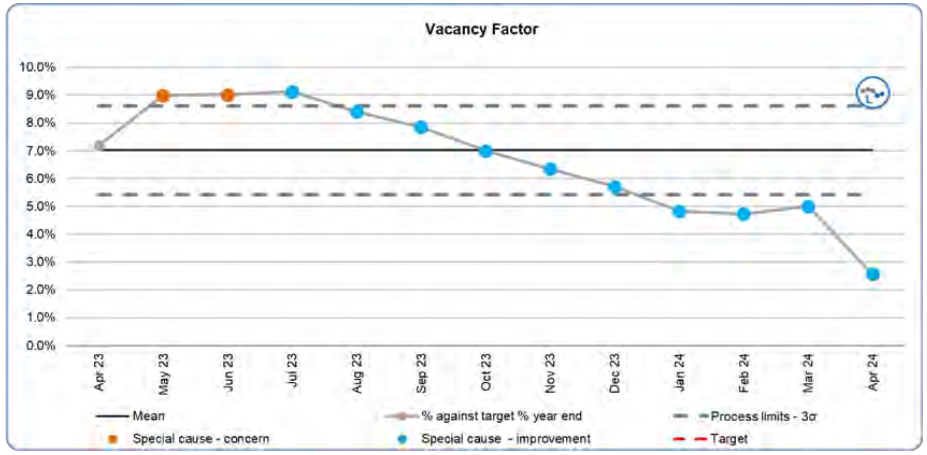


- Trust-wide agency spend has seen a significant decrease between March and April and in those months the Trust was below the 2024/25 target for agency spend – Agency spend must be 3.2% (or less) of the overall pay spend in the Trust. Divisional agency expenditure target shave been set which will deliver the overall Trust target for the year.
- Medical agency there was a 13.66% (-10.27 wte) decline in temporary staffing demand and a 41.12% (-4.40 wte) drop in agency staff between March and April. Work continues with Divisions to address long term Consultant gaps to further reduce reliance on agency workers.
- In the medium to longer term the South-West Medical Agency Reduction project will be implementing a regional rate card which will further see a reduction in the rates paid to agencies to bring this nearer to the NHSE agency cap. This has a flight path of October – December 2024 with work currently taking place to identify exceptions for high risk specialties.

Driver	Action and Impact	Owner	Due
Medical Staffing	Medical agency temp staffing reduction group continuation – development of plans to convert long term agency workers to substantive contracts, provide targeted support to Divisions on alternative approaches to filling long term gaps.	Associate Director Medical Workforce	July 24
Medical Staffing	Pan-regional South-West Medical Agency rate card implementation to bring high-cost agency doctors closer to NHSE Cap	Associate Director Medical Workforce	Oct – Dec 2024
Medical Staffing	Address medical off framework agency use	Associate Director Medical Workforce	July 24
Nursing & Midwifery	SW Regional agency rate reduction programme started continued trajectory for reaching cap compliance (General by July and Specialist by October 24	Associate Director Nursing Workforce Recovery	Complete
Nursing & Midwifery	Revised escalation processes for bank and agency introduced. Review of Bank usage with consideration on if / where focus on reduction needs to be directed	Deputy Chief Nursing Officer	Complete
Non-Clinical AFC	Address remaining outlying AFC areas utilising Off framework Agency	Resourcing Manager	June 2024

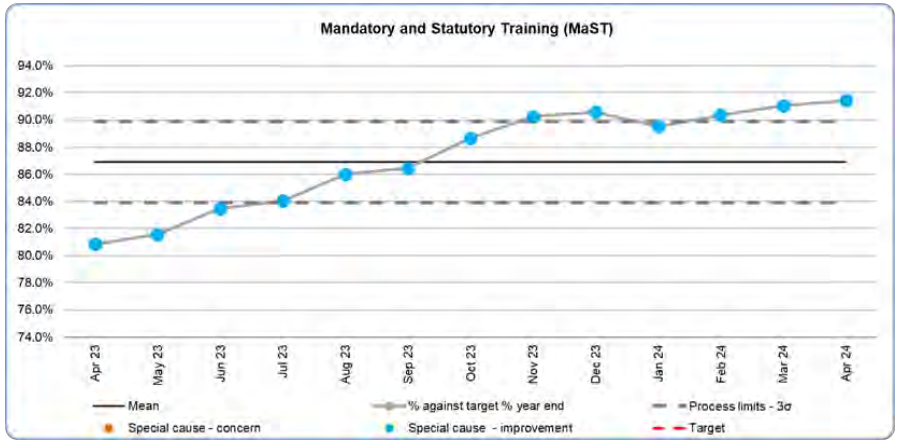
Watch Measures (CPO)





- Both metrics show statistically significant improvement.
- Vacancy Factor for Apr-24 is artificially low as non-recurrent funding for roles has not been reflected in the financial ledger

Watch Measures (CPO)



- Metric shows statistically significant improvement

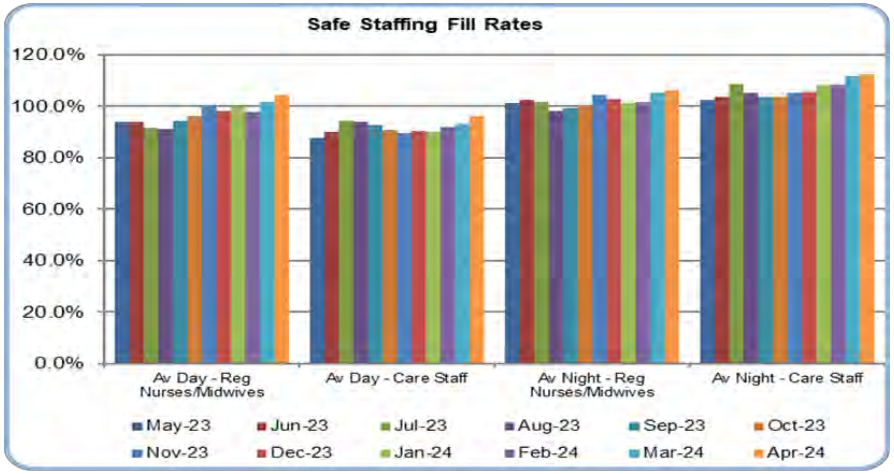
Deterioration – hotspots and mitigating actions
- Honorary (41%), Medical & Dental (79%) staff compliance less than 85%. Direct communications sent to individual staff to encourage compliance.

Improvement – celebrate success and any learning
- All staff 91.5% (↑ from 88.7%).
- Permanent Staff 94% (↑ from 91%).
- Fixed Term Temp 87% (↑ from 79%).
- NBT eXtra 86% (↑ from 49.5%).
- Honorary 41% (↑ from 30.5%).

Deterioration – hotspots and mitigating actions
- The new online system that launched on 1st Apr-24 represents a cultural shift from paper appraisals.
- Work is in progress to ensure our supervisory structures support effective delivery of appraisal

Improvement – celebrate success and any learning
- 98% of staff who have completed their appraisal are happy/very happy with the quality of their conversation.

Safe Staffing



Apr-24	Day shift		Night Shift	
	RN/RM Fill rate	CA Fill rate	RN/RM Fill rate	CA Fill rate
Southmead	104.44%	96.21%	106.43%	112.38%

Ward Name	Registered nurses/ midwives Day	Care staff day	Registered nurses/ midwives Night	Care staff Night
AMU 31 A&B 14031				
Cotswold Ward 01269				
Elgar Wards - Elgar 1 17003				
Neuropsychiatry (Non Medical) 25000				
Ward 25B 14242				
Ward 26B 14312				
Ward 28A 14502				
Ward 32A CAU 14103				
Ward 33A 14221				
Ward 33B 14222				
Ward 34A 14325				
Ward 34B 14324				
Ward 6B (mainly Neuro) 14211				
Ward 7B 14303				
		Below 80%		Over 120%

Safe Staffing Shift Fill Rates:
Ward staffing levels are determined as safe, if the shift fill rate falls between 80-120% , this is a National Quality Board (NQB) target.

What does the data tell us?
For April 2024, the combined shift fill rates for days for RNs across the 28 wards was 104.44% and 106.43% respectively for days nights for RNs. This is reflected through a higher acuity and number of escalation patients in month. The combined shift fill for HCSWs was 96.21% for the day and 112.38% for the night. Therefore, the Trust as a collective set of wards is within the safe limits for March.

April *care staff* fill rates:
- 7.14% of wards had daytime fill rates of less than 80%
- 3.57% of wards had night-time fill rates of less than 80%
- 17.86% of wards had daytime fill rates of greater than 120%
- 28.57% of wards had night-time fill rates of greater than 120%

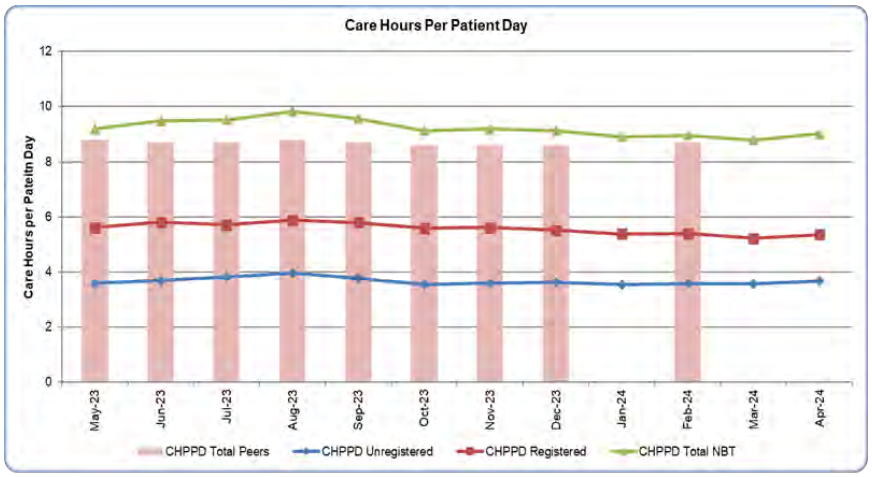
April *registered nursing* fill rates:
- 3.57% of wards had daytime fill rates of less than 80%
- 0.00% of wards had night-time fill rates of less than 80%
- 10.71% of wards had daytime fill rates of greater than 120%
- 10.71% of wards had night-time fill rates of greater than 120%

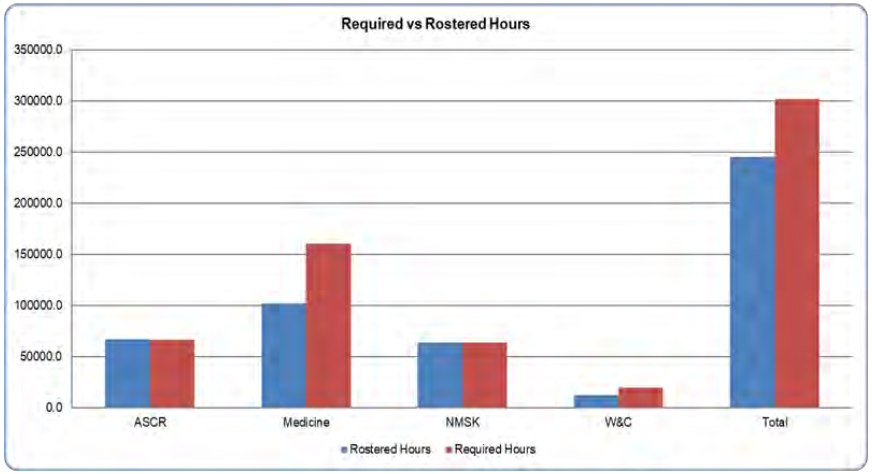
The “hot spots” as detailed on the heatmap which did not achieve the fill rate of 80% or >120% fill rate for both RNs and HCSWs have been reviewed. The fill rate <80% for care staff on the medical wards is due to shortage of HCSWs due to higher number of patients requiring enhanced care and driven by headroom.

The areas above 120% for RNs are driven by winter high acuity and escalation areas in medicine and this is aligned to the recent safer staffing report findings for medicine. It is also driven by some wards who have a high proportion of IENs with poor skill mix. The increased fill rates for the percentage of HCSWs at night reflects the deployment of additional staff in response increased levels of therapeutic observation (enhanced care) to maintain patient safety – medicine and NMSK have seen high numbers of enhanced care patients. We are also currently reviewing the temporary staffing usage at night.

Compliance:
The Safe Care Census regularity has been reduced to twice daily to more closely align with shift patterns. The average compliance is 57.41% and there are plans to improve compliance through robust monitoring at the daily staffing meetings.

Care Hours





Care Hours per Patient Day (CHPPD)
The chart shows CHPPD for the Model Hospital peers (all data from Model Hospital). CHPPD data provides a picture of how staff are deployed and how productively. It provides a measure of total staff time spent on direct care and other activities such as preparing medications and patient records. This measure should be used alongside clinical quality and safety metrics to understand and reduce unwanted variation and support delivery of high quality and efficient patient care.

What does the data tell us?
Compared to national levels the acuity of patients at NBT has increased and exceeded the national position.

Required vs Roster Hours
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 are redeployed between clinical areas and Divisions following daily staffing meetings involving all Divisions, to ensure safety is maintained in wards/areas where a significant shortfall in required hours is identified, to maintain patient safety.

What does the data tell us
The required hours have been augmented using the completion rate for SafeCare patient census data. Where the census completion was less than 100% the required hours have been supplemented by an assumption that for the census periods not completed the patient mix would have been the same on average. The data demonstrates that the total number of required hours has exceeded the available rostered hours.

Finance

Board Sponsor: Chief Financial Officer
Glyn Howells

Statement of Comprehensive Income at 30th April 2024

	Month 1			Year to date		
	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	67.0	66.2	(0.8)	67.0	66.2	(0.8)
Income	7.1	8.3	1.3	7.1	8.3	1.3
Pay	(46.6)	(47.6)	(1.0)	(46.6)	(47.6)	(1.0)
Non-pay	(29.5)	(30.5)	(1.0)	(29.5)	(30.5)	(1.0)
Surplus/(Deficit)	**(2.0)**	**(3.6)**	**(1.6)**	**(2.0)**	**(3.6)**	**(1.6)**

Assurances

The financial position for April 2024 shows the Trust has delivered a £3.6m deficit against a £2.0m planned defecit which results in a £1.6m adverse variance in month and year to date.

Contract income is £0.8m worse than plan. This is driven by a reduction in income with respect to NHSE High Cost Drugs (£0.6m) along with HCTED (£0.3m), both of which are pass-through and should largely be offset with expenditure.

Other income is £1.3m better than plan. This is driven by funding recognised in month in relation to fire dampener work (£0.6m) offset in non-pay, and various income benefits in clinical and corporate divisions.

Pay expenditure is £1.0m adverse to plan. New funding adjustments offset in income (including medical pay award) were £0.6m adverse. The remaining pay variance is £0.4m adverse to plan which has been driven by the Trust seeing increased temporary staffing costs (£1.5m adverse). This is offset by underspends on investment monies £1.9m favourable. Undelivered CIP is £0.7m adverse.
Non-pay expenditure is £1.0m adverse to plan. New funding adjustments offset in income and pass-through drugs were £1.2m favourable. The remaining variance is £2.2m adverse which has been driven by the Trust seeing a £1.5m adverse variance on non-pay in Month 1 linked to increased medical consumables spend. Unidentified CIP is £0.7m adverse.

Statement of Financial Position at 30th April 2024

	23/24 Month 12 £m	24/25 Month 01 £m	In-Month Change £m
Non-Current Assets	**538.4**	**536.9**	**(1.5)**
Current Assets			
Inventories	11.7	12.0	0.3
Receivables	49.4	48.7	(0.7)
Cash and Cash Equivalents	62.7	56.0	(6.7)
Total Current Assets	**123.8**	**116.8**	**(7.1)**
Current Liabilities (< 1 Year)			
Trade and Other Payables	(99.9)	(92.2)	7.8
Deferred Income	(14.4)	(17.7)	(3.3)
Financial Current Liabilities	(23.6)	(23.6)	0.0
Total Current Liabilities	**(138.0)**	**(133.5)**	**4.5**
Non-Current Liabilities (> 1 Year)			
Trade Payables and Deferred Income	(6.2)	(6.7)	(0.5)
Financial Non-Current Liabilties	(571.8)	(596.6)	(24.7)
total Non-Current Liabilities	**(578.0)**	**(603.3)**	**(25.3)**
Total Net Assets	**(53.7)**	**(83.1)**	**(29.4)**
Capital and Reserves			
Public Dividend Capital	485.2	485.2	0.0
Income and Expenditure Reserve	(541.8)	(610.8)	(69.0)
Income and Expenditure Account - Current Year	(69.0)	(29.4)	39.6
Revaluation Reserve	71.9	71.9	0.0
Total Capital and Reserves	**(53.7)**	**(83.1)**	**(29.4)**

Capital spend is £0.6m in month and year-to-date (excluding leases).

Cash is £56.0m at 30th April 2024, a £.6.7m decrease compared with the previous month. The decrease is driven by increased operational spend.

Non-Current Liabilities have increased by £24.7m in Month 1 as a result of the national implementation of IFRS 16 on the PFI. This has changed the accounting treatment for the contingent rent element of the unitary charge which must now be shown as a liability. This change also accounts for the £39.6m increase in the Income and Expenditure Reserve.

13.1

Regulatory

Board Sponsor: Chief Executive
Maria Kane

NHS Provider Licence Compliance Statements at May 2024 - Self-assessed, for submission to NHS

Ref	Criteria	Comp (Y/N)	Comments where non-compliant or at risk of non-compliance
G3	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.
G4	Having regard to NHS England Guidance	Yes	The Trust Board has regard to NHS England guidance where this is applicable. The Organisation has been placed in segment 3 of the System Oversight Framework, receiving mandated support from NHS England & Improvement. This is largely driven be recognised issues relating to cancer wait time performance and reporting.
G6	Registration with the Care Quality Commission	Yes	CQC registration in place. The Trust received a rating of Good from its inspection reported in September 2019. A number of mandatory actions were identified which are being addressed through an action plan. The Trust Board receives updates on these actions via its Quality Committee.
G7	Patient eligibility and selection criteria	Yes	Trust Board has considered the assurances in place and considers them sufficient.
C1	Submission of Costing Information	Yes	A range of measures and controls are in place to provide internal assurance on data quality, including an annual Internal Audit assessment.
C2	Provision of costing and costing related information	Yes	The trust submits information to NHS Improvement as required.
C3	Assuring the accuracy of pricing and costing information	Yes	Scrutiny and oversight of assurance reports to regulators is provided by Trust's Audit and Risk Committee and other Committee structures as required.
P1	Compliance with the NHS Payment Scheme	Yes	NBT complies with national tariff prices. Scrutiny by local commissioners, NHS England and NHS Improvement provides external assurance that tariff is being applied correctly. It should be noted that NBT is currently receiving income via a block arrangement in line with national financial arrangements.
P5	Constructive engagement concerning local tariff modifications	Yes	Trust Board has considered the assurances in place and considers them sufficient. It should be noted that NBT is currently receiving income via a block arrangement in line with national financial arrangements.
IC1	Provision of Integrated Care	Yes	The Trust is actively engaged in the ICS, and leaders participate in a range of forums and workstreams. The Trust is a partner in the Acute Provider Collaborative.
IC2	Personalised Care and Patient Choice	Yes	Trust Board has considered the assurances in place and considers them sufficient.
WS1	Cooperation	Yes	The Trust is actively engaged in the ICS and cooperates with system partners in the development and delivery of system financial, people, and workforce plans.
NHS2	Governance Arrangements	Yes	The Trust has robust governance frameworks in place, which have been reviewed annually as part of the Licence self-certification process, and tested via the annual reporting and auditing processes

Appendix 1: General guidance and NBT Quality Priorities

Unless noted on each graph, all data shown is for period up to, and including, 31st of March 2024 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 2023/24
Outstanding Patient Experience
We will put patients at the core of our services, respecting their choice, decisions and voice whilst becoming a partner in the management of conditions.
High Quality Care
We will support our patients to access timely, safe, and effective care with the aim of minimising patient harm or poor experience as a result.
We will minimise patient harm whilst experiencing care and treatment within NBT services.
We will demonstrate a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
We will make Maternity and Neonatal care safer, more personalised, and more equitable

Appendix 2: Abbreviation Glossary

Abbreviation	Definition
AfC	Agenda for Change
AHP	Allied Health Professional
AMTC	Adult Major Trauma Centre
AMU	Acute medical unit
ASCR	Anaesthetics, Surgery, Critical Care and Renal
ASI	Appointment Slot Issue
AWP	Avon and Wiltshire Partnership
BA PM/QIS	British Association of Perinatal Medicine / Quality Indicators standards/service
BI	Business Intellligence
BIPAP	Bilevel positive airway pressure
BPPC	Better Payment Practice Code
BWPC	Bristol & Weston NHS Purchasing Consortium
CA	Care Assistant
CCS	Core Clinical Services
CDC	Community Diagnostics Centre
CDS	Central Delivery Suite
CEO	Chief Executive
CHKS	Comparative Health Knowledge System
CHPPD	Care Hours Per Patient Day
CIP	Cost Improvement Programme
Clin Gov	Clinical Governance
CMO	Chief Medical Officer
CNST	Clinical Negligence Scheme for Trusts
COIC	Community-Oriented Integrated Care
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computerised Tomography
CTR/NCTR	Criteria to Reside/No Criteria to Reside
D2A	Discharge to Assess
DivDoN	Deputy Director of Nursing
DoH	Department of Health
DPEG	Digital Public Engagement Group
DPIA	Data Protection Impact Assessment
DPR	Data for Planning and Research
DTI	Deep Tissue Injury
DTOC	Delayed Transfer of Care
ECIST	Emergency Care Intensive Support Team
EDI	Electronic Data Interchange
EEU	Elgar Enablement Unit

Appendix 2: Abbreviation Glossary

Abbreviation	Definition
EPR	Electronic Patient Record
ERF	Elective Recovery Fund
ERS	E-Referral System
ESW	Engagement Support Worker
FDS	Faster Diagnosis Standard
FE	Further education
FTSU	Freedom To Speak Up
GMC	General Medical Council
GP	General Practitioner
GRR	Governance Risk Rating
HCA	Health Care Assistant
HCSW	Health Care Support Worker
HIE	Hypoxic-ischaemic encephalopathy

Abbreviation	Definition
HoN	Head of Nursing
HSIB	Healthcare Safety Investigation Branch
HSIB	Healthcare Safety Investigation Branch
I&E	Income and expenditure
IA	Industrial Action
ICB	Integrated Care Board
ICS	Integrated Care System
ICS	Integrated Care System
ILM	Institute of Leadership & Management
IMandT	Information Management
IMC	Intermediate care
IPC	Infection, Prevention Control
ITU	Intensive Therapy Unit

Abbreviation	Definition
JCNC	Joint Consultation & Negotiating Committee
LoS	Length of Stay
MaST	Mandatory and Statutory Training
MBRRACE	Maternal and Babies-Reducing Risk through Audits and Confidential Enquiries
MDT	Multi-disciplinary Team
Med	Medicine
MIS	Management Information System
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Susceptible Staphylococcus Aureus
NC2R	Non-Criteria to Reside
NHSEI	NHS England Improvement
NHSi	NHS Improvement

Appendix 2: Abbreviation Glossary

Abbreviation	Definition
NHSR	NHS Resolution
NICU	Neonatal intensive care unit
NMPA	National Maternity and Perinatal Audit
NMSK	Neurosciences and Musculoskeletal
Non-Cons	Non-Consultant
NOUS	Non-Obstetric Ultrasound Survey
OOF	Out Of Funding
Ops	Operations
P&T	People and Transformation
PALS	Patient Advisory & Liaison Service
PCEG	Primary Care Executive Group
PDC	Public Dividend Capital
PE	Pulmonary Embolism

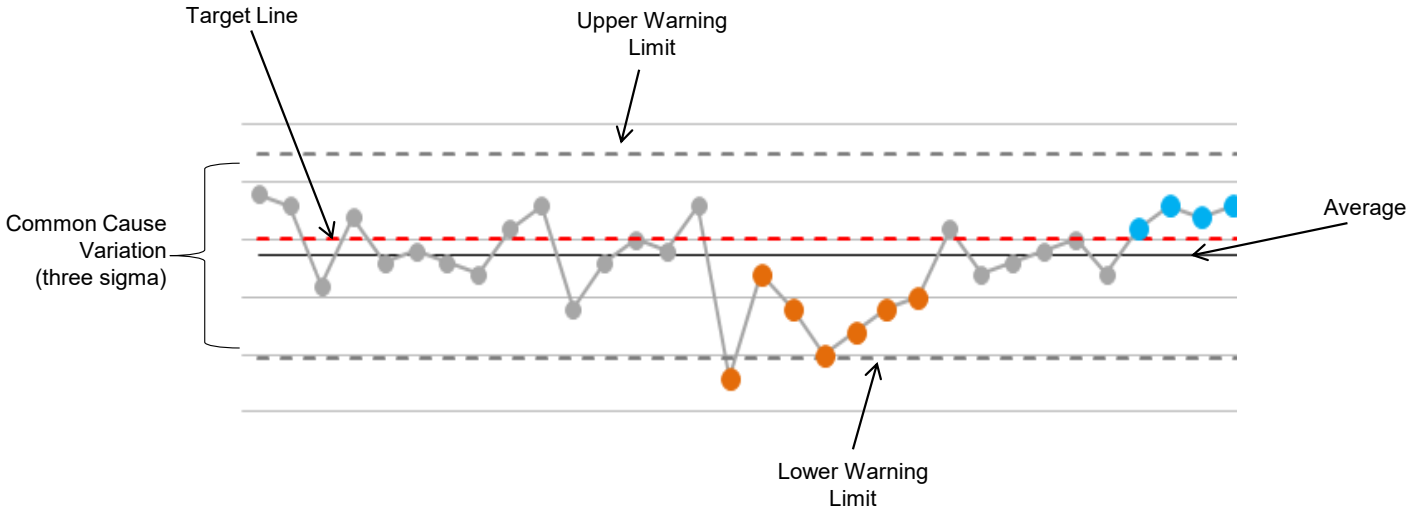
Abbreviation	Definition
PI	Pressure Injuries
PMRT	Perinatal Morality Review Tool
PPG	Patient Participation Group
PPH	Post-Partum Haemorrhage
PROMPT	PRactical Obstetric Multi-Professional Training
PSII	Patient Safety Incident Investigation
PTL	Patient Tracking List
PUSG	Pressure Ulcer Sore Group
QC	Quality Care
qFIT	Faecal Immunochemical Test
QI	Quality improvement
RAP	Remedial Action Plan
RAS	Referral Assessment Service

Abbreviation	Definition
RCA	Root Cause Analysis
RJC	Restorative Just Culture
RMN	Registered Mental Nurse
RTT	Referral To Treatment
SBLCBV2	Saving Babies Lives Care Bundle Version 2
SDEC	Same Day Emergency Care
SEM	Sport and Exercise Medicine
SI	Serious Incident
T&O	Trauma and Orthopaedic
TNA	Trainee Nursing Associates
TOP	Treatment Outcomes Profile
TVN	Tissue Viability Nurses
TWW	Two Week Wait

Appendix 2: Abbreviation Glossary

Abbreviation	Definition
UEC	Urgent and Emergency Care
UWE	University of West England
VSM	Very Senior Manager
VTE	Venous Thromboembolism
WCH	Women and Children's Health
WHO	World Health Organisation
WLIs	Waiting List Initiative
WTE	Whole Time Equivalent

Appendix 3: 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

NHS North Bristol NHS Trust

Report To:	Public Trust Board			
Date of Meeting:	30 May 2024			
Report Title:	Finance, Digital & Performance Committee (FD&PC) Upward Report			
Report Author:	Aimee Jordan, Senior Corporate Governance Officer and Policy Manager			
Report Sponsor:	Richard Gaunt, Non-Executive Director & Committee Chair			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	The Trust Board is asked to: • Receive the report for assurance and note the activities Finance, Digital & Performance Committee has undertaken on behalf of the Board. • Note the key red risk project which are unable to proceed due to lack of funding			
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 July 2024.			

Executive Summary		
The following report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the 23 May 2024 FD&PC.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	✓
	Innovate to Improve – *Unlocking a better future*	✓
	Sustainability – *Making best use of limited resources*	✓
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	Reports received at the meeting support the mitigation of various BAF and Trust Level risks, particularly those relating to patient flow, access to elective care, finance and IMT/Cyber security risks.	
Financial implications:	Business cases approved by the Committee are within the delegated limits as set out in the Trust's Standing Financial Instructions and Scheme of Delegation.	
Does this paper require an EIA?	No as this is not a strategy or policy or change proposal	
Appendices:	Appendix 1: Finance Report	

14

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, Digital and Performance Committee meeting held on 23 May 2024.

2. Background

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

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

3.1 The Committee were joined by the Chief Executive who provided feedback on the South West system meeting with the national team where the submitted operational plan for 2024/25 was tested and challenged on its deliverability and mitigations on risk areas. The Committee noted that the plan had been positively received and discussed the following key points:

- The challenges the system faced delivering a financially balanced plan and the contingencies required to mitigate the risks to delivery.
- The risk to delivering the 78% 4-hour standard and the commitment to achieve it on the conditionality of the system being able to meet 15% No Criteria to Reside (NC2R) and the Trust to maintain 92% bed occupancy.
- The concerns regarding mental health and agency spend.
- The importance of the narrative for productivity to focus on continuous improvement.

3.2 <u>Operational performance summary</u>

The Committee discussed the most recent performance data across unscheduled care and planned care, including diagnostics and referral to treatment (RTT):

- With regards to Unscheduled Care, it was recognised that April and May remained challenging due to:
  - The high volumes of No Criteria To Reside (NC2R)
  - The high bed occupancy
  - The continued increased Emergency Department attendances,
- With regards to Planned Care, the Trust achieved the 2023/24 year-end RTT requirements for zero capacity breaches for patients waiting over 65-weeks for treatment and noted that plans were in place to continue to eliminate the breaches for all specialties, with the exception of DIEPs, by September 2024.
- With regards to Diagnostics, the Trust has maintained zero capacity breaches for patients waiting over 13-weeks for diagnostics and is on track against plan with the aim to achieve the constitutional standard (full recovery).

The Committee discussed the operational performance and acknowledged the achievements in performance metrics and noted the ongoing work with system partners to address challenges and improve service delivery.

3.3 <u>Cancer Briefing</u>

The Committee received a Cancer Briefing presentation from the Deputy Chief Operating Officer. A series of slides were presented which set out:

- The structure of cancer services at the Trust
- The progress against the Major Volume Tumour Sites for 2023/24

- The delivered cancer performance for 2023/24
- An indicative overview of the progress for 2024/25, particularly the improvements and actions for the three key delivery indicators:
    - 28-day Faster Diagnosis Standard (FDS)
    - 31 day target
    - 62 day combined pathway
- The key areas to deliver improvements sustainability such as:
    - Demand management
    - Changes to the referral pathway
    - Clinical leadership and engagement to deliver the pathway change

The Committee discussed the benefits and drawbacks of a centralised vs decentralised structure and received reassurance regarding the Trust's structure of cancer services.

The Committee welcomed the update and recognised the importance of understanding the detail the challenges faced by the service. The Committee discussed and agreed that any red/amber risk tumour sites should be included in the cancer commentary not just the overall cancer achievement statistics, as this masks the true position on key areas and enables better triangulation with Trust Level Risks.

3.4 CIP Programme 2024/25

The Committee received the report which outlined the Cost Improvement Plan (CIP) Programme for 2024/25. The report detailed that the Trust has a £28.7m CIP target for 2024/25 and explained the processes followed to date, the governance around managing CIP delivery and provided an update on the current position. The Committee were also updated on the ongoing work with the divisional teams to reach the procurement target.

The Committee discussed the delivery plan and were informed that it was closely monitored on a monthly basis through the divisional performance review meetings. The Committee questioned the timeline and achievability of the plan and received reassurance that the expectation was to deliver the position, however the challenges were recognised, and CIP delivery has been raised as a Trust Level Risk given the significant value. In addition, it was noted that in order to have a better chance of hitting the CIP budget of £28.7m an increased target would be necessary, and it was confirmed that additional schemes were being worked up which should take the target pipeline closer to £35m.

Discussion also focused on the importance of transformational schemes to deliver the savings, the learning opportunities from regional networks to support and maintain a healthy pipeline, and the ongoing work to achieve agency reduction through a multi-faceted approach. It was requested that further deep dives into some of these areas should be discussed in future meetings, such as agency spend.

The Committee were reassured on the CIP Programme for 2024/25 and welcomed the governance framework in place to ensure the accurate capture of results and sustained focus on achieving targets.

3.5 Finance Report (Month 1)

The Committee received the Month 1 finance report which outlined that the Trust has delivered a £3.6m deficit, which was a £1.6m adverse position. The main driver of this is an under delivery of savings. The Month 1 CIP position showed £0.4m schemes fully

completed. The Trust has a further £7.1m in implementation and planning, and a further £23.5m of schemes identified in the pipeline. The cash at Month 1 amounts to £56.0m.

The Committee received reassurance regarding the cash position and noted that it would be closely monitored and discussed at each committee meeting. The Committee noted that the downward trajectory of cash would lead to a significant problem in 2025/26 if the rate of decline continued.

The full report is appended (see Appendix 1).

3.6 UHBW Five Year Strategy

The Committee received the University Hospital Bristol and Weston NHS Foundation Trust (UHBW) Digital Strategy for 2024-2029 which addresses the Acute Provider Collaborative requirement to deliver a single consistent, high quality digital service including meeting the needs of the Joint Clinical Strategy and noted it for information.

3.7 NBT Extended Digital Strategy 2023-2025

The Committee received the revised NBT Extended Digital Strategy for 2024-2025 which has been developed to maintain the trajectory defined in the original digital vision and to enable the Trust's Clinical Strategy with the ambition towards a single digital community. The seven principles powering the digital strategy include:

1. Joint Governance
2. Upgraded Infrastructure
3. Shared Assets
4. Convergence of Systems & Services
5. One Digital team
6. System-Wide Outreach
7. Joint Digital Strategy

Discussion focused on the importance of digital to drive the joint clinical strategy work, the need for interoperability and the financial challenges to deliver the required work.

The Committee endorsed the NBT Extended Digital Strategy 2023-2025 for Trust Board approval in due course.

3.8 Operational Performance IM&T Update

The Committee received an overall report on performance and priorities within this directorate. A detailed update on the status of each digital programme was provided, recognising areas of challenge and improvement.

The Committee discussed the funding challenges impacting the division, particularly regarding the Careflow digitisation and the Speech and Voice recognition programmes, and the resulting implications of the programmes delays. The Committee recognised the cultural challenges of implementing new systems and the importance of leadership in driving digital change.

The Committee discussed the prioritisation process and the opportunity to receive additional national funding but recognised the potential cash risk if the funding released was CDEL. The Committee received reassurance that work was still progressing on all programmes so that they could progress quickly should further funding become available.

The Committee discussed the IM&T risks and were assured that mitigating actions were in place. The key red risk summary areas are included below for board awareness:

- Risk ID 1928: Digital Infrastructure provision - Unity High Speed Storage Upgrade
  There is a risk of failure of the high-speed storage facility used by the Trust, resulting in an inability to access systems and data in the event of a hardware failure or cyber-attack. This is already operating beyond its original expected life span and the infrastructure is now reaching its end of life and support, therefore requires investment to be replaced with a fully supported solution or further mitigations to be identified.
- Risk ID 1899: Digital Infrastructure provision - Backup Facility Upgrade
  There is a risk that the backup facility used by the trust will fail resulting in an inability to restore systems and data in the event of a hardware failure or cyber-attack. This is already operating beyond its original expected life span and the infrastructure is now reaching its end of life and support, therefore requires investment to be replaced with a fully supported solution

3.9 DQ Position Statement

The Committee received the Data Quality Position Statement for 2023/24which had received a green rating of "significant assurance". The Committee welcomed the report and the significant assurance provided.

3.10 Risk Report

The Committee received and discussed the relevant Trust Level Risks (TLR) across Finance, Performance, Service Delivery and IM&T and Board Assurance Framework (BAF) risks within its purview.

The Committee discussed the new risks and received reassurance that the Head of Risk Management would be working with corporate and divisional teams to support the management of risks.

The Committee again noted the significant number of red rated risks which are outside the board appetite and the need for mitigations to bring these back within target in a reasonable period.

3.11 **Other items:**

The Committee also received the following items for information:

- An update from the Business Case Review Group
- Finance and Performance Committee forward work-plan 2024/25.

4. Identification of new risks & items for escalation

4.1 None

5. Summary and Recommendations

5.1 The Trust Board is asked to:

- Receive the report for assurance and note the activities Finance, Digital & Performance Committee has undertaken on behalf of the Board.
- Note the key red risk project which are unable to proceed due to lack of funding.

Report To:	Finance, Digital & Performance Committee			
Date of Meeting:	23 May 2024			
Report Title:	Finance Report for April 2024 (Month 1)			
Report Author:	Simon Jones, Assistant Director of Finance – Financial Management			
Report Sponsor:	Glyn Howells, Chief Financial Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			X	
Recommendations:	FPC are asked to note the report for information.			
Report History:	Regular report to FPC			
Next Steps:	Trust Board- May 2024			

Executive Summary		
The financial plan for 2024/25 in Month 1 (April) was a deficit of £2.0m. The Trust has delivered a £3.6m deficit, which is £1.6m worse than plan. The Month 1 CIP position shows £0.4m schemes fully completed. The Trust has a further £7.1m in implementation and planning, and a further £23.5m of schemes identified in the pipeline. Cash at Month 1 amounts to £56.0m.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	X
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	N/A	
Financial implications:	The Financial implications are set out in the paper.	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No	
Appendices:	Appendix 1: Finance Month 1 Slides	

NHS North Bristol NHS Trust

14.1

Finance Performance Report

Board Report: Month 1 2024/25

Author: Simon Jones (Assistant Director of Finance)

Sponsor: Glyn Howells (Chief Finance Officer)

NBTCARES

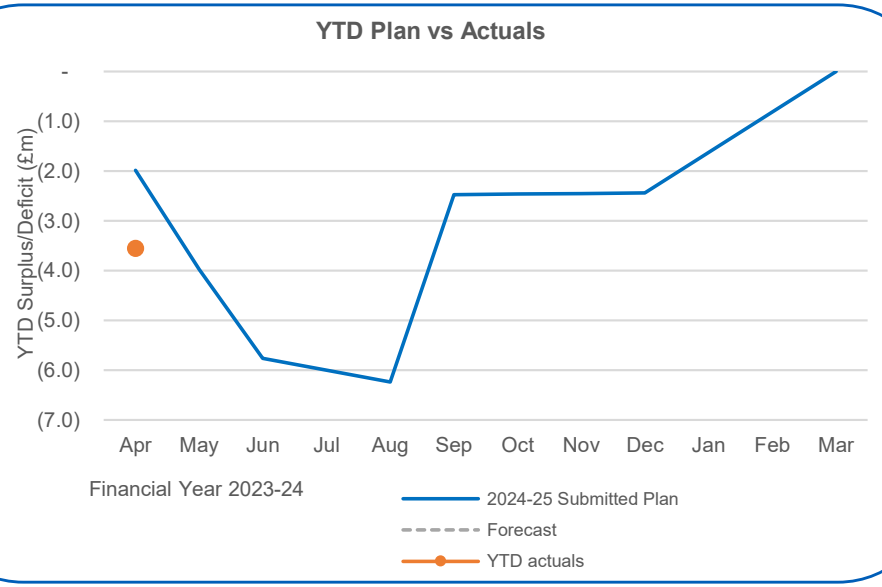
Finance Performance Report

Month 1 (April 2024)

14.1

Finance Summary

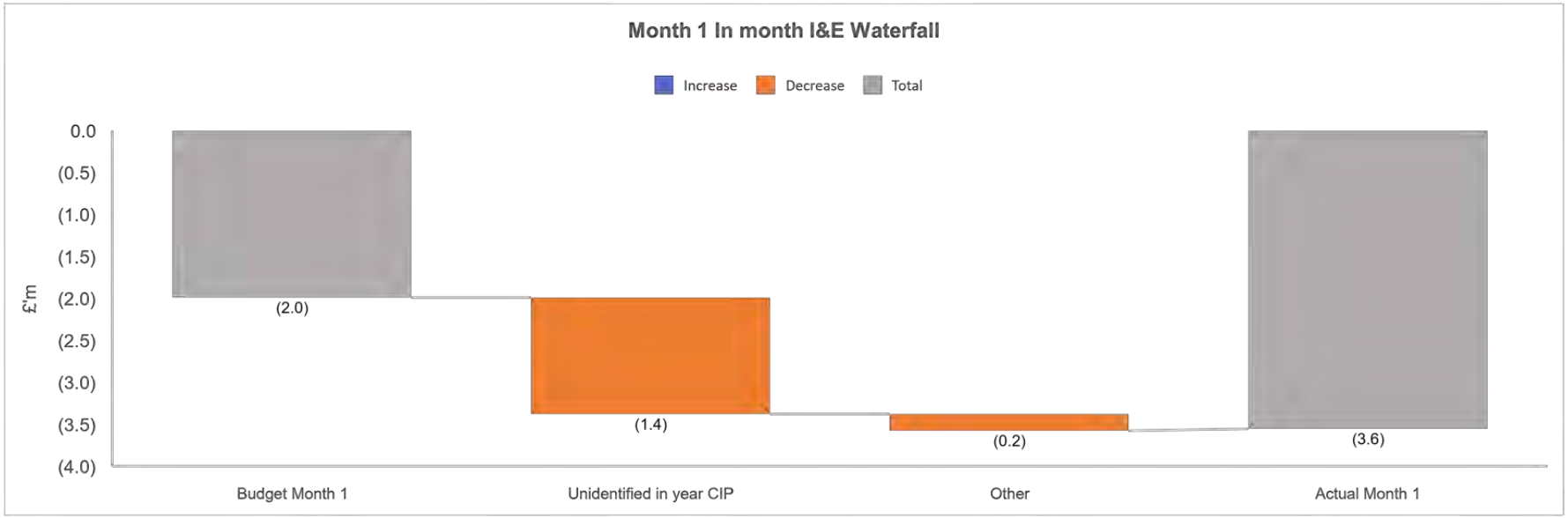
	Month 1			Year to date		
	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	67.0	66.2	(0.8)	67.0	66.2	(0.8)
Income	7.1	8.3	1.2	7.1	8.3	1.2
Pay	(46.6)	(47.6)	(1.0)	(46.6)	(47.6)	(1.0)
Non-pay	(29.5)	(30.5)	(1.0)	(29.5)	(30.5)	(1.0)
Surplus/(Deficit)	**(2.0)**	**(3.6)**	**(1.6)**	**(2.0)**	**(3.6)**	**(1.6)**



Key messages:

- The financial plan for 2024/25 in Month 1 (April) was a deficit of £2.0m. The Trust has delivered a £3.6m deficit, which is £1.6m worse than plan.
- In month 1 the Trust has seen the impact of undelivered CIP across both pay and non-pay, creating a £1.4m adverse variance.
- ERF performance in month has assumed to be on plan until further information is available.
- The Trust cash position at Month 1 is £56m, a reduction of £6.7m from Month 12. This is driven by the Trust underlying deficit and capital spend.
- The Trust has delivered £0.4m of completed cost improvement programme (CIP) schemes at month 1. There are a further £7.1m of schemes in implementation and planning that need to be developed, and £23.5m in the pipeline.

Income and Expenditure: In month I&E waterfall



Finance Performance Report

Month 1 (April 2024)

14.1

Finance Summary – In Month

Overall

Income and Expenditure (I&E) performance in Month 1 generated a £3.6m deficit against a £2.0m planned deficit, which is £1.6m worse than plan.

Income

Commissioning income including pass-through income was £0.8m worse than plan. This is driven by a reduction in income with respect to NHSE High Cost Drugs (£0.6m) along with HCTED (£0.3m), both of which are pass-through and should largely be offset with expenditure.

Non-NHS income was £1.2m better than plan. This is driven by adjustments (£0.1m fav) where the Trust has received new funding (offset by costs) since the plan was approved. The remaining £1.1m favourable variance is driven by funding recognised in month in relation to fire dampener work (£0.6m) offset in non-pay, and various income benefits in clinical and corporate divisions.

Pay

Pay costs were £1.0m worse than plan. New funding adjustments offset in income (including medical pay award) were £0.4m adverse – see table below. The remaining pay variance is £0.6m adverse to plan which has been driven by undelivered CIP of £0.7m adverse.

Non-pay

Non-pay costs including pass-through drugs and devices were £1.0m worse than plan. New funding adjustments offset in income and pass-through drugs were £1.0m favourable – see table below. The remaining variance is £2.0m adverse which has been driven by the Trust seeing a £1.3m adverse variance on non-pay in Month 1 linked to increased medical consumables spend and various items in clinical divisions. Undelivered CIP is £0.7m adverse.

Saving

Savings In month the Trust delivered a £0.4m of savings in Month 1.

Gross capital expenditure was £0.6m in month. This is almost entirely driven by spend on the Elective Centre project, which was in line with the forecasted spend for Month 1.

Capital & Cash

Cash is £56.0m at 30 April 2024, a £6.7m decrease compared with the previous month. The decrease in month is £0.5m adverse to plan & driven by increased operational spend.

		Removed					
	In month variance	NHSE plan adjustments	Research	High cost drugs	HCTED	Fire dampener	Revised variance
	£m	£m	£m	£m	£m	£m	£m
Income	0.4	0.7	(1.0)	(0.6)	(0.3)	0.6	1.0
Pay	(1.0)	(0.6)	0.2				(0.6)
Non-pay	(1.0)	(0.1)	0.8	0.6	0.3	(0.6)	(2.0)
Total	**(1.6)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(1.6)**

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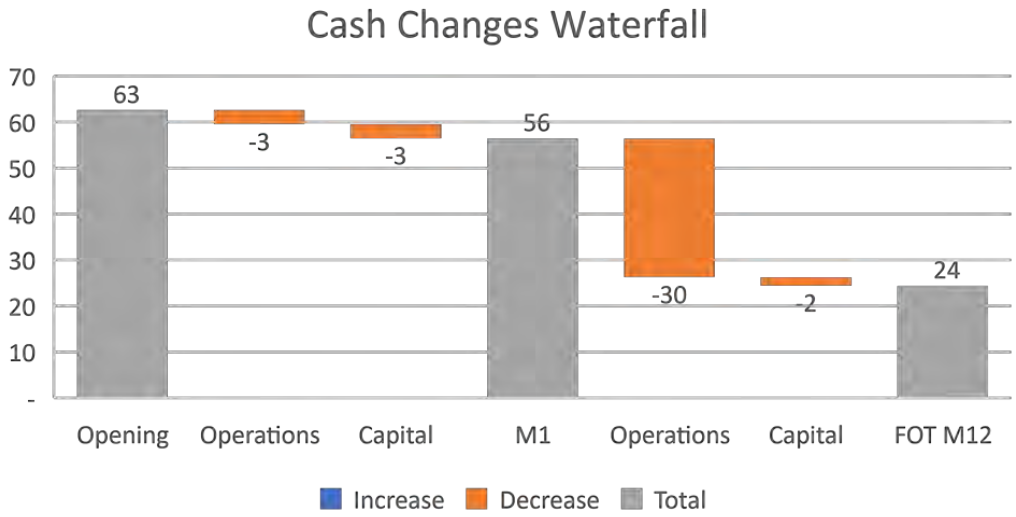
Savings

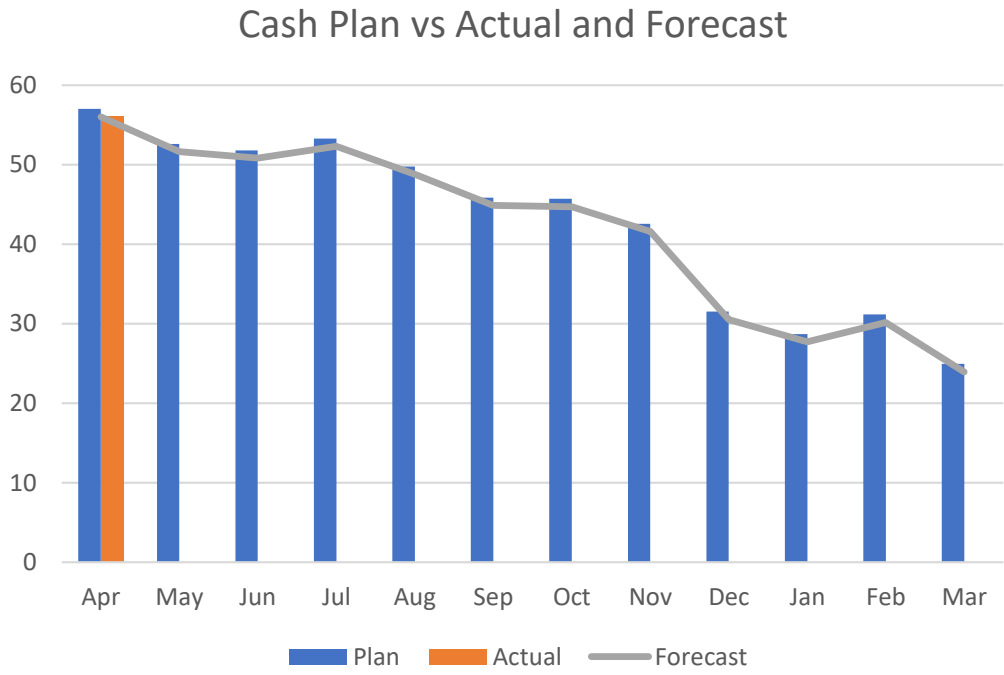
Division (£'m)	FYE Target	Completed Schemes	Schemes in Implementation	Schemes in Planning	Total FYE	Variance FYE	Schemes in Pipeline	Total FYE inc Pipeline
ASCR	5.8	0.1	0.0	3.4	3.4	(2.3)	1.2	4.6
CCS	4.8	0.1	0.0	0.7	0.9	(4.0)	0.6	1.5
MED	4.1	0.0	0.0	0.5	0.5	(3.6)	1.4	1.9
NMSK	3.7	0.1	0.0	2.0	2.1	(1.6)	0.6	2.7
WCH	1.6	0.3	0.0	0.2	0.5	(1.2)	0.7	1.2
FAC	2.5	0.0	0.0	0.1	0.1	(2.4)	1.0	1.1
Corp	2.0	0.1	0.0	0.1	0.2	(1.8)	0.1	0.2
Central	4.1	0.0	0.1	0.0	0.1	(4.1)	18.0	18.0
Total	**28.7**	**0.6**	**0.1**	**7.0**	**7.7**	**(21.0)**	**23.5**	**31.1**

Saving Phasing £'m	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Plan phasing	1.5	1.5	1.7	2.5	2.5	2.5	2.5	2.5	2.5	3.0	3.0	3.0	**28.7**
Delivery FYE	0.6												**0.6**

- The CIP plan for 2024/25 is for savings of £28.7m with £1.4m planned to be delivered by Month 1.
- At Month 1 the Trust has £0.6m of completed schemes on the tracker. There are a further £7.2m of schemes in implementation and planning leaving a remaining £21.0m of schemes to be developed, against this we have £23.5m of schemes identified in the pipeline.
- The surplus to plan on the tracker is £1.4m with pipeline included, with further schemes currently being worked up.
- In the table above the Trust has reflected delivery of £0.6m of savings in 2024/25. This is the full year effect figure that will be delivered recurrently. Due to the start date of CIP schemes this creates a mis-match between the 2024/25 impact and the recurrent full year impact.
- At Month 1 the Trust is showing a £1.4m adverse variance for delays due to in year delivery of CIP, which reflects the fact that most schemes delivered in month 1 are not currently impacting the year to date position. The I&E impact of this is being managed through vacancy factors in funded budgets and delays on implementing investments.

Cash Position





- In month cash is held at £56.0m, which is a £6.7m decrease from Month 12 driven by I&E deficit and carried forward capital payments from March.
- It is expected the trend will continue, resulting in the overall reduction of cash position to approximately £24m.
- The expected year end cash position has deteriorated by £0.5m in month due to a deterioration in the revenue position against the plan.

Risks & Mitigations

Issue	YTD Position £m	Risk	FOT £m	Mitigations	FOT £m	Actions
Under delivery of in year savings	(1.4)	Continued under delivery of CIP	(21.0)	Further development and delivery of pipeline items, with CIP Board holding divisions and directorates to account.	21.0	Continued organisational focus on CIP identification and delivery
Other pressures	(0.2)					
		Expected additional funding not received	(9.0)	Continued engagement with commissioners	9.0	Continued engagement with commissioners to identify additional income opportunities
Total	**(1.6)**		**(30.0)**		**30.0**	

- There is a risk that the cost pressures which have arisen or increased in 2023/24, and which have not been funded externally will risk the Trust's ability to breakeven in 2024/25 if action is not taken to reduce them. TLR 1896.
- There is a risk that the savings requirement of a 3.7% recurrent delivery is not achieved in 2024/25. Thiis is due to an insufficient level of cost releasing and productivity savings being delivered. TLR 1887. There are currently 7.7m of CIP schemes either planned, in implementation or completed leaving a £21m risk remaining.
- There is a risk that the Trust will not receive the full £10m of non-recurrent income assumed in the 2024/25 plan, currently with unidentified sources. Risk ID 1924. currently £1m of identified expected income leaving £39m risk.
- It is currently still expected that all risks will be fully mitigated to deliver a breakeven outturn at year end.

14.1

Appendix – Financial Statements

Income and Expenditure: Main Heading

	Month 1			Year to Date		
	Budget	Actual	Variance	Budget	Actuals	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	67.0	66.2	(0.8)	67.0	66.2	(0.8)
Other Income	7.1	8.3	1.2	7.1	8.3	1.2
Total Income	**74.1**	**74.6**	**0.4**	**74.1**	**74.6**	**0.4**
AHP's and STT's	(7.0)	(6.8)	0.2	(7.0)	(6.8)	0.2
Medical	(13.6)	(13.5)	0.1	(13.6)	(13.5)	0.1
Nursing	(17.2)	(17.6)	(0.5)	(17.2)	(17.6)	(0.5)
Other Non Clinical Pay	(8.9)	(9.7)	(0.8)	(8.9)	(9.7)	(0.8)
Total Pay	**(46.6)**	**(47.6)**	**(1.0)**	**(46.6)**	**(47.6)**	**(1.0)**
Drugs	(5.2)	(4.1)	1.1	(5.2)	(4.1)	1.1
Clinical Supplies (Incl Blood)	(5.0)	(4.5)	0.5	(5.0)	(4.5)	0.5
Supplies & Services	(6.3)	(7.8)	(1.5)	(6.3)	(7.8)	(1.5)
Premises Costs	(9.4)	(10.3)	(1.0)	(9.4)	(10.3)	(1.0)
Other Non-Pay	(3.7)	(3.9)	(0.2)	(3.7)	(3.9)	(0.2)
Total Non-Pay Costs	**(29.5)**	**(30.5)**	**(1.0)**	**(29.5)**	**(30.5)**	**(1.0)**
Surplus/(Deficit)	**(2.0)**	**(3.6)**	**(1.6)**	**(2.0)**	**(3.6)**	**(1.6)**

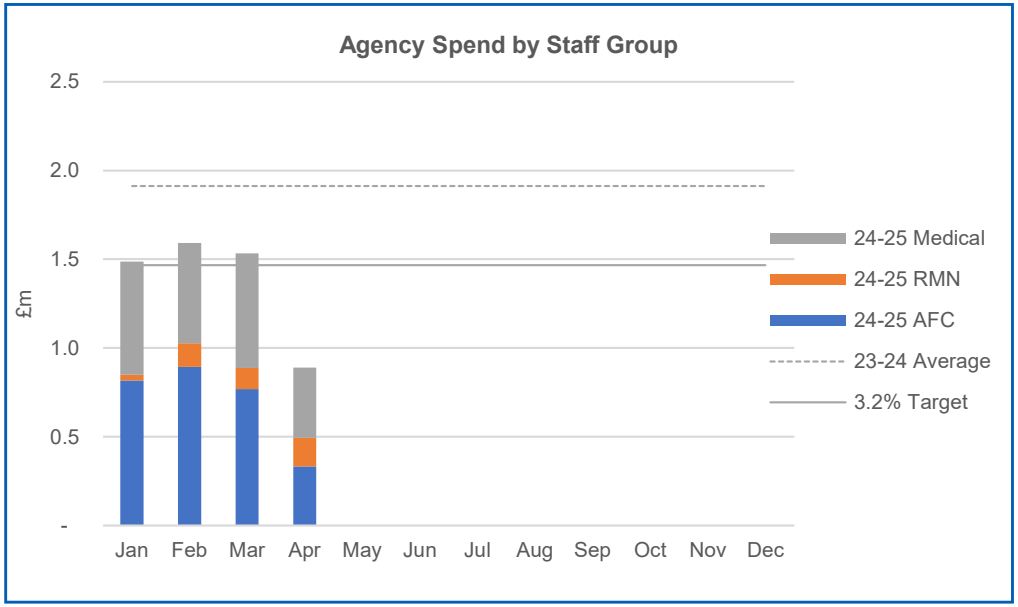
- Detailed Trustwide month 1 and year to date position shown by key headings. This shows further detail from the table shown on slide 2.

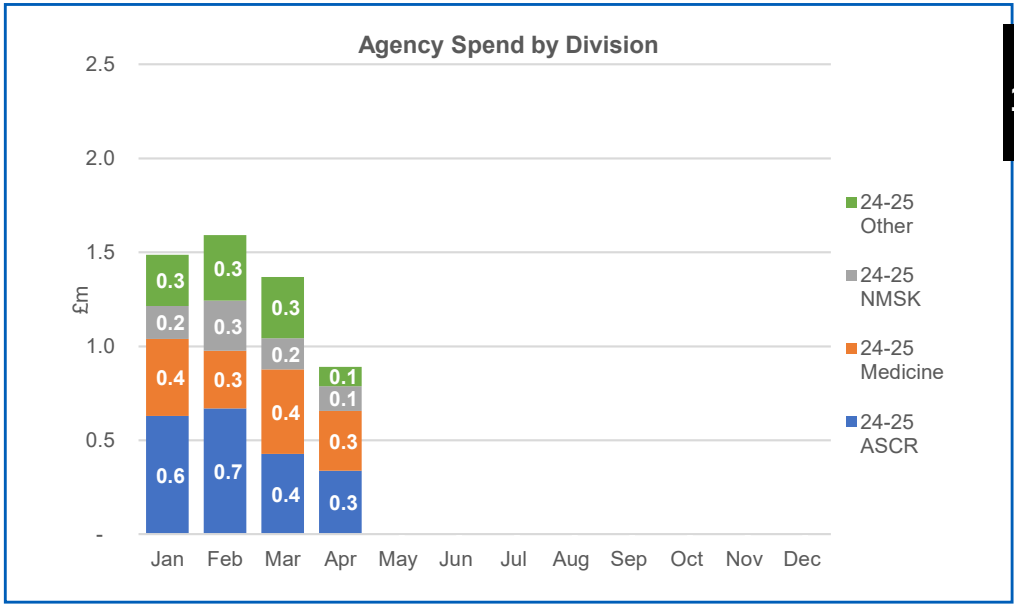
Statement of Financial Position

	23/24 Month 12 £m	24/25 Month 01 £m	In-Month Change £m
Non-Current Assets	**538.4**	**536.9**	**(1.5)**
Current Assets			
Inventories	11.7	12.0	0.3
Receivables	49.4	48.7	(0.7)
Cash and Cash Equivalents	62.7	56.0	(6.7)
Total Current Assets	**123.8**	**116.8**	**(7.1)**
Current Liabilities (< 1 Year)			
Trade and Other Payables	(99.9)	(92.2)	7.8
Deferred Income	(14.4)	(17.7)	(3.3)
Financial Current Liabilities	(23.6)	(23.6)	0.0
Total Current Liabilities	**(138.0)**	**(133.5)**	**4.5**
Non-Current Liabilities (> 1 Year)			
Trade Payables and Deferred Income	(6.2)	(6.7)	(0.5)
Financial Non-Current Liabilties	(571.8)	(596.6)	(24.7)
total Non-Current Liabilities	**(578.0)**	**(603.3)**	**(25.3)**
Total Net Assets	**(53.7)**	**(83.1)**	**(29.4)**
Capital and Reserves			
Public Dividend Capital	485.2	485.2	0.0
Income and Expenditure Reserve	(541.8)	(610.8)	(69.0)
Income and Expenditure Account - Current Year	(69.0)	(29.4)	39.6
Revaluation Reserve	71.9	71.9	0.0
Total Capital and Reserves	**(53.7)**	**(83.1)**	**(29.4)**

Items to note:
Non Current Assets: Movements driven by capital expenditure are offset by in-year depreciation and amortisation.
Inventories: Only Pharmacy inventory is counted on a monthly basis, therefore, the year-to-date movement is minimal.
Receivables: The year-to-date movement is largely driven by receiving payments for year-end invoices from a number of NHS partners.
Cash and Cash equivalents: Please refer to the detailed analysis of key movements on Slide 6.
Trade and Other Payables: The year-to-date movement is driven by paying major year-end balances, such as business rates invoices.
Deferred income: The year-to-date and in-month movements follow a regular cycle of payments in advance from Health Education England, Research Grants and Commissioners.
Financial Liabilities: The year-to-date movement relates to recognition of annual PFI liability remeasurement based on the applicable inflation rate.
Income and expenditure reserve: The year-to-date movement represents a rollover of the final I&E balance from the prior year.
Income and expenditure account - current year: The year-to-date movement represents the cumulative year-to-date I&E position including below control total items, such as annual PFI liability remeasurement.

Pay: Temporary Staffing - Agency





Note: 3.2% target is calculated based on 2024-25 budgeted pay expenditure. The final figure is based on 3.2% of 2024-25 outturn, which will not be known until Month 12.

Agency analysis

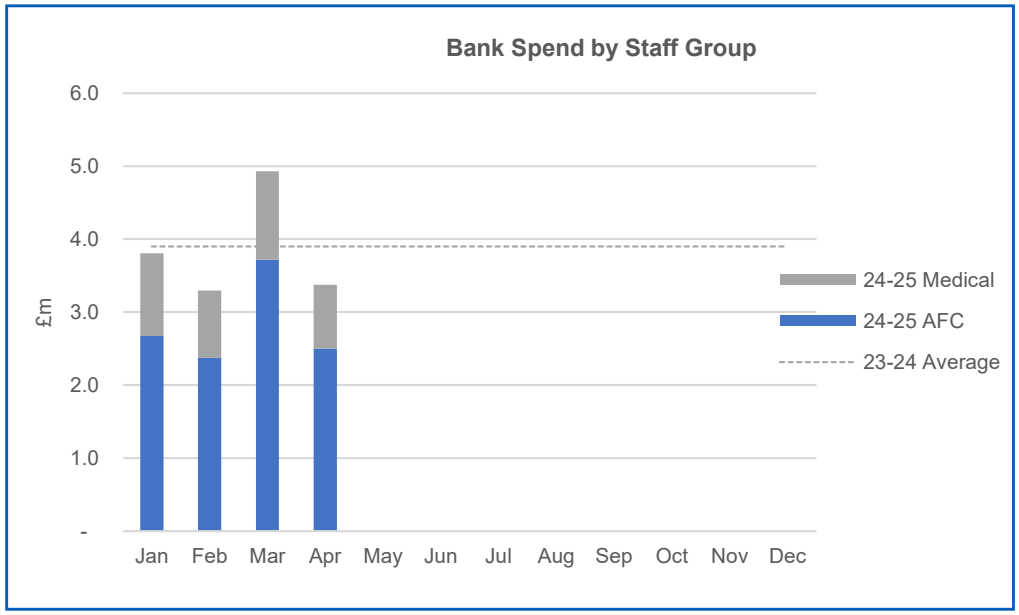
Monthly Trend

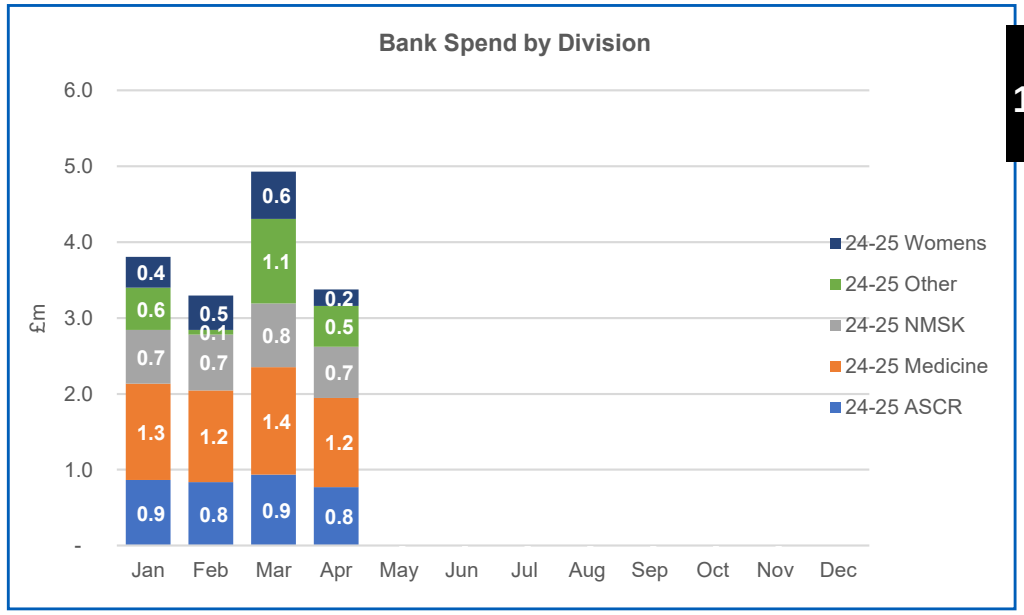
- Agency spend in April has reduced in comparison to prior months.
- Overall spend in month is driven by consultant agency usage in ASCR, NMSK and Medicine covering vacancies as well as RMN usage in Medicine and nursing agency usage in theatres due to ODP incentives. (ASCR)

In Month vs Prior Year

- Trustwide agency spend in April is below 2023/24 spend. This is due to increased controls being implemented across divisions as well as the introduction of the agency rate card across the region.

Pay: Temporary Staffing - Bank





Bank analysis

Monthly Trend

- In April, bank spend has remained at high levels due to the reduction in agency usage across nursing and HCAs. This is driven by spend in the clinical divisions to cover vacancy gaps as well as safer staffing.
- Locum spend also remains high within Medicine covering vacancies.

In Month vs Prior Year

- Bank spend in month is lower than 2023/24 average spend. This is driven by a reduction in supernumerary usage across the clinical divisions.

Report To:	Public Trust Board			
Date of Meeting:	30 May 2024			
Report Title:	Audit and Risk Committee Upward Report			
Report Authors:	Richard Gwinnell, Deputy Trust Secretary			
Report Sponsor:	Shawn Smith, Non-Executive Director (Committee Chair)			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	The Trust Board is recommended (1) to receive the report for assurance (2) to note the activities the Audit and Risk Committee has undertaken on behalf of the Board and (3) to approve the changes to the Standing Financial Instructions which were approved by the Committee (in relation to the line and budget management of the Southmead Hospital Charity).			
Report History:	The report is a standing item to each Trust Board meeting, following every Audit and Risk Committee meeting.			
Next Steps:	The next upward report from this Committee will be to the Trust Board's meeting in June 2024.			

Executive Summary		
The report provides assurances received, issues escalated to the Trust Board and any new risks identified from the Audit and Risk Committee meeting held on 9 May 2024.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	X
	Innovate to Improve – *Unlocking a better future*	X
	Sustainability – *Making best use of limited resources*	X
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	The Audit and Risk Committee has oversight of the Trust's overall risk management systems and processes. No risks arise from this report.	
Financial implications:	None within this report.	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No	

Appendices:	Standing Orders and Standing Financial Instructions (see changes on pages 2 and 93 only)

1. Purpose

1.1 To provide a highlight of the key assurances, escalations to the Board and identification of any new risks arising from the Audit and Risk Committee meeting held on 9 May 2024.

2. Background

2.1 The Audit and 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 systems 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 on 9 May 2024

3.1 External Audit Progress Report and Sector Update

The Committee received an update from the Trust's External Auditors on progress in delivering their responsibilities and on national developments and challenges for the NHS. No further work was required on inventory, as it did not pass the materiality test; everything was in order relating to the PFI liability; and all 2023/24 deliverables were on track, with a report in preparation on the final accounts, in readiness for the June meeting. Meetings were taking place weekly between auditors and Trust officers to ensure there were no surprises at final accounts stage. No significant risks or weaknesses had been identified. The Committee noted and was assured by the update.

3.2 Internal Audit Interim Progress Report

The Committee received an interim progress report from the Internal Auditors, informing them of Internal Audit activity since the last meeting. Progress on audits was good, with only seven overdue audit actions (due on 1 April 2024) across the whole of the Trust, which was exceptionally positive compared to most other trusts. Terms of reference had been agreed for business continuity and payroll audits, and those audits would start soon.

The Committee noted and was assured by the report, agreed to extend the target date for completion of the health and safety training package (to 31 May) and asked that the scope of the workforce audit specifically include long term sickness absence.

3.3 Counter Fraud (CF) Interim Progress Report

The Committee received an update from the Senior Local CF Specialist on progress against the CF workplan presented to the Committee in March. KPMG had completed all the work required of them (when their contract ended at the end of March) and had conveyed the necessary audit-end data to ASW Assurance. This required verification by the Chair of this Committee and the Chief Finance Officer, which was in progress. Work was being done to launch the new CF service at NBT and share fraud awareness training for staff of both NBT and UHBW, in liaison with NBT's Communications and HR teams. Work was also being done with the Freedom to Speak Up (FTSU) Lead to understand how

the FTSU network at NBT worked and how ASW could best engage with FTSU members and staff groups. The Committee noted and was assured by the progress report.

3.4 Losses and Overpayments March 2024

The Committee received an update on losses and overpayments, and details of action in progress to reduce them. No losses had occurred in March and five special payments (totalling £14k) had been made. A further report on fee-paying generally was planned for the Committee's meeting in August.

Committee members asked whether there may be opportunities to streamline processes (e.g., to reduce late notification of staff changes to payroll) through the Patient First (PF) approach. They were informed that PF training was underway in the team and there were potential opportunities to reduce wasted effort and bottlenecks in process. A separate piece of work was progressing with regard to overseas patients, involving reclaiming costs from insurers, and contracts had been reviewed to limit the Trust's exposure to overseas patient costs in future. The Committee noted and was assured by the report and actions in progress to reduce losses and overpayments.

3.5 Cyber-Security Biannual Report

The Committee received details of the extensive work in progress to continue to ensure, and tackle potential gaps in, cyber-security. The recent KPMG audits of data security and protection (DSPT) and the DSPT annual return gave additional significant assurance that NBT's efforts were effective, as did the recent third-party cyber-security assessment and IT Health Check. The Committee was informed of recent cyber-attacks on other NHS Trusts and that cyber-attacks were a real and constant threat.

NBT followed the National Cyber Security Centre's ten steps to cyber-security outlined in the report (as did NHS England), with "defence" at the top of the priority list. NBT's exposure score was one of the lowest in the UK and a great deal of work was taking place internally and with partners to maintain effective cyber-security. The Committee heard details of various workstreams including server, end-user equipment and operating system replacement, cyber-threat alerts, system updates and patching, micro-segmentation work and external testing. External partners were used, to try to deliberately hack into and break NBT's systems or crack passwords, to test vulnerability, alongside internal vulnerability scanning. The Committee also heard details of cyber-security governance structures, performance highlights and plans to stretch targets even further in the year ahead.

Questions were asked and answered about targets for the year ahead, the business case for back-up infrastructure work, the lack of capital funding and the micro-segmentation plans. The Committee noted and was assured by the work in progress.

3.6 E-Rostering and e-Job Planning Update

The Committee received an update on the deployment of e-Rostering and e-Job Planning, as it requested in May 2023, following the audit by KPMG, and an update on the progress made against KPMG's recommendations. The system was in the process of being rolled out to divisions, with progress good, albeit more advanced in some areas than others. The two-year deployment plan (to the whole Trust) was due for completion in December 2025. A new governance structure was being put in place to assist with implementation and the

challenges with deployment and engagement were gradually being tackled. The benefits and importance of having one system, and electronic records, were reiterated.

The Committee noted the progress made and was assured that implementation was being monitored closely by the People and EDI Committee.

3.7 BWPC Procurement Update

The Committee received the usual BWPC dashboard report, showing details of progress on compliance with procurement processes, key projects and performance. Due to the reporting period (including the end of the last financial year, when timescales were tight for capital spending in particular), compliance had dipped and single tender actions had shown a slight increase, but this was in line with expectations. Work was continuing to address the audit risks identified by KPMG and good progress was being made around segregation of procurement roles and in-sourcing for example.

The Committee was reminded of the ongoing roll-out of the new purchasing system, which was progressing at pace, and its benefits, including the need for additional approvals if staff wished to depart from established suppliers or purchasing mechanisms. Completion of the roll-out was approximately nine months away.

The Committee noted and was assured by the progress reported.

3.8 Draft Annual Governance Statement (AGS) 2023/24

The Committee received a draft of the AGS. This provided the information required (by the NHS Code of Governance) about NBT's governance during the year, acknowledged the challenges NBT faced (e.g., industrial action) and concluded that there were no significant internal control issues to report. It also explained the Trust's exception to the Code, with regard to the number of independent non-executive directors (NEDs) on the Trust Board. The Committee approved the draft AGS, subject to minor amendments to update some NED biographies.

3.9 Standing Financial Instructions (SFIs) Review

The Committee received proposed changes to the SFIs, to reflect the proposed changes to budget management arrangements for the Southmead Hospital Charity. The Committee was informed that the Southmead Hospital Charity Committee had approved the changes to the line management arrangements. The Committee approved the changes to the SFIs (attached as an appendix) subject to the changes also being agreed by the Board and the Corporate Trustee in due course.

3.10 Declarations of Interest (DOI) Biannual Update

The Committee received an update on DOI, containing details of declarations made by decision-making staff between 1 November 2023 and 30 April 2024. The Committee heard about the processes in place to ensure the robustness of declarations and compliance with the DOI Policy, including regular cross-checks against external evidence (e.g. Companies House records) and about positive progress against the recommendations of the follow-up audit reported by KPMG in October 2023. The Committee noted and was assured by the update.

3.11 Other items:

The Committee also noted its work plan and discussed the need to consider governance arrangements for the Hospital Group later in the year.

4. New risks or items for escalation

One issue was flagged by the Committee for the Trust Board's attention; that being the limits on capital funding for greater investment in cyber-security and the risks this created.

5. Summary and Recommendations

The Trust Board is recommended (1) to receive the report for assurance (2) to note the activities the Audit and Risk Committee has undertaken on behalf of the Board and (3) to approve the changes to the Standing Financial Instructions which were approved by the Committee (in relation to the line and budget management of the Southmead Hospital Charity).

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

Internal Policy Number: CO12

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

Main Author(s):	Chief Executive (for SOs and SRP) Chief Finance Officer (for SFIs and SoDA) Director of Corporate Governance/Trust Secretary
Consultation:	Executive Team Audit & Risk Committee Trust Board
Ratifying Committee:	Trust Board
Executive Lead:	Xavier Bell, Director of Corporate Governance/Trust Secretary
Date of Approval:	9 November 2023
Next Review Due:	8 November 2024 – or earlier if required by legislation or regulatory change
Version:	9.1

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 V8.2 November 2021 – Annual Review V8.3 January 2022 – update following discontinuation of the role of Executive Director of Estates, Facilities & Capital Planning (referred to as 'Director of Facilities' in previous versions of this document).

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.

15.1

	V9.0 November 2022 – Annual Review. Key changes provide clarity on use of seal, electronic signature of documents, procurement processes and approval routes and business case approval routes. V9.1 September 2023 – Updated with changes to section 5 of the SoDA as approved by Trust Board, increasing value of non-contract spend at which BWPC validate quotation / value for money process. V9.2 April 2024 – Updated with changes to Section 16 of the Scheme of Delegated Authorities regarding Southmead Hospital Charity spend approval limits

Trust Standing Orders

Contents

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NHS North Bristol NHS Trust

Foreword to Standing Orders

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

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

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

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

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

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

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

1 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.

Introduction

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

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

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

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

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

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

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

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

Interpretation

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

X. The following definitions apply for this document.

Legislation definitions:

- the **2006 Act** is the National Health Service Act, 2006
- the **2012 Act** is the Health and Social Care Act, 2012
- **Membership and Procedure Regulations** are the National Health Service Trust (Membership and Procedure) Regulations 1990 (SI(1990)2024), as amended.

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Other definitions:

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

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practising upon the Trust's premises and shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust).

- **SFIs** are the Standing Financial Instructions.
- **SOs** are the Standing Orders.
- **Trust** is the North Bristol NHS Trust.
- **Trust Board** (or the **Board**) is the Chair and Non-Executive Directors and Executive Directors
- **Trust Secretary** is the officer appointed to provide advice on corporate governance issues to the Board and the Chair; and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance.
- **Vice Chair** means the Non-Executive Director appointed by the Trust to take on the Chair's duties if the Chair is absent for any reason.
- **Working day** means any day, other than a Saturday, Sunday or legal holiday

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

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

Part I – Membership

1. *Name and business of the Trust*

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

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

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

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

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

2. *Composition of the Trust Board*

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

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

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

Appointees can fulfil more than one of the roles identified.

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2.3. The Executive Directors shall include:

2.3.1. Chief Executive

2.3.2. Chief Finance Officer, or equivalent

2.3.3. Chief Medical Officer

2.3.4. Chief Nursing Officer, or equivalent

2.3.5. Chief Operating Officer

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

3. *Appointment of the Chair and directors*

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

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

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

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

4. *Vice-Chair*

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

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

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

5. *Tenure of office*

5.1. The regulations governing the period of tenure of office of the Chair and Non-Executive Directors and the termination or suspension of office of the Chair and Non-Executive Directors are contained in the Membership and Procedure Regulations and as directed by NHSI, under its delegated authority from Secretary of State for Health.

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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.

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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 theChief Executive and the Trust Secretary and in the case of Standing Financial Instructions the Chair shall be advised by the Chief Finance Officer.

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13. *Voting*

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

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

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

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

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

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

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

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

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

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

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14. Quorum

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

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

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

15. Record of attendance

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

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

16. Minutes

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

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

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

17. Notice of motion

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

18. Motions

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

18.1.1. an amendment to the motion.

18.1.2. the adjournment of the discussion or the meeting.

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

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

18.1.5. that the motion be now put

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

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

19. *Right of reply*

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

20. *Motion to rescind a decision of the Trust Board*

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

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

21. *Declaration of Interests and Register of Interests*

Declaration of Interests

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

21.2. Interests are:

21.2.1. Financial interests, where an individual may get direct financial benefit from the consequences of a decision they are involved in making.

21.2.2. Non-financial professional interests, where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

21.2.3. Non-financial personal interests, where an individual may benefit personally in ways which are not linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

21.2.4. Indirect interests, where an individual has a close association with another individual who has a financial interest, a non-financial

professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

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

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

21.5. Declarations of interests should be considered by the Trust Board and retained as part of the record of each Trust Board meeting. Any changes in interests should be declared at the next Trust board meeting following the change occurring.

21.6. If a conflict of interest is established during the course of a Trust Board meeting, whether arising from a declared interest or otherwise, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. The declared conflict of interest should be recorded in the minutes of the meeting. When a Director has declared an interest arising solely from a position with a charity or voluntary body under this Standing Order, the Trust Board may resolve that the director may remain in the meeting and take part in the discussion, but not vote on the relevant item. A record of this decision shall be made in the minutes.

21.7. Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

Register of Interests

21.8. The Trust Secretary will ensure that a Register of Interests is established and maintained to record formally declarations of interests of directors and other decision-making staff. The Register of Interests will include details of all directorships and other relevant and material interests which have been declared by both executive and Non-Executive Directors.

21.9. These details will be kept up to date by means of an annual review of the Register of Interests in which any changes to interests declared during the preceding twelve months will be incorporated.

21.10. The Register of Interests will be available to the public and open to inspection at the Trust's usual place of business at any time during normal business hours (between 09:00am and 17:00pm on any working day).

21.11. With the exception of the requirement to report interests in the Annual Report (Standing Order 21.7), this Standing Order also applies in full to any committee or sub-committee or group of the Trust Board; and to any member of such committee or sub-committee or group (whether or not they are a director).

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NHS North Bristol NHS Trust

22. Disability of directors in proceedings on account of pecuniary interest

22.1. Subject to Standing Order 21 and the provisions of this Standing Order, if a director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

22.2. The Secretary of State may, subject to such conditions as they may think fit to impose, remove any disability imposed by this Standing Order, in any case where it appears to them to be in the interests of the NHS that the disability should be removed.

22.3. The Trust Board, or any committee or sub-committee may, if it thinks fit, provide for the exclusion of a director from a meeting while any contract, proposed contract or other matter in which that person has a pecuniary interest, direct or indirect, is under consideration.

22.4. Any remuneration, compensation or allowances payable to a director by virtue of paragraph 233, Part 11 of the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

22.5. For the purpose of this Standing Order a director shall be treated, subject to Standing Order 2 as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

22.5.1. they, or a nominee of theirs, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or,

22.5.2. they are a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

22.5.3. and in the case of persons living together as a couple, whether married or not, the interest of one person shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

22.6. A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

22.6.1. of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

22.6.2. of an interest in any company, body or person with which they are connected as mentioned in Standing Order 22.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

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

22.7.1. They have an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, **and**

22.7.2. the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, **and**

22.7.3. the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of the class.

This does not affect their duty to disclose the interest

22.8. This Standing Order also applies in full to any committee or sub-committee or group of the Trust Board; and to any member of such committee or sub-committee or group (whether or not they are a director).

23. Standards of Business Conduct

23.1. The Trust considers it to be a priority to maintain the confidence and continuing goodwill of its patients, public and fellow service providers. The Trust will ensure that all staff are aware of the standards expected of them and will provide guidance on their personal and professional behaviour.

23.2. The NHS Constitution 2016 identifies a number of key rights that all staff have and makes a number of further pledges to support staff in delivering NHS services. It goes on to set out the legal duties and expectations of all NHS staff, including:

- to accept professional accountability and maintain the standards of professional practice as set out by the relevant regulatory bodies;
- to act in accordance with the terms of contract of employment;
- not to act in a discriminatory manner;
- to protect confidentiality;
- to be honest and truthful in their work;
- to aim to maintain the highest standards of care and service;
- to maintain training and personal development to contribute to improving services;
- to raise any genuine concerns about risks, malpractice or wrongdoing at work at the earliest opportunity;
- to involve patients in decisions about their care and to be open and honest with them and;
- to contribute to a climate where the truth can be heard and learning from errors is encouraged.

23.3. The Trust adheres to and expects all staff to abide by the seven principles of public life set out by the Parliamentary Committee on Standards of Public Life. These are:

- **Selflessness:** Holders of public office should act solely in terms of the public

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interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

- **Integrity:** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- **Objectivity:** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Accountability:** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- **Openness:** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- **Honesty:** Holders of public office should be truthful.
- **Leadership:** Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

23.4. All staff are expected to conduct themselves in a manner that reflects positively on the Trust and not to act in a way that could reasonably be regarded as bringing their job or the Trust into disrepute. All staff must:

- act in the best interests of the Trust and adhere to its values and this code of conduct;
- respect others and treat them with dignity and fairness;
- seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion;
- be honest and act with integrity and probity;
- contribute to the workings of the Trust and its management and directors in order to help them to fulfil their role and functions;
- recognise that all staff are individually and collectively responsible for their contribution to the performance and reputation of the Trust;
- raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate and;
- accept responsibility for their performance, learning and development.

23.5. All Directors must act in accordance with the Professional Standards Authority's 'Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England' 2012.

23.6. All staff shall declare any relevant and material interest, such as those described in Standing Order 21 and in the Trust's Declarations of Interest Policy. The declaration should be made on appointment to the Executive Director, clinical director, or senior manager to whom they are accountable. If the interest is acquired or recognised subsequently, a declaration should be made via the Trust's online declarations of interest system in line with the Declarations of Interest Policy. The system will then add the interest to the Trust's Register of Interests.

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

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

23.9. Gifts and hospitality shall only be accepted in accordance with the Trust's Declarations of Interest Policy. Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any rewards or gifts of significant value.

23.10. All gifts and hospitality, other than those that are of clearly minimal value (as determined in the Trust's Declarations of Interest Policy), should be declared via the Trust's online declarations of interest system. Acceptance of gifts by way of inducements or rewards is a criminal offence under the Fraud Act, 2006 and the Bribery Act 2010.

23.11. In addition to Standing Orders 21 and 22 and this Standing Order, an officer must also declare to the Chief Executive or Trust Secretary any other employment, business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with interests of the Trust, unless specifically allowed under that officer's contract of employment.

Part III – Arrangements for the exercise of functions by delegation and committees

24. Exercise of functions

24.1. Subject to Standing Order 3 and any such directions as may be given by the Secretary of State for Health, the Trust Board may delegate any of its functions to a committee or sub-committee appointed by virtue of Standing Order 25, or to a director or an officer of the Trust. In each case, these arrangements shall be subject to such restrictions and conditions as the board thinks fit.

Emergency powers

24.2. The powers which the Trust Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair acting jointly and, if possible, after having consulted with at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Trust Board for ratification.

Delegation to committees

24.3. The Trust Board shall agree from time to time to the delegation of specific powers to be exercised by committees or sub-committees, which it has formally constituted. The Trust Board shall approve the constitution and terms of reference of these committees and their specific powers.

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Delegation to officers

24.4. Those functions of the Trust, which have not been retained as reserved by the Trust Board or delegated to a committee of the Trust Board, shall be exercised on behalf of the Trust Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust Board.

Schedule of Decisions Reserved for the Trust Board

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

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

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

Scheme of Delegated Authorities

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

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

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

25. Appointment of committees

25.1. Subject to Standing Order 3 and such directions as may be given by, or on behalf of, the Secretary of State for Health, the Trust may, and if directed by them, shall appoint committees of the Trust, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust. Committees will be subject to review by the Trust Board from time to time.

25.2. A committee appointed under Standing Order 25 may, subject to such directions as may be given by, or on behalf of, the Secretary of State for Health or the Trust Board, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the committee (whether or not they include directors of the Trust).

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

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

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

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

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

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

Statutory and Mandatory Committees

Role of Audit & Risk Committee

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

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

Role of Auditor Panel

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

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

25.13. The terms of reference of the Auditor Panel shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes

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of the Trust Board and may be varied from time to time by resolution of the Trust Board.

Role of Remuneration and Nominations Committee

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

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

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

Charity Committee

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

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

Non mandatory committees

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

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

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

25.22. The current non-mandatory committees in place are (November 2022):

- Quality Committee
- Finance and Performance Committee
- People Committee

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

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

26. Proceedings in committee to be confidential

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

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

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

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

27. Election of Chair of committee

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

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

28. Special meetings of committee

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

Part IV – Custody of seal and sealing of documents

29. Custody of seal

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

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30. *Sealing of documents*

30.1. The Seal of the Trust shall only be attached to documents where there is a legal requirement for sealing and the subject matter of the relevant document has first been approved in accordance with these Standing Orders and Standing Financial Instructions.

30.2. The seal shall be affixed in the presence of the signatories in accordance with Paragraph 33 of Schedule 4 of the 2006 Act:

"33 Instruments etc.
(1) The fixing of the seal of an NHS trust must be authenticated by the signature (a) of the chairman or of some other person authorised (whether generally or specifically) by the NHS trust for that purpose, and (b) of one other director."

31. *Bearing witness to the affixing of the Seal*

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

32. *Register of sealing*

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

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

Part V – Appointment of directors and officers of the Trust

33. *Canvassing of, and recommendations by, directors*

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

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

34. *Relatives of directors or officers of the Trust*

34.1. Candidates for any appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any director or senior officer

of the Trust. Failure to disclose such a relationship is likely to disqualify a candidate and, if appointed, render them liable to instant dismissal.

34.2. Every director and senior officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that director or senior officer is aware. It shall be the duty of the Chief Executive to report to the committee with responsibility for oversight of remuneration and terms of service any such disclosure made.

34.3. Where the relationship to the director or senior officer of the Trust is disclosed, Standing Order 21 (Declarations of Interests and Register of Interests) shall apply.

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

Part VI – Tendering and contracting procedures

35. General

35.1. The Trust use Bristol and Weston Purchasing Consortium (BWPC) otherwise known as its Trust's procurement service supplier.

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

- 35.2.1. these Standing Orders
- 35.2.2. the Trust's Standing Financial Instructions
- 35.2.3. any direction by the Trust Board

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

35.4. The Trust shall comply with all UK procurement legislation and any European Union retained procurement law in all of its procurements. The Trust's procurement service provider is responsible for ensuring compliance with such legislation.

35.5. The Chief Executive shall be responsible for ensuring that 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.

35.6. Contract procedures shall take account of the Trust's Declarations of Interest Policy and the necessity to avoid any possibility of collusion or allegations of collusion between contractors and suppliers; or between contractors and suppliers and staff of the Trust.

35.7. The application of the provisions of this part of the Standing Orders to contracts and purchases may be varied by resolution of the Trust Board from time to time.

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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 UK procurement legislation and any European Union retained procurement law and which shall deal with:

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

38. Disposals of land and buildings

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

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Part VII – Miscellaneous

39. Suspension of Standing Orders

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

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

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

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

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

40. Variation of Standing Orders

40.1. These Standing Orders shall be varied only if:

- 40.1.1. A notice of motion under Standing Order 17 has been given **and**
- 40.1.2. no fewer than half of the appointed Non-Executive Directors vote in favour of such variation **and**
- 40.1.3. at least two-thirds of the directors who are eligible to vote are present **and**
- 40.1.4. the variation proposed does not contravene a statutory provision or direction made by the Secretary of State for Health.

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

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

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

41. Availability of Standing Orders

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

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

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42. *Signature of documents*

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

42.2. The Chief Executive or Nominated Officer(s) shall be authorised 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 in accordance with these Standing Orders and Standing Financial Instructions.

42.3. Unless there is a legal requirement for sealing, the Chief Executive or Nominated Officer(s) shall also be authorised to execute any agreement or other document (the subject matter of which has been approved in accordance with these Standing Orders and Standing Financial Instructions) as a deed on behalf of the Trust by signing in the physical presence of an attesting witness.

42.4. Unless there is a legal requirement for a physical seal or a wet ink signature, any signature under SO 42.1, 42.2 or 42.3 may be provided in electronic form and shall not be invalid on this basis.

42.5. Unless there is a legal requirement for signature by a specific Officer, any person authorised to sign a document on behalf of the Trust under SO 30.2, 42.1, 42.2 or 42.3 shall have the power to delegate such authority to their deputy or another Nominated Officer where such person is unavailable, provided advance written confirmation of such delegation is given to the Director of Corporate Governance/Trust Secretary

43. *Standing Financial Instructions*

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

44. *Review of Standing Orders*

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

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

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This version of the Standing Orders can only be guaranteed to be the current adopted version, if it is opened directly from the Trust's intranet library of policies and procedures.

North Bristol NHS Trust Board

Appendix 1 – Schedule of decisions reserved to the Trust Board

Introduction

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

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

1.1. Approve, including variations to:

1.1.1. Standing Orders for the regulation of its proceedings and business (SO40).

1.1.2. this Schedule of matters reserved to the Trust Board (SO 24).

1.1.3. Standing Financial Instructions (SO 43, SO 44, SFI 2)

1.1.4. Scheme of Delegated Authorities, including financial limits in delegations, from the Trust Board to officers of the Trust (SO 24, SO 40).

1.1.5. suspension of Standing Orders (SO 39)

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

1.2.1. administration of public and private agendas of Board meetings (SO 8)

1.2.2. calling extra-ordinary meetings of the Board (SO 9)

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

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

1.4.1. delegate functions from the Board to the committees (SO 24)

1.4.2. delegate functions from the Board to a director or officer of the Trust (SO 24)

1.4.3. approve the appointment of members of any committee of the Trust Board or the appointment of representatives on outside bodies (SO 25)

1.4.4. receive reports from Board committees and take appropriate action in response to those reports (SO 25)

1.4.5. confirm the recommendations of the committees which do not have executive decision-making powers (SO 25)

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

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

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

1.5.1. Appoint the Chief Executive (SO 3)

1.5.2. Appoint the Executive Directors (SO 3)

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

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

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

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

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

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

2. *Determination of strategy and policy*

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

2.2. Approve the Trust's strategic direction:

2.2.1. annual budget, strategy and business plans

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

2.2.3. clinical and service development strategy

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

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

3. *Direct operational decisions*

3.1. Approve capital investment plans:

- 3.1.1. the annual capital programme
- 3.1.2. all variations to approved capital plans over £1 million (SoDA 11)
- 3.1.3. to acquire, dispose of, or change of use of land and/or buildings (SO 38)
- 3.1.4. capital investment over £2.5 million in value, supported by a business case and in line with the approval guidance issued by NHS England & Improvement. (SoDA 4)

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

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

- 3.3.1. Tenders and quotations over the lifetime of the contract (SoDA 5)
- 3.3.2. Revenue funded service developments, in line with the approval guidance issued by the NHS England & Improvement (SoDA 4)
- 3.3.3. Orders processed through approved supply arrangements (SoDA 5)
- 3.3.4. Orders processed through non-approved supply arrangements (SoDA 5)
- 3.3.5. Receipt of loans and trials equipment and materials (SoDA 13)
- 3.3.6. Prepayment agreements for services received

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

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North Bristol NHS Trust Standing Financial Instructions

Appendix 2 – Standing Financial Instructions

1. Interpretation

1.1. The Chair of the Trust is the final authority in the interpretation of Standing Orders on which the Chief Executive and Trust Secretary shall advise them. In the case of the Standing Financial Instructions they will be advised by the Chief Finance Officer.

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

Legislation definitions:

No additional legislation

Other definitions:

1.2.1. **Budget manager** is the director or employee with delegated authority to manage the finances (Income and Expenditure) and resources for a specific area of the Trust.

1.2.2. **Commissioning** is the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.3. **Contracting and procuring** is the process of obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.4. **Divisional Operations Directors (Corporate Manager)** are the senior operational managers; and their formally nominated deputies, for the division or specialty, as designated by the Executive Director.

1.2.5. **Procurement Service provider** is the group that manages the Trust's procurement strategy and processes. The current service provider: Bristol and Weston NHS Purchasing Consortium (BWPC) is hosted by the Trust

1.2.6. **Shared Business Service (SBS)** is the NHS Shared Business Services, which is contracted by the Trust for general ledger provision and maintenance, core accounting for accounts payable and receivable and VAT processes.

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

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

North Bristol NHS Trust Standing Financial Instructions

2. Introduction

2.1. These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of the Trust, its directors and officers in relation to all financial matters with which they are concerned.

2.2. The SFIs explain the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

2.3. They identify the financial responsibilities which apply to everyone working for the Trust; and shall be used in conjunction with the Schedule of Decisions Reserved to the Board (Appendix 1) and the Scheme of Delegated Authorities (Appendix 3) which both also form part of the Trust's Standing Orders.

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

2.5. These SFIs do not refer to all legislation or regulations and advice issued by the Department of Health applicable to the Trust. Any uncertainty regarding the application of these SFIs should be discussed with the Chief Finance Officer, prior to action.

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

Compliance with these SFIs

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

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

Responsibilities and delegations

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

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

2.10.1. approving the financial strategy

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

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

2.10.4. approving the method of providing financial services.

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

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

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

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

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

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

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

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

2.14. **The Chief Finance Officer** is responsible for:

2.14.1. maintaining and implementing the Trust's financial policies

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

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

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

2.15.1. the security of the property of the Trust

2.15.2. avoiding loss

2.15.3. achieving economy and efficiency in the use of resources

3. Financial framework

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

4. Business and budget plans

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

4.2. The plans will include:

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

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

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

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

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

4.3.3. reflect resource plans, including workload and workforce plans

4.3.4. be prepared within the limits of available funds

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

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

4.3.7. include summary financial projections for the longer term

4.3.8. identify and assess significant financial risks.

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

5. Management of the financial resource

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

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

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

Setting the annual financial plan

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

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

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

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

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

Managing and reporting the financial position during the year

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

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

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

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

5.9.4. monitoring and reporting financial performance against plans and forecasts

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

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

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

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

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

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

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

5.13.3. trends and projections

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

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

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

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

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

5.16.2. financial consequences of changes in Trust policy

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

5.17. The **Chief Finance Officer** shall:

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

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

6. Annual accounts, reports and returns

6.1. The **Chief Finance Officer** shall:

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

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

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

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

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

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

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

7.1. The **Chief Finance Officer** is responsible for:

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

7.1.2. the prompt banking of all monies received.

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

Fees and charges for the provision of healthcare

7.3. The **Chief Finance Officer** shall:

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

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

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

7.4. The **Chief Finance Officer** shall approve all property and non-clinical equipment leases, property rentals and tenancy agreements. The **Director of Operational Estates & Facilities** or another individual with appropriate expertise within the Estates & Facilities division shall advise on these arrangements.

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

NHS service agreements for the provision of services

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

7.7. The **Chief Finance Officer** shall provide up to date advice on:

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

7.7.2. costing and pricing of services

7.7.3. payment terms and conditions

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

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

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

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

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

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

7.11. **Budget holders** with responsibilities for managing delivery against service

agreements must ensure they understand and use the contract monitoring information for the financial management of their service areas.

Research and development

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

Sponsorship and concession agreements

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

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

7.15. The **Chief Finance Officer**, advised by the Director of Operational Estates & Facilities or another individual with appropriate expertise within the Estates & Facilities division shall review and propose plans for all concession agreements proposed for the Trust, including arrangements that do not incur an immediate direct cost for the Trust, but can expose it indirectly to significant liability. The Chief Finance Officer shall authorise all concession agreements entered into by the Trust.

8. Procurement, tendering and contracting procedure

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

8.2. All contracts made shall ensure best value for money using the Trust's procurement service provider and processes established by the Chief Finance Officer. For each contract a Trust Officer shall be nominated and hence responsible for overseeing and managing the contract on behalf of the Trust.

Legislation and guidance regarding public procurement

8.3. The Trust shall comply with all UK procurement legislation, any European Union retained procurement law and directives in all of its procurements, including any advertising and award requirements.

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

Competitive tendering and quotations

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

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

8.6.1. the supply of goods, materials and manufactured articles

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

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

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

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

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

8.7.3. the supply is a compliant call off against a Framework, Contract, or other appropriate legal mechanism which has been established following a formal tendering process carried out by its procurement services provider

8.7.4. the supply is a compliant call off against a Framework, Contract, or other appropriate legal mechanism which has been established by NHS or Government organisation, that has been evaluated and approved for use by its procurement services provider and authorised by the Trust.

8.7.5. The requirement is in relation to the purchase of memberships, licenses, permits, and permissions required by the Trust to carry out its normal business.

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

- the **Chief Executive** decides that formal tendering procedures would not

be practicable

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

Note that section 8.3 takes precedence over the above list of exemptions to competitive tendering. The Trust should take the advice of BWPC when enacting any of the aforementioned exemptions. Approval of any exemptions should be carried out with reference to SoDA 5 (Single Tender Actions)

8.9. The **Chief Executive** shall provide formal approval, which may be retrospective where time constraints apply, in each instance where competitive tendering requirements are waived under SO 8.8. These instances will be reported to each meeting of the Audit Committee.

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

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

8.10.2. waivers to competitive tendering procedures are not used to avoid competition, for administrative convenience

8.10.3. 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

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

- record of issue of invitations to tender
- submission, storage and audit trail for receipt of tenders
- process and record of opening tenders
- evaluation of tenders (inc. completeness, accuracy, compliance with prescribed format etc)
- admissibility of tenders, including treatment of tenders received after the deadline but prior to other bids being “opened”

- reasons behind decision to award the contract

8.11. The procurement service provider shall ensure that:

8.11.1. Tenders are fair, transparent, competitive and at all times compliant with UK procurement legislation, and in accordance with the Scheme of Delegated Authorities (Appendix 3)

8.11.2. Tenders and quotations expressly state suppliers' obligations to comply with all relevant legislation including but not limited to:

- Human Rights Act, 1998
- Equality Act, 2010
- Health and Safety at Work Act, 1974
- Modern Slavery Act 2015
- Environment Act, 2021

8.11.3. Tenders comply with Government guidance to evaluate suppliers on the grounds of:

- Decarbonisation
- Social Value contribution
- management of Modern Slavery within their supply chain

8.11.4. Tender processes and rules are in accordance with up-to-date and relevant specialist guidance, which is recognised, or recommended by the DH

8.11.5. It maintains a record of competitive tenders and subsequent contract awards.

8.11.6. Award notices are published for all contracts with a total value above £25,000.

8.11.7. Procurement Strategy reports are created for all contracts with a total value above £100k unless they are exempted from the formal tendering process (under SO 8.7 or SO 8.8).

Quotations: competitive and non-competitive

8.12. The **Trust Board** shall approve the value range whereby formal tendering procedures are not adopted, but quotations will be required. This range is currently for intended expenditure that is reasonably expected to exceed £25,000.

8.13. The **Chief Finance Officer** shall determine the procedures to be followed in respect of competitive and non-competitive quotations. These will include:

8.13.1. Procedures for expenditure that is less than £25,000 (SoDA 5)

8.13.2. types of service or supply to be sought through quotations

8.13.3. minimum number of competitive quotes to seek, currently set at three

8.13.4. requirement for written quotations

8.13.5. retention of records

8.13.6. confidentiality across the process

8.13.7. recording the decision to go to contract

Temporary suspension of procedures in exceptional circumstances

8.14. The **Trust Board** shall allow the SFIs to be suspended temporarily in exceptional circumstances, where the circumstance is:

8.14.1. a Trust wide problem, rather than a directorate specific issue.

8.14.2. of sufficient scale that failure to act quickly and decisively would put the Trust at significant financial and reputational risk

8.14.3. unforeseen and rapidly developing

8.14.4. such that following normal procedures would hinder the recovery of the situation

8.15. The **Chief Finance Officer** shall identify specific procedures to be followed in the instance of a recognised event of exceptional circumstance.

9. Contracts and purchasing

9.1. The **Trust Board** shall only enter into contracts on behalf of the Trust that are within the statutory powers delegated to it by the Secretary of State and shall comply with:

9.1.1. the Trust's Standing Orders and Standing Financial Instructions

9.1.2. UK procurement legislation, European Union retained procurement law and other statutory provisions

9.1.3. any relevant directions issued, or recognised by the DHSC

9.2. In all contracts made by the Trust, the **Trust Board** shall:

9.2.1. seek to obtain best value for money

9.2.2. for contracts subjected to tendering or quotation, ensure that the contracts contain the same terms and conditions of contract as was the basis on which tenders or quotations were invited (unless otherwise permitted by the selected procurement process).

9.3. The **Chief Executive** and **Executive Directors** shall nominate managers to oversee and manage each contract on behalf of the Trust

9.4. The procurement service shall maintain a record of the details of all requisitions and orders placed. No requisition or order shall be placed for items for which there is no provision in an authorised budget.

Longer term commitments

9.5. All contracts, leases, tenancy agreements and other commitments, which might result in a long-term liability, must be notified to and authorised, in accordance with the limits set out in the Scheme of Delegated Authorities, in advance of any commitment being made.

Healthcare Service Agreements

9.6. The **Chief Finance Officer** shall ensure that SLAs and extra-contractual

arrangements agreed with other NHS trusts, for provision of services to the Trust, are agreed in accordance with the current guidance set out by the DHSC.

In-house services

9.7. The **Trust Board** shall determine which in-house services should be market tested by competitive tendering; and the frequency with which this should be done. In instances where competitive tendering is required, the Board shall nominate suitably qualified staff to administer the process and ensure that EU procurement and competition laws, legislation and DHSC guidance are applied correctly, including:

9.7.1. setting clearly defined specifications for the service

9.7.2. clear separation between the in-house service provider tender team and the Trust's commissioning team

9.7.3. independent evaluation process

9.8. The **Chief Executive** shall ensure that best value for money can be demonstrated for all services provided on an in-house basis and shall nominate officers to oversee and manage the contract on behalf of the Trust, separate from those that are providing the service.

10. Non-pay expenditure

10.1. Requisitions and orders are subject to the delegations and limits set out in SFI 8 and SFI 9.

10.2. The **Chief Finance Officer** shall:

10.2.1. maintain the list of managers who are authorised to place requisitions and orders for the supply of goods and services

10.2.2. set the maximum value of each requisition or order and the system for authorisation above that level

10.2.3. set out procedures for seeking of professional advice regarding the supply of goods and services

10.3. These delegation limits are maintained in the Scheme of Delegated Authorities.

Requisitioning and ordering goods and services

10.4. The **Chief Finance Officer** shall maintain adequate systems and procedures for the ordering (including requisitions) of goods and services. These shall include:

10.4.1. procedural instructions and guidance on the obtaining of goods, works and services incorporating the thresholds identified in the Scheme of Delegated Authorities

10.4.2. recognition of the Trust's approved supply arrangements, including, but not limited to the following:

- recognised Trust wide procurement systems, (EROS and NHS Supply

Chain) which incorporate automatic system controls to ensure adherence to approval and authorisation requirements

- other recognised controlled ordering systems for specific service areas (Pharmacy, Estates, Catering, Disablement Services) providing that they can evidence a secure audit trail
- framework agreements made by the Trust, or by the Procurement Service, including approved suppliers of temporary, locum and interim staff placements; and contractual arrangements for on-going ad-hoc support from chosen service suppliers (eg emergency maintenance and repair services for medical equipment)

10.5. **Employees** responsible for placing requisitions and orders; and **managers** responsible for authorising the orders shall ensure that:

10.5.1. approval is obtained in advance from the Chief Finance Officer for any contractual arrangement that may involve taking on an ongoing obligation, or legal responsibility.

10.5.2. sufficient budget exists to pay for the item ordered, or if insufficient budget is available, the **Chief Finance Officer** has authorised the purchase

10.5.3. a Purchase Order is raised on an approved electronic ordering system prior to the goods or services being received.

10.5.4. orders are not split, or otherwise manipulated to circumvent authorisation and delegation limits

10.5.5. goods and equipment are not accepted on trial, or on loan, where there is an associated risk or commitment to current or future expenditure, unless specifically approved by the **Chief Finance Officer** as advised by BWPC.

10.6. Employees shall use the Trust's approved supply arrangements.

10.7. Where the service is provided by or maintained by the Shared Business Service, the arrangements shall be set out in the SLA.

Receipt of goods and services and system of payment and payment verification

10.8. The **Chief Finance Officer** shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or with national guidance (such as the Better Payments Practice Code).

10.9. Such requirements will be specified in any SLA with the Shared Business Service provider.

10.10. The **Chief Finance Officer** shall:

10.12.1. ensure the prompt payment of all properly authorised accounts and claims

10.12.2. maintain an adequate system of verification, recording and payment of all amounts payable, including relevant thresholds. The system will include:

- a record of Trust employees, including specimens of their signatures and/or facilities for secure electronic certification, authorised to raise requisitions and certify invoices

- certification that:
  - goods have been duly received, examined and are in accordance with specification and the prices are correct
  - work done or services rendered have been satisfactorily completed in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct
  - contractual measurement units, such as time, materials or expenses are accurate, meet contractual requirements; are supported by appropriate confirmation; and are charged at the agreed rates
  - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained
  - the account is arithmetically correct
  - the account is in order for payment

10.12.3. identify procedures to follow for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

10.12.4. maintain instructions to employees regarding the handling and payment of accounts within the Finance Department.

Prepayments and payments on account

10.11. The **Chief Finance Officer** shall specify the circumstances under which goods and services can be paid in advance of receipt, through the use of prepayments. These circumstances will include instances where one or more of the following apply:

10.11.1 the **Chief Finance Officer** has approved that the pre-payment, in part, or in full, is specified in the agreed contractual arrangement

10.11.2 the proposed arrangement is compliant with EU public procurement rules, where the contract is above a stipulated financial threshold

10.11.3 the financial advantages are shown to outweigh the disadvantages and risks

10.11.4 it is customary for the payment in advance for a service that is provided for a specific period of time (e.g., rates, rentals, service and maintenance contracts, insurance, utilities standing charges)

10.12. The **budget holder** shall confirm that the goods and services due under a prepayment arrangement are received satisfactorily and in accordance with the contractual arrangements.

Payments to contractors by instalments

10.13. The **Chief Finance Officer** shall identify adequate procedures to address interim payments made on-account in contracts for building and engineering works. These will include arrangements for receipt of independent and appropriate certificates and confirmations of work completed, to the required standards.

10.14. Final payments shall only be made after the Trust's nominated contract manager has certified the accuracy and completeness of the value of the final account submitted by the contractor; and has confirmed that the procedure set out in the contract terms has

been followed properly.

Approvals for Business Cases

10.15. With reference to Appendix 3 (SoDA), 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 the Trust's procurement service provider.

10.16. All Options Appraisals, and ultimately procurement Business Cases must include Whole Life Cost estimates as well as identification of projected savings.

*A genuine pre-estimate of contract value must be ascertained and should not automatically be based on previous years' expenditure, but also based on an estimate of future demand, and any additional value gained by the supplier. Contract durations should not be artificially curtailed to bring values below approval thresholds.

Variations and extensions to contracts

10.17. Contracts may be designed to allow for variations to the sum agreed, or the works, goods and/or services to be delivered. These variations shall be clearly identified and shall be approved in accordance with the relevant contract process.

10.18. Where a variation to contract (or the aggregate of several variations to contract) leads to an increase in contract cost of either the lower of 10% of contract cost or £100k, (a cost overrun) then this shall be approved in accordance with the Scheme of Delegated Authorities. For the avoidance of doubt the total contract cost, rather than the additional amount, shall be used to determine the correct level of Authority.

10.19. Where new material variations are needed in an emergency, approval should be sought from a relevant authorising officer (which in most cases will be the Chief Finance Officer); and shall be confirmed and authorised, using the relevant contract procedure, on the next working day or otherwise as soon as possible.

10.20. Extensions to contracts which exceed the maximum term of the contract shall be confirmed in writing and authorised in accordance with the Scheme of 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

10.21. Payments to local authorities and voluntary organisations shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with current legislation.

11. Terms of service and payment of members of the Trust Board and employees

Board members, directors and specified senior managers

11.1. The **Trust Board** shall be accountable for taking decisions on the remuneration and terms of service of directors and senior managers not on Agenda for Change terms and conditions. The Board shall establish a Remuneration and Nominations

Committee responsible for determining the remuneration of, and appointment of directors and senior staff in accordance with Standing Orders.

11.2. The **Remuneration and Nominations Committee** shall:

11.2.1. advise the Board about appropriate remuneration and terms of service for the Chief Executive, other directors and any staff remunerated outside of the Agenda For Change arrangements, (as described in the terms of reference of the Committee), employed by the Trust:

- all aspects of salary (including any performance-related elements and bonuses)
- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms

11.2.2. advise the Board on the remuneration and terms of service of directors and any staff remunerated outside of the Agenda for Change arrangements to ensure they are fairly rewarded for their contribution to the Trust, whilst having proper regard to the Trust's circumstances and performance, and to the provisions of any national arrangements for such members and staff where appropriate

11.2.3. monitor and evaluate the performance of individual directors and senior employees

11.2.4. advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate

11.3. The Trust shall pay allowances to the Chair and Non-Executive Directors of the Board in accordance with instructions issued by the DHSC.

Other employees

11.4. The Trust Board shall consider and approve proposals presented by the **Chief People Officer** for the setting of remuneration and conditions of service for those employees not covered by the Remuneration and Nominations Committee.

Funded establishment and staff appointments

11.5. The staff establishment plans incorporated within the annual plans approved by the Trust Board shall be regarded as the funded establishment. The funded establishment of any department should reflect the Trust's approved workforce plans, which form part of the Trust's budget plans submitted to the NHS England.

11.6. The **Chief People Officer** shall ensure adherence to the Agenda for Change rules and approved policies and procedures and terms and conditions for employees paid on alternative contractual arrangements, including the consultant contract. These procedures shall address:

11.6.1. setting starting pay rates and conditions of service, for employees

11.6.2. approving plans to engage, re-engage employees, either on a permanent or temporary nature, or hire agency staff

11.6.3. agreeing to changes in any aspect of remuneration, including re-grading, within the Agenda for Change allowed rules.

11.6.4. ensuring that all employees are issued with a contract of employment in a form which complies with employment legislation

11.7. The **Budget Holder** shall ensure that the cost of the appointment, or change in conditions can be met within the limit of their approved budget and funded establishment.

Processing payroll

11.8. The **Chief Finance Officer** shall maintain procedural instructions for delivery of the Trust's payroll function. These procedures shall be compliant with employment legislation, the Data Protection Act and HM Revenues and Customs regulations.

11.9. The **Chief Finance Officer** shall ensure that the arrangements for providing the payroll service are supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures; and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies

11.10. Under the delegated authority of the Chief Finance Officer, the **Head of Payroll** shall:

11.10.1. specify timetables for submission of properly authorised time records and other notifications

11.10.2. agree the final determination of pay and allowances

11.10.3. arrange to make payment on agreed dates

11.10.4. agree allowed methods of payment.

11.11. **Nominated managers** shall ensure that the electronic staff record, including the approved staff establishment, is kept up to date. Nominated managers shall ensure that all staff are keeping their records complete, including requirements to:

11.11.1. submit time records, and other notifications in accordance with agreed timetables

11.11.2. complete time records and other notifications in accordance with the Chief Finance Officer's instructions

11.11.3. submit forms notifying change in circumstances and termination of employment in the prescribed form, as soon as these changes are reported to them

Travel and subsistence expenses

11.12. Reimbursement of expenses incurred by Trust staff shall be made by the Payroll Service in accordance with the Trust's relevant current policy and procedures, and subject to verification and authorisation of the claim by an officer with delegated authorisation for this purpose.

Use of self-employed management consultants and contractors

11.13. The **People Division** shall establish procedures to ensure that the Trust's interests are protected in the contractual arrangements entered into with self-employed consultants and contractors. These procedures shall ensure that the contractual arrangements do not contravene HM Revenues and Customs' requirements regarding the avoidance of tax and national insurance contributions through the use of intermediaries, such as service companies or partnerships, known as Intermediaries Legislation, or "IR 35".

11.14. All Trust officers responsible for procuring services from self-employed individuals shall ensure that they comply with the procedures established.

12. Insurance, including risk pooling schemes administered by the NHS Litigation Authority

12.1. The **Trust Board** shall determine the Trust's arrangements for insurance cover, including the option to insure through the risk pooling schemes administered by NHS Resolution; or to self-insure for some or all of the risks covered by the risk pooling schemes.

12.2. If the Trust Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers and third-party liability) covered by the scheme, this decision shall be reviewed annually.

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

12.3.1. documented procedures cover the Trust's insurance arrangements, including for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed

12.3.2. the arrangements entered into are appropriate and complementary to the risk management programme.

12.3.3. the Trust Board is informed of the nature and extent of the risks that are self-insured in the event that the Board decides not to use the risk pooling schemes administered by the NHSR for one or other of the risks covered by the schemes

12.4. The Chief Finance Officer shall determine the level of insurance cover to be held by the Trust in the three discrete areas where the Trust can use commercial insurers:

12.4.1. insuring motor vehicles owned by the Trust including insuring third party liability arising from their use

12.4.2. where the Trust is involved with a consortium in a PFI contract and the other consortium members require that commercial insurance arrangements are entered into

12.4.3. where income generation activities take place, which are not covered by the NHSR risk pool

13. Capital investment, private financing, fixed asset registers and security of assets

13.1. The **Chief Finance Officer** is responsible for compiling and submitting for Board approval an annual capital programme, which is affordable within available resources

over the lifetime of the investment.

13.2. The **Chief Finance Officer** shall report to the Board, the progress of delivery of the capital programme, against plan, during the year.

13.3. The **Chief Executive** shall ensure that:

13.3.1. there is an adequate appraisal and approval process in place for determining capital expenditure priorities and supporting systems to identify and assess the financial effect of each proposal on business plans

13.3.2. all stages of capital schemes are managed and controlled adequately; and that schemes are delivered on time and to cost

13.3.3. capital investment is risk assessed against the declared commissioning strategic plans of significant commission organisations and is consistent with the Trust's long term strategic plans

13.4. For every capital expenditure proposal, the Chief Executive shall ensure that a business case, or statement of need, is produced in accordance with the Trust's approved procedures and is considered by the **Finance and Performance Committee**, where required. The business case shall set out, as a minimum:

13.4.1. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs

13.4.2. the involvement of appropriate Trust personnel and external agencies

13.4.3. appropriate project management and control arrangements

13.5. The approval of a capital programme shall not constitute approval for expenditure on any scheme.

13.6. The **Chief Finance Officer** shall:

13.6.1. review the costs and revenue analysis, including revenue consequences included in the business case

13.6.2. ensure that, in higher cost, or higher risk investments, advice has been sought from the NHS England & Improvement; and that appropriate Risk Evaluation for Investment Decisions (REID) analysis has been completed

13.7. For approved capital schemes, the Chief Finance Officer shall:

13.7.1. issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes

13.7.2. agree arrangements for managing stage payments

13.7.3. maintain procedures for monitoring and reporting on the progress of delivery of contracts; and capital expenditure and commitments against plans and against the Trust's capital programme

13.8. The Trust's **Procurement Service** shall advise the Chief Finance Officer, on the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

13.9. Authorisations issued to the manager(s) responsible for any scheme shall be made in accordance with the value limits set out in the Scheme of Delegated Authorities:

13.9.1. specific authority to commit expenditure

13.9.2. authority to proceed to tender

13.9.3. approval to accept a successful tender

Private Finance Initiatives (PFI)

13.10. The **Chief Finance Officer** should normally test for PFI when considering capital procurement. If this test supports a proposal to use finance which is to be provided through PFI arrangements, the Chief Finance Officer shall:

13.10.1. demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector

13.10.2. refer any investment proposal over £1 million to NHS England for a risk assessment and decision to approve the borrowing

13.11. Any PFI proposal shall be specifically agreed by the **Trust Board**.

13.12. Where a capital scheme is funded using the PFI, any variations to the contract will be dealt with under procedures for variations in capital contracts and shall be authorised by the Trust Board.

Instructions specific to the Southmead Hospital PFI

13.13. The **Trust Board** shall approve and authorise the schedule of payments payable by the Trust to the PFI Project Co (Hospital Company (Southmead) Limited), as documented in the Project Agreement made between the Trust and the PFI Project Co dated 25 February 2014 ("Project Agreement").

13.14. The Schedule of Service Payments (Project Agreement, Schedule 18, Appendix I) shall be fixed for the duration of the Project Term save in respect of

13.14.1. inflationary adjustments

13.14.2. procurement of additional works (i.e. Small Works etc.)

13.14.3. variations in accordance with Schedule 22 of the Project Agreement.

13.15. Inflationary adjustments shall be calculated annually and presented to the Trust Board for approval. Arrangements for the procurement of additional works and variations shall be dealt with in accordance with the procedures for variations in capital contracts and shall be authorised by the Trust Board.

13.16. During the Operational Term, the **Chief Finance Officer** or an individual nominated by the Chief Finance Officer shall be responsible for monitoring the proper performance and implementation of the Project Agreement by the Project Co and the Trust. In accordance with the monthly reporting arrangements, the **Chief Finance Officer** or an individual nominated by the Chief Finance Officer will be responsible for ensuring the invoices issued by the Project Co are analysed to ensure compliance with the terms of the Project Agreement. This will include verifying records of:

13.16.1. performance failures

13.16.2. unavailability events

13.16.3. service failure points

and associated "deductions" against Trust records.

13.17. The **Chief Finance Officer**, or their nominated deputy shall authorise payment of invoices submitted by the Project Co in accordance with Schedule 18 of the Project Agreement, provided that:

13.17.1. they are satisfied that the appropriate level of Deductions have been applied

13.17.2. the invoice complies with the requirements of Schedule 18

13.17.3. the Trust does not dispute all or any part of the invoice

where all or any part of an invoice is to be withheld, approval of the Chief Finance Officer is required

13.18. The **Chief Finance Officer,** or in their absence, the **Chief Executive** shall approve any decision to withhold, or delay payment of invoices, at the risk of incurring penalties and interest charges for the late payment of amounts due.

13.19. The **Assistant Chief Finance Officer (Financial Services)**, or their nominated deputy, shall process payments of invoices submitted by the Project Co in accordance with Schedule 18, subject to the approval of the Director of Operational Estates & Facilities and, where appropriate, the Chief Finance Officer.

13.20. The **Chief Finance Officer** or an individual nominated by the Chief Finance Officer shall oversee procedures for determining variations to the Project Agreement. Any such variations shall be subject to authorisation in accordance with the limits set out in the Scheme of Delegated Authorities.

Asset registers

13.21. The **Chief Finance Officer** shall maintain registers of assets and shall maintain procedures for keeping the registers up to date, including provision for arranging for physical confirmation of the existence of assets against the asset register to be conducted once a year.

13.22. The **Chief Finance Officer** shall maintain procedures for verifying additions and amendments to the assets recorded in the asset register. These procedures and records will include:

13.22.1. additions to the fixed asset register clearly identified to an appropriate budget manager

13.22.2. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties

13.22.3. records of costs incurred within the Trust, on stores, requisitions and labour including appropriate overheads

13.22.4. lease agreements in respect of assets held under a finance leases

13.23. The **Chief Finance Officer** shall maintain procedures for controlling the disposal of assets and updating of asset registers and financial records to reflect the event. These procedures will include the requirement for the authorisation and validation of the de-commissioning and disposal of the asset.

13.24. The **Chief Finance Officer** shall approve procedures for:

13.24.1. applying depreciation charges and indexation valuation adjustment to assets,

using methods and rates as specified in the Manual for Accounts issued by the DH

13.24.2. reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers

Security of assets

13.25. The **Chief Executive** shall maintain procedures for controlling the security of assets, including fixed assets, cash, cheques and negotiable instruments. The procedures will include:

13.25.1. recording managerial responsibility for each asset

13.25.2. identification of additions and disposals

13.25.3. identification of all repairs and maintenance expenses

13.25.4. physical security of assets

13.25.5. periodic verification of the existence of, condition of, and title to, assets recorded

13.25.6. identification and reporting of all costs associated with the retention of an asset

13.25.7. reporting, recording and safekeeping of cash, cheques, and negotiable instruments

13.26. **All employees** are responsible for the security of property of the Trust and for following such routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices, or damage and losses to Trust property shall be reported in accordance with agreed procedures.

13.27. Where practical, assets should be marked as Trust property.

Disposals and condemnations

13.28. The **Chief Finance Officer** shall prepare procedures for the disposal of assets including condemnations and ensure that these are notified to managers. The procedures will include arrangements to be followed for:

13.28.1. condemning and disposing of unserviceable and redundant assets

13.28.2. maintaining records of assets disposed of, including confirmation of destruction of condemned assets

13.28.3. specific processes to be followed in instances where assets are passed on for future use to another organisation

13.28.4. the sale of assets, including through competitive bids and negotiated bids; and sales linked to larger contracts for work, such as assets arising from works of construction, demolition or site clearance

13.29. The **departmental manager** responsible for the decision to dispose of an asset shall advise the Chief Finance Officer of the estimated market value of the asset, taking account of professional advice where appropriate.

North Bristol NHS Trust Standing Financial Instructions

14. Bank accounts and Government Banking Service accounts

14.1. The **Trust Board** shall:

14.1.1. approve the banking arrangements for the Trust.

14.1.2. As the Corporate Trustee, approve separate banking arrangements for the Trust's Charitable Funds

14.2. The **Chief Finance Officer** is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of bank accounts. This advice will take into account guidance and Directions issued by the Department of Health.

14.3. The **Chief Finance Officer** shall:

14.3.1. establish and maintain necessary commercial bank accounts and Government Banking Service (GBS) accounts

14.3.2. establish separate bank accounts for non-exchequer funds, including charitable funds

14.3.3. advise the Trust's bankers, formally in writing, of the conditions under which each account will be operated (the bank mandate)

14.3.4. seek to limit the use of commercial bank accounts and the value of cash balances held within them

14.3.5. conduct the Trust's main banking services and financial transactions using accounts provided by the GBS

14.4. Only the **Chief Finance Officer**, or their nominated representative, is authorised to open, operate and control a bank account, where monies owned by the Trust, including charitable funds, are received or expended. All such accounts must be held in the name of the Trust. It is a disciplinary offence for any other officer of the Trust to establish and operate such an account.

14.5. The **Chief Finance Officer** shall:

14.5.1. Ensure that payments made from bank or GBS accounts do not exceed the amount credited to the account

14.5.2. monitor compliance with DHSC guidance on the level of cleared funds.

Where such processes are undertaken by a Shared Business Service (SBS) these will be specified in a Service Level Agreement with the SBS.

Banking procedures

14.6. The **Chief Finance Officer** shall prepare detailed instructions on the operation of bank and GBS accounts which shall include:

14.6.1. the conditions under which each bank and GBS account is to be operated

14.6.2. details of those authorised to sign cheques or other orders drawn on the Trust's accounts

14.6.3. details of limits to delegated authority, including the number of authorised signatories required, and arrangements for authorising alternative mechanisms for 'signing' cheques and orders

Tendering and review

14.7. The **Chief Finance Officer** shall review the commercial banking arrangements of the Trust at regular intervals to ensure they continue to reflect best practice and represent best value for money.

14.8. Competitive tenders should be sought at least every five years. The **Chief Finance Officer** shall report to the Trust Board the reason(s) for continuing existing banking arrangements for longer than five years, without competitive review.

14.9. The **Chief Finance Officer** shall report the results of any tendering exercise to the Board. This review is not necessary for GBS accounts.

Trust credit cards

14.10. The **Chief Finance Officer** shall approve the allocation and operation of credit cards on behalf of the Trust; implement arrangements to monitor whether the credit cards are being used appropriately; and take action where inappropriate use is identified.

Security of cash, cheques and other negotiable instruments

14.11. The **Chief Finance Officer** shall:

14.11.1. approve the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable

14.11.2. maintain adequate systems for ordering and securely controlling any such stationery

14.11.3. provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, and procedure notes for the safe storage of keys, and for coin operated machines

14.11.4. prescribe systems and procedures for handling cash and negotiable securities on behalf of the Trust

14.12. Where such issues are undertaken by the Shared Business Service, detailed requirements will be specified in a Service Level Agreement with The Shared Business Service.

14.13. The Trust's money shall not under any circumstances be used for the encashment of private cheques.

14.14. All cheques, postal orders, cash etc, shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

14.15. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisations or individuals absolving the Trust from responsibility for any loss.

15. Investments

15.1. Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board. The current rules require that surplus funds are held in the Trust's GBS accounts.

15.2. The **Chief Finance Officer** shall advise the Charity Committee on investments made with endowment funds held; and prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

16. Management of debtors

16.1. The **Chief Finance Officer** shall:

16.1.1. maintain effective processes for the appropriate recovery action on all outstanding debts

16.1.2. deal with instances of income not received, in accordance with losses procedures

16.1.3. maintain effective processes to prevent, or detect overpayments and initiate recovery when this occurs

17. Stores and receipt of goods

17.1. The **Chief Finance Officer** shall determine procedures for the management stocks of resources, defined in terms of controlled stores and departmental stores. These will address the procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses; and include the principles that stocks are:

17.1.1. managed so that best value for money can be achieved whilst maintaining minimum safe stock levels

17.1.2. subjected to annual stock take as a minimum, where rolling stock checks are not in place

17.1.3. valued at the lower of cost and net realisable value

17.2. The **Chief Finance Officer** shall:

17.2.1. delegate responsibility for the management of stores to relevant, suitably qualified departmental managers

17.2.2. (taking expert advice where necessary) define the security arrangements and the custody of keys for any stores and locations in writing. Wherever practicable, stocks should be marked as health service property

17.2.3. approve alternative arrangements for the management of stores where a complete system of stores control is not justified

17.2.4. identify those authorised to requisition and accept goods supplied

17.3. The **designated store manager** shall:

17.3.1. Maintain stocks in line with clearly defined local procedures that are consistent with the overall requirements set out by the Trust

17.3.2. implement periodic review of slow moving and obsolete items; and for condemnation, disposal, and replacement of all unserviceable articles

17.3.3. report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice in the management and use of stocks

18. External borrowing and Public Dividend Capital

18.1. The **Chief Finance Officer** shall advise the Board on the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The Chief Finance Officer shall also provide periodic reports to the Board concerning the PDC debt and all loans.

18.2. The **Trust Board** shall agree the list of employees authorised to make short term borrowings on behalf of the Trust. This shall include the Chief Executive and the Chief Finance Officer.

18.3. The Chief Finance Officer shall prepare detailed procedural instructions concerning applications for loans and shall ensure that:

18.3.1. all short-term borrowings are kept to the minimum period of time possible, consistent with the Trust's overall cashflow position, represent good value for money, and comply with the latest guidance from the DH

18.3.2. the Trust Board is made aware of all short term borrowings at the next meeting

18.4. The **Finance and Performance Committee** shall ensure that all proposed long-term borrowing is consistent with the Trust's financial plans; and is approved by the Trust Board.

19. Losses and special payments

19.1. The **Chief Finance Officer** shall prepare procedural instructions for maintaining a register of losses and special payments, including write-offs, condemnations and ex-gratia payments; and on the recording of and accounting for losses and special payments, including ex-gratia payments. The records will include:

19.1.1. the nature, gross amount (or estimate if an accurate value is not available), and the cause of each loss

19.1.2. the action taken, total recoveries and date of write-off where appropriate

19.1.3. the category in which each loss is to be noted

19.2. The **Chief Finance Officer** shall determine the nature and/or value of losses which must be reported immediately to the **Chief Finance Officer** or **Chief Executive**:

19.2.1. where fraud or bribery is suspected, this shall be reported to the Local Counter Fraud Specialist, in accordance with the Trust Counter Fraud and Bribery Policy

19.2.2. where a criminal offence is suspected, the **Chief Finance Officer** must immediately inform the Local Security Management Specialist who may inform the police if theft or arson is involved

19.2.3. where losses, other than those that are clearly trivial, are apparently caused by theft, arson, neglect of duty or gross carelessness, the Chief Finance Officer must immediately notify the external auditor and the Trust Board

19.3. **Any employee** discovering or suspecting a loss of any kind shall immediately inform their head of department and ensure that the loss is recorded in accordance with instructions.

19.4. The **Trust Board** shall approve the write off of losses, compensations and ex-gratia payments, within the limits delegated to it by the Department of Health.

19.5. The **Audit Committee** shall receive regular reports of losses, compensations and ex-gratia payments made.

19.6. The **Chief Finance Officer** and the Shared Business Service shall be authorised to:

19.6.1. take any necessary steps to safeguard the Trust's interests in the event of bankruptcies and company liquidations

19.6.2. investigate whether any insurance claim can be made

20. Patients' property

20.1. The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival (see "Guidance for NHS organisations on the secure management of patients' property", NHS Protect, July 2012; and Health and Social Care Act 2008, (Regulated Activities) regulations 2010).

20.2. The **Chief Executive** shall ensure that patients or their guardians, as appropriate, are clearly and suitably informed before or on admission into hospital that the Trust will not accept responsibility or liability for patients' property brought into NHS premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

20.3. The **Chief Finance Officer** shall provide procedural instructions on the collection, custody, banking, recording, safekeeping, and disposal of patients' property. (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. These instructions will include arrangements for:

20.3.1. managing large amounts of money handed over by longer stay patients

20.3.2. restricting the use of patients' monies for purposes specified by the patient, or their guardian

20.4. In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

20.5. **Departmental and senior managers** shall inform staff of their responsibilities and duties for the administration of the property of patients.

21. Funds held on Trust

21.1. The **Trust Board**, as Corporate Trustee, is responsible for the management of funds it holds on trust and for meeting the requirements of the Charities Commission.

21.2. The **Trust Board's** corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

21.3. Trustee responsibilities for non-exchequer funds for charitable and non-charitable purposes shall be discharged separately and full recognition shall be given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

21.4. The Charity Committee shall ensure that each trust fund for which the corporate trustee is responsible is managed appropriately in terms of its purpose and requirements.

22. Retention of records

22.1. The **Chief Executive** is responsible for managing all NHS records, regardless of how they are held; and shall require policy and procedures to be followed that ensure compliance with the current DHSC best practice guidelines on records management. These procedures will include arrangements for:

22.1.1. managing archives of all records required to be retained in accordance with DHSC guidelines

22.1.2. records held in archives to be accessible for retrieval by authorised persons

22.1.3. destruction of records in accordance with the DHSC "Records Management: NHS Code of Practice" Part 1 (30 March 2006) and Part 2 (8 January 2009)

22.2. Where documents are held by a Shared Business Service detailed records storage requirements will be set out in a SLA with the Shared Business Service.

23. Information Technology and data security

23.1. The **Chief Finance Officer** shall be responsible for the accuracy and security of the performance and financial data of the Trust and shall devise and implement any necessary procedures to ensure:

23.1.1. computer assets and data programmes are protected from theft or damage

23.1.2. adequate and reasonable protection of the Trust's data from deletion or modification; accidental or intentional disclosure to unauthorised persons, having due regard for the Data Protection Act 1998

23.1.3. adequate controls operate over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and

timeliness of the data

23.1.4. controls exist such that the computer operation is separated from development, maintenance and amendment

23.1.5. adequate audit trails exist through the computerised system; and that these are subjected to periodic reviews as the Director may consider necessary

23.2. Where computer systems have an impact on corporate financial systems, the Chief Finance Officer shall ensure that new systems and amendments to existing financial systems are developed in a controlled manner and thoroughly tested prior to implementation. The Chief Finance Officer shall gain assurance that:

23.2.1. systems acquisition, development and maintenance are delivered in line with contractual agreements and Trust procedures

23.2.2. new systems that have an impact on, or are replacing existing financial systems are developed in a controlled way and thoroughly tested before they are put into practice. External organisations providing this service will need to provide assurances that what they do is adequate

23.2.3. data produced for use with financial systems is adequate, accurate, complete and timely, and that a management audit trail exists

23.2.4. finance staff have the necessary levels of access to such data

23.2.5. such computer audit reviews as are considered necessary are being carried out

23.3. The **Chief Executive** shall maintain a Freedom of Information (FOI) Publication Scheme, consistent with models approved by the Information Commissioner.

Contracts for computer services with other health bodies or outside agencies

23.4. The **Chief Finance Officer** shall ensure that any contract for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract shall also ensure rights of access for audit purposes.

23.5. Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

Risk assessment

23.6. The **Chief Information Officer** shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered; and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

24. Risk management

24.1. The **Chief Executive** shall ensure that the Trust has adequate procedures for managing risk and meeting current DHSC requirements for assurance frameworks, which shall be approved and monitored by the Trust Board.

24.2. The programme of risk management shall include:

- 24.2.1. arrangements for identifying and quantifying risks and potential liabilities
- 24.2.2. promotion, to all levels of staff, of a positive attitude towards the identification and management of risk
- 24.2.3. procedures to ensure all significant risks and potential liabilities are assessed and addressed, including through maintenance of effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk
- 24.2.4. contingency plans to offset the impact of adverse events
- 24.2.5. arrangements for reviewing the effectiveness of the risk management processes in place, including: internal audit; clinical audit; and health and safety review
- 24.2.6. arrangements for reviewing the risk management programme

24.3. The Chief Executive shall ensure that the existence, integration and evaluation of the risk management system is used to inform the Annual Governance Statement within the Annual Report and Accounts as required by current DHSC guidance.

25. Audit

25.1. In accordance with Standing Orders, the Board shall formally establish an **Audit Committee**, with clearly defined terms of reference. The Committee will seek assurance for the Board on the range of issues in accordance with guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

- 25.1.1. overseeing internal and external audit services
- 25.1.2. reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments
- 25.1.3. reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives
- 25.1.4. monitoring compliance with Standing Orders, Standing Financial Instructions, delegations and reservations
- 25.1.5. reviewing schedules of losses and compensations and advising the Board where necessary
- 25.1.6. reviewing the arrangements in place to support the application of the Assurance Framework on behalf of the Board and advising the Board accordingly.

25.2. Where the Audit Committee considers there is evidence of *ultra vires* transactions, or

improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health (to the Chief Finance Officer in the first instance).

25.3. It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided. The Audit Committee shall be involved in the selection process when the internal audit service provision is subjected to market testing.

25.4. In the case of the Shared Business Service, the Chief Finance Officer shall ensure that maintenance of an adequate internal audit service is specified in any service level agreement and shall further specify assurance arrangements between the Trust's internal and external auditors and the Shared Business Service's auditors.

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

25.5.1. there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an independent and effective internal audit function

25.5.2. the Head of Internal Audit is sufficiently qualified and experienced to perform that role; to facilitate the effective discussion of the results of internal audit work with senior management

25.5.3. the internal audit service is adequate and meets the NHS Internal Audit Standards (DH, April 2011)

25.5.4. the internal audit service provides the Audit Committee with an annual report of the coverage and results of the work of the service. The report must address, as a minimum:

- a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health
- major internal financial control weaknesses identified
- progress on the implementation of internal audit recommendations
- progress against plan over the previous year
- strategic audit plan covering the forthcoming three years
- a detailed audit plan for the next financial year

25.5.5. the police are informed at the right time, in cases of misappropriation and other irregularities not involving fraud or bribery

25.5.6. there is effective liaison with the Trust's appointed Local Counter Fraud Specialist (LCFS), or NHS Counter Fraud Authority on all suspected cases of fraud and bribery and all anomalies which may indicate fraud or bribery

25.6. The **Chief Finance Officer** and designated auditors are entitled to require and receive, without necessarily giving prior notice, the following:

25.6.1. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature

25.6.2. access at all reasonable times to any land, premises or members of the Board

or employees of the Trust

25.6.3. sight of any cash, stores or other property of the Trust under the control of any member of the Board or Trust employee

25.6.4. explanations concerning any matter under investigation

Internal Audit

25.7. The internal audit service shall:

25.7.1. provide an independent and objective assessment for the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance arrangements support the achievement of the Trust's objectives.

25.7.2. operate independently of the decisions made by the Trust and its employees; and of the activities which it audits. No member of the team providing the internal audit service will have executive responsibilities.

25.8. The **Head of Internal Audit** shall develop and maintain an Internal Audit Strategy for providing the Chief Executive with an objective evaluation of; and opinions on the effectiveness of the Trust's risk management, control and governance arrangements. The planned programme of work will inform the Head of Internal Audit's opinion. This will contribute to the framework of assurance that supports completion of the Annual Governance Statement, which forms part of the annual financial accounts.

25.9. The **Head of Internal Audit** shall ensure that the audit team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience needed to deliver the internal audit plan in line with the NHS Internal Audit Standards (DH, April 2011).

25.10. The **Head of Internal Audit** will normally attend Audit Committee meetings and has an independent right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

25.11. The **Head of Internal Audit** shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards.

25.12. The internal audit service will review, appraise and report upon:

25.12.1. the extent of compliance with and the financial effect of, relevant policies, plans and procedures

25.12.2. the adequacy and application of financial and other related management controls

25.12.3. the suitability of financial and other related management data

25.12.4. the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from

25.12.5. fraud and other offences

25.12.6. waste, extravagance and inefficient administration

25.12.7. poor value for money or other causes

25.13. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

25.14. In obtaining third party assurance from other auditors, for example SBS's auditors, the Head of Internal Audit should follow the Internal Auditors Practitioners Group (IAPG) assurance guidance.

External Audit

25.15. The **External Auditor** is appointed by the Trust's Auditor Panel and paid for by the Trust. The Audit Committee shall ensure that a cost-effective service is provided. If the Trust Board has concerns about the service provided by the External Auditor, which cannot be resolved by the Board, this should be raised with the External Auditor.

Counter Fraud and Bribery

25.16. In line with their responsibilities the Trust **Chief Executive** and **Chief Finance Officer** shall ensure compliance with section 24 of the NHS Standard Contract;

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

25.17.1 the Trust's Counter Fraud and Bribery Policy is maintained and remains up to date;

25.17.2 an NHS accredited Local Counter Fraud Specialist is appointed to the Trust to deliver the requirements of the Policy in accordance with the NHS Counter Fraud Authority Standards;

25.18. The appointed **Local Counter Fraud Specialist** shall report to the Chief Finance Officer and shall work with staff in NHS Counter Fraud Authority, when required;

25.19. The Local Counter Fraud Specialist will provide a written report to the Audit Committee, on an annual basis at least, on the counter fraud work completed within the Trust;

25.20. In accordance with the Trust's Counter Fraud Policy, any suspicions involving financial crime must be reported to the Local Counter Fraud Specialist, and/or the Chief Finance Officer or via the NHS Fraud and Bribery Reporting Line.

All reported concerns will be treated in the strictest confidence and professionally investigated in accordance with the Fraud Act 2006 and Bribery Act 2010.

Where evidence of Fraud and/or is identified all available sanctions will be pursued against offenders. This may include internal and professional body disciplinary sanctions, criminal prosecution and civil action to recover identified losses.

Security Management

25.21. The **Chief Finance Officer** shall ensure that a qualified Local Security Management

Specialist is appointed to provide security management services to the Trust, in accordance with the requirements of the NHS Standard Contract (currently 2013/14).

25.22. The **Local Security Management Specialist** will provide a written report to the Audit Committee, on an annual basis at least, on the security management work completed within the Trust.

ENDS

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Appendix 3 – Scheme of Delegated Authorities

1. Trust Policies and procedural guidance

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Adoption (and responsibility for currency of): - Trust Policies	Relevant Director to be appointed as Policy owner	SFI 2 *Policy on Policies*
	- Procedural guidance (Procedure notes, Standard Operating Procedures, Protocols, Guidance)	Officer nominated by the Relevant Director	SFI 2 *Policy on Policies*
	Maintain and update Trust's financial procedures (eg administrative procedure notes, desktop guides, guidance to Budget Managers)	Chief Finance Officer	SFI 2.14

2. Planning and budget management

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Financial Framework Advising the Board on the financial framework within which the Trust operates	Chief Finance Officer	SFI 3.1
	Compliance with and update of Trust financial framework	Chief Finance Officer	SFI 3.1
	Business and budget plans		SFI 4
	Preparation of strategic and annual plans for the Trust	Chief Executive	SFI 4.1
	Preparation of annual (and longer term) financial budget for the Trust	Chief Finance Officer	SFI 4.3
	Contribute to the preparation of annual budgets	All nominated Budget Managers	SFI 4.4

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Budget management (and responsibility levels)		SFI 5
	i. at individual cost centre level	Budget Manager or nominated deputy	SFI 5
	ii. at department level	Departmental Manager or nominated deputy	SFI 5
	iii. division level	Clinical Director / Corporate Manager (some or all of the Division Management Team as authorised by the Clinical Director / Corporate Manager)	SFI 5
	iv. at Executive Director level	Executive Director, or nominated deputy	SFI 5
	Recognition and adoption of the annual budget at cost-centre level	Budget Managers	SFI 5.9
	Variations from reserves (additional funds provided to address inflationary pressures and/or investments and/or risks) *Report periodically to the Finance & Performance Committee*	Chief Finance Officer or nominated deputy	SFI 5

Approval of variation of budgets, including authority to vire

SoDA	Delegated Authority	Between budget lines	Capital to revenue & *vice versa*	SFI reference
	Within a cost centre	Budget manager **plus** one of: Head of Nursing, Matron, Divisional Operations Director, Assistant Department Manager	Agreement between Business Partner and Director of Operational Finance , with the	SFI 5.9
	Within a department, or specialty; between cost centres	Department Manager **plus** one of: Director, Deputy Director, Head of Nursing, Matron, Divisional Operations Director		SFI 5.9
	Within a division; between departments and specialties	Director, **or** Deputy Director **or** Divisional Operations Director		SFI 5.9

	Between divisions, up to **£5,000**	Deputy Director of both divisions	express agreement of the Chief Finance Officer	SFI 5.9
	Between divisions, over **£5,000**	Executive Director of both divisions		SFI 5.9

Preparation of financial reports and returns

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Preparation of annual financial accounts and associated financial returns For Board approval	Chief Finance Officer	SFI 6.1
	Preparation of Annual Report (or equivalent) For Board approval	Chief Executive	SFI 6.3
	Preparation of monthly and quarterly financial returns to NHSI	Chief Finance Officer or nominated deputy	SFI 6.1

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3. Contracted Income and Expenditure[1]

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Setting of fees and charges for NHS services		SFI 7
	Agree and execute service level agreements in accordance with NHS standard commissioning contract terms		SFI 7.6 SFI 7.7
	i. under or equal to £2 million	i. Chief Finance Officer	
	ii. over £2 million	ii. Chief Executive and Chief Finance Officer	
	Subject to all approvals required in accordance with this SoDA and the relevant procurement process being completed, d, execute Agreements/Contracts (including Service Level Agreements and variations[2]) with NHS and non-NHS bodies for the purchase or provision of works, goods and/or services i. Up to £250,000 ii. >£250,00 to £2 million iii. over £2million	i. Divisional Operations Director or relevant Corporate Director ii. Chief Finance Officer iii. Chief Executive and Chief Finance Officer	SFI 7.8 SFI 9.5 SFI 9.6
	Contract management, monitoring and reporting	Chief Finance Officer or nominated deputy	SFI 7.9 SFI 7.10
	Subject to all approvals required in accordance with this SoDA, execute Business Transfer Agreements i. under or equal to £2 million (including nil value) ii. over £2million	i. Chief Finance Officer ii. Chief Executive and Chief Finance Officer	SFI 7.6 SFI 7.7
	Private Patients i. set pricing policy and price structure	i. Chief Finance Officer ii. Chief Finance Officer iii. Chief Finance Officer, Medical	SFI 7.3

[1] All legally binding documentation must be entered into in the name of "North Bristol NHS Trust" as the relevant legal entity
[2] If any variation is not included within the original Agreement/Contract, such variation shall require approval as if a new Agreement/Contract (SFI 10.18)

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	ii. set payment policy, including use of deposits, income guarantees, arrangements with insurance companies iii. approve service coverage policy (i.e. clinical services offered)	Director, and Chief Executive	
	Overseas visitors i. set pricing policy and price structure ii. set payment policy, including use of deposits, income guarantees	i. Chief Finance Officer ii. Chief Finance Officer	SFI 7.3
	Approve sponsorship deals i. Approve and execute Agreements to receive sponsorship from third parties (including funding of staff and loan of equipment): up to £15,000 ii. £15,000 to £50,000 iii. over £50,000	i. Divisional Operations Director ii. Chief Finance Officer iii. Chief Executive	SFI 7.13
	Approve and execute concession arrangements	Chief Finance Officer	SFI 7.15
	Approve research projects and clinical trials, including approvals to apply for research funding and approvals to undertake research, once considered by the Research and Development Committee i. execute required Agreements/Contracts and authorise grant submission	i. Deputy Director of Research or nominated Deputy	SFI 7.12

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Approve funded training posts	Head of Learning and Development	Not within SFIs
	Tenancy agreements and licences Approve and execute all tenancy agreements and licences for staff (subject to Trust policy on accommodation) form of tenancy agreements i. signature of individual tenancy agreements ii. extensions to existing agreements	i. Chief Finance Officer or an individual nominated by the Chief Finance Officer ii. Residences Manager	SFI 7.4 SFI 9.5
	Approve letting of premises to/from third parties (including leases and licences) i. execute documentation where not a Deed ii. executive documentation where a Deed but the Trust Seal is not required iii. execute documentation where the Trust Seal is required	i. Chief Finance Officer ii. As per SO 42.3 iii. As per SO 30.2	SFI 7.4
	Approve rent based on professional assessment	Chief Finance Officer or individual nominated by the Chief Finance Officer	SFI 7.4
	Legal Services i. authority to engage with legal advisors ii. maintenance of framework arrangements with approved legal advisors iii. approval of call-off of services	i. Chief Executive ii. Trust Secretary iii. Trust Secretary (delegated to Commercial and Legal Services Manager)	SFI 8

4. Approval of Business cases

Before any case can progress through the approval processes detailed below, divisional and corporate support is needed for both capital and revenue cases as follows:

Divisional 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): o To ensure trust-wide impacts have been understood within the case o To maintain consistent quality standard for cases going through for approval • Provide an approval recommendation to the Chief Finance Officer or Chief Executive on finalised business cases • Test and confirm procurement strategy • Monitor development and delivery of business case pipeline • Provide a report to Trust Management Team and Finance & Performance Committee listing all business cases that it has reviewed, and which have subsequently been approved in accordance with the SoDA.

The business case process outlined below applies to all contract renewals and extensions as well as new revenue, capital, or combined spend

Approval Process - Business Cases

Full life cost of new expenditure - Revenue, Capital or Combined (for recurring revenue commitments - annual costs)				
	<£1m	**≥£1m, <£2.5m**	**≥£2.5m, <£15m**	**≥£15m**
Business Case Review Group	Review and provide approval recommendation			
Executive Team	Review and approve cases >£100k (only where the business case relates to any item that has not already been identified and agreed as an investment priority as part of annual business planning)			
Chief Finance Officer	Approval	Approval	Approval	Approval
Chief Executive		Approval	Approval	Approval
Finance & Performance Committee			Approval	Approval
Trust Board			Approval	Approval
NHS England				Approval

This approval process shall also apply to any business case of lesser value, or no monetary value, where, in the considered opinion of the Chief Finance Officer, it carries a significant reputational risk or requires strategic input. The Chief Finance Officer shall determine the relevant approvals based on the level of risk / input identified (note also Schedule of Decisions Reserved to the Trust Board 3.2).

Value	**<£100k**	**≥£100k, <£2.5m**	**≥£2.5m, <£15m**	**≥ £15m**
Business Case type required	**CFO business case**	**Single-stage Business Case**	**OBC and FBC**	**SOC, OBC and FBC**

Key
CFO – Chief Finance Officer
SOC – Strategic Outline Case
OBC – Outline Business Case
FBC – Full Business Case

Order of Approvals

Approvals are sequential and all steps in the process need to be followed in order i.e., for a revenue scheme of £1m+ the order of approvals are:

5. Approvals to Award from Tenders and Quotations (revenue and capital)

Definitions	
Non-Contracted spend	Spend that cannot be demonstrated as assigned to a valid contract Spend that should the proposed action not be completed will become unsupported by a contract (ie. spend approaching contract expiry date or contract extension date)
Compliant Procurement Process:	A procurement activity that complies with PCR (Public Contracts Regulations)
Recommendation Report:	Report created by BWPC seeking approval of the outcome of a compliant procurement process, prior to contract award or extension Value contained within recommendation report identifies the initial contract term, plus extensions. However, initial approve is ONLY for contract term, secondary recommendation report required to extend contract
Exception Report:	Report created by BWPC, seeking directional guidance on a procurement process where a non-compliant outcome is preferred by the Trust, prior to contract award or extension
STA:	A document used to seek approval, with justification, for award of contract or out-of-scope extension without documented proof of value of money via direct comparison

BWPC remit	As custodians of the Procurement Process, BWPC are tasked with two aspects of validation: 1. Adherence to Trust SFI's; in simplified terms a requirement to ensure due process has been performed that will prove value for money 2. Adherence to The Public Contracts Regulations 2015 and other relevant legislation The intention of BWPC is to offer insight into the compliance of both aspects of validation for all relevant procurement activities As the element of risk concerning exceptions to Trust SFI's &/or PCR/OJEU non-compliance resides with the individual Trust/s, BWPC remit remains one of guidance and not decision maker.

Management of non-Contracted Spend			
	Description	Consortium	
1. Up to £5,000	*No requirement to evidence value for money*	5,000	Budget manager
2. £5,000 to £25,000	*Trust responsible for quotation provision and showing evidence of value for money. Records of evidence should be retained and will be subject to audit.*	25,000	Divisional Operations Director or Executive Director or nominated Deputy
Written Quote Requirement	*The number of quotes required prior to a Purchase Order being progressed*	3	

For values between £5k and £25k (the "Medium value process")

Procedure	Outcome Detail	Governance mechanism
Quotation Process	*3 or more valid quotes provided*	PO progressed
Quotation Process	*Fewer than 3 valid quotes*	STA and PO progressed
Framework Agreement (Internal, External)	*Compliant direct award*	PO progressed

For values between £25k and £100k (the "High value process")

Procedure	Outcome Detail	Governance mechanism
Tender Process (Local Quote, Framework Tender, Find a Tender Service (FTS))	*2 or more competitively priced bids received, provided that a minimum of 3 quotes or tenders were requested*	Recommendation Report
Tender Process (Local Quote, Framework Tender, FTS)	*2 or fewer competitively priced bids received, where fewer than 3 quotes or tenders were requested*	Recommendation Report incorporating an STA
Tender Process (Local Quote, Framework Tender, FTS)	*Contract not awarded to process winner*	Exception Report, followed by STA if exception awarded
Framework Agreement (External, Internal)	*Compliant direct award*	Short form Recommendation Report

Framework Agreement (External, Internal)	*Non-compliant direct award*	Exception Report, followed by STA if exception awarded
Compliant call off from approved Framework/ Call off agreement	*None required*	PO Progressed
Contract Modification	*Contract Variation / Extension (In scope)*	Short form Recommendation Report
Contract Modification	*Contract Variation / Extension (Out of scope)*	Exception Report
No Tender Process	*Non-compliant direct award*	Exception Report incorporating an STA

For values above £100k (the "Very high value process")

Procedure	Outcome Detail	Governance mechanism
Procurement strategy creation	*Requirement for spend above £100k*	Procurement Strategy Report
Tender Process (Local Quote, Framework Tender, FTS)	*2 or more competitively priced bids received, provided that a minimum of 3 quotes or tenders were requested*	Recommendation Report
Tender Process (Local Quote, Framework Tender, FTS)	*2 or fewer competitively priced bids received, where fewer than 3quotes or tenders were requested*	Recommendation Report incorporating an STA
Tender Process (Local Quote, Framework Tender, FTS)	*Contract not awarded to process winner*	Exception Report, followed by STA if exception awarded
Framework Agreement (External, Internal)	*Compliant direct award*	Recommendation Report
Framework Agreement (External, Internal)	*Non-compliant direct award*	Exception report, followed by STA if exception awarded
Contract Modification	*Contract Variation / Extension (In scope)*	Recommendation Report
Contract Modification	*Contract Variation / Extension (Out of scope)*	Exception Report
No Tender Process	*Non-compliant direct award*	Exception Report incorporating an STA

STA & Exception Report - Authorisation Values

Up to £25k
Director of Procurement

£25k to £500k
Chief Finance Officer

£500k-£1m
Chief Executive

£1m+
Trust Board

Recommendation Report – Authorisation Levels

Up to £100k
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Executive Director

£100k to £1m
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Executive Director **and**
Chief Finance Officer

>£1m – £2.5m
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Executive Director **and**
Chief Finance Officer **and**
Chief Executive

>£2.5m
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Executive Director **and**
Chief Finance Officer **and**
Chief Executive **and**
Trust Board

6. Contract Signature

After all relevant approvals have been obtained, contract signatures shall be as per Table 3 above ("Contract Income and Expenditure").

7. Contract Management

Other tendering and contractual arrangements

	Delegated matter	Authority delegated to	Delegation ref.
	Approve insurance policies i. Schemes administered by the NHSR ii. Other insurance arrangements	i. Chief Finance Officer or nominated deputy ii. Chief Finance Officer or nominated deputy	SFI 12.1 SFI 12.4
	Affix Trust Seal to documentation Where there is a legal requirement for a physical seal (e.g. by the Land Registry or HMRC) as advised by internal or external legal	Chair of the Trust and Chief Executive	SO 30
	Executive documentation as a Deed Including Agreements, Leases and Licences, provided there is no legal requirement for a physical seal (as above)	As per Table 3 above ("Contracted Income and Expenditure"), in the physical presence of an attesting witness for each signature	SO 42.3

Non-pay requisitions, orders, and payment authorisation

Financial thresholds in this section mirror the procurement limits and as such exclude VAT and/or delivery charges. Where there is an order/contract for more than one financial year, the total cost must be included not just the 12 months element.

	Delegated Matter	Authority Delegated to	Delegation Ref.
	Maintain records of officers who are authorised to place requisitions and orders; and the maximum value of orders that they have the authority to place.	Chief Finance Officer	SFI 10.2
	Identify the Trust's approved supply arrangements (controlled procurement systems, framework agreements)	Chief Finance Officer	SFI 10.4

Trust-wide ***(excepting elements of delegated authority for specific disciplines specified in the subsequent tables)***

8. Ordering limits (EROS)

Up to £2,500	Authorising manager approved by Divisional Operations Director/Corporate manager
Over £2,500	Vetting manager approved by Divisional Operations Director/Corporate manager

9. Oracle Limits - Invoice processing

a. General Oracle Limits

Up to £25,000	Budget holder/manager designated by Divisional Operations Director or equivalent
£25,000 to £100,000	Divisional operations Director//Corporate Manager
£100,000 to £1m Grouped NHS Supply Chain invoice up to £500K	Executive Director Director of Procurement
Over £1m	Chief Finance Officer/Chief Executive

b. Subsidiary Systems

Subsidiary Systems where grouped requisitions are used:

	Pharmacy	**Capital Estates**
Grouped requisitions up to £500k per week	Director of Pharmacy or nominated deputy	Capital estates Mailbox
Grouped requisitions over £500k per week	Director of Pharmacy	Chief Finance Officer or nominated Deputy

c. In addition to the general oracle limits, additional limits are in place within the finance department which are used to process high value pre-approved invoices e.g Unitary Payment, loan repayments etc.

Up to £1m	Head of Financial Control
£1m-£10m	Assistant Chief Finance Officer (Financial Services) or Assistant Chief Finance Officer (Planning & Income) (or nominated deputies in their absence)
Over £10m	Director of Operational Services or Chief Finance Officer

10. Workforce and payroll

Appointment of Senior Medical Staff and team (investment may include capital elements)

		Replacement posts	New posts / clinical teams[1]	
		Within existing budget	Up to £500k	Over £500k
	Approval / Sign-Off[2] by:			
	Executive Team		Agree project mandate and priority	
	Finance Business Partner	Sign	Sign	Sign
	HR advisor	Sign	Sign	Sign
	Divisional Operations Director or equivalent corporate manager	Sign	Sign	Sign
	Clinical Director	Sign	Sign	Sign
	Chief Operating Officer	-	Sign	Sign
	Chief Finance Officer	-	Sign	Sign
	Consultant Post Panel	**Approve**	**Approve**	Recommend

Approval of new posts/clinical teams must follow the business case approval processes outlined in this SoDA

[1] New clinical teams to deliver new services. Approach follows the same sign-off steps as for new service developments

[2] Signature indicates sufficient understanding and confidence in the details of the business case to confirm responsibility for support for the proposal

Payroll authorities

	Approval / Sign-Off by:	Existing establishment Within existing budget	New posts / Outside of establishment With specifically allocated funding	 Without specifically allocated funding
	Fill funded post on establishment with permanent staff (subject to any vacancy review policy in place)	General / Corporate Manager **or** nominated deputy **and** finance Business Partner **and** HR advisor[1]	-	-
	Appoint staff to post not on formal establishment	-	General / Corporate Manager **or** nominated deputy **and** finance Business Partner **and** HR advisor[1]	General / Corporate Manager **or** nominated deputy **and** finance Business Partner **and** HR advisor[1]
	(Re)new fixed term contracts	General / Corporate Manager	General / Corporate Manager	General / Corporate Manager
	Engage non-medical, non-payroll consultancy staff (subject to contracting rules):			
	- Below **£100k** gross commitment	-	General / Corporate Manager or Executive Director	
	- **£100k** to **£500k** gross commitment	-	Chief Finance Officer	
	- over **£500k** gross commitment	-	Chief Executive	
	- over 6 months length of contract	-	Chief Executive	

[1]Need to ensure fit with workforce plans

Bank, agency and locum staff	Within establishment		Extra to establishment	
	Within budget	Without budget	Within budget	Without budget
Nursing	(Deputy) Budget Manager	Chief Nursing Officer or Chief Medical Officer and Chief Finance Officer **or** Chief Executive	Budget Manager	Chief Nursing Officer or Chief Medical Officer and Chief Finance Officer **or** Chief Executive
Clerical support services	(Deputy) Budget Manager		Budget Manager	
Medical	(Assistant) General / Corporate Manager		Divisional Operations Director/ / Corporate Manager	
Through non-framework agency	As above, plus Executive Director approval		As above, plus Executive Director approval	

Approvals relating to staff on the payroll

	General approvals	Approval / sign off
	Grant additional increments to staff (outside of Department of Health national T&C)	Director of People & Transformation **and** Chief Finance Officer
	Authorise (electronic and paper) timesheets and other positive reporting forms which will affect the amount of salary to be paid to confirm: attendance at work; sickness and absence records; overtime and unsocial hours	Line Manager **or** Authorised Signatories
	Authorise travel and subsistence claims (only available through e-expenses)	Line Manager

	Approve departure under compromise agreement (excluding mutually agreed resignation scheme (MARS) arrangements) i. directors and very senior managers ii. other staff	i. Remuneration and Nominations Committee and Chief Finance Officer ii. Chief People Officer and Chief Finance Officer
	Approve redundancy (and mutually agreed resignation schemes, or similar arrangements) **i.** payment up to **£100k** **ii.** payment over **£100k**	i. Chief People Officer and Chief Finance Officer ii. Remuneration and Nominations Committee and Chief Finance Officer

11. Approval for variations to capital plan

Change to Total Annual Capital Expenditure Plan	Delegated Authority
Up to **£500k**	Capital Planning Group
£500k to **£1m**	Finance & Performance Committee
Over £1m	Trust Board

Funding capital investments through Private Finance Initiative

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Assess comparative merit of progressing scheme through PFI	Finance and Performance Committee, advised by Chief Finance Officer	SFI 13.10
	Authorise payment of the sums identified in the schedule of the unitary payment (being the annual service payment defined in Schedule 18 of the Project Agreement) to be made to the PFI partner over the lifetime of the scheme (project term). Authorise annual Retail Price Index (all items) adjustment, in accordance with the PFI Project Agreement.	Trust Board	SFI 13.13
	Oversee delivery of the PFI contract terms, ensuring appropriate delivery and monitoring of the PFI contract; and including agreement of fee adjustments resulting from facilities management service and performance issues, to verify the invoice total.	Chief Finance Officer or an individual nominated by the Chief Finance Officer	SFI 13.14 SFI 13.15
	Approve decision to withhold, or delay payment of all or part of an invoice submitted by the PFI partner, at risk of incurring penalties and late payment charges	Chief Finance Officer	SFI 13.16
	Process payment of monthly account to the PFI partner, in accordance with the Trust Board authorisation.	Assistant Chief Finance Officer (Financial Services), or nominated deputy	SFI 13.17

Fixed assets records and accounting for fixed assets

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Maintain register of (fixed) assets Including verification of additions and disposals, revaluations, calculation of annual capital charges	Chief Finance Officer	13.21 to 13.27

12. Bank and cash and investments

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Day to day operation of bank accounts i. maintain list of approved signatories ii. approval to pay	i. Shared Business Services (SBS), under terms of contract with the Trust ii. SBS following confirmation of availability of cash required by Head of Financial Control	SFI 14.5
	Determine when to subject commercial bank service supplier to competitive tendering	Chief Finance Officer	SFI 14.8
	Establish, or close a petty cash facility	Chief Finance Officer (or nominated deputy)	Not within SFIs
	Approve the use of Trust credit cards (in the name of North Bristol NHS Trust only)	Chief Finance Officer (or nominated deputy)	SFI 14.10
	Investment of funds i. surplus exchequer funds ii. charitable fund cash balances	i. Chief Finance Officer ii. Investment advisors appointed by the Charity Committee	SFI 15

13. External borrowing and Public Dividend Capital

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Short-term borrowing (temporary borrowing limit)	Trust Board	SFI 18.2 SFI 18.3
	Borrowing, including commercial loans	Trust Board	SFI 18.4
	Borrowing of Public Dividend Capital	Trust Board	SFI 18.1 SFI 18.4

14. Disposals, write-offs losses and special payments

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Terminate lease and rental arrangements early at cost to the Trust	Chief Finance Officer	SFI 7.4, 13.28
	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 13.28
	Dispose of x-ray films	Radiology Departmental Manager\Clinical Director	SFI 13.29

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Disposal of mechanical engineering plant. With replacement value estimated at: i. up to £10,000 ii. £10,000 to £100,000 iii. over £100,000	i. Head of Estate Maintenance ii. Director of Operational Estates & Facilities iii. Chief Finance Officer	SFI 13.28
	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. Chief Medical Officer ii. Chief Finance Officer iii. Chief Finance Officer **and** relevant Executive Director	SFI 13.28
	Approve losses, write-offs and compensation payments due to / made under: • theft, fraud, overpayment of salaries and overpayment of third parties; • fruitless payments, including abandoned capital schemes; • bad debts and claims abandoned, including in respect of Private Patients, Overseas Visitors and other third parties; • damage to buildings, fittings, furniture, equipment and property in stores and in use due to culpable cause (e.g. fraud, theft, arson); • additional payments made to third parties in connection with or arising out of contractual liabilities, including sums payable under agreed settlements and court judgments; • personal injury claims involving negligence (legal advice must be obtained and guidance applied); • ex-gratia payments patients and staff for loss of personal effects;	i. Assistant Chief Finance Officer (Financial Services) or nominated deputy in their absence ii. Chief Finance Officer or deputy iii. Audit & Risk Committee	SFI 19 Schedule of reservations 3

	i. up to £1,000 ii. £1,000 up to £50,000 iii. Over £50,000 *All to be reported to the Audit & Risk Committee.*		
SoDA	**Delegated matter**	**Authority delegated to**	**Delegation ref.**
	Report incidents to the Police i. general ii. where a fraud is involved	i. departmental manager (inform General / Corporate Manager or Director as soon as possible. Also inform Local Security Management Specialist) ii. Chief Finance Officer or Local Counter Fraud Specialist	SFI 19 *Counter Fraud and Bribery Policy*

15. Patients' property

Delegated authority	Holding	Receive and safeguard valuables	Discharge patients' valuables
Valuable items	Ward safe	Any member of nursing staff	Any member of nursing staff
Cash under **£5k**	Ward safe	Ward Manager	Ward Manager

16. Access to charitable funds

Delegated authority	Approve expenditure from charitable funds
Up to £1,000	One fund signatory
£1,000 to £10,000	Two fund signatories
£10,001 to £25,000	Two fund signatories plus the Director of Communications
£~~10,000~~ £25,001 to £50,000	Two fund signatories plus the Chief Finance Officer (or nominated deputy)
Over £50,000	Two Fund signatories and the Charity Committee.

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Spending plans will be submitted to the Charity Committee for approval in March each year. Approval is delegated to approve additional spending plans that arise during the year as follows:

Delegated authority	Approve expenditure from charitable funds
Up to £10,000	Assistant Chief Finance Officer (Financial Services) or nominated deputy in their absence
£10,001 to £25,000	Director of Communications
£25,001~~10,000~~ to £50,000	Chief Finance Officer (or nominated deputy)

16. Access to charitable funds

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	**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:	Public Trust Board			
Date of Meeting:	30 May 2024			
Report Title:	Provider Licence – Self-Certification			
Report Author:	Xavier Bell, Director of Corporate Governance			
Report Sponsor:	Xavier Bell, Director of Corporate Governance			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
	X			
Recommendations:	That the Trust Board: • Approve self-certification for licence condition G5 and approve self-certification for licence condition NHS2.			
Report History:	Self-certification against various sections of the provider licence is an annual process. This was last carried out in May 2023.			
Next Steps:	The final self-certification response must be published on the Trust's website no later than 30 June 2024.			

Executive Summary

In 2017 NHS Improvement (now NHS England) issued guidance requiring all NHS trusts to annually self-certify their compliance with the terms of the NHS Provider Licence. This guidance was last updated in March 2019.

In April 2023 the terms of the NHS Provider Licence were updated and reissued. The new licence contains broadly equivalent terms to those referred to in the 2019 guidance; however, the specific paragraph references have changed and no longer align to the 2019 guidance.

In the absence of updated guidance, this self-certification exercise follows the 2019 guidance but refers to the new licence paragraphs.

The 2019 guidance requires trusts to self-certify as to whether they have:

a. effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (previously condition G6, now condition G5)
b. complied with governance arrangements (previously condition FT4, now condition NHS2), and
c. the required resources available if providing Commissioner Requested Services (CRS) (previously condition CoS7). This condition previously only applied to NHS Foundation Trusts but now applies to NHS Trusts. NBT's contracting team has contacted commissioners to determine whether any services at NBT are designated as CRS; however, this information is not yet available, so this self-certification does not cover this section.

The report recommends that the Board certify “confirmed” against conditions G5 and NHS2.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	N/A	
Financial implications:	No specific implications	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No. This not a new or significant change to a service, function, strategy, or policy that could have an impact on people	
Appendices:	Appendix 1 – Condition G5 Appendix 2 – Condition NHS2	

1. Purpose

This report provides evidence and recommendations to support the Board's self-certification against the NHS Provider Licence.

2. Background

2.1. NHS Trusts are required to self-certify that they can meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements.

2.2. New licence conditions were issued in 2023 and came into effect from 1 April 2023.

3. Self-Certification Requirements

3.1. Providers need to self-certify the following after the financial year-end:

NHS provider licence condition
The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (new Condition G5)
The provider has complied with required governance arrangements (new Condition NHS2)

3.2. Providers must publish their self-certification against condition G5 no later than 30 June 2024.

3.3. NHS England may contact a select number of trusts to ask for evidence that they have self-certified. This can be through providing the completed templates or relevant board minutes and papers recording sign-off.

4. Proposed Outcome

Condition G5:

4.1. This licence condition requires providers to have processes and systems that:

- Identify risks to compliance with the licence, NHS Acts and NHS Constitution; and
- Take reasonable mitigating actions to prevent those risks and failure to comply from occurring.

4.2. Providers must annually review whether these processes and systems are effective.

4.3. Providers must self-certify by answering "confirmed" or "not confirmed" to the following statement:

"*Following a review for the purpose of paragraph 2(b) of licence condition G5, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended,*

the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under NHS Acts and have had regard to the NHS Constitution".

4.4. **Recommendation:** Given the Trust's robust governance and assurance processes, which represent good precautions in order to comply with relevant licence conditions, the recommendation to the Board is that the Condition G5 Self Certification is formally signed-off as "Confirmed" with respect to 2023/24.

4.5. **Appendix 1** sets out the systems and processes the Trust has in place to identify risks to compliance with the Provider Licence and associated statutory duties, and guard against their occurrence and describes their effectiveness.

Condition NHS2

4.6. This licence condition sets out the expected governance arrangements for providers, including having regard to regulatory guidance, effective board and committee structures, clear reporting and accountability, and systems and processes which ensure compliance with the board's various statutory and regulatory duties.

4.7. Under the old licence terms NHS providers were required to self-certify against condition FT4:

"…confirming compliance with this Condition [now NHS2] as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks."

4.8. Providers should review whether their governance systems meet the standards and objectives in the condition. There is no set standard or model to follow; instead in reaching the conclusion that the Trust is compliant, the Trust should assess effective board and committee structures, reporting lines and performance and risk management systems.

4.9. **Recommendation:** based on the evidence highlighted in **Appendix 2**, it is recommended to the Board that each of the six governance-related statements from 'Condition NHS2 Self Certification are formally signed-off as "Confirmed".

North Bristol NHS Trust

Appendix 1 – Evidence to support Condition G5 compliance

G5: Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

a. the Conditions of this Licence,

b. any requirements imposed on it under the NHS Acts, and

c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence and

b. regular review of whether those processes and systems have been implemented and of their effectiveness.

The Trust Board is assured of compliance because:

- Annual Governance Statement – An Annual Governance Statement for 2023/24 has been reviewed by Audit & Risk Committee. This statement includes a description of the Trust's system of internal control and assurance frameworks. It will be reviewed by the Trust's external auditors as part of the finalisation of the 2023/24 Annual Report.

- The Annual Head of Internal Audit Opinion (HOIAO) for 2023/24 concluded "'Significant assurance with minor improvement opportunities' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control".

- The 2023/24 Internal Audit review of Risk Management concluded "Significant assurance"".

- Risk Registers – The Trust has a Board Assurance Framework which is reviewed by the Board on a quarterly basis, and a Trust risk register with Board-level oversight of Trust Level Risks via the Audit & Risk Committee, other Committees and the Trust Board on a quarterly basis.

- The Board has well established sub-committees, chaired by Non-Executive Directors and with appropriate Executive Director membership. The Trust Chair and Trust Secretary undertake annual reviews of the Board's committee structure.

- In 2023/24 the Board's Committees have undertaken deep dives into various areas of potential concern or risk, including reviews of workforce transformation, a never events thematic review, stroke service, medical equipment replacement, outpatients and UEC recovery, and equality, diversity and inclusion.

- An Integrated Performance Report is received by the Board each month, which sets out performance against various operational, quality, and financial targets, and provides an opportunity for discussion and challenge.

- The Trust has a robust internal audit programme in place, informed by its risk registers, Executive Team and with input from Audit & Risk Committee and Board Committee Chairs. Reports are reviewed by the Audit & Risk Committee and other Trust Board committees, with actions overseen by Executive leads.

Appendix 2 - Evidence to support Condition NHS2 compliance

Condition NHS2 – NHS trust governance arrangements

The Licensee is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.

Recommend that this statement is **CONFIRMED**

The Board is satisfied because:

- Annual Governance Statement – An Annual Governance statement for 2023/24 has been reviewed by the Audit & Risk Committee. This statement includes a description of the Trust's risk management and assurance frameworks. It is reviewed by the Trust's external auditors.
- The Annual Head of Internal Audit Opinion (HOIAO) for 2023/24 concluded "'Significant assurance with minor improvement opportunities' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control".
- A Board Assurance Framework is in place, and is regularly updated by Executive leads, and is reported to the Board quarterly. An internal audit review of risk management in 2022/23 provided an opinion of "significant assurance with minor improvement opportunities identified". In 2023/24, the conclusion was "significant assurance".
- The Trust has up-to-date Standing Orders and Standing Financial Instructions in place.
- The Trust has a robust internal audit programme in place, informed by its risk registers, Executive Team and with input from Audit & Risk Committee and Board Committee Chairs. Reports are reviewed by the Audit & Risk Committee and other Trust Board committees, with actions overseen by Executive leads.
- The external developmental well-led review undertaken by AuditOne in 2023 provided a positive view of the Trust's governance arrangements.

The Licensee shall:

- **Have regard to such guidance on good corporate governance as may be issued by NHS England from time to time**
- **Have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health**
- **Have Corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity.**

Recommend that this statement is **CONFIRMED.**

Examples of compliance:

- External Auditors provide sector guidance in their regular reports to Audit and Risk Committee.
- The Chief Executive's report to Trust Board identifies new or revised regulatory guidance where appropriate.
- Performance Reports to Trust Board are aligned to the System Oversight Framework.
- The Trust is actively engaged in the system sustainability work programmes, and interrogates the organisation's Green Plan on an annual basis.
- The Trust has a well-established Information Management and Technology (IM&T) Function, with a clear Digital Strategy and an IM&T Board which is in a position to escalate any issues or risks of non-compliance with guidance on Digital Maturity. The Trust has appointed a Joint Chief Digital Information Officer with UHBW to further progress Digital Maturity.

The Licensee shall establish and implement:

- **Effective board and committee structures**
- **Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees and**
- **Clear reporting lines and accountabilities throughout its organisation.**

Recommend that this statement is **CONFIRMED.**

The Board is satisfied because:

- There are clear Terms of Reference for Board sub-committees, including clear requirements for membership and description of the group's purpose and business.
- The Trust was subject to a CQC inspection in June/July 2019, and achieved an overall rating of "Good", with "Outstanding" for the Well-Led domain, which incorporates governance arrangements and structures. The Trust Secretary maintains an internal well-led self-assessment document. The CQC's limited inspection of Maternity Services in 2023 did not change this assessment.
- The Board's sub-committees provide assurance to the Board on topics within their remit.
- Annual review of the Board and its sub committees' performance and effectiveness is carried out. In 2023/24 this included an external external developmental well-led review undertaken by AuditOne in 2023 provided a positive view of the Trust's governance arrangements.
- Sub-committees and groups provide upward reports and assurance, and the Board receives regular and detailed reports from its key sub-committees.

- Divisional reviews take place on a monthly basis and an accountability framework is in place.

- Standing Orders and Standing Financial Instructions are up-to-date and reviewed annually.

- Clear divisional structure charts are available on the trust website, and governance structures and policy documents are available to staff on the intranet.

The Licensee shall establish and effectively implement systems and/or processes:

- **To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively**
- **For timely and effective scrutiny and oversight by the Board of the Licensee's operations**
- **To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions**
- **For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)**
- **To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making**
- **To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence**
- **To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery and**
- **To ensure compliance with all applicable legal requirements.**

Recommend that this statement is **CONFIRMED.**

<u>The Board is satisfied because:</u>

- The Trust will report a small surplus position for 2023/24.

- The Trust has a comprehensive annual operational/business planning process aligned to national planning and contracting timeframes which is assured via Board Committee/sub-committee and NHSI submission.
- The annual operational plan is received and approved by the Board.

- The Board is kept up-to-date via its sub-committee on systems, processes and governance in place within the Trust to meet the requirements of the Workforce Race Equality Standard, Equality Act 2010 and the Public Sector Equality Duty.

- An accountability framework and divisional performance review meetings provide assurance on the operational and financial performance of the Trust's clinical divisions.

- Regular Health and Safety reports are received by the Board's People and EDI (Equality, Diversity and Inclusion) Committee.

- Quality Committee has oversight of quality and CQC regulatory compliance.

- The Trust also:

    - Undertakes benchmarking against peers
    - Produces a monthly Integrated Performance Report
    - Undertakes committee deep dives
    - Has an external audit of the Trust Annual Accounts
    - Has an up-to-date Risk Management Policy
    - Regularly reviews risk registers across the organisation
    - Has a strong internal legal function, and effective relationships with national law firms, and
    - Is implementing the Patient First improvement programme.

The systems and/or processes referred to above should include but not be restricted to systems and/or processes to ensure:

- **That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided**
- **That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations**
- **The collection of accurate, comprehensive, timely and up to date information on quality of care**
- **That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care**
- **That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources and**
- **That there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.**

Recommend that this statement is **CONFIRMED.**

<u>The Board is satisfied because:</u>

- The Board and the Executive Team have undertaken development programmes in 2023/24 and have further development work scheduled in 2024/25.

- Recruitment to vacant Non-Executive and Executive Posts includes consideration of the skills and experience required by the Board.
- There are currently no vacancies in the Executive Team.
- The Trust is actively engaged with the local Health Scrutiny Committee, Health and Wellbeing Board and Healthwatch.
- The monthly Integrated Performance Report includes a quality section and is reviewed by the Board.
- Quality reports are reviewed by the Quality Committee, which also undertakes deep dives where appropriate.
- Various regulatory annual reports are received by Committees/the Board, including Quality Accounts and Children's and Adult Safeguarding Annual Reports.
- The Board has a Patient & Carer Experience Committee to expand focus on this area.
- Freedom to Speak-up (FTSU) Guardian reports are received by Board. The Trust has also invested in a FTSU Guardian with ring-fenced time.
- The Executive Team, Trust Chair and Non-Executive Directors undertake walk-arounds across the Trust.
- The Board receives regular patient or staff stories at the beginning of each public meeting.
- Quality Impact Assessments are undertaken in relation to relevant decision-making.

The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Recommend that this statement is **CONFIRMED**

<u>The Board is satisfied because:</u>

- There are currently no vacancies in the Executive Team.
- The Board receives regular Safe Staffing reports.
- A doctor revalidation process is in place, and the Board receives an annual report from the Medical Director in this regard.

- The Trust has a Fit & Proper Persons Policy and carries out checks on Board members to ensure they comply with the requirements of the regulations and the new 2023 Fit and Proper Persons Framework.

- Decision-making staff make an annual declaration of interest, and the Trust maintains a register of interests including gifts and hospitality. This is reported regularly to the Audit & Risk Committee.

- The Trust has invested significantly in staff health and wellbeing to support the resilience of the workforce and invests in leadership development at all levels in the organisation, including the new Healthcare Excellence in Leadership and Management (HELM) programme from 2023/24.

- The Trust maintained an Associate Non-Executive Director programme in 2023/24 to support the talent pipeline for Non-Executive Directors within the NHS.

- The Trust has a robust appraisal process and Executive and Non-Executive Directors undertake annual appraisals.