NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Meeting in common of the Board of Directors of University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and the Board of Directors of North Bristol NHS Trust (NBT) in Public on Tuesday, 08 April 2025, 13.00 to 16.00 at The Jessop Suite, Gloucestershire County Cricket Club, Seat Unique Stadium, Nevil Road, Bristol, BS7 9EJ

AGENDA

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMING
1.	Apologies for Absence	Information	Joint Chair	13.00 (5 mins)
2.	Declarations of Interest	Information	Joint Chair	
3.	Patient Story	Information	UHBW Patient & Public Involvement Lead	13.05 (20 mins)
4.	Minutes of the last meetings **UHBW: 11 March 2025** **NBT: 27 March 2025**	Approval	Joint Chair	13.25 (5 mins)
5.	Matters Arising and Action Logs	Approval	Joint Chair	
6.	Questions from the Public	Information	Joint Chair	13.30 (10 mins)
7.	Joint Chair's Report	Information	Joint Chair	13.40 (10 mins)
8.	Joint Chief Executive's Report	Information	Joint Chief Executive	13.50 (10 mins)
Strategy and Planning				
9.	Summary Group Benefits Case	Approval	Joint Chief Executive	14.00 (15 mins)
10.	Group Name	Approval	Joint Chief Executive	14.15 (15 mins)
BREAK – 14.30 TO 14.40				
11.	Joint Clinical Strategy Update	Information	Chief Medical Officers	14.40 (10 mins)
12.	UHBW & NBT Operating Plans 2025-2026	Approval	Hospital Managing Directors	14.50 (10 mins)
Governance and Risk				
13.	Group Board Assurance Framework	Approval	Chief Corporate Governance Officer	15.00 (10 mins)
14.	Board Workplan and Committee Terms of Reference	Approval	Chief Corporate Governance Officer	15.10 (10 mins)
15.	Key Governance Documents	Approval	Chief Corporate Governance Officer	15.20 (10 mins)
16.	Committee Upward Reports	Information	Committee Chairs	15.30 (10 mins)

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMING
	• UHBW Quality & Outcomes Committee • UHBW People Committee • UHBW Finance, Digital & Estates Committee			
Quality and Performance				
17.	Joint Integrated Quality and Performance Report	Information	Hospital Managing Directors and Executive Leads	15.40 (15 mins)
Concluding Business				
18.	Any Other Urgent Business – *Verbal Update*	Information	Joint Chair	15.55 (5 mins)
19.	Time and Date of Next Meeting **Tuesday, 13 May 2025**	Information		

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public		
Date of Meeting:	08 April 2025		
Report Title:	What Matters to Me – a Patient Story		
Report Author:	Tony Watkin – Patient and Public Involvement Lead		
Report Sponsor:	Deirdre Fowler – Chief Nurse and Midwife UHBW		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			Yes
	Patient stories reveal a great deal about the quality of our services, the opportunities we have for learning, and the effectiveness of systems and processes to manage, improve and assure quality. The purpose of presenting a patient story to Board members is: • To set a patient-focussed context for the meeting. • For Board members to understand the impact of the lived experience for patients and for Board members to reflect on what the experience reveals about our staff, morale and organisational culture, quality of care and the context in which clinicians work.		

Key Points to Note *(Including any previous decisions taken)*

This experience of care story introduces Angela and Jenny, who are cardiology patients receiving care at University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and North Bristol NHS Trust (NBT). Angela and Jenny have recently participated in patient focus groups as part of the Acute Provider Collaborative programme to develop a 'Single Managed Service' in Cardiology.

In sharing their experiences, Angela and Jenny will draw on their observations about some of the transactional and relational aspects of their care. This will include reference to how hospital processes sometimes cause uncertainty and distress, and how the behaviours and attitudes of staff may unintentionally impact on care.

The Board will hear what it felt like being "held for several weeks" at Southmead Hospital awaiting a bed at the Bristol Heart Institute; how the physical environment of a hospital plays an important role in well-being and the overall satisfaction of care; how the personal qualities of staff can stand out and offer reassurance; how such reassurance can be undone on receiving contradictory information; and, how the little things matter at a time of vulnerability.

By way of additional context:

Angela's journey began in Easter 2023 when she first visited her GP having experienced prolonged episodes of breathlessness. She was referred for an appointment to Southmead

Hospital which she received for January 2024. There followed an appointment with a Cardiologist at the Bristol Heart Institute in November 2024. At the time of writing, Angela is awaiting the fitting of a pacemaker to regulate her heart rhythm prior to undergoing an AV node ablation later in the year. Jenny's journey started in April 2024. Having arrived by ambulance at Southmead Hospital's Emergency Department she was admitted to Ward 27 where she received care until she was transferred in June 2024 to the Bristol Heart Institute where she underwent a triple heart by-pass operation. Angela and Jenny have consented to their names being shared and are active participants in cardio rehabilitation and well-being programmes.
Strategic and Group Model Alignment
This story aligns to the UHBW Experience of Care strategy, the Joint Clinical Care Strategy and the Acute Provider Collaborative.
Risks and Opportunities
By listening to and working with patients and community partners we are better able to design and deliver services that better meet their needs and in doing so improve health care outcomes, tackle health inequalities and deliver better value for money.
Recommendation
This report is for **INFORMATION.** The Board is asked to **NOTE** the report **.**
History of the paper (details of where paper has <u>previously</u> been received)
Not applicable.

Appendices:	**None.**

University Hospitals Bristol and Weston NHS Foundation Trust

BOARD OF DIRECTORS (IN PUBLIC)

Minutes of the meeting held on Tuesday 11 March 2025 from 13:15 to 16:30 in the Clifton and Hotwells Meeting Rooms, St James' Court, Bristol

Present

Board Members

Name	Job Title/Position
Ingrid Barker	Joint Chair
Sue Balcombe	Non-Executive Director
Rosie Benneyworth	Non-Executive Director (*online*)
Paula Clarke	Executive Managing Director, Weston General Hospital
Neil Darvill	Joint Chief Digital Information Officer
Jane Farrell	Chief Operating Officer
Deirdre Fowler	Chief Nurse and Midwife
Marc Griffiths	Non-Executive Director
Susan Hamilton	Associate Non-Executive Director
Maria Kane	Joint Chief Executive for UHBW and NBT
Neil Kemsley	Chief Financial Officer
Linda Kennedy	Non-Executive Director
Rebecca Maxwell	Interim Chief Medical Officer
Roy Shubhabrata	Non-Executive Director
Martin Sykes	Vice Chair, Non-Executive Director
Anne Tutt	Non-Executive Director
Stuart Walker	Hospital Managing Director, UHBW
Emma Wood	Chief People Officer & Deputy Chief Executive

In Attendance

Mark Graham	Chief Executive For All Healthy Living Company *(For Patient Story, item 3)*
Tina Johnson	Deputy Divisional Director of Nursing *(For item 13)*
Emily Judd	Corporate Governance Manager *(Minutes)*
Jenny Kerridge	Health Equity Lead, Weston General Hospital
Mark Pender	Head of Corporate Governance
Joanna Poole	Weston General Hospital
Sazia Salim	Community Development Worker For All Healthy Living Company (For Patient Story, item 3)
Eric Sanders	Director of Corporate Governance
Bethany Shirt	Deputy Head of Nursing Quality *(For item 13)*
Chris Swonnell	Associate Director of Quality and Compliance *(For item 13)*
Tony Watkin	Patient Story *(For item 3)*

The Chair opened the Meeting at 13.15pm

Minute Ref.	*Item*	*Actions*
01/03/25	**Welcome and Apologies for Absence**	
	Ingrid Barker, Joint Chair welcomed members of the Board and all those in attendance to the meeting. It was noted that apologies of absence had been received from Arabel Bailey, Non-Executive Director.	

Minute Ref.	*Item*	*Actions*
02/03/25	**Declarations of Interest**	
	There were no new declarations made.	
03/03/25	**Patient Story**	
	Tony Watkin, Patient and Public Involvement Lead introduced Mark Graham and Saz Salim, of the For All Healthy Living Company (FAHLC). Tony explained that the patient story would explore the value of collaborating with healthcare partners to advance the experience of care and clinical outcomes for people. Mark Graham, FAHLC Chief Executive explained that the charity represented an under resourced area of Weston-Super-Mare through a not-for-profit charity, which aimed to promote and work in partnership with local people and partners in order to increase access and ensure local residents were key partners in the design and delivery of local services. Saz Salim, FAHLC Community Development Worker provided an example of a community service user that had attended Weston General Hospital for a surgical procedure and after a short stay in the hospital their care was transferred to the community. Saz provided further context around the patient's specific safeguarding issues which the charity had identified and improved, for example by providing the patient's family access to the company's food bank. It was noted that UHBW had not been aware of the safeguarding issues on discharge from hospital, and so this was where the charity attempted to provide the link between healthcare providers to better support patients. Mark provided further information around the work of the charity, including a process called tribal mapping which aimed to provide better insight into a patient's private life to start joining up the dots within the system to ensure patients were discharged to a safe home or community environment. He said that work would progress with the Health Equity Lead at Weston General Hospital to improve access and flow throughout the hospital and into the community, seeking to support the management of patients with No Criteria to Reside. He added that a local network, referred to as a "squad" had been established to work with other local agencies to support people in their homes to ensure they were safe. During the ensuing discussion, the following points were made: • Maria Kane, Joint Chief Executive noted how the charity had strong community ties and that it was a hub for the people of Weston-Super-Mare, making it a model anchor institution. Maria said there would be much to think about in terms of people going in and out of hospital and what more could be done within the community to support their care. • Susan Hamilton, Associate Non-Executive Director, asked for a reflection on how the hospital's ways of working was supporting the facilitation of the project. Mark said at the Health and Wellbeing Board meetings there was a genuine joint understanding developing and noted that trauma informed practice and shared learning were fundamental elements that were being undertaken by the hospital and charity.	

Minute Ref.	Item	Actions
	• Marc Griffiths, Non-Executive Director, asked whether there was an opportunity for student placements at the charity. Mark agreed this would be a good initiative and there was discussion around how going back to the educational setting would bring in more trauma informed research. • Paula Clarke, Executive Managing Director, Weston General Hospital noted how there would be some people that would not want to put their trust into the hospital services and suggested there was more work to do to build a bridge to these people. Paula said the next steps would be to scale up the "squad" charity support workers within the community by opening educational opportunities and by broadening the model out to other organisations within the Integrated Care System. • Deirdre Fowler, Chief Nurse and Midwife echoed Paula's comments and said the Trust should be open and humble enough to be trained by the charity and communities to share lived experiences. Deirdre said she would contact Paul to develop this idea. • Martin Sykes, Non-Executive Director asked the Board whether there had been any progress with discussions held with the Locality Partnerships to increase the support for this type of community initiative. The Board agreed that there had been a recent shift and acknowledged that now was the time to learn from local experiences. • Sue Balcombe, Non-Executive Director referred to the success of the community improvements at Bourneville Estate which the charity had directed, and she asked what FAHLC needed from the Board to do the same for other communities. Mark said by inviting FAHLC into these conversations was already making an important, positive difference. Ingrid and the Board thanked Paul and Saz for their story, and they then left the meeting. **RESOLVED that the Patient Story be received and noted for information.**	
04/03/25	**Minutes of the Last Meeting – 14 January 2025**	
	The Board reviewed the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust Board held in public on 14 January 2025. **RESOLVED that the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust Board held in public on 14 January 2025 be approved as a true and accurate record.**	
05/03/25	**Matters Arising and Action Log**	
	Ingrid Barker, Chair noted that there were no outstanding actions from the previous meeting. *04/01/25 Minutes of the Last Meeting* *Trust Secretariat to update the previous set of Public Board minutes from November 2024 to reflect the comments made.* The minutes from November's Public Board meeting had been updated to reflect the comments made**. Action closed** *04/01/25 Minutes of the Last Meeting T*	

Minute Ref.	Item	Actions
	Trust Secretariat to add a sustainability update to a future meeting agenda of the Board. An item on sustainability would be added to the forward planner to be discussed by the Board at its meeting in April. **Action closed** *08/01/25 Joint Chair's Report Director of Corporate Governance/ Trust Secretariat to include visits to South Bristol Community Hospital and the Unity Sexual Health Services on the NED Site Visit schedule.* These would be offered to NEDs as options for visits. **Action closed** **RESOLVED that the updates to the action log be approved.**	
06/03/24	**Questions from the Public**	
	One question had been received from a member of the public which Ingrid asked Neil Darvill, Joint Digital Officer to respond to. *"What preparations is the Trust making to address Microsoft ending Windows 10 support in October 2025, particularly for equipment that may not be compatible with Windows 11?"* Neil explained that support for Windows 10 would elapse in October 2025, and it would then become a significant cyber vulnerability if it continued to be used by the Trust. Neil confirmed that within the existing plan of digital work, all software would be replaced with Windows 11 by October, and all incompatible devices will be upgraded to comply with the new software. Neil assured the Board that there was a good programme of work in place and flagged one minor risk which was that some of the machines were compatible with Windows 11 but might suffer performance issues with the new software, and he assured the Board that support would be provided to any users experiencing issues. Subsequently, the formal response was provided as the following: *"In response to your question regarding the upcoming end of support for Windows 10 and the Trust's transition to Windows 11. As previously stated, Microsoft's support for Windows 10 will cease in October 2025, continuing to use the operating system beyond this date would present a significant cybersecurity risk to the Trust.* *We can confirm that, as part of the existing digital transformation plan, all software on end user devices will be upgraded to Windows 11 by October 2025. Additionally, any devices incompatible with Windows 11 will be upgraded or removed from service to ensure compliance with the new system.* *There is a risk concerning some devices that, whilst technically compatible with Windows 11, may experience performance issues once upgraded. To address this, support will be provided to staff encountering difficulties. Capital funding may be sought to replace any equipment where performance is deemed unacceptable."*	
07/03/25	**Joint Chair's Report**	
	Ingrid Barker, Joint Chair introduced the Chair's activity report which was presented for information. Key points to note were as follows:	

Minute Ref.	Item	Actions
	• A reciprocal tour with Non-Executive Directors from both Trusts to Weston General Hospital had taken place. • The Health Equity Delivery Group held an inspiring meeting to discuss some of the equitable challenges patients were faced with. • Paul Miller, Chair, Avon and Wiltshire Mental Health Partnership NHS Trust had visited UHBW. • A meeting with the Patient Carer Partnership Group at North Bristol NHS Trust (NBT) had taken place to hear what 'good' would look like from the patient's point of view. • An update on the group development was included within the report and it was noted that the next Board meeting in Public in April would be held jointly with North Bristol NHS Trust (NBT). Ingrid also reported that meetings with the Council of Governors had taken place to discuss the draft benefit realisation case and the new operational model. • An introductory meeting with Stephen Peacock, Chief Executive of the West of England Combined Authority, had been held. • A Chairs Reference Group had been established within the Bristol, North Somerset and South Gloucestershire (BNSSG) system. **RESOLVED that the Joint Chair's report be received and noted for information**.	
08/03/25	**Joint Chief Executive's Report**	
	Maria Kane, Joint Chief Executive introduced her report to the Board and highlighted the following points: • The first Strategic Partnership Event had taken place in February to bring together key stakeholders from across the city, system and region. The focus was to engage partners in interactive sessions, sharing the development of the group and the joint clinical strategy, and to gain their input and insights to support the design for the hospitals and community resources of the future. • Maria noted the recent leadership changes going on at national level with NHS England and it was reported that locally, Sarah Truelove, Chief Finance Officer and Deputy Chief Executive of the BNSSG Integrated Care Board (ICB) would take over as the Chief Executive of Gloucestershire ICB later this year. • The Trust assisted His Majesty's Assistant Coroner at the Second Inquest into the death of Ben Condon during February 2025. Evidence was heard from clinicians involved in Ben's care in 2015 and two experts instructed by the assistant coroner. The coroner recorded a narrative conclusion, and the full details were outlined within the full Joint Chief Executive report. Maria noted how the Trust remained deeply sorry that Ben died whilst in its care and noted the significant learning and reflection in the ten years since then. Stuart Walker, Hospital Managing Director added that the clinical governance processes in place had been through an independent assurance review, and he assured the Board that he had full confidence in the clinical teams running the Paediatric Intensive Care Unit (PICU). • Maria had hosted a visit to the North Bristol Community Diagnostic Centre from Darren Jones, MP for North West Bristol. Maria noted other visits from Kerry McCarthy, MP for Bristol East to discuss the hospital group model general service developments, and a visit from	

Minute Ref.	Item	Actions
	the Prime Minister, Sir Keir Starmer which had coincided with the announcement on elective recovery commitments by the government. • One-to-one meetings continued with consultants of the Trust to discuss the group model and clinical service developments. Maria commended the clinicians for their hard work on driving forward the joint clinical strategy. **RESOLVED that the Joint Chief Executive's report be received and noted for information.**	
09/03/25	**Board Assurance Framework**	
	Eric Sanders, Director of Corporate Governance, introduced to the Board the Board Assurance Framework (BAF) and highlighted the following key points: • There had been no overall change to the strategic risk profile for the Trust. • There were two proposed changes to the risk descriptions for Risk 4, Estate Infrastructure, and Risk 8, Change Management because of a recent quarterly review by Executives. • The movement in the corporate risks had been outlined within the report. • Looking forward, a BAF was being created to suit both Trusts in line with the group model and a Task and Finish Group had been established with members from both Trust Boards to explore the format in more detail. A first draft of this framework would be presented to the first joint Board meeting in Common in April. During the ensuing discussion, the following points were made: • In response to a query from Rosie Benneyworth, Non-Executive Director, relating to the decreasing score of Risk 528 on preventable pressure damage, Deirdre Fowler, Chief Nurse and Midwife said the pressure ulcer performance had remained on or below the threshold, therefore presenting a downward trend. Deirdre assured Rosie that the peak shown within the Integrated Performance Report was because of winter pressures and was an exception on this occasion. It was suggested that more detail on pressure ulcers would be provided to the Quality and Outcomes Committee. • Rosie also requested that thought to be given by the Board on how the BAF was presented for next year, considering the tight financial situation and the potential impact on quality and safety of care. Eric responded that it would be front and centre of the Task and Finish Group's thinking to factor in that connection with the quality and safety agenda. The BAF would also be reviewed regularly by the Board going forward to ensure financial constraints and risks were being captured effectively. • Maria Kane, Joint Chief Executive asked whether the Board could quickly identify an overall sense of what the main risks were from the report and asked if there was a new way the Board could see the risks. Eric responded that at the last Well Led Review, a process was conducted with the Board to determine the top risks for the organisation, and he noted that this could be refreshed due to the changing picture to ensure it was still the risk profile of the Trust and	

Minute Ref.	Item	Actions
	to engineer the process so that it highlighted opportunities in line with Patient First. • Roy Shubhabrata, Non-Executive Director referenced Risk 7, relating to Digital and Cybersecurity, and asked whether the risk that patients might not have migrated from Millenium to Medway was still relevant. Neil Darvill, Joint Chief Digital Officer confirmed it was still a risk and agreed to re-evaluate the scoring of the risk. **Action – Joint Chief Digital Officer to review the score for the risk that patients may not have migrated from Millennium to Medway.** **RESOLVED that the Board Assurance Framework be received for information.**	Joint Chief Digital Information Officer
10/11/24	**Quality and Outcomes Committee – Chair's Report**	
	Sue Balcombe, Chair of the Quality and Outcomes Committee, presented her Chair's report from January's and February's meetings of the Committee. Key points from these meetings included: • The Committee received feedback after the clinical risk summit and the Committee remained concerned around the number of No Criteria to Reside patients and the impact this was having on clinical pressures and patients. • The Committee heard that Martha's Rule has been successfully launched in Bristol Children's Hospital. • The Committee was briefed on the delay in implementing the Careflow Vitals Sepsis Module which would not be available until 2026. The actions to manage and mitigate the clinical risk were discussed. • The Committee received the Safeguarding Service Review following the implementation of the safeguarding service joint leadership pilot with NBT. The review had identified a number of issues, and a detailed plan would come to the Committee on a quarterly basis to track progress. • The Committee reviewed progress against the Trust's Health Equity Delivery Plan where it was agreed to extend the programme until March 2026 in order to allow time to work more closely with NBT, to deliver the objectives and to commence the co-design of future priorities with patients and communities. During the ensuing discussion, the following points were made: • In response to a query from Linda Kennedy, Non-Executive Director, on the support provided at system level to tackle No Criteria to Reside, Sue explained that it was a national issue and being discussed as a priority by the wider system. Jane Farrell, Chief Operating Officer added that a local transformation programme was being refreshed to review the patient pathway, and it had been recognised nationally that this area was under-performing. Jane added that the Trust remained under quarterly review with the Department of Health and Deirdre noted that both Trusts had	

Minute Ref.	Item	Actions
	escalated concerns to the Integrated Care Board (ICB) following a review, the outcome of which was awaited. • Stuart Walker, Hospital Managing Director, noted the launch of Martha's Rule in Children's and reported that the initial outcome of analysis of the early learning was showing very positive results. He added that Martha's Rule was also being rolled out for adults. **RESOLVED that the Quality and Outcomes Committee Chair's Report be noted for information.**	
11/03/25	**Integrated Quality and Performance Report**	
	The Board received an update on the Trust's performance on quality, access and workforce standards, incorporating an update against the Patient First Strategic Priorities. The following points were highlighted: Deirdre Fowler, Chief Nurse and Midwife provided an overview on quality: • During January 2025 there were 195 falls (5.549 per 1000 bed days) which was above the Trust target of 4.8 per 1000 bed days. A high proportion of these occurred in outpatient settings and improvement work was being explored to address this rise. A detailed update would be presented to the Quality and Outcomes Committee. Rebecca Maxwell, Interim Medical Officer provided an update on quality: • To support improvements to sepsis screening, new sepsis medical and nursing posts were being recruited. Emma Wood, Chief People Officer provided a workforce update: • Appraisal compliance had reduced to 80.4% in January compared to 81.0% in December. Work was ongoing to explore the reasons for this in line with the Staff Survey results and going forward the process would be amalgamated with NBT's appraisal procedures. • As part of the Pro Equity Corporate Project all Divisions now had a Pro-Equity plan in place and work was ongoing to launch into the public domain from April to share what the Trust was doing against the equality agenda. It was expected for NBT to launch their pro-equity statement in the summer which would open the gate to working collaboratively to produce an anti-racist framework as a group. Jane Farrell, Chief Operating Officer provided an overview on timely care: • The hospitals had seen increased pressure during December and January, due to the winter pressures and the peak of influenza and norovirus. • During January, the average daily number of patients in hospital with No Criteria to Reside increased but an improvement had been seen since then and was currently being reported as 105 beds being occupied. • Performance against the 12-hour standard had deteriorated to 5.9. • Performance against the 4-hour standard was being reported as 73.3% against a system and NHSE ambition of 78% and was an improved picture compared to the previous year. The Trust was participating in daily review meetings to monitor the performance due to the tiering system. Overall, the performance going into March was	

Minute Ref.	Item	Actions
	improving but it was unclear whether the Trust would meet the target of 78%. • Against elective national priorities, the Trust continued to deliver Referral-to-Treatment (RTT) for 52 and 65 Week Waits. • It was noted that all cancer targets were being met and sustained. During the ensuing discussion, the following points were made: • Rosie Benneyworth, Non-Executive Director asked for an indication of the number of sepsis incidents occurring due to delayed diagnosis. Rebecca said this data could be collated and assured the Board that performance issues were not because of delayed diagnosis. • Marc Griffiths, Non-Executive Director asked about the downward trend relating to patient complaints and if there was anything the Board could do to improve this picture. Deirdre explained that process issues were being looked at to align with NBT and noted that cultural issues within the team were also being addressed. • Roy Shubhabrata, Non-Executive Director asked for the process in place to ensure that Venous Thromboembolism (VTE) risk assessments were being carried out and Rebecca responded that the rollout of electronic prescribing would address this, as currently two systems were being used which was having a detrimental impact on the performance. Rebecca assured the Board that a manual audit had demonstrated that the Trust was compliant and that nationally it was not an outlier. • Marc Griffiths, Non-Executive Director said the pro-equity work was excellent and asked what support might be available for people who were reading it for the first time. Emma said this would need to be explored with the Diversity and Inclusion Manager to see where lessons could be learned from The University of the West of England. **RESOLVED that the Integrated Quality and Performance Report be received and noted for information.**	
12/03/25	**Learning from Deaths Quarter 3 report**	
	Rebecca Maxwell, Interim Chief Medical Officer introduced the Learning from Deaths Quarter 3 report to the Board. The following key points were noted: • There were no major concerns to flag to the Board in Q3 report. • The volume of Medical Examiner (ME) referrals into UHBW appeared to be rising from the previous two reports, however the Q3 report showed a decrease. This would continue to be monitored. • The previous reports highlighted the number of Structured Judgement Reviews (SJRs) triggered for potential care concerns (corrected for number of deaths) was considerably higher in Weston in-patients, as compared to the Bristol Royal Infirmary in-patients. This discrepancy was no longer seen within the data for Q3.	

Minute Ref.	Item	Actions
	• It was noted that since the ME went statutory, the Trust was seeing more concerns from the discharge process and pathways outside of the hospital within the community which was a shift, and it was complex to work with these referrals. It was noted that work was ongoing regarding how best to target queries and concerns to the correct organisation best placed to address and provide assurance. • A ReSPECT Learning Disability and Autism audit had been completed at UHBW for 10 patients. The audit findings had been disseminated into Divisions via the Mortality Surveillance Group and the End-of-Life Steering Group. During the ensuing discussion, the following points were made: • Rosie Benneyworth, asked for more details about the ReSPECT process and whether the Trust ensured people were given sufficient time to have these conversations at the end of their life and whether the Board should have a closer look at how it was managed. Rebecca assured the Board that Learning Disability and Autism was a mandatory SJR category which was being monitored and reported as being stable with no care concerns. It was noted that the Trust no longer had a ReSPECT lead, as this was something that should be everyone's responsibility. Work was now ongoing to develop that responsibility and to track compliance against the Oliver McGowan essential training module. • Susan Hamilton, Associate Non-Executive Director, asked about the processes associated with the duplication of Patient Safety Incident Response Framework (PSIRF) reviews and Learning from Deaths reviews, and how it may evolve with learning. Rebecca said the Task and Finish Group would be meeting for the first time to see whether the two should be linked together and how reports should be shared with the coroner. **RESOLVED that the Learning from Deaths Quarter 3 report be received and noted for information.**	
13/03/25	**Surveys: Under 16 Cancer Experience Survey and National Urgent & Emergency Care Survey reports**	
	Chris Swonnell, Associate Director of Quality and Compliance, Beth Shirt, Deputy Head of Nursing Quality, and Tina Johnson, Deputy Divisional Director of Nursing presented the surveys to the Board. Chris Swonnell and Bethany Shirt highlighted the following key points to the Board for the results of the Under 16 Cancer Experience Survey from 2023: • The 2023 survey involved 13 Principal Treatment Centres (PTCs), composed of 16 NHS Trusts. UHBW had 62 respondents to the survey out of a total of 216 eligible patients which equated to a 29% response rate, which was above the national average. UHBW scored above the national average on 12 questions. • Picker recommended that PTCs should take caution when benchmarking their results against those of other PTCs due to several reasons including small response numbers and results not being adjusted for patient profile differences across PTCs.	

Minute Ref.	Item	Actions
	• Overall, 77% of children, and 80% of adults felt they had received good care with 100% of children saying their outreach nurses were friendly at home or school, and nobody feeling that they could not access help when they needed it. • The shortfalls demonstrated that 30% of respondents said there wasn't enough to do in terms of distraction in hospital, only 56% of the respondents were offered a referral to psychology, and 27% patients were offered contact with other families which was a reduction since the pandemic. • The ambition going forward was to improve the response rates by sending the survey link directly to families and improving the response rates for more vulnerable groups of patients. • It was noted that a project was ongoing to improve the communication between UHBW and the non-operational delivery network partners. • The end of treatment offer would be reviewed to make improvements. • Work was ongoing with the development team at Picker to explore the quality of the questions within the survey and to see how they could be improved so that the data at the end was better informed. During the ensuing discussion, the following points were made: • Linda Kennedy, Non-Executive Director noted the variety of the feedback received within the report and asked how the team would prioritise the areas for improvement, and furthermore how the Board could support those areas. Beth said the conversations with families would help identify the areas to tackle first by seeing what was most important to them. Deirdre Fowler, Chef Nurse and Midwife, noted the difficulties in identifying which organisation was being discussed through the survey feedback which made it challenging to focus on improvements. Deirdre added that it would be important to move together, as treatment centres, and to keep sharing learning. • In response to a query from Sue Balcombe, Non-Executive Director, Beth confirmed that the actions within the report were for UHBW and noted that the improvements would be made across all the providers within the network so that it moved forward together. • Susan Hamilton, Associate Non-Executive Director, recognised the work ongoing with Picker to refine the survey questions to create more precise data and she asked whether more statistics and feedback could be triangulated from other surveys to add to the intelligence. The Board decided that it was challenging to evaluate the data effectively from the survey due to the outdated feedback from 2023 and acknowledged that the triangulation of data from other surveys was vital in being able to progress improvements. Chris Swonnell and Tina Johnson highlighted the following key points to the Board for the results of the National Urgent and Emergency Care Survey from 2024: • UHBW ranked 13th out of 120 Trusts nationally and the Trust was in the top 10% for overall experience. The BRI Emergency department	

Minute Ref.	Item	Actions
	(ED) ranked 10th out of 175 ED sites nationally, again in the top 10%, and WGH ED ranked 35th place nationally which was in the top 20%. • UHBW performed above the national average in all sections of the survey. The highest performing sections included 'Respect and dignity', 'Tests', 'Support and care after leaving A&E' and 'Overall experience'. The lowest performing sections were 'Waiting' and 'Information to support recovery' which aligned to the national results. • It was noted this was the first time that WGH ED was included in the sample for the survey following agreement with the Care Quality Commission (CQC) that the hospital met the eligibility criteria for inclusion. It was therefore not possible to compare the results for UHBW with previous years because of the new data set. • Tina reported that much work had been completed to improve the dementia areas of the ED with two unique cubicles for patients, the teenage ED units had been upgraded to make the transition from children's services to adult's easier, and there was a new sensory suite in the fast-flow area that was located away from the main waiting area and therefore quieter. Other highlights worth noting were the installation of new artwork on ceiling tiles within the resuscitation area to inform patients where they were, as well as new signage being used at WGH in multiple languages making the entrance to the hospital more accessible. The Board commended the results and congratulated the teams for the innovative improvements which humanised the overall patient experience. **RESOLVED that the surveys be received noted, for information.**	
14/03/25	**Finance, Digital & Estates Committee Chair's Report**	
	Martin Sykes, Non-Executive Director and Chair of the Finance, Digital & Estates Committee, presented his report from the last meeting of the Committee held in January and February 2025 and highlighted the following: • The Committee discussed how whole-time equivalents (WTEs) had risen significantly in excess of the budgeted establishment and had asked for more detail to demonstrate whether these were being driven by escalation capacity. • The Committee reviewed the operations plans for the next financial year which presented a challenging situation, and the Committee would continue to monitor the position in order to deliver the financial targets. • In terms of digital, the Committee heard that work was progressing on the medical records transformation project. • An update was going to the Committee every month on the progress of the electronic prescribing (CMM) project which remained on track, and it was hoped that the improvements would positively impact on patient discharge.	

Minute Ref.	*Item*	*Actions*
	• The Committee discussed the capital programme for the next financial year and heard about the green programme. **RESOLVED that the Finance, Digital and Estates Committee Chair's Report be received and noted for information.**	
15/03/25	**Monthly Finance Report**	
	Neil Kemsley, Chief Financial Officer, informed the Board of the Trust's overall financial performance for from 1st April 2024 to 31st January 2025 (month 10). Key points included: • Neil was able to bring the Board up to date on the current position for month 11 and reported that improvements had been made from a £6.1m deficit to a £2.5m deficit for the year-to-date position. It was expected that UHBW would break-even at year-end. • The Cost Improvement Programme (CIP) was projected to end the year having delivered £32m against a £41m target. • In terms of the elective recovery fund, this month there was a £300k improvement which was expected to be £2.9m under target for the year to date. • The Divisions continued to hit or out-perform the trajectories set in September. Specialised Services, Estates and Facilities, Weston, and Medical were all under-spent which was recognised as outstanding financial performance. • Over the next month, the capital needed to be landed to fully utilise the capital limit of £15m. • The actual establishment was currently over-funded due to the high level of bank staff usage which needed to be brought back into budget. During the ensuing discussion, the following points were made: • Anne Tutt, Non-Executive Director noted the positive financial position and the work of the Divisions to out-perform their set trajectories. Anne went on to ask whether there were any incorporated significant one-off benefits within the finance report, and Neil said in terms of setting the operation plan for the financial year, within the savings plan there was a non-recurring item of £7m which had always been part of the plan. The broader plan included £14m of technical savings that were also classed as one-off. It was noted that these were not part of the savings delivery but formed part of the financial plan and could therefore not be relied on for 2025/26. • Furthermore, Anne asked about the capital spend and noted that it would be important for this spend to not have any impact on the accounting treatments. Neil agreed and explained that part of the way to land the capital spend within this financial year was vesting equipment that has been accounted for as an only-asset and Neil noted that the external auditors were aware of this arrangement. **RESOLVED that the Monthly Finance Report be received and noted for information**.	
16/03/25	**People Committee Chair's Report**	

Minute Ref.	*Item*	*Actions*
	Linda Kennedy, Chair of the People Committee, introduced the report from the meeting of the People Committee held during January 2025 and highlighted the following: • The Committee heard about the work associated with Optimising the Medical Workforce which included details of a review of the Resident Doctor rotas, the roll out of e-job planning and e-rostering solutions. • The Committee discussed the development of a funded strategic long term medical workforce plan. • The Committee received an update on the Joint Resourcing Programme which was the first corporate function to engage in service collaboration as part of the group model with NBT. • The Committee discussed the national violence prevention and reduction standard and the areas of focus going forward which included the embedding of the trust wide policy, embedding the pro-equity campaign, monitoring the results from quarterly scorecards, and the establishment of a new Security Assurance Group. • The Committee heard the preliminary 2024 Staff Survey results and it was noted that the response rate was up and above the Picker average. • The Committee Chairs had been invited to observe the meetings at the Royal Free London NHS Foundation Trust and Linda had attended their People Committee. Deirdre Fowler, Chief Nurse and Midwife, informed the Board that there had been a recent increase in patient on staff violence and aggression which appeared to be linked to patients lacking in capacity, which triangulated with No Criteria to Reside patient statistics. She noted the importance of reducing these numbers. **RESOLVED that the People Committee Chair's Report be received and noted for information.**	
17/03/25	**Annual Safe Working Hours Guardians' Reports**	
	Rebecca Maxwell, Interim Chief Medical Officer introduced the Annual Safe Working Hours Guardians' Reports to the Board for both Bristol and Weston sites up until July 2024, and noted the following key points: • The Guardian of Safe Working reports highlighted an increase in establishment and proportional fall in locum hours. Rebecca noted that the ongoing rota review would help to unpick this data and said that some of the reasons behind it was related to different training regimes and having less full-time equivalent doctors. • Divisions now received a monthly report which was supporting the progression of key issues. • In terms of the Weston report, exception reporting was at a level that did not raise any concerns and there was a reduction in exception reporting over the 12-month period which was testament to the additional workloads staff were achieving.	

Minute Ref.	Item	Actions
	• It was noted that both sites continued to hold Junior Doctor Forums. • Guardian fines were levied at Bristol and funding from the Guardian fines account, was provided for breakfast clubs in Oncology and Trauma and Orthopaedics plus pizza for Foundation trainee induction to support staff wellbeing. Rosie Benneyworth, Non-Executive Director asked about the study budget for locally employed doctors and whether the Trust understood the impact on patient safety if this was not being used to support the development of the staff. Rebecca explained this was complex as the headcount had increased by 300 locally employed doctors and the study budget had not changed in line with this. It had been decided to use the money to fund an International and Guardian Lead. Furthermore, divisions were now asked to specify their training budget of £500 per doctor within their financial plans. Emma Wood, Chief People Officer added that other initiatives, such as rotations and career pathways, were ongoing to develop this staff group and assured the Board that the data demonstrated good retention rates within this area. **RESOLVED that the Annual Safe Working Hours Guardians' Reports be received and noted for information.**	
18/03/25	**Audit Committee Chair's Report**	
	Anne Tutt, Non-Executive Director and Chair of the Audit Committee introduced the report from the meeting of the Audit Committee in January 2025 meeting and highlighted the following key points: • The Committee reviewed the counter fraud progress reports for the Trust. • The Committee considered various internal audit review reports and members of the executive team attended to discuss the issues raised for those with limited assurance, and whether reports to committees on these areas would be useful. • The Draft Strategic Audit and Assurance Plan (2025/2026-2027/2028) was considered by the Committee. • The Committee signed off a letter to its auditors to discuss the processes for fraud and bribery. • Anne was pleased to see the overdue audit actions being reduced and thanked everyone for making the effort to work on those. Ingrid Barker, Joint Chair asked about the learning audit and whether it would be discussed by the Quality and Outcomes Committee. Deirdre Fowler, Chief Nurse and Midwife said that action had been taken to address the issues and that updates would go to Care Quality Group and escalated to the Committee via that route. **RESOLVED that the Audit Committee Chair's Report be received and noted for information.**	
19/03/25	**Well Led Action Plan**	
	Eric Sanders, Director of Corporate Governance, presented an update on the Well Led Review action plan since March 2024 for the Board's	

Minute Ref.	*Item*	*Actions*
	consideration and said that Board agreement was sought after in order to close the action plan. Eric noted that all actions had now either been completed, had moved into business-as usual processes, or were incorporated into the group development work. In response to a query from Marc Griffiths, Non-Executive Director, relating to the actions being reviewed and monitored, Eric confirmed that the Board would be sighted, and the actions were being reported under business as usual. Roy Shubhabrata, Non-Executive Director, asked what would happen with Well Led Reviews as a Board in common and Eric explained that there would be a point in time where an external viewpoint would be brought in. He also suggested that the Board needed to determine what the value would be, as the current reviews tended to focus on individual organisations. **RESOLVED that the Well Led Action Plan be received and APPROVED.**	
20/03/25	**Register of Seals**	
	Eric Sanders, Director of Corporate Governance, presented the Register of Seals report for the information of the Board and said there had been one sealing since the previous report. **RESOLVED that the Register of Seals be received and noted for information.**	
21/03/25	**Governors' Log of Communications**	
	Eric Sanders, Director of Corporate Governance, presented the Governors' Log of Communications for the information of the Board and highlighted that the questions outstanding were with the communications team for approval and would be followed up in order to be closed. **RESOLVED that the Governor's Log of Communications be received and noted for information**.	
22/03/25	**Any Other Urgent Business**	
	Ingrid Barker, Chair, noted that the nomination period had closed for this year's Governor elections at UHBW, and reported that a total of 25 candidates had applied for the 15 seats available. Ingrid reported that voting would go live on 24 March and all our Foundation Trust Members, and UHBW colleagues, within the relevant constituencies would have a chance to vote.	
23/03/25	**Date of Next Meeting:** Tuesday, 08 April 2025	

North Bristol NHS Trust

DRAFT Minutes of the Public Trust Board meeting held on Thursday 27 March 2025 at 10.00am in Seminar Room 4, Learning and Research Building, Southmead Hospital and virtually via Microsoft Teams

Present (Board members):			
Ingrid Barker	Joint Trust Chair and Non-Executive Director (NED)	Maria Kane	Joint Trust Chief Executive
		Glyn Howells	Hospital Managing Director
Sarah Purdy	Vice Chair and Non-Executive Director	Neil Darvill	Joint Chief Digital Information Officer
		Steve Hams	Chief Nursing Officer
Kelvin Blake	Non-Executive Director	Sarah Margetts	Deputy Chief People Officer
Richard Gaunt	Non-Executive Director	Elizabeth Poskitt	Chief Finance Officer
Jane Khawaja	Non-Executive Director	Nick Smith	Chief Operating Officer
Kelly Macfarlane	Non-Executive Director	Tim Whittlestone	Chief Medical Officer
Shawn Smith	Non-Executive Director		
Also in attendance:			
Elliot Nichols	Director of Communications	Richard Gwinnell	Deputy Trust Secretary *(minutes)*
Xavier Bell	Director of Corporate Governance and Trust Secretary	Kelly Jones	Corporate Governance Officer *(shadowing)*
Presenters:			
Kerry Than	Head of Patient Experience *(present for minute items TB/25/03/03 to 03/11)*	Kathryn Tudor-Thomas	Volunteer Service Manager *(minute items TB/25/03/03 to 03/11)*
		Bwalya Treasure	Volunteer Service Manager – Operations *(minute items TB/25/03/03 to 03/11)*
Paul Cresswell	Director of Quality Governance *(minute items TB/25/03/03 to 03/11)*		
Helen Lewis-White	Deputy Director of Research and Development *(minute item 25/03/13)*	Caroline Hartley	Associate Director of Culture and Staff Experience (*minute item TB/25/03/12)*
Guests:			
Yogi Ragoo – CQC Operational Manager 2 colleagues (Consultants) 1 member of the public			

TB/25/03/01	**Welcomes and apologies for absence**	**ACTION**
	Ingrid Barker, Joint Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), welcomed everyone to the meeting, including members of the public and staff who were observing. Ingrid reminded everyone that the meeting would be recorded, and the recording placed on the Trust's website after the meeting. Apologies were received from Peter Mitchell, Chief Officer, for whom Sarah Margetts was deputising. Ingrid also reminded the Board that this was the last meeting of the Board of NBT on its own; the next meeting (8 April 2025) and future meetings would be held jointly with the UHBW Board. The agenda for this meeting did not therefore include the Integrated Performance Report (which was traditionally a standing item) as that would be submitted on 8 April.	

TB/25/03/02	**Declarations of Interest**	
	No interests were declared in items on the agenda, nor any changes made to the Trust Board register of interests currently published on the NBT website and annexed to the Board papers. Kelvin Blake (NED) reminded the Board during agenda item 9 (see minute 25/03/09 below) that he was a Trustee on the Bristol City FC Robins Foundation.	
TB/25/03/03	**Volunteer Story**	
	Paul Cresswell, Director of Quality Governance, introduced Kerry Than, Interim Head of Patient Experience, Kathryn Tudor-Thomas, Volunteer Service Manager and Bwalya Treasure, Volunteer Service Manager - Operations. The Board watched a video introduced by Emily Ayling, Head of Patient Experience, in which Stewart, a Volunteer Befriender at NBT, told his story of being a volunteer, what his role involved, why he started it, what the main challenges were and what was most rewarding about the role. Stewart had been a patient for five months at NBT and had received no visitors, apart from his wife, which had been very difficult for him at the time. When Stewart was well again, he decided to become a volunteer and visit wards (neurosurgery and neurology) to befriend patients, who may also lack visitors and need someone to talk to. Stewart had been a volunteer for two years, enjoyed the role, was well supported by the Volunteer Services team and colleagues, and made a real difference to patients, who may also be lonely, isolated and "in a dark place", as he had once been. The role could be challenging at times, when patients did not want to talk, or were experiencing severe illness, but was also very rewarding to him and important to those he visited. Volunteers were an extra pair of eyes on the ward and could highlight previously unknown issues to staff. They could also resolve "minor" issues at times, such as patient car parking. Paul, Kerry, Kathryn and Bwalya outlined the importance of the volunteer role and of having the right volunteer in the right place at the right time. They outlined the diverse range of backgrounds of the volunteers at NBT and the recruitment and suitability considerations for volunteers (which involved DBS checks, application forms, interviews, probation periods, shadowing and regular support and supervision sessions) and the wide range of roles played by volunteers at NBT (including Volunteer Befrienders, Move Makers, Ward Support Volunteers, Patient and Carer Partners, and Purple Butterfly Volunteers, who supported patients who were approaching the end of their lives). Board members congratulated the team for all their inspiring work and referred to the vital role played by volunteers, including the NHS Cadets, who were young people, allied to St John Ambulance, learning about future roles they might play and career opportunities in the NHS. It was recognised that the volunteering service was a key part of NBT's commitment to the community. The huge impact of volunteers, their vital and selfless work, their key role and their successes were emphasised and celebrated. **RESOLVED: the Board welcomed the volunteer story and the work being done at NBT to better engage with patients through the work of volunteers.**	
TB/25/03/04	**Questions from the Public**	
	No public questions were received.	

TB/25/03/05	**Minutes of the previous Public Trust Board Meeting**	
	RESOLVED: the minutes of the Public Trust Board meeting held on 30 January 2025 were approved as a correct record of proceedings.	
TB/25/03/06	**Action Log**	
	RESOLVED: the Action Log updates were noted.	
TB/25/03/07	**Matters arising from the previous meeting**	
	No matters were raised.	
TB/25/03/08	**Joint Chair's Report**	
	Ingrid Barker presented her report, highlighting: • a recent visit she had undertaken with Tim Whittlestone, Chief Medical Officer, to a children's hospital transport service, and the vital service they provided, saving children's lives • her recent joint visits with the Chair of Avon and Wiltshire Mental Health Partnership (AWP) to 136 suite, the Mum and Baby Unit and the Drug and Alcohol Service, all of which played a vital role in physical and mental health; further joint visits were planned • her recent meeting with the Patient and Carer Partnership Group and the heartwarming enthusiasm they displayed; their work was also vital and further developments were planned to ensure they remained at the heart of NBT decision-making, when the Patient and Carer Experience Committee was disbanded as part of the move to a Hospital Group • Non-Executive Directors' (NEDs) recent visit to Weston Hospital, where she and other NEDs had witnessed inspiring work, connecting with local communities and working in partnership • a number of recent VIP visits to NBT, including a visit by HRH The Princess Royal, to the wards at NBT where she had been treated after her accident at Highgrove in 2024, and the visit of the Prime Minister Sir Kier Starmer to the Community Diagnostic Centre at Cribbs Causeway • a recent visit by the "Metro Mayor" of the West of England Combined Authority (WECA) to celebrate and recognise NBT's signing of the Good Employment Charter • that 28,000 employees (1 in 10 of the population) in the WECA region were now covered by the Charter; others were encouraged to join up, including employers in the aerospace industry • her continuing meetings with councillors, MPs, partner organisations, the Integrated Care Board (ICB) Chair and others and • the extensive work and visits undertaken by the Vice-Chair, Sarah Purdy. **RESOLVED: the Board noted the activities and key developments reported by the Joint Chair.**	
TB/25/03/09	**Joint Chief Executive's Report**	
	Maria Kane presented her report, commenting specifically on: • the earlier issue of operational planning guidance this year • that NBT and UHBW had submitted fully compliant operational plans to NHS England, earlier today (which was a significant achievement compared to many other NHS Trusts), enabling a breakeven position at NBT and UHBW (and the Bristol, North Somerset and South Gloucestershire (BNSSG) ICB) • her thanks to the Chief Finance Officer and the Chief Operating Officer and their teams for all their hard work on the NBT operational plan	

- the current period of instability and anxiety in the wider NHS, with the recent announcement by the Prime Minister of the abolition of NHS England and the requirement for a 50% headcount reduction at all ICBs
- leadership changes at the BNSSG ICB and early plans emerging around the potential future of NHS corporate services
- NBT and UHBW's positive position, given their move to a Group model and commitment to joined-up services and productivity gains
- the very positive staff survey results at NBT, particularly the response rate, and the high confidence among staff that they would recommend NBT to their relatives; she thanked everyone involved in the People Team and wider NBT for their efforts
- performance; with continuing challenges in urgent and emergency care, particularly caused by the ongoing high rate of patients with no criteria to reside (NCTR) (currently 23%), meaning approximately 200 people per day were in hospital beds when they need not be
- a number of Executive-to-Executive meetings held with other system partner organisations including AWP and Sirona to discuss issues of common interest
- the significant public engagement carried out on the NHS 10-year plan
- the very successful Cancer Alliance conference she had attended recently
- NHS Impact meetings she had been involved in, with discussions focussed particularly on productivity, continuous improvement and good practice, training being planned on leadership and psychological safety for clinical and operational colleagues nationwide, and the "productive ward" initiative
- community engagement activities she was involved in, including meetings with councils, Bristol Sports, the Robins Foundation and others on reducing youth violence, as well as visits to local schools, promoting apprenticeships and the employment of more people from the most socio-economically challenged local areas and communities
- the partnership event held in February, about what a hospital of the future should (and should not) look like, and what hospitals could do to make life better for local people and
- several regional and national events and meetings she had attended, in which she represented NBT, helping to shape the future of the NHS.

Kelvin Blake, NED, reminded the Board that he was a Robins Foundation Trustee.

Board members commented on and discussed in brief (key points):

- the need for all organisations to work together to divert young people into positive activities
- the key role and power of hospitals in connecting with communities
- the importance of NBT continuing its focus on delivering outstanding patient care, especially given the extensive instability in the wider NHS
- the extensive range of work and initiatives NBT was involved in
- the extensive change taking place in and around NBT and UHBW, and NBT's (and UHBW's) strong positions, compared to many other Trusts, with a balanced budget and breakeven financial position at NBT, positive staff survey results and many other achievements
- their thanks to the Executive Team and other all other staff for their work
- the need for new and innovative solutions to be found by NBT working with BNSSG partners to the long-standing problem of no criteria to reside.

RESOLVED: the Board noted the Joint Chief Executive's report.

TB/25/03/10	**Volunteer Services Strategic Plan 2025 to 2028**	
	Steve Hams, Chief Nursing Officer, introduced this agenda item, commenting on the positive alignment of the Volunteer Services Strategic Plan with the Trust Strategy and the Patient and Carer Experience Strategy. Kathryn Tudor-Thomas and Bwalya Treasure then presented the report in detail, outlining the components of the previous (2021 to 2024) plan and the progress achieved, including the use of the TRAC recruitment system, links with the Bristol Sight Loss Council, SGS Filton College and universities, training for volunteers, the new volunteer roles created, including Patient Buddies and Purple Butterfly Volunteers, an annual volunteer survey and the work around equality, diversity and inclusion (EDI). They outlined the vision and the detailed objectives of the new plan, as contained in the report, which involved maximising inclusiveness and putting patients at the heart of everything we do. The plans included building even stronger links with UHBW, with monthly meetings and sharing of policies and best practice already taking place and being stepped up. The plans also included celebrating and promoting the work of volunteers during Patient Experience Week, due to take place in late April, and continuing to report on the work of the team, through mandatory data reporting to NHS England and through the NHS Futures Group; data was published nationally. The visibility of volunteers to patients (e.g. when they first visited the hospital and didn't know where to go for their appointment) was vital and was a key focus, as was support for volunteers, recruiting more volunteers and working with universities and colleges to attract future generations of volunteers. Board members commented on and discussed (key points): • the significant and inspiring progress made, and Board members' thanks to all the staff and volunteers involved • the range of non-clinical roles which could be carried out by Cadets and the need for continued engagement with them • the clear need for links between the Volunteer Service and the People Team, with potential for volunteers to become apprentices and employees • the ongoing conversations already held with volunteers about potential careers in the NHS, and the need to record and report on these • the opportunity to actively promote volunteering opportunities to doctors and other staff who were nearing retirement • that several volunteers were retired staff; promoting volunteering opportunities further with staff approaching retirement was very welcome • more work was being done all the time to recruit a diverse range of volunteers, and overcome barriers to people volunteering, with help from other colleagues, such as the Patient Experience team • the "humbling and amazing" work of volunteers, for other people and the extraordinary work of the Purple Butterfly volunteers, about all of whom NBT should be very proud • the excellent work of the team, with more than 400 volunteers already at NBT and the number increasing further • the need to publicise and promote this work further afield, and for volunteers to be recognised (perhaps through local and national awards). **RESOLVED: the Board welcomed and approved the Volunteer Services Strategic Plan 2025 to 2028.** *Paul Cresswell, Kerry Than, Kathryn Tudor-Thomas and Bwalya Treasure left the meeting.*	

TB/25/03/11	Patient First (PF) Update	
	Glyn Howells, Hospital Managing Director presented the report, which looked back at progress to date with Patient First, with a forward-looking report to be submitted to the Joint Board in the near future. Glyn highlighted: • the completion of two-thirds of the early adopters training and the significant number of people already trained, close to reaching the tipping point of 16% (whereby those already trained took the learning they gained to others and it began to permeate throughout the Trust as a whole) • steady progress with capability building • two of eight breakthrough objectives showed sustained improvement (innovate to improve and staff turnover) • three breakthrough objectives showed no material change (outstanding patient experience and commitment to our community (disparity ratio and employing 38% of staff from our most socio-economically challenged areas)) • one breakthrough objective showed a deteriorating position (ambulance handovers) • two breakthrough objectives showed signs of improvement, but with that improvement not yet sustained (cost improvement programme and timely cancer treatment) • that the Patient First approach helped with the breakthrough objectives, even where positive outcomes were not yet clearly evident • early support from two divisions for a business-partnering approach, involving Patient First team members going into clinical teams and working with clinicians to help identify and implement continuous improvement • significant successes in some areas (e.g. the % of calls answered within 5 minutes increasing from 16% in January 2023 to 99% in January 2025 in the outpatient contact centre) • medium-term work ongoing in pathology and imaging and planned in ASCR (meetings and governance, breast care services and patient experience) as well as elsewhere • the planned rollout of the business partnering approach and National Trust Board education programme and • the planned refresh of PF priorities by NBT and UHBW and more work on alignment of the Trusts'/Group's priorities. Board members commented on and discussed (key points): • the improving picture with Patient First and what was being achieved • the importance of being data-driven but not data-controlled • the need to keep things simple and ensure resources were available to improve services wherever that was possible • the need to keep energy high and focus on long term outcomes; to date the outcomes were positive, as reflected in improving services and the staff survey results • momentum was building; the result would be better outcomes for patients • bottom-up efficiency and productivity improvements were key to success, especially in the context of the financial pressures on the NHS • the level of staff buy-in to PF; this varied by clinical area and was much higher, where people had been trained in PF or had seen positive results • PF was resulting in more structured, action-oriented and business-like processes and hence better outcomes; there was a degree of cynicism remaining in areas where PF had not yet had an impact • reaching the training tipping point would help • more work was being done on some of the breakthrough objectives and whether the best measures had been determined, for example on patient experience (where the Friends and Family Test (FFT) may not be the best	

	indicator) and on the disparity ratio, as the ratio in itself should not be the key focus • the power of PF and the aspiration it represented; better understanding of the data was critical. Ingrid welcomed the progress being made generally and significant successes in some areas, emphasised the importance of working closely with UHBW going forward and thanked everyone involved for their hard work. *Caroline Hartley joined the meeting during the above discussion.* **RESOLVED: the Board noted progress with the Breakthrough Objectives and noted the current status of capability building and plans for developing this further with divisions.**	
TB/25/03/12	**Staff Survey 2024 Results**	
	Sarah Margetts, Deputy Chief People Officer presented the report, highlighting the key headlines of the staff survey, including: • NBT received 6,531 responses (62%), its highest ever response rate, and 13% higher than the national average • staff responses to 86% of NBT staff survey questions were the same or better than the national comparator average • NBT was rated (by staff) above the national comparator average across all nine People Promise themes • all People Promise scores/themes (except one: staff engagement) had shown improvement on the 2023 scores, with: "we are always learning" showing the greatest increase • "we are compassionate and inclusive" was the highest-scoring theme (at 7.44 out of 10 for NBT; above the national average of 7.21 and close to the best comparator, which scored 7.69) • improvements demonstrated in terms of WRES (workforce race equality standards) and WDES (workforce disability equality standards) indicating positive experiences of global majority staff in particular, as well as improvements in disabled staff feeling valued and engaged • some concerns around the rising incidence of unacceptable patient behaviour (which reflected national trends) and the impact of that behaviour on staff, with more work to be done on violence and aggression, sexual safety and disability-based bullying and harassment in some areas • the South-West region was rated second highest (after the South-East region) in the UK for People Promise scores, with BNSSG ranked third (after Somerset and Dorset) in the region for People Promise scores • NBT was ranked number 1 in the South-West for "people recommending the Trust as a place to work" and number 1 for "people recommending the standard of care provided at NBT to friends or relatives" • 80% of staff at NBT agreed that care of patients was the Trust's top priority (NBT was rated a close second to UHBW and ahead of all other Trusts regionally for this question) • the % (92.13%) of staff having an appraisal (7% higher than the national comparator average), and the quality of appraisals, which were rated significantly higher than in previous years • improvements had been seen in all areas of NBT, including in those where ratings were not as high as other areas of NBT (such as women's and children's services) • the ongoing focus on staff satisfaction among healthcare support workers and healthcare scientists in particular • that NBT's and UHBW's scores were very similar	

	• next steps: the results had been disseminated to divisions to enable a more local focus and action on the results, with Bank staff survey results expected soon and analysis taking place of free text comments, alongside links being made between the survey and "Living our Values". Board members commented on and discussed (key points): • the excellent results and achievements across the whole of the Trust • their thanks to everyone involved, in the People Team and across NBT as a whole, for their hard work • the challenges of dealing with violent or aggressive patients, including patients with dementia, who may not know they were causing anxiety to staff, and the need to deal with this and support staff appropriately • the need for a zero-tolerance approach to incidents of unwanted sexual attention or behaviour and staff-on-staff abuse • the importance of aligning resources and priorities with the staff survey results and NBT's success in this; for example, the % of staff having an appraisal had risen by 18.54% (to 92.13%) since 2020 • the importance of initiatives such as the HELM Programme (Healthcare Excellence in Leadership and Management) • the ageing population and increasing challenges and numbers of people with dementia, as well as patients frustrated with being in hospital when they might not need to be (with no criteria to reside) due to shortages of resources in social care • the need for careful consideration of security measures and de-escalation training for staff, equipping them to be safer and avoid harm • the wider context of NHS staff cuts and productivity gains; staff needed more support in times of anxiety and uncertainty • the importance of the hospital environment and having engaging activities for elderly patients and those with dementia, especially for patients who had been in hospital for a long time and needing to regain mobility and confidence • de-escalation training and body-worn cameras (in the Emergency Department) were in place, as were Dementia Friends and a Dementia Matron, but more work was always needed • a hospital was a very busy and stimulating environment for Autistic people and people with other neurodiversity challenges • the recent transfer of some staff health and safety responsibilities to the People Team from the Estates Team (e.g. violence and aggression) • the financial pressures on the NHS, which may limit capacity to provide meaningful activities (such as arts) for patients and make the job of improving patient experience more difficult • the need to be clear with patients (and their families); what was acceptable behaviour and what was not; and to take sanctions where necessary. Ingrid concluded the discussion, welcoming the staff survey results and all the hard work they evidenced, emphasising the need to celebrate the many successes, welcoming the confluence with the UHBW results and welcoming the further work planned and divisional ownership. **RESOLVED: the Board noted and welcomed the staff survey results.**	
	Caroline Hartley left the meeting. *The Board adjourned at this point for a brief comfort break.* *Helen Lewis-White joined the meeting.*	

TB/25/03/13	**Research and Development Annual Report**	
	Helen Lewis-White, Deputy Director of Research and Development presented the report, highlighting: • an exceptional year of research performance and numerous successes against key performance indicators, building on previous years' successes • progress against the NBT 2022-27 Research Strategy, including the establishment of robust baselines for future work • NBT was well-resourced with clinical academics, research nurses, midwives and so on, with close to 10,000 research participants currently and participant recruitment proceeding well above target • an increase in income through commercial research by 47% since 2022 • a capital grant, which had enabled improvement works at the Clinical Research Centre, enabling NBT to attract and deliver more commercial research • the significant opportunities to expand commercial research further at NBT, providing opportunities to offer more innovative research to patients and deliver additional income and savings for the Trust • two bids for funding submitted to the National Institute for Healthcare Research (NIHR), in a highly competitive process, which NBT had won • NBT's work across the UK with other leading research partners and its place as an environmental leader in the way it delivered research • robust systems were in place to recruit research participants, with currently 7% of global majority participants on average (16% to 18% in Renal) and work ongoing to improve the representation of global majority communities • research was for and by global majority people, and the ratio of global majority staff working in research and development was very positive • a draft Bristol Hospital Group Joint Research Strategy had been prepared, building on the strengths of NBT and UHBW, and would be presented to the Joint Board in the near future. Board members commented on and discussed (key points): • the excellent research being conducted at NBT and the hard work of Helen and everyone else involved, for which they were thanked • the importance of research grants and what was learnt from the research enabled by that funding • the growing recognition nationally of Bristol as a leading research provider and talks taking place with universities around the need for more clinical academics (for example in neurosciences and stroke) to maintain and enhance research capacity and capability further • potential opportunities which may present themselves as a result of joint working with UHBW, such as in urology cancer care (where patients currently had their surgery at NBT and their chemotherapy at UHBW) and in terms of sharing staff and knowledge • the University of Bristol had been recognised in the Times Awards as the foremost university in the world for medical research; much of that research took place at NBT; the Trust should be very proud of its staff • the challenging commercial growth targets and the opportunity that might present to reinvest and expand research capacity and capability further • the overlaps between research and innovation, and the need to integrate and join up wherever possible • the massive achievement of NBT in its successful bids to NIHR; winning such bids and obtaining funding was extremely competitive and difficult. Ingrid concluded the discussion, commenting on the excellent research taking place, Bristol's position as a global player in research, and the positive news on	

	increased income and cost avoidance. She particularly welcomed better outcomes for patients and the joint working with UHBW. Helen Lewis-White thanked the Board for all their support. **RESOLVED: the Board noted the report, including progress against the 2022-27 Research Strategy and towards the creation of a Hospital Group Strategy, and commended research-active staff across the Trust for their commitment, compassion and curiosity to identify better approaches to patient health and wellbeing.** *Helen Lewis-White left the meeting.*	
TB/25/03/14	**South Gloucestershire Joint Health and Well-being Strategy**	
	Tim Whittlestone presented the report, commenting on NBT's key role as a member of the multi-agency South Gloucestershire Health and Well-being Board and the significant strategic alignment between this strategy and NBT's own strategic plans. Board members referred to the significant engagement with local communities on the joint strategy, and the positive welcome given by local people to the planned developments in community-based healthcare it envisaged. **RESOLVED: the Board confirmed the Trust's support of the strategy and the commitments required of partner organisations.**	
TB/25/03/15	**Operational Plan 2025/26 Final Submission**	
	Elizabeth Poskitt, Chief Finance Officer presented the final Operational Plan, highlighting: • that the plan had been approved and submitted by the Joint Chief Executive and the Hospital Managing Director, under delegated powers, earlier today, to meet the NHS England deadline • the final plan had been submitted to and endorsed by the Finance, Digital and Performance Committee on 18 March • the plan aligned closely with the ICB plan • the plan contained three key elements; performance, finance and workforce • the Board was asked to note the plan (including the capital programme) and approve the budget for the year ahead • confirmation had been received in relation to Elective Recovery Funding • the plan included the Bristol Surgical Centre and the staff Bank, agency and headcount reductions required by the national guidance • the plan was for a breakeven position, taking into account the £42 million underlying deficit and significant non-pay pressures in the year ahead • significant savings (5%) would be required in the year ahead, to achieve breakeven, which would be very challenging • good news on capital funding availability; around £22 million, with permitted over-programming and further funds to be bid for nationally and at ICB level • the cash position was challenging, with significant capital spend taking place in March and more work to be done on drawing down cash when needed • the Board assurance framework contained in the report gave assurance to the Board that everything required was in place • discussions were continuing with regional and national teams around the treatment of the PFI and its impact on productivity pack completion. Nick Smith, Chief Operating Officer outlined the performance elements of the plan and the Trust's compliance already with several targets, including the 52-week target. He commented that the Trust was in a good position compared to many	

	other Trusts and that this plan was about continuing what NBT was already doing, and improving even further, from its existing solid base. Maria Kane referred to the upheaval at ICB level and the importance of NBT committees closely monitoring delivery of the plan. Richard Gaunt, Chair of the Finance, Digital and Performance Committee commented (key points): • that NBT had always achieved breakeven, but this was the most challenging plan to date; monitoring delivery closely throughout the year was crucial and quarter 1 would be critical • achieving savings of 5% would be particularly challenging • that it would be useful to calculate the monetary value of each 1% of patients with no criteria to reside (NCTR), especially given that achieving the plan was predicated on NCTR being reduced to 15% • NBT was making significant productivity and efficiency gains, but this did not always appear obvious in financial out-turns • headcount reductions would be important, especially in the context of the required headcount growth associated with the Bristol Surgical Centre. Glyn Howells, Hospital Managing Director, referred to NBT's strong track record of financial monitoring and the very good co-operation and help of all Executives in achieving plan objectives. Executive Management Team meetings had a key focus on financial planning and operational delivery, and discussions were already taking place about quarter 1. NBT was in a good position compared to many other Trusts. **RESOLVED: the Board:** **(1) noted the final position for NBT business and operational planning for 2025/26; the plan will deliver a breakeven financial position and is compliant across performance metrics** **(2) noted that the Joint Chief Executive and the Hospital Managing Director had approved the plan for submission to NHS England, in line with their delegation from the Trust Board, due to the timing of the submission, on the same day as the Trust Board meeting** **(3) noted the changes to the plan between the headline submission and the final submission on 27 March 2025** **(4) noted the approach to capital funding and allocation, including the over-programming** **(5) noted the risks included in the plan and the approach to mitigating these risks** **(6) approved the final budget for 2025/26, as contained in the report, in advance of the start of the new financial year.**	
TB/25/03/16	**Quality Committee Upward Report**	
	Sarah Purdy, Vice-Chair of the Trust Board and Chair of the Quality Committee, presented the upward report of the Committee, arising from its meetings held in February and March 2025. Sarah highlighted the Committee's focus on: • an in-depth review of the longest-standing risks within the Committee's remit, which had been a very useful and assuring exercise • the significant (23%) reduction in falls achieved at NBT and the links to no criteria to reside (with many patients who accidentally fell and suffered injury not needing to be in hospital but with nowhere else suitable to go) • the rollout later this year of a new electronic prescribing and medicines administration (EPMA) system, which would have a major positive impact on patient safety, especially where patients had allergies to medications • the Trust's good relationship and close working with the CQC	

	• concerns around C.Difficile and needlestick injury rates, on which the Committee had asked for future reports back. **RESOLVED: the Board noted the Quality Committee upward report and the Committee's assurance on behalf of the Board.**	
TB/25/03/17	**Patient and Carer Experience Committee Upward Report**	
	Kelvin Blake, Non-Executive Director and Chair of the Patient and Carer Experience Committee presented the Committee's upward report. Kelvin highlighted: • that the Committee had held its last meeting on 10 March 2025, before the Committee was disbanded as part of the Hospital Group's evolution • the Committee had heard many patient stories and celebrated its success, as well as the successes of the Patient Experience Team and others • that nine out of ten patients rated NBT positively; this was a very significant achievement and demonstrated that NBT got things right most of the time • that the Committee had agreed updates to the Mental Health Strategy and the Patient Experience Strategy • the importance of the work of the Committee and its sub-groups, and of continuing that work in the new Group structures, after the Committee had been disbanded and its role included in that of the Quality and Outcomes Committee. Ingrid commented on the significant impact the Committee had had on raising the profile of patient and carer experience issues, the many positive outcomes achieved to date, and NBT's commitment to carry on and build on that good work. **RESOLVED: the Board noted the Patient and Carer Experience Committee report and its assurance on behalf of the Board.**	
	The Board adjourned at this point for a brief comfort break. *Yogi Ragoo (CQC Operational Manager) left the meeting.*	
TB/25/03/18	**People and EDI Committee Upward Report and Long-term Workforce Plan**	
	Kelvin Blake, Non-Executive Director and Chair of the People and Equality, Diversity and Inclusion (EDI) Committee presented the Committee's upward report. Kelvin highlighted the Committee's focus on key health and safety issues and other key People and EDI metrics. Glyn Howells and Sarah Margetts commented on the importance of all staff "Living our Values", everyone knowing what the Trust's values were, staff speaking up if they felt threatened, and staff knowing where to go for support. **RESOLVED: the Board noted the People and EDI Committee report and its assurance on behalf of the Board.**	
TB/25/03/19	**Finance, Digital & Performance Committee Upward Report**	
	Richard Gaunt, Non-Executive Director and Chair of the Finance, Digital and Performance Committee, presented the Committee's upward report, highlighting the Committee's consideration of: • positive performance in diagnostics, planned care and cancer services • ongoing challenges in urgent and emergency care • the Operational Plan and Capital Programme • longest-standing risks within the Committee's purview • the Green Plan; where the Committee heard that achieving Net Carbon Zero by 2030 was challenging, if not unlikely.	

	Elizabeth Poskitt briefly outlined the Month 11 finance report, referring to and thanking everyone concerned at NBT for their collective action and hard work to achieve the predicted breakeven position by year-end. Ingrid Barker reiterated these thanks and looked forward to confirmation next week of the delivery of breakeven. **RESOLVED: the Board noted the Finance, Digital and Performance Committee report and its assurance on behalf of the Board, and noted the month 11 finance report.**	
TB/25/03/20	**Audit and Risk Committee Upward Report**	
	Shawn Smith, Non-Executive Director and Chair of the Audit and Risk Committee, presented the Committee's upward report, highlighting: • positive assurance received from the Trust's Internal Auditors, in areas they had reviewed • the lack of any concerns raised by External Auditors • the Committee's welcome of longest-standing risks reviews • the Committee's review of SAP Ariba implementation, with an internal audit expected in the year ahead and • the excellent work of the finance team, as demonstrated through the work on the operational plan, grip and control report and others. Elizabeth Poskitt pointed to the draft Head of Internal Audit Opinion, which was that NBT was "strongly satisfactory" in the areas tested (with a prediction of that rating rising even further during later analysis). **RESOLVED: the Board noted the Audit and Risk Committee report and its assurance on behalf of the Board.**	
TB/25/03/21	**Any Other Business**	
	No other business was raised.	
TB/25/03/22	**Date of Next Meeting**	
	The next Board meeting in public was scheduled to take place on Tuesday 8 April 2025, at 10am, jointly with the UHBW Trust Board.	
TB/25/03/23	**Exclusion of the Press and Public** **The Board RESOLVED:** that representatives of the press and other members of the public be excluded from the Trust Board meeting, having regard to the confidential nature of the business to be transacted at the Private Board meeting later in the day, publicity on which would be prejudicial to other public interest (section (2) Public Bodies (Admission to Meetings) Act 1960).	

The meeting ended at 1.45pm.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting in common of the Board of Directors of University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and the Board of Directors of North Bristol NHS Trust (NBT) in Public on Tuesday, 08 April 2025

UHBW Action Log

Outstanding actions from the meeting held in March 2025					
No.	**Minute reference**	**Detail of action required**	**Executive Lead**	**Due Date**	**Action Update**
1.	***09/03/25 Board Assurance Framework***	Joint Chief Digital Officer to review the score for Risk 7, relating to Digital and Cybersecurity, that patients may not have migrated from Millennium to Medway.	Joint Chief Digital Information Officer	April 2025	Verbal update to be provided.
Closed actions from the meeting held in March 2025					
1.	***04/01/25 Minutes of the Last Meeting***	Trust Secretariat to update the previous set of Public Board minutes from November 2024 to reflect the comments made.	Director of Corporate Governance/ Trust Secretariat	March 2025	**Action Closed** The minutes from November's Public Board meeting have been updated to reflect the comments made.
2.	***04/01/25 Minutes of the Last Meeting***	Trust Secretariat to add a sustainability update to a future meeting agenda of the Board.	Director of Corporate Governance/ Trust Secretariat	March 2025	**Action Closed** An item on sustainability will be added to the forward planner to be discussed by the Board at its meeting in April.
3.	***08/01/25 Joint Chair's Report***	Director of Corporate Governance/ Trust Secretariat to include visits to South Bristol Community Hospital and the Unity Sexual Health Services on the NED Site Visit schedule.	Director of Corporate Governance/ Trust Secretariat	March 2025	**Action Closed** These will be offered to NEDs as options for visits.

North Bristol NHS Trust

Trust Board - Public Committee Action Log

NBT Trust Board - Public ACTION LOG

Closed	Action completed and can be filtered out	Amber	Status not updated/completed and/or the deadline passed.
Blue	Completed and will be removed from chart for next iteration. A = On current meeting agenda.	Red	Status not updated/completed and/or deadline passed by more than one month.
Green	Status updated and on track within timescale.		

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

Questions from Members of the Public submitted to the UHBW Board of Directors from Page Nyame in respect of the BRI Pharmacy

(Answers provided in italics below).

1. **Is the pharmacy currently meeting its key performance indicators (KPIs), including the average turnaround time for dispensing a prescription and what are the figures for the quarter?**

   We are currently in a three month KPI grace period following the transition of our Outpatient Dispensary service from Lloyds Pharmacy Healthcare Services (LP HCS) to Rowlands on 12th January 2025. We therefore do not have a whole quarter's worth of figures to share, we can however share that the average turnaround time for the Bristol site for w/c 3rd March was 26 minutes and for Weston 29 minutes.

2. **What is the average wait time for a patient depositing a prescription (that is the wait time of the first depositing queue, not the second dispensing queue)? If this is not a KPI, please could you clarify why, and whether it might be considered in the future?**

   This is not a KPI as there isn't the ability to capture data about when a patient first joins the depositing queue. Deploying a member of staff to record this would increase overall waits within the store as they would be diverted from processing prescriptions or other operational duties.

3. **What are the reasons for the BRI Outpatient Pharmacy coming under new management?**

   LP HCS Limited is owned by the Halo Healthcare Group which made a corporate decision to re-structure and to exit the provision of outpatient pharmacy services. This affected all its outpatient contracts with hospitals in England. LP HCS sought permission from the Trust to novate the contract to Rowlands. After careful consideration, UHBW determined that Rowlands was a suitable alternative provider. With effect from 12 January 2025, the contract between UHBW and LP HCS was novated to Rowlands. The terms of that contract remained the same.

4. **In the March 2025 Board papers (page 197/347), an individual raised concerns about pharmacy wait times and whether local pharmacy processing was possible. Was this long waiting time referring to the BRI Outpatient Pharmacy? Additionally, is there any provision for prescriptions issued from the BRI to be collected from a local pharmacy, or could more information be provided at the BRI Outpatient pharmacy explaining why this is not possible?**

   This comment was from the 2024 National Urgent and Emergency Care Survey and is therefore anonymous so it is not possible to say whether it referred to the BRI or Weston outpatient pharmacy. The comment would have been submitted in February 2024, where at that time Boots were our incumbent Outpatient Pharmacy provider. Since April 2024, when LP HCS commenced providing this service, it has been possible to collect prescriptions from the following local pharmacies, as an

alternative to waiting at the BRI or Weston Outpatient Pharmacy. This is explained during the outpatient appointment by the patient's clinician:

- *Day Lewis, 6 Arnside Road, Southmead, Bristol, BS10 6AT*
- *Day Lewis, Medical Centre, Love Lane, Burnham-on-Sea, TA8 1EU*
- *Day Lewis, The Square, Axbridge, BS26 2AR*
- *Day Lewis, 3 Broad Street, Congresbury, Bristol, BS49 5DG*
- *Day Lewis, 493 Bath Road, Saltford, Bristol, BS31 3HQ*
- *Day Lewis, 508 Filton Avenue, Horfield, Bristol, BS7 0QE*
- *Day Lewis, 1 Trevelyan Walk, Henbury, Bristol, BS10 7NY*

5. It was previously mentioned that responses to questions submitted for the July 2024 would be made available online. Could you confirm where these are published online please?

The responses to the questions submitted to the July 2024 Board meeting were appended to the minutes of that meeting, which were published as part of the papers for the following meeting held in September 2024 – please see page 20 of 247 here: https://www.uhbw.nhs.uk/assets/1/v2_public_board_-_10_sep_-_agenda_and_papers.pdf

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public		
Date of Meeting:	8 April 2025		
Report Title:	Joint Chair's Report		
Report Author:	Ingrid Barker, Joint Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)		
Report Sponsor:	Ingrid Barker, Joint Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			✓
	The report sets out information on key items of interest to the Trust Board including activities undertaken by the Joint Chair, and Vice Chairs.		

Key Points to Note *(Including any previous decisions taken)*

The Joint Chair reports to every Public Board meeting with updates relevant to the period in question. This report covers a shorter period (5 March – 8 April) as the last, separate UHBW Board meeting was held on the 11 March 2025, and the last separate NBT Board meeting was held on the 27 March 2025. There may by some duplication with the most recent NBT report due to these timings.

Strategic and Group Model Alignment

The Joint Chair's report identifies her activities, along with key developments at the Trust and further afield, including those of a strategic nature.

Risks and Opportunities

Not applicable.

Recommendation

This report is for discussion and information. The Board is asked to note the activities and key developments detailed by the Joint Chair.

History of the paper (details of where paper has <u>previously</u> been received)

n/a	
Appendices:	n/a

1. Purpose

1.1 The report sets out information on key items of interest to the Trust Board, including the Joint Chair's attendance at events and visits as well as details of the Joint Chair's engagement with Trust colleagues, system partners, national partners and others during the reporting period.

2. Background

2.1 The Trust Board receives a report from the Joint Chair to each meeting of the Board, detailing relevant engagements she has undertaken and important changes or issues affecting UHBW and NBT and the external environment during the preceding months.

3. Activities across both Trusts (NBT and UHBW)

3.1 The Joint Chair has undertaken several meetings since the last UHBW specific Board report submitted on 5 March 2025:

- Monthly meeting with both organisations' Non-Executive Directors (NEDs)
- Monthly meeting with the Vice-Chairs
- Meeting with Lead Governor, Ben Argo
- Visit to a number of areas in the UHBW Children's Hospital, including the emergency department, intensive care unit and Lighthouse Ward
- Visit to the UHBW adult emergency unit, Acute Medical Unit (AMU) and Same Day Emergency Care Unit (SDEC)
- Met with the UHBW Sustainability Team, hosted by Ned Maynard, Head of Sustainability
- Visit to NBT's Elgar Ward Visit on 21 March
- Critical Care Transport Base Anniversary event, attended by colleagues across both Trusts, the local MP for Filton and Bradley Stoke, a representative for NHS England, and external stakeholders. This event celebrated the anniversary of the co-location of the Southwest Critical Care Transfer Services. In 2024, the Severn region services moved into a shared operational base in North Bristol, one of the first times such a co-location of services has been successfully achieved in England

4. Communications

The Communications teams of both Trusts have been very helpful in making the above visits more visible to all colleagues and to UHBW Governors. For UHBW this has been through its platform Viva Connect and a newsletter to Governors. I would like to thank both teams for their support in this. For NBT this has been through its weekly staff newsletter, NBT News and intranet platform, LINK.

5. Connecting with our Partners

5.1 The Joint Chair has undertaken several visits and meetings with our partners:

- Visit by Dan Norris, in his capacity as WECA Metro Mayor to mark NBT and UHBW joining WECA's Good Employment Charter
- Attended the City Partners Conference Call
- Attended an engagement meeting with Evelyn Welch the Vice Chancellor of the University of Bristol

- Attended an engagement meeting with Steve West, the Vice Chancellor of the University of the West of England
- Visit to For All Healthy Living Centre in Weston with Mark Graham, Chief Executive Officer
- Meeting with Mike Bell, Leader of North Somerset Council

6. National and Regional Engagement

6.1 Together with the Joint CEO, attended a national meeting of chairs / CEOs hosted by NHS England to discuss a 'financial reset, announcements regarding the future of NHSE and ICSs and expectations of provider trusts.

6.2 The Joint Chair has also attended an NHS Confederation Conference webinar with a focus of 'your role in an Anchor System'.

7. Vice-Chairs Report

The Vice-Chairs undertook a variety of visits and meetings:

7.1 Vice Chair (UHBW)

- Visits to Emergency Department, Same Day Emergency care and medically Fit for discharge areas.
- Bi-monthly meetings with site managing director
- Regular meetings with chair and NBT vice chair
- Interview panel for group chief of staff

7.2 Vice Chair (NBT)

- Visit to the Women & Children's division
- Visit to Critical Care Services
- Visit to the Cardiology department
- Attendance at the NHSP Chairs and CEO network
- Board Insight visit to the Fracture clinic
- Visit to Medicine Divisional Tri

8. Summary and Recommendations

The Trust Board is asked to note the content of this report.

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of NBT and the Board of Directors of UHBW held in Public		
Date of Meeting:	8 April 2025		
Report Title:	Joint Chief Executive Report		
Report Author:	Suzanne Priest, Executive Co-ordinator		
Report Sponsor:	Maria Kane, Joint Chief Executive		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	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.		

Key Points to Note *(Including any previous decisions taken)*

The report seeks to highlight key issues not covered in other reports in the Board pack and which the Board should be aware of. These are structured into four sections:

- National Topics of Interest
- Integrated Care System Update
- Strategy and Culture
- Operational Delivery
- Engagement & Service Visits

Strategic Alignment

This report highlights work that aligns with the Trust's strategic priorities.

Risks and Opportunities

N/A

Recommendation

This report is for Information. The Trust Board is asked to note the contents of this report.

History of the paper (details of where paper has <u>previously</u> been received)

N/A	
Appendices:	N/A

Group Chief Executive's Report

Background

This report sets out briefing information from the Group Chief Executive for Board members on national and local topics of interest that have taken place since the last UHBW Board meeting held on 13 March and the last NBT Board meeting held on 27 March.

1. National Topics of Interest

1.1. Letter from the Chief Executive of NHS England – Sir James Mackey

The new Chief Executive of NHS England, Sir James Mackey has recently written to Trust and ICB Chairs and CEOs to set out the next steps in working towards the reform of the NHS which was recently announced by the Government. The letter reflects on the considerable amount of work which has been done by providers to set breakeven budgets and deliver key operational standards.

Once the outcome of the current comprehensive spending review is known, and the publication of the 10 year plan takes place, there will be a shift towards medium-term planning and a new process will be initiated by September. This will help to set out the parameters for the 2026-27 planning guidance. The aim is to get to a more devolved, rules-based system that is built on Board accountability.

Sir Mackey also reflected on how ICBs will hold a critical role as strategic commissioners and this will be pivotal in delivering the 10 year plan. The collective challenge over the coming weeks for NHS England and ICBs to reduce their workforce by 50% will be:

- To maintain some core staff, such as recently delegated commissioning staff and continuing healthcare staff
- To maintain or invest in core finance or contracting functions in the immediacy
- To invest in strategic commissioning function, building skills and capabilities in analytics, strategy, market management and contracting
- To commission and develop neighbourhood health, with the delivery being a provider function over time

Regional Directors will be holding the ring with the ICB CEOs on identifying how they will make the reductions, whilst accepting that to work this may need to rely on cross-system arrangements.

Providers are being asked to reduce their corporate cost growth by 50% during Quarter 3. Savings should be reinvested locally to enhance frontline services.

Results of the consultation on the NHS Standard Contract will be published soon and will provide a more flexible approach to planning elective activity. Guidance on Wholly Owned Subsidiaries will include a more streamlined process for approval whilst ensuring that certain conditions are met. This is expected very soon.

Work on the creation of a single aligned centre for the NHS within the Dept of Health and Social Care is being led by Penny and Alan Milburn and is expected to progress at pace.

1.2. The NHS Performance Assessment Framework for 2025-26

The new NHS Performance Assessment Framework for 2025-26 was published on 27 March. This new framework will be used to assess both ICBs and Trust providers to ensure that health services are effective, efficient and patient-centred. It will be used to replace the previous framework which has been in place since 2022.

The framework will be released for consultation and testing, which does include applying it to Trust and ICB plans for 2025-26 during quarter one. Feedback will be collected as part of the testing and will help inform the finalised framework that will be issued for use from July.

In summary, every ICB and provider will be allocated a segment that will indicate its level of delivery from 1 (high performing) to 4 (poorly performing), and with an additional segment 5 to indicate those where the greatest level of support and improvement required. Organisations will be assessed across a wide range of functions from both a tactical and strategic perspective. Provider segmentation score will be based on their delivery score only. It is anticipated that high performing organisations in segment 1 will receive greater autonomy. Segment 3 and 4 organisations will be considered for further support and interventions which may include enforcement. Segment 4 organisations will receive a diagnostic review and this will determine if they will enter segment 5 and under the Recovery Support Programme. Data used to calculate segments will be published in an interactive web-based public accountability tool which will be made available from July.

Leadership capability will form part of the assessment process and insights gathered will be used to help direct performance improvement activities from the central and regional NHS teams. Guidance on this is still being developed and will be published once ready

1.3. Thirlwall Inquiry

On 19 March 2025, Lady Justice Thirlwall concluded seeking evidence submissions to the Inquiry. The Inquiry will now move to the next phase, which includes writing the report and is expected in November 2025.

2. Strategy and Culture

2.1 Output from the Strategic Partnership Event

The recent Strategic Partnership event which took place in February focused on a number of areas which asked for input and feedback from attendees. A total of 69 colleagues from the local and regional health and care system, local authorities, emergency services and charity and community organisations joined the day. There was an enthusiasm from those attending for continued collaboration and involvement in some strategic discussions.

During the day there were two key breakout sessions. Feedback was captured on the day through interactive applications and personal facilitation. Key findings were:

- The future of acute healthcare
  - Enhance
    - Support for a digital first approach integrating AI and automation
  - Left Shift
    - Care must shift towards a community-based model with decentralised services

  - Retain
    - Workforce wellbeing and retention will remain key priorities

- The Hospital Group's role in the community
  - There was strong support for deeper partnerships with education and training partners
  - Hospitals should advocate for social determinants of health including housing and transport
  - Sustainability must be prioritised.

Attendees were also asked to provide feedback on the proposed Group name. 72% of people thought the proposed name aligns with ambitions and clarity. It was clear from responses that the name should be clear and easily understood by patients and the public.

2.2 NHS Impact Meeting

I have attended two National Improvement Board meetings since the last report. The business plan for 2025-26 has been refined and is now focused on delivery of the following key objectives:

- Establish a joined-up system for improvement across the NHS, its partners, and the communities it serves.
- Develop the skills and capability of NHS Managers and leaders in improvement and system leadership.
- Accelerate both the small steps of continuous improvement and the bigger leaps of radical transformation
- Create an NHS wide learning system to more rapidly spread innovation, reduce unwarranted variation and enable sharing of practice from "the best of the NHS to the rest of the NHS."

3. Engagement and Visits

3.1 Community Engagement meeting – Bristol City Robins and Bristol Sport Foundation

Dan White, CEO of the Bristol City Robins Foundation and Sarah Mortiboys of the Bristol Sport Foundation met with me recently. The meeting discussed how we can work together to look at initiatives to support young people across the city. This is one of the partnerships we are working on with community organisations as an anchor and as a key partner in the work to reduce youth violence.

3.2 Service Visits

I have visited a number of areas, and met with senior clinical staff across the Trusts including:

- Emergency Department
- Intensive Care Unit

Recommendation
The Board is asked to note the report.

Maria Kane
Joint Chief Executive

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public		
Date of Meeting:	8 April 2025		
Report Title:	Group Benefits Case		
Report Author:	Paula Clarke, Group Development SRO Emma Mooney, UHBW Director of Communications and Engagement Lucy Thorp, Teneo		
Report Sponsor:	Maria Kane, Joint CEO		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	x		
	This is the final version of the Summary Group Benefits Case, incorporating feedback from the Boards and engagement with stakeholders, including patient representatives.		

Key Points to Note *(Including any previous decisions taken)*

This is the final version of the Summary Group Benefits Case, which is a distillation of the long-form Group Benefits Case. The document is intended for a broad audience and will be made publicly available.

The document was last reviewed by the Boards on 05 February 2025 and feedback has been incorporated. Engagement with our key partners and stakeholders was undertaken during March 2025, alongside testing the preferred option for the Group name. A wide range of stakeholders including staff from both Trusts, BNSSG ICB and wider integrated care system partners such as Local Authorities, Primary Care, university partners and patient and carer forums, were invited to comment on the document and whether the benefits case supported the vision of the role of hospitals in BNSSG in meeting the future needs of local communities. Stakeholders were asked:

- Is the document clear and understandable?
- Is there anything missing?
- Is there anything that could be improved?

Feedback received was positive and supportive, stakeholders liked the clarity of the information and the clear ambition outlined in the document. Some feedback suggested drawing out a bit more of the voice of staff and patients to describe what would be different for them and this has been incorporated by the inclusion of ‘voices of the future’ in the document.

The opportunities are structured around five benefit strands:

- Delivering outstanding care for everyone who needs it
- Supporting our people to thrive and excel
- Getting the most out of our resources for the communities we serve
- Excelling in groundbreaking Innovation, Research and Development

- Working with our partners as one team

With benefits described against our '4Ps' – patients, people, population and the public purse.

Strategic and Group Model Alignment

This paper is aligned with the Trusts' strategic intention to form a Hospital Group. It summarises the benefit opportunities of Group development against each of the 4Ps – Patients, Population, People and Public Purse.

Risks and Opportunities

- Creation and use of the Summary Benefits Case for external and internal audiences is an opportunity to build our reputation and engage effectively with our internal and external stakeholders.
- It is also a reputational risk if we do not get this right.

Recommendation

This report is for **Approval.**

The Boards are asked to approve the Summary Benefits Case.

History of the paper (details of where paper has <u>previously</u> been received)

UHBW and NBT Boards meeting in common	05/02/2025

Appendices:	No appendices are included.

NHS
Bristol
NHS Group
Bristol | Weston

Our Group Summary Benefits Case

Seamless, high quality, equitable and sustainable care

A partnership between
North Bristol NHS Trust, and
University Hospitals Bristol and Weston NHS Foundation Trust

Introduction

North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) are high-performing organisations with a track record of successful collaboration and proud histories of providing excellent care and world-leading teaching and research.

The Boards of UHBW and NBT have made the decision to form a Hospital Group with a shared ambition to enable our Joint Clinical Strategy vision for ***seamless, high quality, equitable and sustainable care***. This strategy has been, and will continue to be, our guiding star.

We were appointed as Group Chair and Group Chief Executive Officer in summer 2024 and we are now delighted to introduce our Group Benefits Case. This sets out the difference that the Group will make for our **patients**, our 28,000 **people**, the **populations** we serve, and the **public purse**. It has been developed with the support of colleagues, patient representatives and our partners in the health and care system – to everyone who has been involved: thank you!

In every region and every system, the NHS is facing very real and profound challenges. These come in the form of rising demand, constrained funding and an ageing estate. We have also lagged behind other nations in terms of our investment in medical technology, digital and innovation.

The Government has been clear that the NHS must transform – and together, NBT and UHBW will meet that challenge. If we are successful, how and where we deliver healthcare will be radically different in 10 years' time. More care will be delivered in patients' homes and communities, our resources will be focused on preventing ill health, and not just treating illness, and digital technologies will radically change how we operate.

To continue to deliver the outstanding care that our patients rightly expect we need real and meaningful change. Working together in a Group Model gives us the best possible opportunity to address our challenges and achieve these transformations - we can learn from each other, share resources, remove wasteful duplication and ensure that all patients, no matter who they are, where they live, or where they are treated, get access to the same high-quality care.

This is a once in a lifetime opportunity for our people and the patients and communities we serve.

Maria Kane
Group CEO
North Bristol NHS Trust and University Hospital Bristol and Weston NHS Foundation Trust

Ingrid Barker
Group Chair
North Bristol NHS Trust and University Hospital Bristol and Weston NHS Foundation Trust

Our Group Benefits Case is built around five key themes:

- Delivering **outstanding care for everyone who needs it** (p.7)
- Supporting our **people** to thrive and excel (p.9)
- Getting **the most** out of our resources for the **communities we serve** (p.11)
- Excelling in groundbreaking **Innovation, Research & Development** (p.13)
- Working with **our partners** as one team (p.15)

Why we must change

- We believe that all our patients, regardless of who they are, where they live and where they are treated, deserve the same high-quality care and positive experience of receiving it. We need to be honest and upfront that currently this is not always the case.
- When a patient needs care from both of our hospitals there can be delay, confusion and risk. We need to organise our services around people and not organisational boundaries - patients don't see them and neither should we.
- Demand for our services is increasing. Only by working together and sharing our resources will we be able to meet the future needs and expectations of our patients and local communities.
- Some of our services - both clinical and corporate - are fragile; acting as a Group will allow us to protect their future and take advantage of advancements in technology, new innovations in clinical practice, support each other and address shortages in key skills within the workforce.
- There is a lot of duplication between our organisations. By working more closely together we can free-up time and resources for front-line patient care.
- The government has set out an ambitious plan to transform the way health is delivered over the next 10 years, focusing on three key shifts; hospital to community, treatment to prevention and analogue to digital. We need to step up to this ambition and act as one acute voice so we can work with partners to make these changes.

Why a Group

Group Models are increasingly common in the NHS – they provide a way for separate legal entities (Trusts) to collaborate without needing to merge.

The word 'Group' does not have a strict definition and is used to refer to a range of shared leadership and governance arrangements that support organisations to collaborate.

Forming a Group is an enabler for the delivery of our Joint Clinical Strategy. The Group Model will allow us to break down organisational barriers and set out a new future for NBT and UHBW which is one of ever closer alignment and collaboration.

We have already had many successes collaborating as two separate organisations – but it has been harder than it needs to be and progress has been slower than we would have liked. The Group Model will allow us to change to address this.

Many of the challenges we face are shared. By working together, we stand the best possible chance of meeting these challenges.

Forming a Group will significantly enhance the efficiency, quality and sustainability of both Trusts. By working together we can share resources, streamline services and reduce costs - all while enhancing patient care, the experience of our people, the health of our population and delivering value for the public purse.

The Group Model enables us to…

- **Make decisions in the best interests of patients and not organisations**
- **Spread learning, best practice and innovation between teams and organisations**
- **Create a default culture of collaboration not competition**
- **Remove organisational barriers to collaboration by standardising systems, policies and processes**
- **Remove wasteful duplication; doing things once wherever possible**
- **Share resources and expertise**
- **Benefit from economies of scale**

All for the benefit of…

Our Patients

Our Population

Our People

The Public Purse

For the benefit of:

our patients, our population, our people and the public purse.

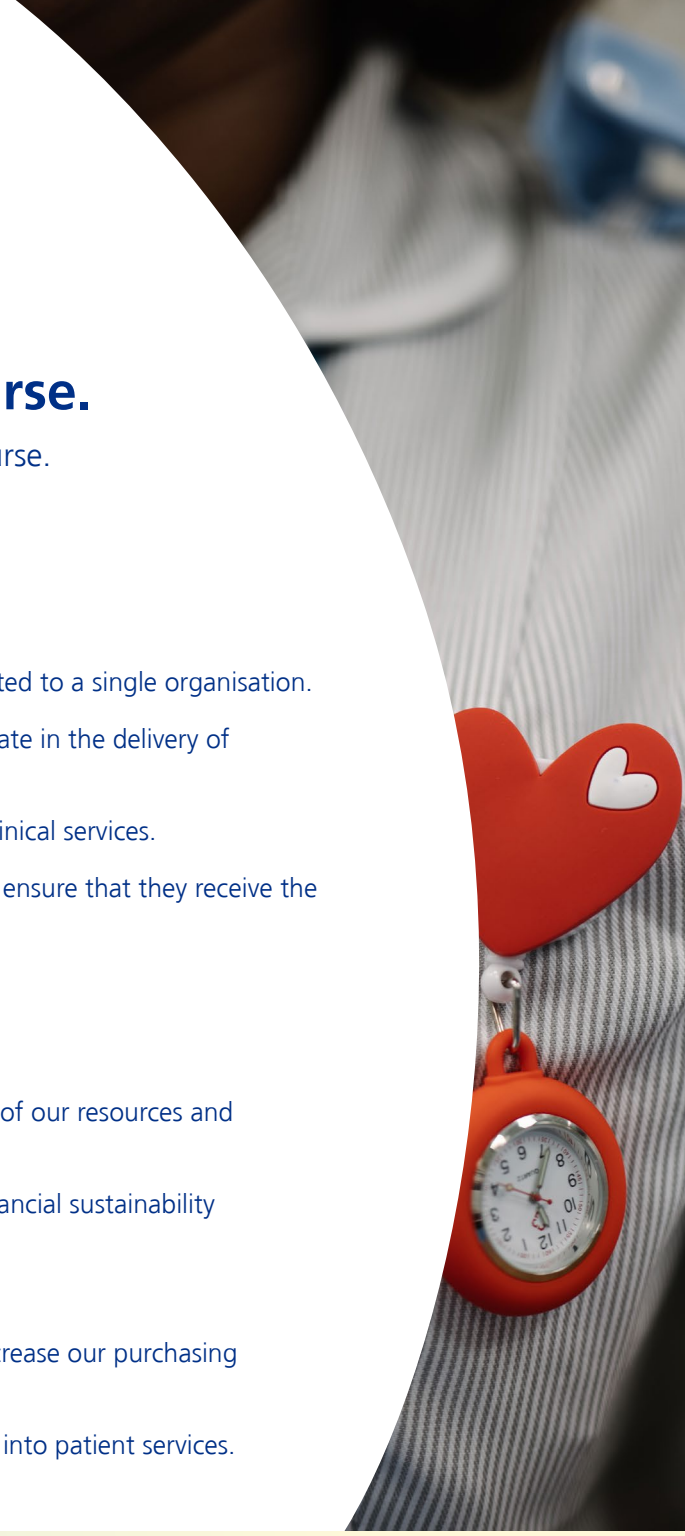
Our benefits are described around our Four Ps – our patients, our population, our people, and the public purse.

Our patients

- Will receive more consistent, high-quality care across their lifetime.
- Will face less unwarranted variation in their care experiences and outcomes; wherever they are treated in Bristol and Weston.
- Will have improved access to services and receive more care closer to their homes, decreasing waiting times and improving outcomes.
- Will have better care experiences through optimised clinical pathways.
- Will have expanded access to pioneering, modern healthcare and treatment options through expansion in our Research & Development and innovation activities as a Group.

Our population

- Will receive greater support for prevention and population health, as we work more closely than ever with our external partners on these programmes.
- Will have greater access to innovations that are in the best interests of our population, as we develop further partnerships across health, care and life sciences.
- Will experience improvements in the health and wellbeing of their communities, local economic growth and advances in sustainability in all of its forms, as we expand our role as anchor institutions.



For the benefit of:

our patients, our population, our people and the public purse.

Our benefits are described around our Four Ps – our patients, our population, our people, and the public purse.

Our people

- Will be effectively supported to thrive at work and will have a more equitable experience.
- Will have access to new and exciting roles and career prospects, with opportunities no longer limited to a single organisation.
- Will have expanded opportunities – both clinical and non-clinical colleagues – to lead and participate in the delivery of research, innovation and education.
- Will be part of a more sustainable and resilient workforce, able to meet future demands for our clinical services.
- Will be part of a Group with a more prominent profile; celebrating the successes of our people to ensure that they receive the recognition they deserve.

The public purse

- There will be reduced duplication and more standardised processes to make the best possible use of our resources and free-up additional capacity to invest in front-line care.
- There will be reduced areas of fragility across our clinical and corporate services, and increased financial sustainability within the BNSSG system.
- Greater value and quality will be achieved through our combined scale.
- More cost-effective investments will be made based on need, value and risk levels, and we will increase our purchasing power by doing this as one.
- There will be new and expanded opportunities to generate income, which can then be reinvested into patient services.

Delivering outstanding care for everyone who needs it

By working as a Group, we will ensure all of our patients receive the highest quality of care regardless of who they are, where they live, or where they are treated. We will enable more care to be delivered out of hospital, make better use of our capacity, and ensure that all services are safe and sustainable in the long-term.

Our objectives	Our patients	Our population	Our people	The public purse
We will eliminate unwarranted variation in patient access, outcomes and experience	✓			✓
We will improve the delivery of local care for local people	✓	✓		✓
We will create seamless patient journeys across our organisations	✓		✓	✓
We will make the best possible use of our available clinical capacity	✓			✓
We will ensure all services are safe and sustainable in the long-term	✓	✓	✓	✓

Delivering outstanding care for everyone who needs it

To deliver our objectives, **we will prioritise the following actions:**

Through the work of our Single Managed Services, we will:

- Develop new models of care and pathways that are clinically led, evidence based, aligned to best practice and consistently implemented on all sites.
- Make best possible use of the collective capacity of all of our hospitals and all of our people to reduce waiting times.
- Ensure waiting times are kept to a minimum through a single points of referral access and joint management of waiting lists.
- Deliver care closer to home wherever possible and consolidate expertise and technology wherever necessary.
- Learn from each other to enhance quality and experience.
- Develop new models of care that transform how we support patients with long-term conditions.
- Work together with our partners in primary and community care to integrate services around the needs of patients not organisational boundaries.
- Move from treating illness to preventing it, and play a greater role in reactive monitoring - helping patients to live well at home for longer.
- Work together to deliver more targeted education that allows patients to better understand and take control of their health.
- Improve communication channels and referral pathways between our organisations; and
- Use our scale to ensure we are enabling innovation, pioneering clinical practice and technology-enabled care.

Supporting our people to thrive and excel

By working as a Group, we have an exciting opportunity to ensure our people thrive and excel in all that they do. As a Group, we can provide better learning and development opportunities, address short and long-term workforce shortages, and deliver vital People Services to a higher standard and lower cost. We will make our Group a great place to work for all, which will in turn improve the experience and outcomes for our patients.

Our objectives	Our patients	Our population	Our people	The public purse
We will create a more equitable experience for our people	✓	✓	✓	
We will invest in our people's career paths and opportunities through the Group	✓	✓	✓	✓
We will use the scale of the Group to enhance our education, learning and workforce development offer		✓	✓	✓
We will create integrated workforce plans; addressing our short-term gaps and jointly planning for our future	✓		✓	✓
We will support and facilitate more people to work across the Group where they wish to	✓		✓	✓

Supporting our people to thrive and excel

To deliver our objectives, **we will prioritise the following actions:**

- We will align our approaches to wellbeing, Equality Diversity and Inclusion, and staff engagement & recognition to create a shared sense of identity and belonging.
- We will engage and listen – hearing our colleagues' voices louder and clearer to ensure we deliver on our People Promise.
- We will become an anti-racist and pro-equity Group.
- We will ensure everyone has access to the development and career progression opportunities currently available across both Trusts.
- We will develop a Group Learning and Workforce Development Strategy.
- We will align curriculum and training programmes to drive greater equity, diversity, accessibility and consistency in all staff groups within the Group.
- We will work with our educational partners to develop and train the workforce of the future.
- We will provide mutual aid between both Trusts to mitigate workforce shortages – helping us to ensure that services are always safe and resilient.
- We will align approaches to workforce planning; creating a single long-term strategic workforce plan for the Group.
- We will develop a framework for cross-site working – bringing clarity and consistency to the way we support colleagues and removing duplication (e.g., of employment checks and repeated training).

Getting the most out of our resources

for the communities we serve

Together we have a turnover of approximately £2.2bn and the value of our estate and equipment is significant. In a Group, we can maximise the value of these assets, use our resources more efficiently, attract income and investment, and lower costs through economies of scale. This will free up resources to invest in the digital infrastructure which is vital if we are to deliver modern, integrated and efficient healthcare services.

Our objectives	Our patients	Our population	Our people	The public purse
We will transform and modernise the delivery of corporate functions for the Group			●	●
We will use our scale to support partners by seeking opportunities to 'do things once' on behalf of the system			●	●
We will deliver more clinical activity in-house and unlock the commercial potential of improved productivity	●		●	●
We will prioritise and allocate capital investment based on patient need, value and risk	●	●	●	●
We will use our scale to reduce the price we pay for goods and services				●
We will converge digital systems to support joined-up working and release savings	●		●	●

Getting the most out of our resources

for the communities we serve

To deliver our objectives, **we will prioritise the following actions:**

- We will create a joint Digital Strategy for the Group – leading on the Government's 'analogue to digital' shift.
- We will identify opportunities to bring corporate functions together to share resources, learning and access economies of scale.
- We will standardise policies, systems, processes and ways of working across the Group.
- We will pursue opportunities to modernise our corporate services through digitisation and automation.
- We will offer corporate services to our partners, so that they too can benefit from the scale of the Group.
- We will make best possible use of our capacity across the Group – ensuring that we are using all of our clinical spaces optimally before resorting to outsourcing.
- We will learn from each other and problem solve together to identify ways to improve productivity and reduce waste.
- Through the work of our Single Managed Services, we will identify how existing clinical space and medical equipment can be used to manage future investment requirements.
- We will integrate our governance, so that investment decisions are made jointly across the Group.
- We will ensure that we are buying together wherever possible to drive down unit cost.

Excelling in groundbreaking

Innovation, Research & Development

By working as a Group, we will firmly establish ourselves as a globally recognised powerhouse for R&D and innovation. The expertise of our people is formidable, and by working together we will build our reputation, attract partnerships and investment, and deliver the most advanced care possible.

Our objectives	Our patients	Our population	Our people	The public purse
We will be an engaged and effective partner	✓	✓	✓	✓
We will give every patient the opportunity to benefit from research	✓	✓		
We will provide more colleagues with the opportunity to lead and be part of R&D			✓	
We will celebrate innovation and champion a culture of curiosity	✓	✓	✓	
We will support an ecosystem of health, care and life sciences innovation across BNSSG		✓	✓	✓

Excelling in groundbreaking

Innovation, Research & Development

To deliver our objectives, **we will prioritise the following actions:**

- We will develop joint R&D and Innovation Strategies for the Group.
- We will ensure that our research prioritises the needs of our local populations – for example, by working alongside local authority, primary and community care colleagues to lead research in support of reducing health inequalities across BNSSG.
- We will create new and exciting opportunities for our people to lead and take part in R&D.
- We will address the organisational barriers that currently inhibit cross-site trials and ensure that clinical trials are open to all patients across the Group.
- We will increase opportunities to protect time to do R&D across the Group.
- We will make research more accessible for everyone, regardless of professional background.
- We will work as 'one team' within our R&D functions, to maximise the opportunity to share the skills and expertise that exists across the two teams.
- We will develop a Group Innovation Hub, investing in the expertise and resources required to kick-start our innovation journey.
- We will ensure that innovation is central to everything we do; helping us recruit and retain the brightest minds.
- We will maximise income generation from innovation and R&D, to reinvest in patient services.

Working with our partners as one team

By working as a Group, we will make it simpler and easier for our partners to work with us. We will work with partners across the BNSSG health and care system to improve access, outcomes and experience for our patients and communities. We aim to be a trusted 'partner of choice', leveraging our combined scale and expertise to make us more attractive to community and industry partners. We will advocate for our services and patients with one unified voice, enabling us to influence regional and national agendas. We will raise our shared profile by celebrating our successes and sharing our work widely, building a strong brand recognised for excellence and innovation. We will enhance our combined role as an anchor institution, using our size and expertise to improve the health and wellbeing of our local communities.

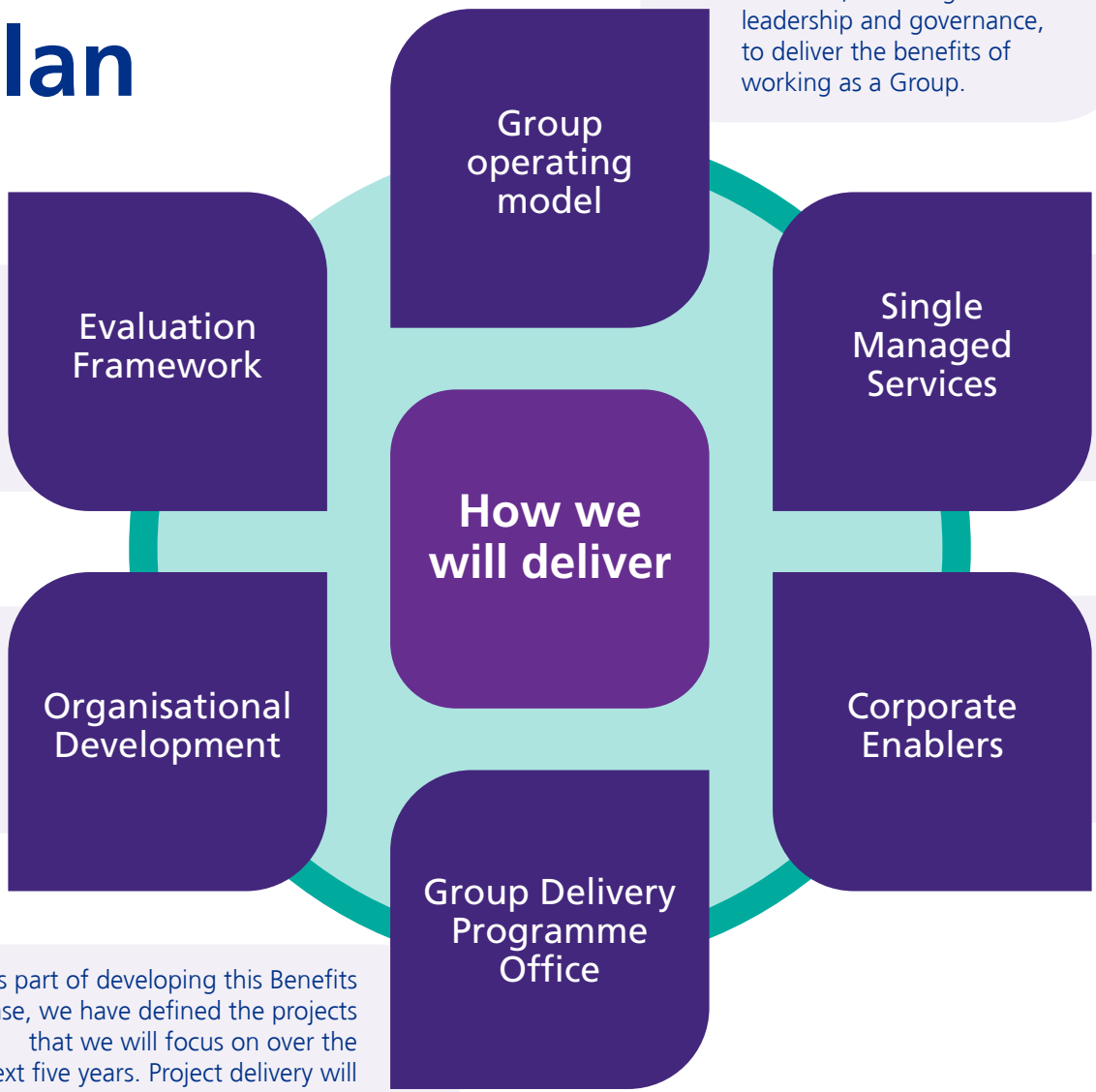
Our objectives	Our patients	Our population	Our people	The public purse
We will strive to be the best possible partner we can be.				
We will advocate for our patients and services with one voice.				
We will raise our profile and celebrate our successes.				
We will use our role as anchor institutions to improve population health, drive economic growth and support environmental sustainability.				

Working with our partners as one team

To deliver our objectives, **we will prioritise the following actions:**

- We will create a single point of access for community and industry partners and by doing so, make it easier for them to understand where to go and how to work with us.
- We will reduce and remove red tape so that potential partners find it easy and enjoyable to work with us.
- We will develop and use our Group brand to raise our profile and to reinforce that we are "one team".
- We will reduce duplicate representation at system meetings – allowing us to speak with a single voice for the acute sector in BNSSG and releasing the time of our leaders.
- We will deliver clear and more consistent messages about the needs of our services, patients and populations.
- We will speed up decision making to deliver what our system partners need of us.
- We will engage with and listen to our patients and populations to ensure that we are advocating for their needs.
- We will build our reputation as a great place to work, thereby helping us to attract and retain the talent of the future.
- Through our role as anchor institutions we will work with partners to improve the health and wellbeing of our local population and drive economic growth for the benefit of our communities.
- We will work together to support environmental sustainability and decarbonisation by developing an effective and planned approach to achieving net-zero emissions by 2040, in line with the NHS target.

Delivery Plan



Our Group Operating Model shows how we will organise ourselves, including our leadership and governance, to deliver the benefits of working as a Group.

Our Single Managed Services programme is supporting our clinical teams to work together to deliver the Joint Clinical Strategy.

Our corporate teams are working together to align policies, processes and systems to enable us to operate as a Group.

As part of developing this Benefits Case, we have defined the projects that we will focus on over the next five years. Project delivery will be driven by our Group Delivery Programme Office.

We are creating a culture of collaboration. We will support our teams to work together, while retaining the identity of people's place of work.

We are working with our academic partners to create an evaluation framework to test the effectiveness of the Group Model against our four Ps.

What will success look like in five years?

If we are successful:

- Patients will wait less time to be diagnosed and treated, and they will have the same high-quality experience and outcomes, regardless of who they are or where they live
- We will meet rising demand by maximising the use of our available resources
- More care will be delivered nearer to patients; in their homes or the community
- Digital technologies will have transformed the way we work and the way we deliver care
- Our people will feel engaged, energised and empowered by their work
- We will be known as a place where people enjoy working, training and building a career
- Our volume of globally renowned research and innovation will have grown significantly
- We will contribute to system financial balance

Voices of the future If we are successful:

Our Patients

I'm used to having to tell and retell my health story to different people. It made a refreshing change that the doctors at both hospitals knew all about me and we didn't have to go back over old ground.

I was seen and diagnosed really quickly and began my treatment soon after giving me peace of mind.

I was proud and grateful to be part of a clinical trial that helped me and will help many others too.

Our Population

It's amazing to benefit from the pioneering research that's happening across the hospitals that look after me.

I was really anxious about going to a big hospital, so I was grateful to be seen close to my home instead.

They've got some great jobs for local people. I never thought I'd get to work for the NHS but there's so many opportunities.

My local hospital is world class.

Our People

Working across sites is easy to do and I'm getting access to experience that I wasn't before which is helping me develop my skills and my future career too.

We've got each other's backs. When my team needs support, it's given, and we do the same in return. We are one team.

Our systems and teams talk to each other. This is a better experience for my patients who are having treatment at both Trusts, and it makes my job quicker and easier too.

The Public Purse

What they give back to local communities is making a real difference.

The patient really does come first, which is why we're all here after all.

They are so easy to work with. We really are one team - this is true collaboration.

I know if a member of my family needs healthcare they'll be getting the very best, on our doorstep.

NHS
Bristol
NHS Group
Bristol | Weston

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public		
Date of Meeting:	8 April 2025		
Report Title:	Group name		
Report Author:	Emma Mooney, Director of Communications UHBW Elliot Nichols, Director of Communications NBT		
Report Sponsor:	Maria Kane, Joint Chief Executive NBT & UHBW		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	Yes		
	This report provides an overview of engagement undertaken to test the preferred name 'Bristol NHS Group' with key stakeholders to inform Board decision making on the name.		

Key Points to Note *(Including any previous decisions taken)*

The following report builds on updates provided to the Boards at meetings on 3 December 2024 and 5 February 2025, when the Boards supported Bristol NHS Group as the preferred option in principle and supported moving to testing this name with key stakeholders.

The outcome of the engagement was presented to Joint Executive Group on 19 March 2025 who supported bringing the name Bristol NHS Group for consideration and approval by both boards at the meeting in common on 8 April 2025.

Strategic and Group Model Alignment

The report aligns with the strategic direction to form a Group between North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).

Risks and Opportunities

The name of the Group is a key component to progress formally launching the partnership. There is a risk that in the absence of an agreed name, the space will be filled by multiple alternatives which would lead to confusion.

Recommendation

This report is for **Approval.**

The Boards are asked to:

- Note the engagement undertaken and feedback obtained during testing the preferred name for the Group.
- Approve the name Bristol NHS Group
- Approve the NHS logo for the Group
- Approve the approach to application of the Group name.

History of the paper (details of where paper has <u>previously</u> been received)	
N/A	N/A
Appendices:	N/A

1. Purpose

This report provides an overview of engagement undertaken to test the preferred name 'Bristol NHS Group' with key stakeholders to inform Board decision making on the name.

2. Background

It was felt necessary to have a name for the Group which made it easy to refer to, and better signalled our partnership intentions rather than just being the sum of two hospital trusts. In developing a name for the Group, the following has been taken into account:

- Careful review of feedback obtained from a number of internal workshop and engagement sessions, which took place between December 2024 and February 2025. These involved NBT and UHBW Boards, Senior Leadership teams from both organisations and UHBW Council of Governors.
- Adherence to NHS Identity Guidelines on partnership branding, specifically naming principles, NHS logo development (NHS partnership logo = NHS + Geographic reference + partnership descriptor) and application.

Through this process 'Bristol NHS Group' emerged as the preferred option.

This option along with the key themes obtained during feedback, shortlisted options explored and plan for wider stakeholder testing of the preferred name was presented to both Boards in February 2025. Both Boards supported the preferred option in principle and moving to testing Bristol NHS Group with key stakeholders.

3. Stakeholder engagement – Bristol NHS Group

3.1 Approach

Engagement to test the preferred name was undertaken during March 2025 and outlined how a range of factors had been considered in reaching this option. These included ensuring the name is clear and logical, aligned with NHS brand guidelines, and geographically relevant while recognising the importance of inclusivity.

Stakeholders were invited to comment on the name and whether it appropriately signified the Group's aims and ambitions in a simple collective way, whilst recognising the Trusts continue to serve local populations.

Stakeholders included staff from NBT & UHBW, NBT Patient and Carer Partners Forum, BNSSG ICB and wider integrated care system partners such as Local Authorities, Primary Care, university partners, elected representatives, and patient and carer forums.

Communications and engagement activities during this period included, written correspondence, 1:1 conversations, focused engagement sessions, meetings and forums, and the recent Strategic Partnership Event, where it was discussed in detail by 69 delegates from across the community and system.

3.2 Feedback

Overall, there is a large majority in support of 'Bristol NHS Group'. A summary of wider feedback received is outlined below:

- The name is simple, strong and will resonate. People will still refer to the local hospitals e.g. Weston General Hospitals, Bristol Royal Infirmary, Southmead etc and felt that this would ensure local identity would not be adversely impacted.
- The term 'Group' continued to be supported as the partnership descriptor.
- Strong support for maintaining the NHS brand, with no suggestions to deviate.
- Some views that inclusion of the word 'hospital' should be considered as the Group will not encompass all health provision. However, more feedback supports not including (or does not mention inclusion of) the word so the name better aligns with national direction and 'left shift' of hospital to community and better reflects that not everything the Trusts do is carried out within the four walls of a hospital.
- Some support for including Healthcare or Health and/or Care. Stronger view that this was explicit in the NHS elements of the name and should not be included.
- Mixed views remain around inclusion of Weston in the name and can be summarised as:
    - Without inclusion the name is too grounded in Bristol, and this may impact on recruitment and movement of clinical workforce if everything is perceived to be geographically rooted in Bristol.
    - Staff in Weston have been through difficult and uncertain times over a number of years prior to merger.
    - Including Weston is too similar to UHBW and might lead to confusion.
- Much more effective at signalling intentions to wider partners – academic, commercial, and global.

3.3 NHS logo

The proposed logo for the Group is shown below. References to the locations of our main hospital sites (Bristol and Weston) have been added to ensure inclusivity.

NHS
Bristol
NHS Group
Bristol | Weston

In addition, and in line with NHS guidelines, when the Group logo is used the following text will be included on the document carrying the logo to ensure transparency of the accountable organisations who make up the Group:

A partnership between:

North Bristol NHS Trust and

University Hospitals Bristol and Weston NHS Foundation Trust

When the individual Trust logo is used:

The following text could be included for example on a letterhead to indicate the organisation is part of the Group:

Part of Bristol NHS Group

3.4 Application of the name

During engagement it was clear that application of the Group name will be important to ensure local Trust identities are maintained.

It is envisaged that most of the time it will be the individual Trust logos and names that are used, for example in patient correspondence, signage on sites and vehicles, individual organisational templates such as correspondence from the Hospital Managing Directors, social media, websites and the majority of internal communications.

Group branding would be used on official correspondence from the Joint Chair or Joint CEO office, joint strategies and documents such as the Summary Benefits Case, internal messaging from the Joint CEO/Chair etc and stakeholder events and updates.

4. Summary and Recommendations

The Boards are asked to:

- Note the engagement undertaken and feedback obtained during testing the preferred name for the Group.
- Approve the name Bristol NHS Group
- Approve the NHS logo for the Group
- Approve the approach to application of the Group name.

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public		
Date of Meeting:	8 April 2025		
Report Title:	Joint Clinical Strategy Update		
Report Author:	Valerie Clarke, Programme Director		
Report Sponsor:	Tim Whittlestone, Chief Medical Officer, NBT Rebecca Maxwell, Chief Medical Officer, UHBW		
Purpose of the report:	**Approval**	**Discussion**	**Information**
		X	**X**
	The purpose of the paper is to provide an update on the implementation of the Joint Clinical Strategy that includes the launch of our first Group Clinical Service in our pathfinder speciality, Cardiology and sets out an overview of the wider delivery plan for 2025-26.		

Key Points to Note *(Including any previous decisions taken)*

- The **Group Cardiac Service** is central to the development of our Hospital Group and its launch is a significant milestone in the maturation of the Joint Clinical Strategy.
- An Accountability Framework, Delegation Agreement and Group Staff Sharing Agreement are all agreed and support the governance of the Group Cardiac Service.
- In Phase 1 of our Joint Clinical Strategy, all 44 duplicated services have been mapped to one of the three Group clinical operating models and prioritisation of implementation is underway across a two-year horizon; the split is Group Clinical Model (29 specialities), Aligned Services (11 specialities). 4 services have been reclassified as Clinico-Corporate services.
- Our pathfinder learning means that we can now accelerate the implementation of Group Clinical Services in Q1 2025/26 (Trauma & Orthopaedics, Haematology, Liaison Psychiatry, Safeguarding, Dermatology, Rheumatology and Pain Services).
- In addition, minimum standards are in development for the 11 Aligned.
- Patient and Carer Engagement will be further strengthened with the introduction of a Patient and Carer Partnership Group (PCPG) that build on our initial engagement activities.
- An Equalities Framework is also in development that will ensure the equity lens informs our programme and contributes toward “left shift” opportunities.
- A key next step priority of the Group Cardiac Service is to identify opportunities for population disease prevention, out of hospital testing/treatment and the deployment of left shift methodology to its practice and pathways.

Strategic and Group Model Alignment
The launch of the first single managed service (SMS), the Group Cardiac Service, is an important milestone in the delivery of the Joint Clinical Strategy and therefore supports the progress of the Group Model.
Risks and Opportunities
• There is a risk that if we do not properly record the details of how the Group Cardiac Service will work, with clarity around delegated authority/responsibility, accountability arrangements, and responsibility for shared/jointly appointed staff, we will not be able to evidence to patients, staff, regulators and the public that our arrangements are robust. • There is a risk that continued duplicity of service management and delivery will result in us failing to realise the benefits of a single service. • 2025-26 will be a "shadow" year when we will continue to develop the Accountability Framework based on the Group Cardiac Service and further roll-out. This provides an opportunity for us to refine our approach as we learn by doing. • Undoubtedly, the creation of a Group Executive (subject to ongoing consultation) will simplify the accountability framework of Group Services and will provide additional assurance for benefits realisation. This move is supported by the learning from Cardiac Services. • There is an opportunity for the single management team in Cardiac Services to now consider the wider potential for pre-hospital and out of hospital patient and population care, to de-scale the density of work provided in specialist settings whilst ensuring the Bristol becomes recognised as a centre for cardiac excellence and a beacon of cardiac research. • There is an expectation that the senior managers in the Group Cardiac Service (clinical and non-clinical) will mentor those individuals embarking on the Single Managed Service journey in other specialities.
Recommendation
The Board of Directors of University Hospitals Bristol and Weston, in common with The Board of Directors of North Bristol NHS Trust are asked to note the significant milestone that the launch of your Group Cardiac Service represents. We invite you also to note: • The next steps for the 2025-26 delivery plan • The introduction of the Patient and Carer Partnership Group, which will hold its first meeting in July 2025.
History of the paper (details of where paper has <u>previously</u> been received)
N/A

Appendices:	Presentation will be provided at the Board

1. Purpose

1.1 The purpose of the paper is to provide an update on the implementation of the Joint Clinical Strategy that includes the launch of our first Group Clinical Service in our pathfinder speciality, Cardiology and sets out an overview of the wider delivery plan for 2025-26.

2. Background

2.1 Our Joint Clinical Strategy was published in March 2024, and over the last 12 months we have had eight single managed service projects underway, progressing at different paces, providing learning for their specialities and the remaining duplicated services.

2.2 As part of the Hospital Group development, we have defined the three Group clinical operating models that all services will follow and developed an Accountability Framework, necessary to establish the Group Clinical Services.

2.3 Our pathfinder work means we have now achieved a significant milestone that will enable us to accelerate the single managed services programme to realise benefits for our patients, our people, the population we serve and the public purse.

3. Group Clinical Service Launch

3.1 The Group Cardiac Service will launch mid-April with UHBW's Specialised Services Division taking the lead on the ongoing development of this Group Clinical Service. The Cardiology Leadership Forum that has overseen the collaboration to date will be repurposed to the Cardiac Service Delivery Group. NBT's Medicine Division will provide continued support for a shadow period as will the JCS Programme team.

3.2 The Joint Executive Group approved the Accountability Framework that sets out how the Group Cardiac Services will run, enabled by collaborative working across the corporate functions. The Accountability Framework is supported by a Delegation Agreement between both trusts and an overarching Group Staff Sharing Agreement that facilitates individual staff members working across both sites. These are key foundations for all future Group Clinical Services.

3.3 Our Joint Clinical Strategy has been pivotal in providing a clear strategic direction for clinical services in Bristol and Weston as well as introducing Single Managed Services as the critical vehicle for delivery. We learned many important lessons and principles from our Group Cardiac Service:

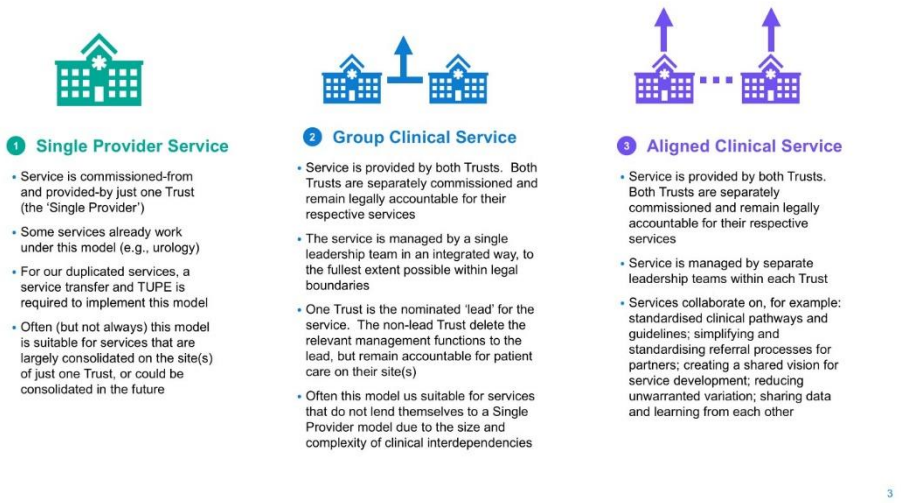
- Asking teams to come together for the benefit of the whole population is a principle that clinicians and service managers can readily understand.
- Bringing together teams from our two Trusts that have traditionally competed and often had significant differences is challenging but ultimately possible through a development programme that debunks myths, shares opportunities and challenges and puts patients first. Involving clinical teams early in the process is key.
- Removing organisational boundaries – governance, financial, physical estates, workforce and digital – are critical to the full deployment of a Group Service.

- Removing accountability and strategic ambiguity, ensuring single lines of accountability and clear ultimate Executive responsibility strengthens and hastens the Group Service and should be a priority of the Group moving forward.
- A stepwise, structured and incremental programme for population and patient engagement is essential for the Group Service to adapt its clinical pathways for maximum benefit, community engagement and left shift realisation.
- Providing additionality for management time, thinking time, planning and non-direct clinical care medical time is crucial for the planning and delivery of Group Services.

4. Existing programme and 2025-26 priorities

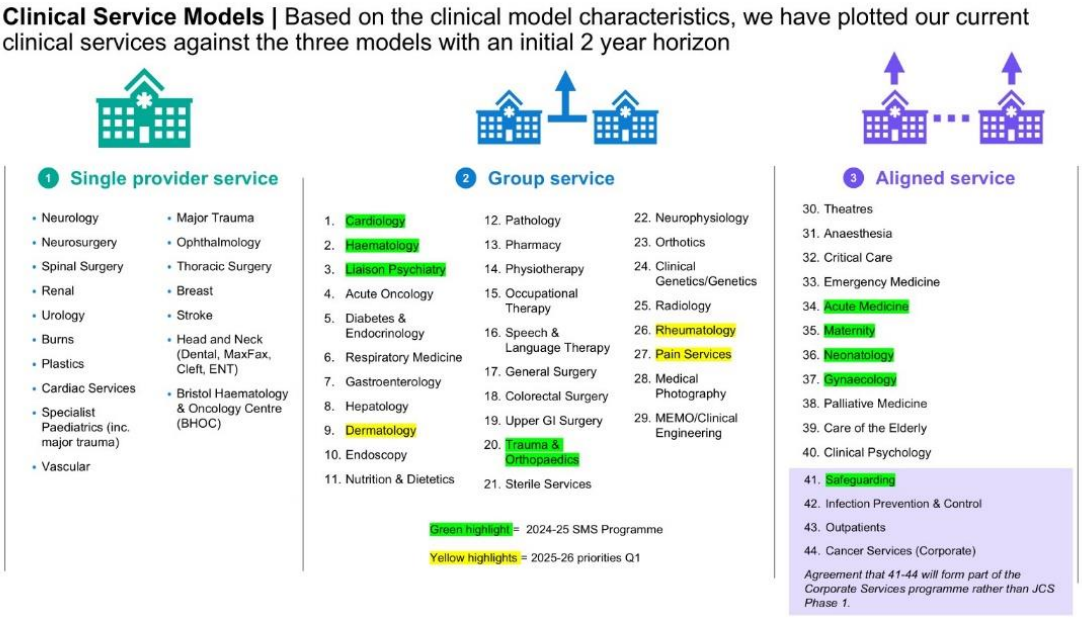
4.1 Three Group clinical operating models have been defined as part of Phase 1 of the Joint Clinical Strategy as outlined in Figure 1.

Figure 1



4.2 All 44 duplicated services have been allocated to one of the model, as summarised in Figure 2 below. Most specialities lend themselves to a Group Clinical Service model (29), with Aligned Services (11) and the remainder (4) to be progressed as part of the corporate services work.

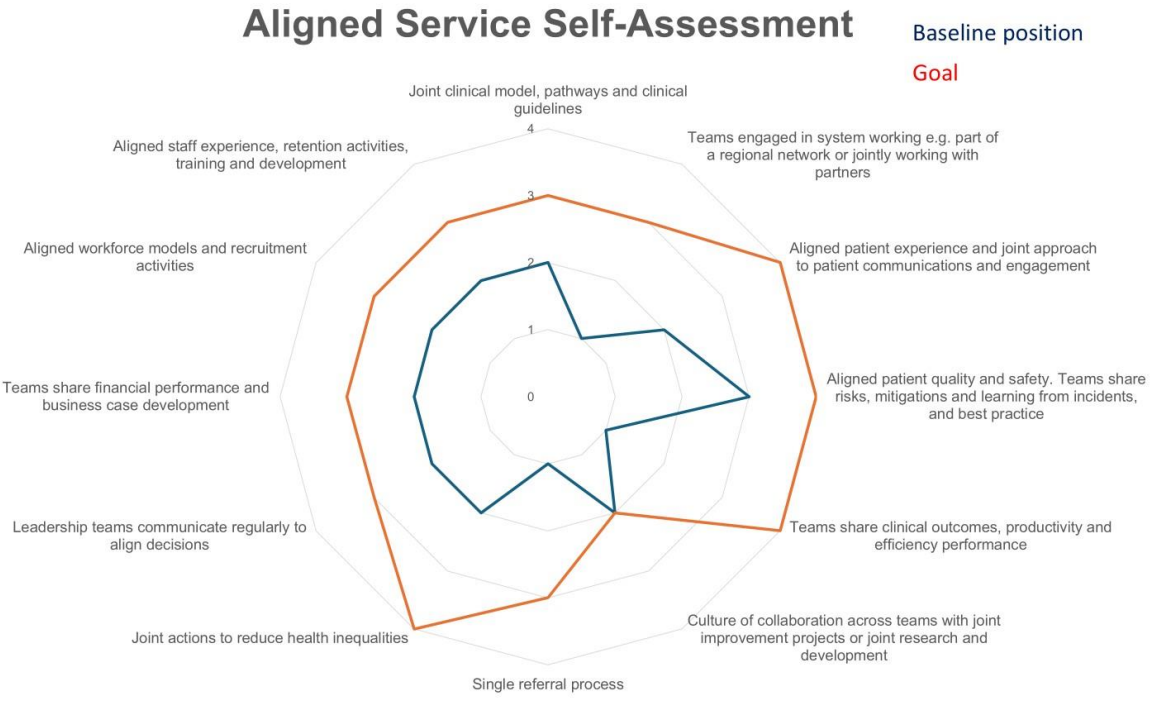
Figure 2



4.3 In 2025-26, a further 7 specialities are on track to form Group Clinical Services (1. Trauma & Orthopaedics, 2. Haematology, 3. Liaison Psychiatry, 4. Safeguarding, 5. Dermatology, 6. Pain Services, 7. Rheumatology) and the remaining specialities will be scheduled over a two-year horizon.

4.4 In parallel, the specialities working towards Aligned Services will participate in a supported programme where minimum standards will be set for joint working that teams will work towards. The speciality teams will undertake a joint self-assessment of their existing levels of alignment and will set shared goals that strengthen their collaboration. Figure 3 illustrates the tool that is in development. In the future, aligned services can progress to Group Clinical Services.

Figure 3

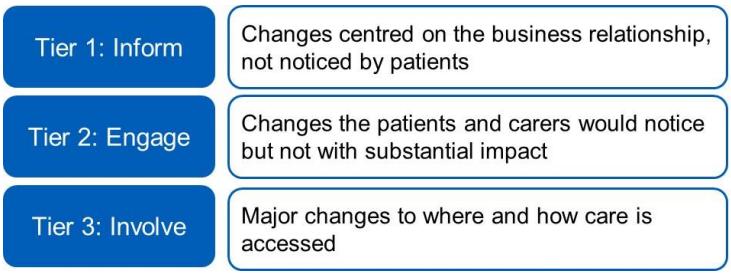


5. Patient and Carer Engagement

5.1 The Cardiology and Maternity, Neonatology and Gynaecology pathfinder SMSs have adopted a range of engagement practices to understand the experiences of patients. For Cardiology, this included focus groups (both in-person and virtual), patient conversations, and surveys, with 477 patients actively participating. These interactions have informed the design of the Group Cardiac Service model and our approach to effective engagement for subsequent Single Managed Services.

5.2 There is a strong working relationship between the respective patient and carer experience teams at NBT and UHBW. The teams are committed to supporting and enabling a proportionate and appropriate approach to engagement across the services which constitute the SMS programme. A tiered approach to engagement will focus on the scale of proposed service change and the potential impact on patients and carers as outlined in Figure 4.

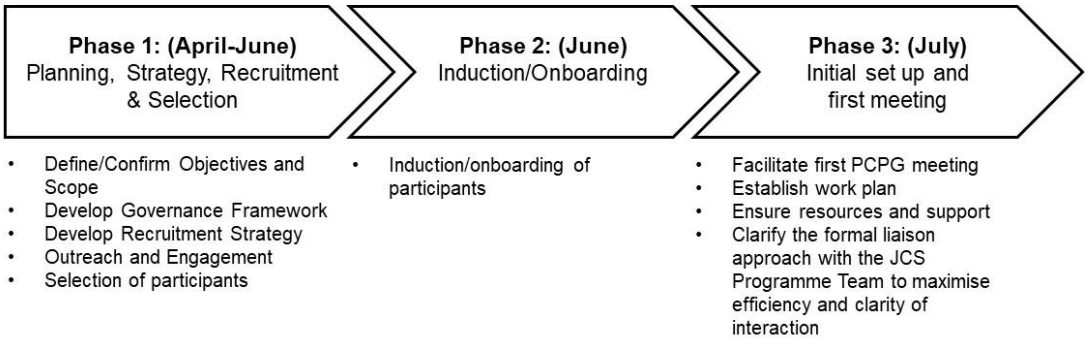
Figure 4



5.3 To support this programme, a Patient and Carer Partnership Group (PCPG) will be formed to provide independent oversight, advice and input on planned patient and public engagement. It does not have formal decision-making powers, which are reserved to the project groups overseeing each individual SMS. The PCPG will have diverse representation of people from our communities, Patient and Carer Partners (at NBT) and Governors (at UHBW), providing opportunities for new voices to be heard. Expected input from the group includes exploration of cross-cutting issues affecting patients and carers, such as transport, parking and visiting arrangements, providing independent assessment of appropriate tiers of engagement and reviewing key outputs within each SMS programme, including draft Quality and Equality Impact Assessments.

5.4 Several important tasks need to be undertaken to set up the PCPG. Implementation will be in three phases, as summarised in Figure 5 below, with first meetings of the group scheduled for July 2025.

Figure 5



6. Equalities Framework and supporting the 'left shift'

6.1 We have been developing an Equalities Framework to ensure our programme has addressing inequalities as a fundamental aim for each SMS project.

6.2 There is an opportunity for the single management team in Cardiac Services to now consider the wider potential for pre-hospital and out of hospital patient and population

care, to de-scale the density of work provided in specialist settings whilst ensuring the Bristol becomes recognised as a centre for cardiac excellence and a beacon of cardiac research.

6.3 A key next step priority of the Group Cardiac Service is to identify opportunities for population disease prevention, out of hospital testing/treatment and the deployment of left shift methodology to its practice and pathways.

6.4 A stepwise, structured and incremental programme for population and patient engagement is essential for the Group Service to adapt its clinical pathways for maximum benefit, community engagement and left shift realisation.

7. Recommendations

The Board of Directors of University Hospitals Bristol and Weston, in common with The Board of Directors of North Bristol NHS Trust are asked to note the significant milestone that the launch of your Group Cardiac Service represents.

We invite you also to note:

- The next steps for the 2025-26 delivery plan
- The introduction of the Patient and Carer Partnership Group, which will hold its first meeting in July 2025.

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public		
Date of Meeting:	8 April 2025		
Report Title:	UHBW 25/26 Operating Plan		
Report Author:	Rebecca Dunn, Director of Business Development and Improvement Evelyn Elliott, Head of Commissioning and Planning Jeremy Spearing, Director of Operational Finance David Markwick, Director of Performance Emma Harley, Head of Strategy Workforce Planning and Intelligence		
Report Sponsor:	Jane Farrell, Chief Operating Officer & Neil Kemsley, Chief Financial Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			Y
	To inform the Board of the detail of the UHBW 25/26 Operating Plan, as submitted to NHSE on 27th March 2025.		

Key Points to Note *(Including any previous decisions taken)*

This report summarises the UHBW 2025/26 Operating Plan. It provides an overview of the activity and performance, finance and capital and workforce plans that have been submitted as part of the Bristol, North Somerset and South Gloucestershire Integrated Care System submission to NHS England (NHSE) made on the 27 March 2025.

The UHBW 2025/26 Operating Plan, and the BNSSG ICS Operating Plan is compliant with all the NHSE requirements across performance, finance and workforce.

Performance and activity

The plan is compliant with all national performance requirements. A focus of the work has been on working with divisions to identify productivity. Appendix 1 details the productivity opportunities that were provided by NHSE and are included within UHBW's plan.

The assumed impact of the Elective Centre which is expected to open in Q2/3 has also been included in the performance and activity plans.

Finance

The plan is compliant with breakeven requirements associated with income and expenditure, and capital. The plan is based on delivering £53m of savings. Opportunities for efficiency have been provided by NHSE and incorporated into the UHBW plan. These are detailed in Appendix 2.

Adding to the savings requirement, the plan includes Trust investment decisions to resolve critical quality/safety issues totalling £4.0m.

The Trust capital plan of £44.8m assumes over-programming at c25% (based on previous years); work will be completed in 25/26 to more accurately programme capital expenditure and remove the reliance on overprogramming.

The Trust will need to continue to work on delivery of the financial plan; the key next steps are:

- PFIG materially progressing the savings identification and managing the subsequent delivery against the £53.0m savings requirement;
- Securing formal agreement of Associate Commissioner funding envelopes;
- Finalising the costs associated with elective activity delivery within the envelope available on the expectation of improved productivity;
- Full testing of the Trust's workforce controls and VCP processes in light of the requirement to reduce workforce back to funded establishments;
- Re-visiting the Trust's capital plan in response to the outcome of the national capital bids via the Trust's Capital Group and Capital Programme Steering Group; and
- In light of the risks within the Trust's financial plan, the Trust will look to fully mitigate these during quarter 1 and undertake a formal forecast outturn assessment based on quarter 1 financial results that will inform a potential re-setting of the financial plan, particularly savings and elective activity delivery.

Workforce

The plan is compliant with the workforce reductions that have been outlined by NHSE. The plan assumes a reduction in substantive staff of 337.5 FTE, this is partially offset by investments totalling 175 FTE, leaving a net change of -162.5 FTE to Staff in Post. It is anticipated that this can be achieved through vacancy controls, utilising turnover and attrition. Significant reductions in bank and agency staff are also included, which will support delivery of the Trust savings targets.

Risks to delivery of plan

The key risks to the Trust delivery of the 2025/26 plan are detailed within the report. Operational, financial, quality and workforce risks have been identified and work will be ongoing throughout the financial year to mitigate these risks.

Next steps

- The operating plan for 2025/26 has been approved, and received Board assurance, via the Finance, Digital and Estates Committee on 25th March 2025; the NHSE Board Assurance document can be seen in Appendix 3.
- UHBW has now moved into delivery. This involves further communication and engagement with Divisions, and with staff more widely, and the establishment of monitoring to ensure that delivery is kept on track throughout the financial year.
- Delivery of the plan will be led by the Clinical Divisions and supported by the Trust Executive and corporate functions.
- Included within the delivery of the plan are priorities for improving health inequalities. These have been developed in partnership with the ICS and can be seen in Appendix 4.
- Monitoring of the 25/26 Operating Plan will be ultimately overseen by the Trust Board, with Executive Committee providing oversight of the various Executive-led subgroups with responsibility for the different components of the plan: for example, the Planning and Delivery Group, the Capital Programme Steering Group, the Clinical Quality Group and the Performance and Finance Improvement Group.
- Where the UHBW operating plan interfaces with partner organisations, the Integrated Care System Operational Delivery Groups and Health and Care Improvement Groups will be utilised.

- Partnership working and collaboration will underpin both the delivery of the BNSSG System Plan and the UHBW Operating Plan for 2025/26.

Strategic and Group Model Alignment

This report is directly linked to the following Patient First objectives:

- 'Making the most of our resources'. Achieving break-even ensures our cash balances are maintained and therefore we can continue to support the Trust's strategic ambitions subject to securing CDEL cover.
- 'Timely care', together, we will provide timely access to care for all patients, meeting their individual needs.
- 'Experience of care', together, we will deliver person-centred, compassionate and inclusive care every time, for everyone.

It has been constructed working in partnership with NBT and the ICB.

Risks and Opportunities

The plan is ambitious and there are key risks associated with delivery as set out in section 6.

Recommendation

This report is for **Information.**

Trust Board is asked to note that the UHBW 25/26 Operating Plan was approved by the Finance, Digital & Estates Committee and has been submitted to NHS England. UHBW has moved swiftly into delivery of the plan for the new financial year.

History of the paper (details of where paper has <u>previously</u> been received)

Finance, Digital and Estates Committee	25 March 2025

Appendices:	Appendix 1: Productivity data Appendix 2: Savings plan maturity levels Appendix 3: Board assurance framework Appendix 4: Health inequalities

University Hospitals Bristol and Weston NHS Foundation Trust

UHBW 2025/26 Operating Plan

Public Board
8th April 2025

University Hospitals Bristol and Weston NHS Foundation Trust

UHBW 2025-26 Operating Plan

Contents

Tables

University Hospitals Bristol and Weston NHS Foundation Trust

1. Introduction

1.1 Purpose

1.1.1 The purpose of the paper is:

- To inform the Board of the detail of the University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) 2025/26 Operating Plan, as submitted to NHS England (NHSE) on 27th March 2025.

1.2 External context

1.2.1 National planning guidance[i], published by NHSE, was issued on the 30th January (delayed from expected release in December 2024). The guidance has reduced the number of key priorities for 2025/26:

- Elective Care & Waiting Times: Aiming to ensure 65% of patients receive elective treatment within 18 weeks by March 2026. Each Trust is expected to deliver a 5% improvement. For cancer, systems should aim for 75% compliance with the 62-day diagnosis standard and 80% with the 28-day Faster Diagnosis Standard by March 2026
- Improve A&E waiting times and ambulance response times compared to 2024/25. By March 2026, at least 78% of patients should be seen within four hours in Accident & Emergency (A&E).
- Improve patient access to general practice and improve their experience, while also increasing access to urgent dental care by providing 700,000 additional urgent dental appointments.
- Improve patient flow in mental health crisis and acute pathways by reducing the average length of stay in adult acute beds. Improve access to mental health services for children and young people, aiming to provide care to 345,000 more individuals aged 0 to 25 compared to 2019.

1.2.2 Systems have been asked to deliver the priorities whist continuing to collaborate to:

- Implement reforms;
  - developing neighbourhood health service models (hospital to community)
  - transitioning from analogue to digital, and
  - tackling health inequalities (treatment to prevention)
- Operate within financial budgets and improving productivity
- Prioritise quality and safety of services

1.2.3 The revenue finance and contracting guidance has been set out to support the delivery of the planning guidance. The guidance sets out the arrangements for capping ERF (Elective Recovery Fund) as a fixed allocation (based on month 8 24/25 forecast outturn (FOT)), and capping activity through the use of contractual leavers with both acute trusts and independent sector providers.

1.3 Approach taken to developing the operating plan

1.3.1 The 2025/26 UHBW operating plan has been developed in collaboration with Divisional leadership teams, partners at North Bristol Trust (NBT) and at the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Board (ICB). Working closely with the Divisions a balanced approach to performance delivery and financial management has been achieved. Information provided by NHSE on productivity and efficiency opportunities has been integral to the development of the UHBW plan.

1.3.2 Workforce changes have responded to NHSE requirements and carefully triangulated to savings and investment plans through liaison with various corporate and Divisional teams. Furthermore, realistic targets for key workforce indicators have been agreed through Executive Committee and are aligned to savings plans.

1.3.3 Divisional issues have been collated from known issues raised in Divisional Strategy Deployment Reviews, through Trust governance groups and through review of Divisional risk registers. Risks and

issues have been reviewed and prioritised jointly with the Trust senior leaders, through Planning and Delivery group and Executive Committee.

1.3.4 Non-financial mitigation to clinical risks and quality issues has been encouraged and supported by Executives through Divisional leadership teams wherever possible. Where investment is the only identified means of mitigating a high risk or quality issue, this has been heavily scrutinised by both local and corporate clinical leadership before conclusions have been reached at Executive level.

1.3.5 Changes to service delivery, be that resulting from savings plans or through improvement or transformation work, are tested through UHBW's well established Quality and Equality Impact Assessment (QEIA) process, with line of sight to the Trust Clinical Quality Group and Board-level Quality Committee.

1.3.6 The Trust capital plan has been developed in conjunction with Divisions and iterated through the Capital Programme Steering Group. It responds to opportunities for use of National Capital over and above CDEL (Capital Department Expenditure Limits) restrictions. Furthermore, new system planning mechanisms (an ICB led System Capital Board) have enabled stronger collaboration with local partners than ever before. This has strengthened the development of the System Plan and will ensure that available capital reaches the areas of greatest of need across BNSSG.

1.3.7 Where appropriate, business cases to support the need for investment are moving through the business development process for scrutiny and support across all disciplines.

2. Activity Plan

2.1 Summary of system and Trust approach

2.1.1 The Trust has worked collaboratively with system partners to agree consistent planning assumptions for the 2025/26 annual plan. The Trust approach was initiated with a demand-based modelling exercise to inform activity requirements. This model was based on achieving the national ambitions related to Referral to Treatment (RTT) performance by 31st March 2026. The modelling also focussed on ensuring that both cancer and diagnostic waiting times could achieve the national and local ambitions.

2.1.2 Demand modelling was shared with Divisions who subsequently developed a series of delivery plans describing schemes that will be introduced or continued that will support the levels of activity required to meet the ambitions referenced above. Divisional delivery plans have primarily been focused on productivity benefits and are being reviewed and stress-tested by corporate colleagues, ensuring that the plans are well defined, feasible and affordable.

2.2 Independent sector utilisation

2.2.1 The Trust's review of current independent sector utilisation continues to contribute towards a system wide evaluation of contracted and subcontracted services. Whilst a number of existing contracts will be extended into 2025/26, the delivery planning process is exploring opportunities to repatriate activity from the independent sector to be delivered by the Trust.

2.3 Approach to productivity

2.3.1 The delivery planning process has encouraged Divisions to consider how productivity improvements could address any modelled gap between capacity and demand. The Trust undertook demand and capacity analysis using Gooroo Planner (a modelling tool). The future requirement to achieve a sustainable waiting list size was compared with both the current 2024/25 baseline, but also the activity delivered in the same period in 2019/20. This has enabled the corporate team to explore with divisions how productivity levels could be restored to 2019/20 levels through check and challenge sessions.

2.3.2 **Theatre improvement**
The Trust has an established theatre improvement programme. The focus of this programme in 2024/25 was on establishing 6-4-2, scheduling and utilisation meetings for adults and paediatrics. The benefits of this approach have become business as usual with the Trust now consistently delivering over 80%

capped utilisation. In 2025/26, the Trust's theatre improvement programme will be refocussed to consider the perioperative pathway. The objective is to develop a consistent framework for the Trust's pre-operative assessment services that meets national guidelines. At present, pre-operative assessment is delivered on several different sites by different clinical teams. There will be a consideration of how patients are identified for optimisation in advance of surgery and prehabilitation services. It is anticipated that this approach will reduce the number of last-minute cancellations associated with patients not being fit on the day of their procedure or their operation not being needed. This will also further improve capped utilisation rates towards the Getting It Right First Time (GIRFT) standard of 85% by reducing downtime associated with last minute cancellations. The focus on optimisation also has the potential to reduce length of stay and improve the outcomes for patients admitted for surgery.

2.3.3 **Outpatient programme**

The Trust has an established outpatient improvement programme. In 2024/25, the focus of this programme was on realising the benefits of deploying the DrDoctor patient engagement portal. In 2025/26, there will continue to be a focus on optimising the use of DrDoctor Appointment Notifications, Reminders and Digital Letters. There will also be a new focus on expanding the use of DrDoctor Basic Rescheduling in preparation for a later roll out of Patient Led Booking. The Trust is participating in the national pilot for the Wayfinder project. This enables patients to receive notifications, reminders and letters in the NHS App rather than via the DrDoctor patient engagement portal. The incorporation of Digital Letters in the NHS App is pending. There will also be a focus on the delivery of the Outpatients 2025 business case including the standardisation of clinic builds, establishment of a modern call centre function and corporately led scheduling of outpatient activity. Finally, this programme will also incorporate some of the priorities outlined in the national planning guidance including the expansion of Advice and Guidance services and increase in the use of Patient Initiated Follow Ups (PIFU) for benchmarked specialties like Ophthalmology.

2.4 Summary of Trust activity plan

2.4.1 The Trust activity plan steps up from the previous rolling 12 months and shows a significant increase in activity levels delivered in 2019/20. The ambition to prevent patients waiting 52 weeks or longer and meet core elective care performance targets necessitates this increase and is supported by the operational divisions' productivity-driven delivery plans. The principal risks to delivery are due to limited beds, high volumes of patients with no criteria to reside (with associated length of stay increases) and workforce challenges.

2.4.2 An overview of the Indicative Activity Plan (with Trust adjustments to the 19/20 baseline) is shown below:

Table 1: Trust 2025/26 indicative activity plan

				Plan vs 2024/25		Plan vs 2019/20	
Point of Delivery	**2019/20 Outturn**	**2024/25 FOT**	**2025/26 Plan**	**Difference**	**% Difference**	**Difference**	**% Difference**
Elective Day Cases	74,620	79,497	84,280	4,783	106.0%	9,660	112.9%
Elective Inpatients	14,075	14,605	15,021	416	102.8%	946	106.7%
TOTAL Electives	**88,695**	**94,102**	**99,301**	**5,199**	**105.5%**	**10,606**	**112.0%**
New Outpatients	283,866	281,753	296,795	15,042	105.3%	12,929	104.6%
Follow Up Outpatients	597,622	666,918	686,666	19,748	103.0%	89,044	114.9%
TOTAL Outpatients	**881,488**	**948,671**	**983,461**	**34,790**	**103.7%**	**101,973**	**111.6%**
Emergency Zero LoS	21,214	36,353	39,637	3,284	109.0%	18,423	186.8%
Non Elective Zero LoS	526	198	194	-4	98.0%	-332	36.9%
TOTAL Non Elective Zero*	**21,740**	**36,551**	**39,831**	**3,280**	**109.0%**	**18,091**	**183.2%**
Emergency 1+ Day LoS	42,186	43,618	45,263	1,645	103.8%	3,077	107.3%
Non Elective 1+ Day LoS	2,959	1,984	1,919	-65	96.7%	-1,040	64.9%
TOTAL Non Elective Zero*	**45,145**	**45,602**	**47,182**	**1,580**	**103.5%**	**2,037**	**104.5%**
ED Attendances	**195,698**	**211,911**	**223,754**	**1,580**	**105.6%**	**2,037**	**114.3%**

*Acute specialties only, excludes Well Babies, Maternity

2.4.3 Plans will continue to be stress tested and monitored with divisions to support the delivery of the activity levels and the related performance standards. Associated risks are included below in section 6.

University Hospitals Bristol and Weston NHS Foundation Trust

3. Performance

3.1 Summary of performance targets and objectives

3.1.1 The Trust is working towards delivering the performance standards and targets as set out in the Operational Planning Guidance. Table 2 shows the core national standards confirmed by the Operational Planning Guidance for 2025/26 and the UHBW performance ambition as stated in the Trust's operational planning submission:

3.1.2 ***Table 2: Trust summary of performance targets and objectives***

	Current UHBW performance	2025/26 NHSE target	2025/26 UHBW ambition to be stated in operational planning submission
RTT 18 Weeks Wait	64.2% at end of February 2025	>=65% by March 2026 nationally. Each provider to deliver minimum 5% improvement Baseline for improvement is November 2024. UHBW reported 62.8%. Therefore, target for 2025/26 is 67.8%.	67.8% by end of March 2026
RTT 1st OPA Wait	66.6% at end of February 2025	>=72% by March 2026 nationally. Each provider to deliver minimum 5% improvement Baseline for improvement is November 2024. UHBW reported 66.7%. Therefore, target for 2025/26 is 71.7%.	71.7% by end of March 2026
RTT 52 Weeks Wait	1.5% (824 / 54,000) at end of February 2025	>1% of total waiting list by end of March 2026	>1% of total waiting list by end of March 2026
Cancer 62 Day	74.2% at end of January 2025 (note target for 2024/25 is 70%)	75% by end of March 2026	75% by end of March 2026
Cancer 28 Day FDS	77% at end of January 2025 (note target for 2024/25 is 77%)	80% by end of March 2026	80% by end of March 2026
UEC A&E 4 Hour*	71.7% at end of February 2025	>=78% by end of March 2026 A higher percentage of patients admitted, transferred and discharged from Emergency Department (ED) within 12 hours across 2025/26 compared to 2024/25	78% from September 2025

Notes:
*A&E 4 hour-performance includes a performance uplift applied by NHSE which takes into account the Sirona type 3 performance

3.2 Bristol Elective Centre

3.2.1 The Elective Centre (EC) is currently being constructed on the Southmead Hospital site. It is due to open in the late Summer / Autumn. This standalone facility will feature four operating theatres and 40 beds, as well as 12 medirooms. It will provide capacity for an additional 6,500 procedures per year to be carried out.

3.2.2 The EC will be used to accommodate existing elective orthopaedic activity which will be transferred from the Brunel Hospital building. This will create a corresponding amount of operating theatre and inpatient bed capacity within the Brunel Hospital. The benefit associated with this capacity has been shared between UHBW and NBT.

3.2.3 The Trust has been working with NBT to develop plans for a displacement model. This will involve existing trauma and orthopaedic, Gastrointestinal (GI) surgery and Gynaecology activity transferring from the Bristol Royal Infirmary (BRI), St Michael's Hospital (SMH) and South Bristol Community Hospital (SBCH) into the Brunel Hospital.

3.2.4 The capacity created for backfill on the BRI and SMH sites will be used to deliver additional Thoracic, Oral and Maxillofacial, Ear, Nose and Throat, Cardiac and Paediatric Surgery in the BRI, Ophthalmology (cataract) surgery in SBCH, and it will facilitate the expansion of the Trust's robotic surgery programme, with a second robot being introduced in STMH for Gynaecology and GI Surgery.

3.2.5 Where possible, the plans for transfer and backfill also incorporate opportunities to deliver growth and additional productivity.

3.3 Community Diagnostic Centre (CDC)

3.3.1 The North Bristol Community Diagnostic Centre (CDC) went live in April 2024. These services are provided in partnership between NBT and Inhealth. Some endoscopy activity is delivered by Inhealth under contract with NBT on behalf of NBT, the ICB and UHBW. The Trust continues to work with NBT and Inhealth to ensure appropriate pathways are in place to manage the referrals and activity, and ensure the appropriate process and agreements are in place.

3.3.2 The Weston CDC went live in April 2024 and undertakes activity to support delivery of the performance targets.

4. Financial Plan

4.1 Introduction

4.1.1 The 2025/26 Financial Plan has been constructed with reference to the 2025/26 national planning guidance issued by NHS England on 30th January 2025. The Trust's Financial Plan has been constructed alongside the Bristol, North Somerset & South Gloucestershire System. This narrative describes the System's and the Trust's Financial Plans that will be submitted to NHSE on 27th March 2025 in accordance with the NHSE deadline.

4.1.2 Alongside the national planning guidance, a one-year funding settlement for 2025/26 only has been provided for revenue and capital allocations; the Government's Spending Review will conclude in June 2025 and will set Government Departmental plans for a minimum of three years. The funding allocated to the BNSSG System and Specialised Commissioners has informed the Financial Plan.

4.1.3 Similar to revenue, the capital settlement beyond 2025/26 will be set out in the Spending Review. However, for capital planning purposes beyond 2025/26, systems should assume they will receive at least 80% of their 2025/26 core allocation. The 2025/26 capital guidance sets out the 2025/26 NHS capital allocation which is split into three categories:

- £4.9bn for system level allocations to fund day-to-day operational investments;
- £1.1bn for previously committed funds, for example, the New Hospital Programme; and

- £4.1bn for other national capital programmes.

4.1.4 NHSE has also outlined proposals to introduce adjustments to the capital regime that will provide further financial freedoms and flexibilities for high-performing systems and providers (exclusively Trusts and systems in tiers one and two of the NHS Improvement and Assessment Framework). The Trust is currently operating in tier two. The proposals are:

- Enhanced flexibility for high-performing systems – systems in tier one or two that deliver break-even would be allowed to invest in capital expenditure above their allocated budgets using available cash balances up to a limit set between £20m and £30m; and
- Capital retention for high-performing providers - providers in tier one or two that deliver a surplus would have the flexibility to invest capital equivalent to their surplus for the following two financial years. The capital would have to be directed towards projects that improve revenue performance.

4.1.5 For the 2025/26 Financial Plan submission, providers and Systems have been asked to submit a detailed one-year capital plan and a high-level four-year capital plan that is CDEL compliant on an annual basis.

4.1.6 The development of the 2025/26 Financial Plan requires a sharp focus on break-even underpinned by elective performance recovery, productivity improvement and recurrent savings delivery. The 2025/26 Financial Plan is based on a number of key building blocks:

- The BNSSG system and Trust's recurrent deficit as at 31st March 2025 and 31st March 2026 as per the approved System Medium Term Financial Plan (MTFP);
- The Trust's 2025/26 elective patient care income, elective care payment limits and costs of delivering the waiting time access / performance targets;
- The current status of the Trust's savings program; and
- The inclusion of the NHSE productivity opportunities in the Trust's savings program and/or the Trust's patient activity plan.

4.1.7 In the context of the Trust's significantly rising operating costs, including headcount growth of c20% since March 2020 and a material a deterioration in the Trust's productivity since March 2020 as measured by the National Cost Collection Index (NCCI) from 93 to 107, and the NHSE productivity opportunities, the Trust faces significant challenges and difficult choices in landing the revenue break-even plan. These are:

- The level of expenditure required to deliver the elective patient activity volumes necessary to meet NHSE waiting times performance targets. Four activity scenarios have been considered by the Trust's Chief Operating Officer (COO) in the context of cost affordability. The chosen option predicted to deliver the waiting times performance targets requires a further productivity improvement (beyond c1% for day case and c3.5% for inpatient activity) for the costs of elective delivery to remain affordable;
- Investment plans to resolve new quality and safety risks or regulatory requirements which cannot be deferred for twelve months and can only be mitigated through investment at £4.0m rather than a re-prioritisation of existing Divisional resources. The Trust's Executive Committee agreement to proceed with the investments has resulted in the Trust's savings plan increasing from £49m to £53m;
- The Trust's savings requirement of £53m (or c5% of operating expenditure). The Trust's savings plan includes a planned reduction in the Trust's workforce of at least 300 FTE (full-time equivalent) in both clinical and corporate services against the c2,000 FTE growth since March 2020. (NB the overall headcount reduction will be partially mitigated due to investments being made).
- There is a very clear expectation that all services will also return their staff in post position back to their approved funded establishments.

4.2 2025/26 BNSSG System Financial Plan – revenue

4.2.1 The Trust's Financial Plan should be seen in the context of the financial position of the BNSSG System. The key aspects of the BNSSG System plan are as follows:

- All ICBs have received core allocation growth of 4.40%, with a Convergence Factor applied to ICB Core, Primary Medical Care and Specialised Services Allocations (maximum +/- 0.5%) to move closer to fair share allocations;
- Allocation growth includes a Cost Uplift Factor (CUF) of 4.15%;

- An NHSE efficiency requirement of 2.00%. This is an increase of 0.9% or c£24m from the BNSSG ICB medium-term financial plan and the NHSE requirement in 2024/25;
- The CUF assumes a headline pay award of 2.8% and assumes a 1.8% increase for the employers National Insurance contribution increase as result of the Government's October 2024 budget;
- The Elective Recovery Fund (ERF) mechanism will change in 2025/26. In 2024/25, ERF operated as fully variable income without a limit and any over-performance was paid by central NHSE. For 2025/26, there is a fundamental shift to an elective care payment limit held at ICB level with ICBs now expected to manage the affordability of elective activity. The BNSSG ICB allocation is £283m based on:
    - Funding embedded in core allocations/contracts;
    - 2024/25 allocation for ERF to take funded levels to target (which was 103% of 2019/20);
    - Overperformance in 2024/25 (using submitted forecast outturns from Month 8);
    - Funding for the Elective Centre – this is now aligned on an activity basis to the business case. This is £12.1m and represents an allocation for all ICB commissioners; and
    - A national scale back of 28% to the 2024/25 overperformance.
- Providers and ICBs would need to agree and document a planned level of activity, and associated financial value, to be reimbursed on a variable or activity basis. This financial value represents the elective care payment limit or cap and is the maximum amount the commissioner would be required to pay the provider for elective activity. The value of the elective payment limit for the Trust is £212m;
- NHSE 2024/25 business rules leading to revenue/capital consequences will be adhered to in 2025/26. Based on BNSSG as a system submitting a break-even financial plan for 2025/26 and delivering the 2024/25 break-even plan, BNSSG will receive financial incentive funding of £30.2m in 2025/26 of which c£13m is capital;
- Mental Health Investment Standard (MHIS) retained and must grow in line with ICB core allocation growth of 4.40%; and
- NHS minimum contribution to adult social care will increase in total by 3.90%, which translates to an overall 1.70% minimum contribution to the Better Care Fund (BCF).

4.2.2 The BNSSG System planned net income & expenditure is break-even.

4.3 2025/26 BNSSG System Financial Plan – capital

4.3.1 The 2025/26 BNSSG System capital allocation as advised by NHSE is £160.5m. This allocation consists of £156.7m provider allocation which includes a share of national programme funding of £73.2m. The national programme funding is subject to NHSE scheme approval and scheme delivery in 2025/26. Primary care capital of £3.8m is also available to the system. The overall allocation is as follows:

£m	
72.1	2025/26 BNSSG ICB capital allocation;
2.1	Primary care business as usual and GP IT;
13.1	Fair shares allocation for delivery of system break-even in 2024/25;
87.3	**Subtotal – operational capital allocation**
27.0	National programme funding for estates safety – subject to NHSE approval
24.5	National programme funding for constitutional standards - subject to NHSE approval
1.7	National programme funding for primary care – subject to NHSE approval
20.0	National programme funding - RACC schemes subject to NHSE approval
160.5	**Total – System capital**

4.3.2 The allocation of the System CDEL and the System 2025/26 capital plan was agreed at the System Capital Board meetings on 4th February 2025 and 4th March 2025. Membership includes the BNSSG Chief Finance Officers, Business Planning, Finance, Digital and Estates colleagues. During January and February, the System capital prioritisation undertook a moderation check using provider risk assessments and this was presented to all partner organisations to ensure all partner organisations are aware of the level of estates and operational risks being carried by sovereign Boards.

4.3.3 The national programme funding of £732.2m is pending confirmation from NHSE. The Trust has submitted bids of £41.4m of which £26.8m is included with the Trust's 2025/26 capital plan. The timeline for NHSE approval of the submitted bids is currently unclear.

4.3.4 In addition to the system operational capital at £38.6m, the Trust will receive capital external to the system allocation, for example, charitable funding and PDC directly from NHSE. Therefore, the Trust's total 2025/26 capital plan is £44.8m as per section 4.6.

4.4 2025/26 Trust Financial Plan – revenue

4.4.1 The Trust has constructed the 2025/26 Financial Plan in accordance with NHSE's timetable and aligns with the BNSSG System funding allocation. The key income aspects are as follows:

- Total planned full year income of £1,298.5m includes:

£m	
559.7	BNSSG ICB income
455.6	NHSE Southwest Specialised Commissioning income;
68.5	Associate Commissioners e.g. BSW[1], Somerset, Gloucestershire
81.8	Other patient care income e.g. Local Authorities, private patients;
1,165.6	Subtotal income from patient care; and
132.9	Other operating income.
1,298.5	**Total Income**

- The full year NHSE Specialised Commissioner income of £455.6m is aligned with the Specialised Commissioners position following informal discussions and agreement on methodology.

4.4.2 The Trust's 2025/26 key operating expenditure drivers are:

- The starting point of 2024/25 forecast outturn, removing specific non-recurring items and adding the full year effect of 2024/25 investments.
- The non-recurring items of £87.7m at c6% mainly relate to:

£m	
46.7	Non-recurrent Commissioner income;
15.7	Non-recurrent savings
14.3	Corporate and Division mitigations; and
11.0	Other – net slippage on Divisional cost pressures and investments
87.7	**Total – 2024/25 non-recurring items**

- The net full year effect of 2024/25 investment decisions of £13.3m are:

£m	
(3.7)	FYE of savings delivered in 2024/25;
2.9	Paediatric Gender Service;
2.2	Healthy Weston 2 Phase 1;
1.5	RNDA/TNA[2] apprenticeship programme 2024/25 cohort;
1.3	2024/25 critical safety investments;
1.6	Targeted Lung Health Checks (TLHC) development;
1.5	Digital cost pressures;
1.0	Clinical divisions cost pressures;
1.8	Prior year commissioner funded investments;
3.2	Other divisional FYE items
13.3	**Total – full year effect of 2024/25 investments**

- Inclusion of elective investments at £7.5m to secure additional elective activity to underpin the delivery of the performance targets;
- In the second financial year of Group, gross investments of £7.8m primarily into corporate areas, offset by gross benefits of £5.7m relating to cost savings and income generation opportunities and external funding of £2.1m;
- New for 2025/26, the inclusion of backfilling vacated theatre capacity at the Trust due to activity transferring to the new Bristol Elective Centre at a net cost of £1.5m;
- New for 2025/26, Trust investment decisions totalling £4.0m relating to unavoidable quality, clinical safety or regulatory requirements as agreed by the Trust's Executive Committee as follows:

£m

[1] BSW - Bath and North East Somerset, Swindon and Wiltshire

[2] RNDA/TNA – Registered Nurse Degree Apprenticeship/Trainee Nurse Associate

○ 0.64	Commissioner contract changes;
○ 0.60	D&T[3] Division - regulatory/contractual requirements;
○ 0.39	Women's & Children's Safer staffing review;
○ 0.09	Paediatric BMT[4] Service investment;
○ 0.24	Additional Consultants at Weston General Hospital;
○ 0.18	Additional Emergency Medicine Consultants at the BRI;
○ 0.08	Teledermatology;
○ 0.17	Nursing apprenticeship programme;
○ 0.29	Support of growth in Paediatric Immunology and Nutrition Support;
○ 1.00	Support of activity growth in BHOC[5];
○ 0.10	Neurophysiology service;
○ 0.25	Extension to System C contract;
4.03	**Total – 2025/26 Trust investment decisions**

- Additional net financing costs of £4.7m. Of this, £3.4m relates to additional depreciation costs and £1.1m relates to a planned increase in net interest expenses;
- The application of the NHS gross inflation uplift of 4.15% at £46.3m. A full assessment of any potential shortfall in inflation funding will be undertaken in quarter 1 pending the final 2025/26 pay award for all staff alongside various supplier contracts applying the Retail or Consumer Prices Index;
- Full delivery of Trust's total savings requirement of £53.0m or c5% primarily as a reduction against operating expenditure. The Trust's savings position is set out in section 4.5. The savings target of £53.0m is constructed as follows:

£m	
○ 20.0	National requirement of 2.0%;
○ 29.0	Additional 3% to meet the Systems MTFP recovery trajectory (including recovering the shortfall in recurring savings in 2024/25);
○ 4.0	Additional requirement to fund quality, safety and regulatory issues.
53.0	**Total – Trust's 2025/26 savings requirement**

4.4.3 The Trust's 2025/26 planned net income & expenditure position is break-even and summarised in Table 3.

4.4.4 ***Table 3 – 2025/26 planned net income & expenditure position***

Statement of Comprehensive Income and Expenditure	2024/25 Forecast Outturn £M	2025/26 Financial Plan £M
Operating Income from patient care activities	1,152.8	1,165.6
Other Operating Income	128.7	132.9
Total Income	**1,281.5**	**1,298.5**
Operating Expenditure		
Employee expenses	(771.8)	(795.5)
Non pay expenses	(470.3)	(444.4)
Subtotal - Operating Expenditure	**(1,242.1)**	**(1,239.9)**
Financing		
Depreciation and amortisation	(43.7)	(47.1)
Net finance expense	(11.3)	(12.4)
Total Expenditure	**(1,297.1)**	**(1,299.4)**
Net surplus/(deficit) including technical items	**(15.6)**	**(0.9)**
Less technical items	15.6	0.9
Net surplus/(deficit) excluding technical items	**0.0**	**0.0**

[3] Diagnostic and Therapies
[4] BMT - Bone Marrow Transplant
[5] BHOC – Bristol Haematology and Oncology Centre

4.5 2025/26 Trust Savings Programme

4.5.1 The 2025/26 savings targets for clinical Divisions and Estates & Facilities has been set based on 4.0% of 2024/25 recurrent budget (excluding pass-through costs) and, subject to Executive Committee approval, 5.0% for corporate services, a total of £37.1m. Additional further corporate mitigations of £15.9m are required to reach the Trust's savings target of £53.0m. Currently, the Trust has identified savings of £48.5m or 92% of which £40.7m are recurrent. £4.5m remains unidentified. The position is summarised in Table 4A. Table 4B provides a savings summary by type.

4.5.2 ***Table 4A – 2025/26 Division and corporate services savings summary***

Division	Total Savings Target £M	Total Recurrent Savings Identified £M	Total Non-Recurrent Savings Identified £M	Total Savings Identified £M	Balance (Unidentified) £M
Diagnostics & Therapies	4.1	2.8	0.8	3.6	(0.5)
Medicine	4.6	4.9	0.1	5.0	0.4
Specialised Services	4.6	2.9	0.8	3.7	(0.9)
Surgery	7.5	6.6	1.0	7.6	0.1
Weston	2.4	1.7	0.3	2.0	(0.4)
Women's & Children's	7.1	5.4	1.5	6.9	(0.2)
Estates & Facilities	2.3	2.2	0.3	2.5	0.2
Finance	0.6	0.3	0.2	0.5	(0.1)
HR	0.7	0.7	0.0	0.7	0.0
Trust Headquarters	1.8	1.4	0.1	1.5	(0.3)
Digital Services	1.4	0.6	0.2	0.8	(0.6)
Corporate requirement	15.9	11.2	2.5	13.7	(2.2)
Total	**53.0**	**40.7**	**7.8**	**48.5**	**(4.5)**

4.5.3 ***Table 4B - 2025/26 savings plans by cost type***

Cost Type	Subjective Type	Total Recurrent Savings Identified £M	Total Non-Recurrent Savings Identified £M	Total Savings Identified £M	Workforce Reduction WTE
Pay	Substantive	12.9	1.8	14.7	300.2
Pay	Bank	10.4	0.1	10.5	247.6
Pay	Agency	2.8	0.0	2.8	34.3
Non-Pay	Blood	0.3	0.0	0.3	
Non-Pay	Clinical Supplies	5.6	1.6	7.2	
Non-Pay	Drugs	1.3	0.4	1.7	
Non-Pay	Establishment Expenses	0.2	0.0	0.2	
Non-Pay	Other Expenditure	3.9	3.5	7.4	
Income	Income from Activities	1.9	0.3	2.2	
Income	Income from Operations	1.4	0.1	1.5	
Total		**40.7**	**7.8**	**48.5**	**582.1**

4.5.4 Included within the £53.0m of savings for Trust delivery, the Trust is also required to deliver corporate mitigations of £3.6m through technical financial opportunities.

4.5.5 Based on the 2024/25 forecast outturn savings delivery of £32.6m, a clear step change in savings delivery and productivity is required to achieve the savings target of £53.0m. This significant step-change is in part met through the requirement to reduce both the funded establishment and substantive staff in post by a minimum of 300wte and a reduction in the use of temporary workforce by 282wte.

4.5.6 Productivity analysis data has been developed by NHSE and shared with provider Trusts. For the Trust, this identifies potential productivity opportunities totalling £71.7m. Of the £46.8m of operational productivity identified within this, NHSE expects 50% to be cash releasing. A further £24.8m of Trust efficiency have also been highlighted. This information has been used as part of the Trusts Cost Improvement Programme (CIP) identification process. Further details of which can be found in appendix 1.

4.5.7 The third cut of savings plans from Divisions and corporate services were received on the 12th March 2025 and inform the current savings position. The next six weeks will require considerable focus on CIP implementation in order to increase the confidence that the Trust will deliver its target of £53.0m in year, either by recurring or non-recurring means. However, there is further work to do across the organisation to enact enhanced pay controls and review structures and processes across all Divisions to ensure that reductions are recurrent, safe and sustainable. The intention is to fully identify 100% of savings in the fourth cut due mid-April 2025 with an exit position of 100% of savings being delivered recurrently (full year effect) by 31st March 2026.

4.5.8 The Trust has revised and strengthened the approach to productivity and efficiency to better address the ongoing savings requirement and deliver the targets above. The Productivity and Financial Improvement Group (PFIG) is established along with a number of corporate workstreams focusing on specific areas to drive better savings delivery and productivity. The Trust also retains its existing and well-established system of process and governance.

4.5.9 The Trust continues to use all available benchmarking sources to identify areas for improvement and develop actions plans to ensure delivery. The Trust is using the National Productivity packs, Model Health System, NCCI (National Cost Collection Index), Service Line Reporting (SLR) and GIRFT as key tools to identify efficiency opportunities and a more formal process is being rolled out across the Trust to follow up all opportunities from this source. The Trust is also working with regional groups to identify further opportunities.

4.5.10 The Trust also has a series of programmes focussing on increased and robust expenditure controls including in the areas of non-pay, drugs and pay areas particularly medical staffing and nursing. Further work streams dedicated to delivering transactional savings have also been established.

4.5.11 In the event that we do not make the required progress in closing the current savings gap, or in balancing divisional budgets, the implementation of more stringent workforce cost controls will be required.

4.5.12 Savings schemes are assessed for impact on quality and patient safety through the completion of Quality & Equality Impact Assessments where required based on a clear set of criteria. For schemes meeting the criteria, the QEIA templates are subject to review and sign-off by the Trust's Chief Nurse & Midwife (CNM) and Chief Medical Officer (CMO).

4.5.13 Performance against savings targets is reported monthly and reviewed at regular divisional accountability reviews. Oversight of delivery is provided through the monthly PFIG meeting chaired by the Trust's Hospital Managing Director (HMD). Progress regarding savings delivery is also reviewed monthly at Executive led divisional reviews.

4.6 2025/26 Trust Financial Plan – capital

4.6.1 The Trust's capital plan for 2025/26 is £44.8m. The plan also includes leased assets under IFRS 16 at £7.9m. The plan is pending NHSE decisions in relation to capital bids submitted by the Trust worth £41.1m of which £26.8m would fund capital investment already included in the Trust's plan. The plan has been prioritised using a risk-based approach within the Trust and is co-ordinated by the Trust Capital

Group. The process was also supported by a dedicated Divisional Director and Clinical Chair review in late February. The capital plan is also a result of the joint acute and system approach to capital prioritisation and planning.

4.6.2 Submitting a balanced capital plan within the available envelope has required a reduction in gross capital allocations of £10m pending the outcome of the national capital bids. The plan outlined here for approval will therefore continue to develop under the oversight and governance of the Trust's Capital Programme Steering Group (CPSG) during quarter 1.

4.6.3 In summary, the sources of capital funds to meet the planned expenditure of £44.8m are as follows:

£m	
32.4	NHSE CDEL allocation for non-leased assets;
7.9	NHSE CDEL allocation for leased assets;
1.5	Charitable funding; and
3.0	Public Dividend Capital (PDC) expected from NHSE.
44.8	**Total planned sources of capital funding**

4.6.4 The sources of funds will be applied against the following key scheme headings including planned slippage or over-programming at c25%. The overriding principle of agreeing what can actually be delivered in 2025/26 through monthly scheduling and the conclusion of the 2024/25 financial year mean these may change:

£m	
19.5	Slippage and pre-commitments from 2024/25;
12.1	Multi-year major capital programme;
2.2	Multi-year Strategic Schemes;
12.7	Fixed allocations, mainly estates projects at £10.0m and contingency at £2.0m;
3.0	Digital;
(12.6)	Less assumed over-programming at c25%.
36.9	Subtotal – 2025/26 planned net capital expenditure excluding leased assets
7.9	Leased assets (under IFRS 16)
44.8	**Total planned application of capital funding**

4.7 2025/26 Trust Financial Plan – Statement of Financial Position

4.7.1 The Trust's Statement of Financial Position (SoFP) takes into consideration the Trust's planned revenue net income and expenditure position, planned capital investment and key aspects of treasury management in relation to working capital and financing such as PDC dividend repayment and loan principal repayment.

4.7.2 Key highlights of the Trust's planned SoFP as at 31st March 2026 are as follows:

- Non-current assets increasing to £656.8m as a result of the capital plan of £44.8m, in year depreciation of £47.1m and revaluation of land and buildings of £14.5m, based on 2% increase in indices;
- Net current liabilities of £28.8m from an opening forecast outturn liabilities position of £12.0m;
- Stock levels held at £19.0m;
- A closing cash balance of £54.0m, a planned decrease of £28.8m during the year; and
- A reduction in borrowings of £14.1m relating to £5.8m on loans and on £8.3m leases.

4.7.3 The Trust's Statement of Financial Position is summarised in Table 5.

4.7.4 ***Table 5 - The Trust's Statement of Financial Position***

Statement of Financial Position	2024/25 Forecast Outturn £M	2025/26 Q4 Plan £M
Non-Current Assets		
Property plant and equipment & Intangibles	534.1	546.6
Right of use assets (IFRS16)	109.0	108.7
Receivable	1.5	1.5
Total Non-Current Assets	**644.6**	**656.8**
Current Assets		
Inventories	19.0	19.0
Receivables	49.9	49.9
Cash	82.8	54.0
Total Non-Current Assets	**151.7**	**122.9**
Current Liabilities		
Trade payables	(142.6)	(130.6)
Borrowings	(13.5)	(13.5)
Other	(7.6)	(7.6)
Total Current Liabilities	**(163.7)**	**(151.7)**
Net Current Assets/Liabilities	**(12.0)**	**(28.8)**
Non-Current Liabilities		
Borrowings	(128.8)	(114.7)
Provisions	(2.1)	(2.1)
Total Non-Current Liabilities	**(130.9)**	**(116.8)**
Total Net Assets Employed	**501.7**	**511.2**
Financed by		
Public Dividend Capital	337.7	337.7
Revaluation Reserve	52.4	63.4
Other Reserves	0.1	0.1
Income and Expenditure - Opening	113.5	111.5
Income and Expenditure - In Year	(2.0)	(1.5)
Total Taxpayers' and Others' Equity	**501.7**	**511.2**

4.8 2025/26 Trust Financial Plan – Cashflow Statement

4.8.1 Cash will be a key issue heading into 2025/26 with the majority of NHS organisations having deficit positions in 2024/25 and liquidity constraints as they head into 2025/26. NHSE has written to provider organisations stating that a stricter cash regime and therefore reduced access to emergency cash will be implemented from the 1st April 2025. However, as a result of the Trust's twenty-two year tracked record of break-even or better, the Trust's cash remains relatively very strong for 2025/26.

4.8.2 The cashflow statement summarises cashflows arising from the Trust's planned: operating activities (i.e. revenue financial performance and working capital management); investing activities (mainly the Trust's capital plan); and financing activities (covering leases, loan interest and loan principal repayments).

4.8.3 The key highlights of the Trust's planned cashflow statement are:

- £42.6m net cash inflow from operating activities including a working capital net cash outflow of £12.0m;
- £41.4m net cash outflow from investing activities with £46.0m linked to the Trust's capital plan; and
- £30.0m net cash outflow from financing activities mainly relating to lease and loan principal repayments of £14.0m and PDC payment of £13.6m.

4.8.4 The Trust's planned cashflow statement is summarised in Table 6.

4.8.5 Table 6 - The Trust's Cashflow Statement

Statement of Cash Flows	2025/26 @ 31/03/2026 Plan £M
Cash flows from operating activities	
Operating Surplus / (Deficit)	11.3
Depreciation and Amortisation	44.8
Impairments and Reversals	-
Losses on Disposal	-
Income from Donations	(1.5)
(Increase)/Decrease in Assets	-
Increase/(Decrease) in Liabilities	(12.0)
Net cash flow from operations	**42.6**
Cash flows from Investing Activities	
Interest Received	3.1
Purchase of Assets	(46.0)
Donated Assets	1.5
Net cash flow from Investing Activities	**(41.4)**
Cash flows from Financing Activities	
Public Dividend Capital received	-
Loans	(5.8)
Interest Paid	(2.4)
Capital element - leases	(8.2)
Public Dividend Capital - paid	(13.6)
Net cash flows from Financing Activities	**(30.0)**
Increase/(decrease) in cash	**(28.8)**
Opening balance	82.8
Closing cash balance	**54.0**

4.9 2025/26 Trust Financial Plan – summary

4.9.1 The key headlines for the Trust's Financial Plan are:

- A planned net income and expenditure position of break-even;
- A capital plan at £44.8m that is compliant with the Trust's CDEL with over-programming or slippage assumed at c25%; and
- A cash balance of £54.0m as at 31st March 2026.

4.10 Trust budget setting

4.10.1 2025/26 budgets will be set to divisional operating plans as part of the Trust's annual planning approach and aligned with the methodology used to construct the Trust's Financial Plan. This means budgets are based on 2025/26 divisional normalised financial positions, with 2024/25 rollover recurrent budgets adjusted for material and significant adverse variances which are unavoidable or outside the control of the Division. The 2025/26 recurrent budgets will therefore be set at a level which:

- Includes funding to deliver the required activity volumes;
- Resolves historic funding issues; and
- Removes the need to identify material mitigations to achieve an on-budget position.

4.10.2 Budgets will also be adjusted to remove budget equating to the 2025/26 divisional savings targets, fund the new for 2025/26 unavoidable cost pressures and 'must-do' quality and safety issues agreed by the Trust's Executive Committee, including, for example:

- Support for safer staffing levels on Apollo and Caterpillar wards;
- Investment to restart the Paediatric BMT service;

- Significant growth in BHOC, Paediatric Immunology and Paediatric Nutrition Support.
- Contract changes related to sexual health services and activity from Welsh Commissioners.
- Increases in the consultant workforce to support A&E, Acute and Care of the Elderly services.
- Regulatory compliance within Medical Physics and Laboratory Medicine; and
- Unavoidable contractual commitments e.g. System C contract.

4.10.3 The 2025/26 approach is different from the budget setting approach in 2024/25 and seeks to better align the Trust's Financial Plan with divisional budgets. Divisions have been working with the corporate finance team during Q4 to implement the new approach. Both Division's and corporate teams will know their budgets prior to the 1st April 2025 as the planning process concludes, with the exception of those items pending further discussion and decision regarding elective investments which, when finalised, will be allocated to Divisions in the month the cost commences

4.10.4 The Trust continues to apply and monitor the key financial controls. Financial controls refer to financial procedures, processes, and governance as well as the operational management and decision-making regarding use of resources. The financial controls in place to support the Trust to deliver its responsibilities cover:

- Financial reporting and review;
- Financial oversight; and
- Financial controls and processes.

4.11 Financial Risk Assessment

4.11.1 The key financial risks are presented here.

4.11.2 Risk of not delivering the Trust savings of £53m

The Trust's recurring savings requirement of £53m is a 65% increase on the Trust's 2024/25 forecast savings delivery of £32.6m. Securing additional savings plans alongside operational delivery will require a significant step change in delivery from Divisions and corporate services. The principle focus of PFIG will be driving pay savings to help secure the step change in delivery. Currently within the plan, identified savings plans have the following maturity level ratings: Maturity 1 & 2 schemes = £24.5m / 47%; Maturity 3 schemes = £24.0m / 45%, Maturity 4 / Unidentified – £4.5m / 9%. Further details can be seen in appendix 2. Due to the additional assurance work required, the risk of delivery for the savings requirement is currently assessed as ***very high***.

4.11.3 Risk that the planned value of elective activity and therefore elective income is not delivered.

The Financial Plan is based on the elective activity plan agreed between the Trust's COO Team and clinical Divisions that delivers required waiting times / performance standards for 2025/26. The activity requires volume increases above 2024/25 forecast outturn levels of c3% for day case activity, c7% for elective inpatient activity and c4% for first outpatient attendance activity. The value of elective patient care income is c£226m. This is significantly higher than the elective care payment limit introduced for 2025/26 of £212m. It is therefore unlikely that elective care income will be lower than the payment limits hence the risk of underperformance against the elective income plan is assessed as ***low***.

4.11.4 Risk that the Trust's elective access / performance targets cannot be delivered within the cost envelope

The break-even plan assumes the revenue cost of meeting the Trust's elective access/performance targets can be delivered within the envelope of £7.5m. This envelope assumes further improvement in operational productivity beyond c1% for day case activity and c3.5% for elective inpatients which is currently under review. This risk is assessed as ***high***.

In the event that, at the end of Q1, there is a mismatch between the costs of delivering performance standards and the funding available, then further consideration will be required at Board level with regard to the performance versus financial dilemma this poses.

4.11.5 Risk that assumed additional income of £14.0m is not secured

The break-even position includes assumed patient care income (not linked to activity) of £11.5m and £2.5m of other operating income. For context, the 2024/25 plan included additional corporate income/mitigations of £13.2m which have been realised in 2024/25. Therefore, this risk is assessed as ***medium***.

4.11.6 Risk that assumed operational expenditure slippage of £10.6m is not repeated in 2025/26

Operational expenditure slippage assumptions of c£10.6m relate to expected ongoing slippage against Divisions budgets and plans to increase their expenditure in 2025/26 as services look to recruit into vacant posts up to their funded establishments in support of elective recovery. Certain operational services have continued to find recruitment into posts challenging due to the lack of workforce supply. The extent to which the financial benefit of £10.6m is repeated in 2025/26 presents a ***medium*** risk to the Trust's break-even plan.

4.11.7 Risk that the Trust does not deliver capital expenditure in line with its CDEL of £40.3m

The Trust's net capital plan assumes schemes to the value of c25% will not be delivered in 2025/26 due to constraints relating to operational access (disruption to services and decant challenges), supplier selection and lead-time constraints and regulatory compliance (2024 Building Safety Act). A recent assessment of the Trust's buildings has concluded that the majority of the buildings fall within the scope of Building Safety Act which will add additional lead times to projects of typically six months. Therefore, this risk is assessed as ***high***.

4.11.8 Risk that the assumed funding from all Commissioners are materially mis-aligned

Against the Trust planned patient care income of £1,165.6m, the Trust has not received a formal response to the Trust's income proposals from associate Commissioners. Approximately £68m or c12% of the Trust's planned income is, therefore, at risk. The Trust has applied a methodology broadly based on the 2024/25 forecast outturn (for which we are currently being paid) adjusted to 2025/26 prices. The Trust has formally written to the associates accordingly. This risk is assessed as ***medium***.

4.11.9 Strategic Financial Risks

The scale of the Trust's recurrent deficit and CDEL constraints presents a significant risk to the Trust's strategic ambitions. Further work is required to develop the mitigating strategies whilst acknowledging the Systems strategic capital prioritisation will now need to take forward the Joint Clinical Strategy. This risk is assessed as ***high***.

4.12 Key next steps for the Finance Plan

4.12.1 The Trust will need to work through a number of significant remaining next steps in order to progress delivery of the 2025/26 Financial Plan. The key next steps are:

- PFIG materially progressing the savings identification and managing the subsequent delivery against the £53.0m savings requirement;
- Securing formal agreement of Associate Commissioner funding envelopes;
- Finalising the costs associated elective activity delivery within the envelope available on the expectation of improved productivity;
- Full testing of the Trust's workforce controls and VCP processes in light of the requirement to reduce workforce back to funded establishments;
- Re-visiting the Trust's capital plan in response to the outcome of the national capital bids via the Trust's Capital Group and Capital Programme Steering Group; and
- In light of the risks within the Trust's financial plan, the Trust will look to fully mitigate these during quarter 1 and undertake a formal forecast outturn assessment based on quarter 1 financial results

that will inform a potential re-setting of the financial plan, particularly savings and elective activity delivery.

4.13 Conclusion and recommendation

4.13.1 The Trust's 2025/26 Financial Plan presents a significant revenue financial challenge for the Trust with a savings requirement of £53.0m. However, the early conclusion of the Financial Plan provides the System, Trust and the Divisions with a clear focus on savings identification and delivery and elective activity delivery necessary to deliver the break-even plan.

4.13.2 The Committee is recommended to approve the 2025/26 Financial Plan under delegated authority on behalf of the Trust Board and to note, in doing so, the risk assessment in section 4.11 and the key next steps section 4.12

5. Workforce plan

5.1 System approach

5.1.1 The BNSSG workforce planners' network provided oversight in the construction of each organisation's workforce plan ensuring that they are developed consistently and in line with NHSE/I guidance. The Trust's workforce plan will be submitted as an excel full-time equivalent (FTE) plan alongside a Workforce Checklist both documents have been issued as part of the NHSE workforce planning instructions.

5.2 Summary of Trust plan

5.2.1 The submission of the 27th March will include a reduction in staff in post of 337.5 FTE profiled across the year. This includes transfer of 10 FTE to the Elective Centre, changes in commissioning requirements of 27.5 FTE, and a reduction of 300 FTE as part of CIP delivery (including the planning guidance ambition to reduce support functions). There is also growth in Staff in Post (SIP) of 175 FTE through roles associated with service developments, priority services and the Group transitional investment requirements. This gives a net change of -162.5 FTE to Staff in Post. It is anticipated that this can be achieved through vacancy controls, utilising turnover and attrition.

5.2.2 There is also a planned average bank reduction of 187 FTE, with a figure of 341 FTE in March 2026, and a reduction in agency of 33 FTE.

Table 7: Trust 2025/26 funded establishment plan

	Funded Establishment		
	Year End (31-Mar-25)	Year End (31-Mar-26)	Change
	FTE	FTE	FTE
Total Workforce (WTE)	12,922.0	12,760.3	-161.7

Table 8: Trust 2025/26 staff in post plan

Staff-in- Post		
Year End (31-Mar-25)	Year End (31-Mar-26)	Change
FTE	FTE	FTE

Total Workforce (WTE)	13,297.0	12760.8	-536.2
Total Substantive	12,328.6	12166.1	-162.5
Total Bank	866.0	525.0	-341.0
Total Agency	102.4	69.7	-33

5.2.3 Monitoring of the plan will be managed via the monthly Provider Workforce Returns (PWR) returns to NHSE/I and shared with ICB.

5.3 Workforce challenges

5.3.1 The Workforce plan submission will address the following assumptions:

5.3.1.1 Agency

30% reduction in Agency spend (as per NHSE planning guidance)

The Trust is expecting to deliver a reduction in agency spend, through a saving in pay (rates) reduction in addition to a reduction in than FTE. The key assumptions included in the plan are:

- Direct engagement rolled out to all agency staff.
- Continue roll out of regional of price caps to deliver significant savings
- Agency rates, particularly for medical staff, are high, meaning that small reductions in FTE usage will achieve more than 1 FTE average cost saving, and that reductions in agency may not directly correlate with reduction in staff in post.
- Additional agency controls have been instigated for medical agency booking including sign off from Divisions Pay Control Panels, and sign off required from the Medical Directors Office, Head of Medical Strategic Workforce Planning and the Head of Resourcing.
- Agency FTE usage reductions for nursing will focus on the reduction in RMN usage through the corporate Mental Health Care Support Workers project as well as continued control processes that have delivered will in 2024-25.
- As per planning guidance there will be a focus on removing the minimal use of administration and clerical agency FTE.

5.3.1.2 Bank

10% reduction in Bank (as per NHSE planning guidance)

The revised plan assumes a Bank target reduction to 5.2% Maximum FTE as % of total workforce numbers, currently use is at 6.4%. Stringent bank controls will be necessary across all staff groups, for nursing this will be undertaken by the Nursing Establishment Controls group.

In addition, there will be a focus on reducing bank rates, this includes plans not to apply the full pay award to bank rates once the pay award for 2025/6 is announced. The interim pay award will be applied in April 2025 because it is necessary to comply with the National Living Wage.

A review of break-glass rates has reduced the allowance from 50% to 30% and in all cases will be subject to Executive or on-call manager approval out of hours. The ‘allocate on arrival’ incentive has been reduced from 30% to 20% and its application restricted further. Any remaining specialty specific bank rates that had been agreed through the Trust Pay and Assurance Group will be reviewed with the intention to reduce or remove, most of which will cease from March 2025.

5.3.1.3 Delivery of Pay CIP

The plan assumes a 300 FTE reduction in SIP and funded establishments to support CIP achievement (based on staff in post FOT March 31st 2025 to March 31st 2026). This reduction is inclusive of the annual planning target to reduce growth in support function since 2022.

5.3.2 These reductions will be assessed for impact on quality and patient safety through the completion of a QEIA where required based on a clear set of criteria.

Options to deliver substantive workforce FTE reduction include:

1. ***Vacancy Controls*** have been developed and will be operationalised through Divisional Pay Control Panels. These controls are role specific, and monitoring will be undertaken via a workforce subgroup tasked with overseeing its implementation by Productivity and Financial Improvement Group (PFIG). Current leaver numbers demonstrate that significant savings can be achieved through turnover and attrition if vacancy controls are implemented, this will support delivery of the 300 FTE staff in post reduction required to deliver CIP.

2. ***Alternative options for delivery*** include permanent hours reductions, and there is potential for a Mutually Agreed Redundancy Scheme although, details are yet to be confirmed by NHSE. It is unlikely that redundancy will be a key driver of headcount reductions, because there is no funding available in year for redundancy costs and will likely take 9 months to achieve thereby not delivering in year savings.

5.3.2.1 **Other Staff in Post changes**

- The plan includes growth in funded headcount establishment of 175 FTE.
- This is associated with service developments, priority services and the group transitional investment requirements.
- Staffing to provide additional operating capacity associated with the Elective Centre is included within this figure. Recruitment will be phased over the year in preparation for September 2025, the date that UHBW will utilise the additional theatre capacity.

5.4 Workforce priorities in 2025/26

5.4.1 The workforce plan is predicated on the control of workforce numbers, primarily through the Divisional vacancy control process, delivery of identified workforce cost savings, reductions in high-cost agency and premium workforce costs and improvements in productivity.

5.4.2 PFIG will lead and oversee the delivery of work-streams through the following programmes/groups associated with workforce productivity and controls:

- Nursing Establishment Controls Group, including bank and agency controls.
- Medical and Dental Workforce advisory group oversees the job plan review. and agency controls. Agency controls will be monitored via the South West Regional Medical Sub-group and Strategic Workforce Oversight Group through the ICB and into NHSE
- Divisional Pay Control Panels and Strategic Delivery Group meetings.

5.4.3 The Trust Strategic Workforce Priorities are:

- Mission Critical Medical Workforce Plan
- Corporate Project Pro- Equity
- The People Strategy will be redrafted in collaboration with our Group partners at NBT.

6. Summary of key risks to delivery of the 2025/26 Operating Plan

6.1 Operational

- If the no criteria to reside bed consumption is not reduced there is a risk that availability of acute beds will impact on performance delivery
- There is a risk that urgent and emergency growth impacts planning assumptions
- There is a risk that the expected headcount reduction in the acute sector adversely impacts on performance delivery and quality of care, QEIAs will be used to mitigate this

- Failure of critical equipment / infrastructure due to CDEL constraints and access to clinical areas for redevelopment work
- Delivering improvements in productivity is fundamental to achievement of the plan, there is a risk that this will be slower to deliver than the plan allows
- Increasing follow up demand presents a risk to new to follow up ratio which could impact RTT performance delivery
- Impact of Collective Action from General Practice and Pharmacies and any further Industrial Action

6.2 Financial

- Corporate mitigations are not available in 2025/26, there is therefore a risk that the breakeven plan has no contingency available should, for example, savings delivery does not meet plan requirements
- There is a risk that the capital plan cannot be delivered in accordance with CDEL due to operational constraints, e.g. access to clinical areas, supplier lead times, project management capacity
- There is a risk of material misalignment between the Trust's income assumptions and the commissioner allocations, leading to non-delivery of the financial plan

Finance risks are further detailed in section 4.11.

6.3 Quality

- There is a risk that the QEIA process does not accurately capture the risks associated with CIP delivery and/or service developments and that there are unintended consequences on patient care/staff wellbeing
- There is a risk that areas of known quality and safety risks cannot be resolved within financial plan

6.4 Workforce

- There is a risk that recruitment to key long-standing vacancies is not achieved, therefore compromising operational delivery and/or savings plans
- There is a risk that vacancy controls place undue pressure on staff wellbeing therefore impacting key workforce metrics, such as turnover and sickness absence rates

7. Operating plan next steps and monitoring

7.1 Next steps

- The operating plan for 2025/26 has been approved, and received Board assurance, via the Finance, Digital and Estates Committee on 25th March 2025; the NHSE Board Assurance document can be seen in Appendix 3.
- UHBW has now moved into delivery. This involves further communication and engagement with Divisions, and with staff more widely, and the establishment of monitoring to ensure that delivery is kept on track throughout the financial year.
- Delivery of the plan will be led by the Clinical Divisions and supported by the Trust Executive and corporate functions.
- Included within the delivery of the plan are priorities for improving health inequalities. These have been developed in partnership with the ICS and can be seen in Appendix 4.
- Monitoring of the 25/26 Operating Plan will be ultimately overseen by the Trust Board, with Executive Committee providing oversight of the various Executive-led subgroups with responsibility for the different components of the plan: for example, the Planning and Delivery Group, the Capital Programme Steering Group, the Clinical Quality Group and the Performance and Finance Improvement Group.
- Where the UHBW operating plan interfaces with partner organisations, the Integrated Care System Operational Delivery Groups and Health and Care Improvement Groups will be utilised.
- Partnership working and collaboration will underpin both the delivery of the BNSSG System Plan and the UHBW Operating Plan for 2025/26.

University Hospitals Bristol and Weston NHS Foundation Trust

7.2 Recommendations

7.2.1 The Trust Board is asked to note that the UHBW 2025/26 Operating Plan was approved by the Finance, Digital & Estates Committee and has been submitted to NHS England. UHBW has moved swiftly into delivery of the plan for the new financial year.

[i] 2025/26 priorities and operational planning guidance

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Appendix 1: Productivity Data

Clinical and operational productivity

University Hospitals Bristol and Weston NHS Foundation Trust Opportunity

	Benchmarked position*	*Opportunity (£)*	*Assumed cost base of PoD (£)*	*Opportunity as % of spend*	*Cash releasing (£)*	*Extra activity / beddays*
1 Non-elective overnight stays	47 out of 135 acute and specialist trusts on opportunity as % of spend	£4.8m	£242.5m	2.0%	£2.4m	0.14 LoS opportunity (days) 6,522 Annual beddays opportunity
2 A&E and SDEC	100 out of 135 acute and specialist trusts on opportunity as % of spend	£2.9m	£143.6m	2.0%	£1.4m	2,684 SDEC
3 Elective opportunity	110 out of 135 acute and specialist trusts on opportunity as % of spend	£31.5m	£258.4m	12.2%	£15.7m	18,379 Episodes
4 Outpatient opportunity	80 out of 135 acute and specialist trusts on opportunity as % of spend	£4.3m	£114.9m	3.8%	£2.2m	9,560 Attends
5 Other acute	N/A Assessed as 2.0% of baseline spend	£3.3m	£165.5m	2.0%	£1.7m	N/A
Total ClinOps productivity		£46.8m	Total Trust Opex: £1,251m	3.7%	£23.4m	N/A

- UHBW's productivity opportunity is £46.8m of which NHSE expects 50% as cash releasing
- Trusts are ranked 1 to 135 in terms of opportunity as % of spend - 1st being the largest opportunity and 135th being the lowest (i.e. most productive). Non-elective overnight stays rank is exception to this rule, where UHBW is 47th best of 135.

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Appendix 1: Productivity Data

	Efficiency			
	University Hospitals Bristol and Weston NHS Foundation Trust Opportunity			
	Benchmarked position*	***Opportunity (£)***	***Assumed cost base of PoD (£)***	***Opportunity as % of spend***
6 **Temporary staffing**	83 of 135 acute and specialist trusts on Temporary staffing (as % of pay)	£13.7m	£790m	1.7%
7 **Corporate services**	81 of 135 acute and specialist trusts on savings (as % of corporate services spend)	£8.5m	£65m	13.1%
8 **Medicines**	106 of 135 acute and specialist trusts on savings (as % of total medicine spend)	£2.2m	£189m	1.1%
9 **Commercial**	131 of 135 acute and specialist trusts on savings (as a % of non-pay spend, excluding medicines)	£0.5m	£323m	0.1%
Total Efficiency		£24.8m	Total Trust Opex: £1,251m	2.0%

- The Trust's efficiency opportunity is £24.8m
- The same ranking as for productivity applies – highest opportunity (least efficient) is most highly ranked (i.e. 1/135)

University Hospitals Bristol and Weston NHS Foundation Trust

Appendix 1: Productivity Data

#	Productivity area	From provider productivity pack	From provider productivity pack	Estimation of what can be delivered in 2025/26 (£m)	Activity productivity in plan (Volume)
1	Non-elective overnight	£4.80	2.00%	£2.40	
2	A&E and SDEC	£2.90	2.00%	£1.00	10,934
3	Elective opportunity	£31.50	12.20%	£12.80	1,201
4	Outpatient opportunity	£4.30	3.80%	£1.90	12,849
5	Other acute activity	£3.30	2.00%	£1.30	
6	Temp staffing	£13.70	1.70%	£14.00	
7	Corp services	£8.50	13.10%	£6.90	
8	Medicines	£2.20	1.10%	£1.70	
9	Commercial	£0.50	0.10%	£1.50	
10	Other local opportunities			£9.50	
	Total	**£71.70**		**£53.00**	**24,984**

- UHBW's operational productivity opportunity is £46.8m of which NHSE expects 50% as cash releasing. Trust efficiency is identified as an additional £24.9m.
- An internal assessment of opportunities shows expected savings of £53.0m
- Currently there are £48.5m in the Trust savings programme relating to productivity.
- 24,984 volume of additional clinical activity through productivity – 3.5% ELIP, 1% Day Case, 6.1% OPFA, 5.2% ED attendance.

University Hospitals Bristol and Weston NHS Foundation Trust

2025/26 FINANCIAL PLAN & BUDGET – Appendix 2: CIP Maturity Levels

Subjective Type	Subjective	1	2	3	4	Total
Pay	Admin & Clerical & Estates	£553	£644	£334		£1,530
	Medical staff - Consultants	£829	£559	£2,988		£4,376
	Medical staff - Other	£374	£217	£863		£1,454
	Non Clinical Staff	£147	£515	£308		£969
	Nursing & Midwifery	£804	£4,642	£2,922		£8,368
	Other Clinical Staff	£58	£563	£467		£1,088
	Healthcare Assistants			£299		£299
	Vacancy – Other			£9,893		£9,893
Pay Total		**£2,766**	**£7,139**	**£18,071**	**£0**	**£27,976**
Non pay	Blood	£235	£115			£350
	Clinical Supplies	£426	£3,773	£3,001		£7,200
	Drugs	£397	£775	£529		£1,700
	Establishment Expenses	£137				£137
	Lease	£45				£45
	Other Expenditure	£482	£5,212	£1,711		£7,405
Non pay Total		**£1,722**	**£9,874**	**£5,241**	**£0**	**£16,837**
Income	Income from Activities	£431	£1,520	£251		£2,202
	Income from Operations	£160	£862	£438		£1,460
Income Total		**£591**	**£2,382**	**£689**	**£0**	**£3,662**
Unidentified					**£4,525**	**£4,525**
Grand Total		**£5,078**	**£19,395**	**£24,001**	**£4,525**	**£53,000**
		10%	**37%**	**45%**	**9%**	**100%**

- £28.0m of plans relate to workforce cost reductions (53%)
- £16.8m of plans relate to non-pay cost reductions (32%)
- £3.7m of plans relate to income generation (7%)
- 47% / £24.5m of identified schemes are categorised as maturity level 1 or 2
- 45% / £24.0m of identified schemes are categorised as maturity level 3
- 9% / £4.5m are unidentified and categorised as level 4

University Hospitals Bristol and Weston NHS Foundation Trust

Appendix 3 - Board Assurance Framework- Provider Assurance

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.	YES	Approach and scenarios discussed and agreed at Finance Committee (FDEC) January 2025, detailed review undertaken at Private Board on 11th March. Final approval delegated to FDEC with all components of operating plan approved on 25th March.
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	YES	The plan has been developed and delivered through the Planning and Delivery Group, involving Divisional Clinical Chairs and the Executive Committee, with CMO and CNO engagement within UHBW's corporate governance and in bespoke clinical review sessions over the course of the process.
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	YES	Planning guidance and the key principles were shared with the Board. All prioritisation decisions have been made in conjunction with Divisions and Executives, with the prioritisation proposals presented to the Board.

A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.	YES	QEIA process refreshed in March 2024. Operational for a year now and working in line with NHSE principles for local prioritisation. Quarterly reporting is to Clinical Quality Group with opportunity for escalation into the Quality and Outcomes Committee as required. Detailed QEIA will continue to be undertaken on CIP schemes over the course of the financial year.
The organisation's plan was developed with appropriate input from and engagement with system partners.	YES	Operational delivery groups for urgent, elective and children's care, HCIGs for community and acute, MH and Children's. Tertiary Services Programme Board.
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	YES	National productivity information has been used to inform our planning priorities and decisions. Approach and application to performance and savings delivery shared with Board, including a detailed review of the response to the NHSE Productivity Pack.
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.	YES	As above
The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.	YES	The management of risks and quality issues has been core to UHBW's planning approach, informed our decision making and been embedded into all components of the final plan.

The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.	YES	Full triangulation of plan between finance, performance and workforce has been completed. The risks to the delivery of the plan have been articulated. Delivery of the plan will be contingent on system delivery of critical interrelated components, most prominently achievement of 15% NCTR.

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Appendix 4 – 2025/26 Health inequalities priorities

Priority focus	Guidance	2025/26 UHBW Priorities and approach
Data insights and sharing	**Reforming Elective Care:** · *demonstrable improvements in the completeness and accuracy of coding and recording practices, including ethnicity and housing status coding, by using relevant SNOMED codes*	· Ethnicity recording – continue to aim for 80%+ of RTT waiting list. · Exploring with ICB/NBT a consistent approach to sharing and recording of data on housing status
Elective waiting times	**Reforming Elective Care:** · *undertake quarterly reviews of local waiting list data (children and young people and adults) to better understand areas of inequality, looking at deprivation and ethnicity and using wider Core20PLUS5 approaches* · *embed health inequalities data into performance reporting with a quarterly review at board level*	· Inequalities Performance dashboard available to all specialties and Clinical Divisions for their review. Quartey Board reporting in place · Divisions reporting Health Inequalities data and actions through Division Assurance Reports at Health Equity Delivery Group. To consider Health Inequalities deep dives at Divisional Reviews.
Outpatient access	**Reforming Elective Care:** · *develop and monitor action plans to reduce inequalities in access and quality of Care*	· All Divisions will work on reducing DNAs in services with the largest disparity with DNAs for IMD 1 and 2 and Global Majority groups, relative to overall DNA rates (i.e. Reduce DNAs and narrow the gap)
Prevention	**System priorities:** · Tackling Tobacco Dependency (TTD) in maternity and inpatient settings (system ambition to reduce smoking prevalence below 5% by 2030) · Healthy weight declaration being finalized	· Roll out and embed admissions forms with smoking status, Very Brief Advice and referral to TTD · Commit to Healthy Weight Declaration and develop action plan

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public
Date of Meeting:	8 April 2025
Report Title:	NBT Operational Plan Final Submission 2025/26
Report Authors:	Simon Davies, Director of Operational Finance Henry Yip, Head of Business Planning Nicholas Smith, Interim Chief Operating Officer Caroline Bird, Director of Reset and Recovery Lisa Whitlow, Director of Performance Ben Pope, Associate Director for Workforce Planning, People Systems and Data
Report Sponsor:	Elizabeth Poskitt, Chief Finance Officer

Purpose of the report:

Approval	Discussion	Information
		X

To inform the Board of the detail of the NBT 2025/26 Operating Plan, as submitted to NHSE on 27 March 2025.

This paper was taken to NBT's Trust Board on 27 March 2025 to provide confirmation of:

- The Final position for NBT Business and Operational Planning for 2025/26. The plan will deliver a breakeven financial position and is compliant across performance metrics.
- The Joint Chief Executive and Hospital Managing Director approved the plan for submission to NHS England, in line with delegation from Trust Board, due to the timing of submission on the same day as the Board meeting.
- The amendment between the Headline and Final submission for key metrics to be submitted 27 March 2025.
- The approach to capital funding and allocation, including the over-programming.
- The risks included in the plan, and the approach to mitigating these.
- At that meeting the final budget for 2025/26 was approved, in advance of the start of the financial year.

Key Points to Note *(Including any previous decisions taken)*

The January Trust Board delegated authority to the Joint Chief Executive and Hospital Managing Director to sign off the Final plan in advance of March Trust Board following approval of the Headline submission at Finance, Digital and Performance Committee (FDPC) in February. The March FDPC scrutinised the key elements of the plan.

This is in line with the nationally mandated governance required to provide Board assurance of operational plans for 2025/26. This paper represents the work undertaken since the Headline submission to deliver a Final Operational Plan for the Trust's and BNSSG ICB System's Final submission on 27 March 2025 to NHS England.

This paper outlines the changes to the Headline submission which have delivered a final plan which is financially breakeven and delivers compliant performance levels. The key updates for the final plan are outlined in the below table of changes:

Date	**Position**
Headline submission 27 February 2025	Key areas: • Non-Compliant against delivering a minimum 5% point improvement on patients waiting no longer than 18 weeks for treatment. Target 72% but reporting 67% achievement. • Dependent on sufficient ERF funding: Improve patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026. • All other key performance objectives were targeted to be delivered. • BNSSG financial position reporting a £44.8m deficit, with NBTs contribution to the position at £16.1m.
Final submission 27 March 2025	Key areas: • All key performance objectives are targeted to be delivered. (see table 1) • Workforce – bank and agency reductions in line with guidance are included, as well as changes to substantive headcount, however overall, this is above establishment. • The financial plan is now reflecting a breakeven position. This includes actions to close the £16.1m gap from Headline to Final. Outstanding next steps at Headline submission now resolved at Final plan: • Bristol Surgical Centre – included in plan. • ERF planning – £10m of ERF funding prioritised. • Inflation, depreciation and technical accounting impacts – modelled in, including PFI accounting treatment offset by income. • BNSSG income schedules – included in plan. • Specialised commissioning plans – included in plan. • Cash – Cashflow projections indicate sufficient availability; however, cash balances are expected to decline significantly over the year. • Headcount modelling – included in plan. Additional in year controls will now be put in place. • Temporary staffing savings – included in plan.

	• Savings target – Central actions will be taken to deliver the further 1% / £7.8m to achieve overall total savings of £40.6m. • UEC and NC2R – to be delivered contingent on NCTR being reduced to 15%. • A&E – attendance growth agreed at 4%; c309 attendances per day. • Cancer Delivery – already demonstrated compliance.

Strategic Alignment Group Model Alignment

The Business Planning function enables the Trust to demonstrate plans that aims to deliver against the Trust's strategic priority.

NBT and UHBW work alongside each other to prepare aligned Business and Operational Plans, where appropriate.

Risks and Opportunities

Risks are outlined in the paper.

History of the paper (details of where paper has <u>previously</u> been received)

The approach to planning has been reported via various Business Plan update papers to Finance, Digital & Performance Committee and Trust Board via upward reporting, as well as through Executive Team Meetings and Strategic Leadership Groups. This paper was presented at NBT's Trust Board on 27 March 2025.

Appendices:	Appendix 1: Board Assurance framework Appendix 2: Health Inequalities focus Appendix 3: Productivity response Appendix 4: Workforce Final submission and NBT's Contribution towards national guidance. Appendix 5: Final Budget 2025/26 Appendix 6: 2024/25 Forecast Outturn to Underlying Position Appendix 7: Financial Underlying Position to 2025/26 Final Plan Appendix 8: 2023/24 Underlying to 2024/25 Underlying Position

1. Purpose

This paper is setting out to the Board the Final Business and Operational Planning for 2025/26. This is the position approved by Joint Chief Executive and the Hospital Managing Director in relation to the Final submission due on 27 March 2025. The position in this paper represents the resolution of issues that were outstanding at Headline submission and now reporting a compliant performance and breakeven financial plan. No further updates to the contents as described in this paper were made ahead of Final submission, however delegation of the Final submission was authorised to the Joint Chief Executive and the Hospital Managing Director to accept any changes required. The 27 March 2025 submission to NHS England covers activity, performance, workforce and finance key metrics. Table 1 compares the Headline submission against the Final submission.

Key Performance Metric	Headline submission	Final submission
Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026	Compliant	Compliant: Contingent on NCTR to reduce to 15%
A higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	Relationship between 4 and 12 hrs is maintained	Compliant: Relationship between 4 and 12 hrs is maintained
Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	Compliant	Compliant
Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	67% (non compliant to deliver a 5% improvement)	Compliant (72%)
Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*	Compliant dependant on sufficient ERF funding	Compliant (78%)
Improve performance against the headline 62-day cancer standard to 75% by March 2026	Compliant	Compliant

Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	Compliant	Compliant
Deliver a balanced net system financial position for 2025/26	Non-compliant	Compliant
Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	Non-compliant	Compliant
Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)		Working towards meeting this success criteria once defined.
Improve safety in maternity and neonatal services, delivering the key actions of the 'Three year delivery plan'	Compliant	Compliant
Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people	Compliant	Compliant

Table 1

The approach undertaken aligns with the development of the system plan with the Bristol, North Somerset & South Gloucestershire Integrated Care System (BNSSG ICB), which the North Bristol NHS Trust plan is incorporated into.

2. Background

The work on Business Planning has been reported via various updates to Finance, Digital & Performance Committee and Trust Board, as well as through Executive Team Meetings and Senior Leadership Groups since the launch of 2025/26 planning in September 2024.

National planning guidance was released 30 January 2025. The national message was clearly stated - that NHS organisations are expected to live within their means and that will require maximising productivity. The focus is to maximise resources available for clinical services, given the financial constraints, which may result in difficult decisions being required, including reducing or stopping spending on some services and functions and to achieve unprecedented productivity growth in others.

For the 2025/26 Business Planning round, two submissions are required by NHS England. The first is a Headline submission on 27 February 2025 and then a Final submission on 27 March 2025. Both will have been submitted by the time Board reviews this paper.

Finance, Performance and Workforce Submission templates, alongside a Final submission checklist which includes a narrative covering productivity and efficiency, Elective and UEC plans for 2025/26, at both a provider and ICS level will have been

shared with the ICS on 24 March and these submissions form the basis of this paper.

A Board Assurance Framework (Appendix 1) is requested for Final plan submission. NHS England expect Boards to be involved throughout the development of plans, and ICBs and providers must work together to ensure that the submission reflects the collective intensions of the system.

Whilst the NHS England submission requires key performance metrics, it should be noted that work on wider Operational Planning continues, which includes the refresh of Patient First priorities and work on Health Inequalities. Current assumptions towards delivery of Health Inequalities requirements have been outlined in Appendix 2.

The expectation from NHS England is that providers and systems will breakeven, in addition to achieving the performance standards. The Trust's Final plan is compliant following resolution to issues outlined in the Headline submission.

The sections below set out the activity, performance, workforce and finance elements of the operating plan. These have been aligned through the divisional review process and through the planning working group maintaining links and triangulation between each area.

Planning sessions have been held with each division and corporate directorates in January, February and March. This ensures that planning from a divisional level continues to support the setting of deliverable plans.

3. Operating Plan 2025/26

3.1. Activity plans

Activity plans have been developed on a bottom-up basis at divisional level based on deliverability.

The Headline submission did not include the impact of the Bristol Surgical Centre but that has now been incorporated into the final plan. The plan is based on the 'Displacement' clinical model for the Bristol Surgical Centre which expects the centre to open in mid-August for four theatres of Orthopaedic activity and to start delivering productivity gains from September 2025. The plan also reflects NBT additionality in Brunel (two theatres) and UHBW transfer of activity to NBT (two theatres) and UHBW additionality from mid-August to September 2025.

Prioritisation of Elective Recovery Funding (ERF) has been concluded, and the prioritised investments are reflected in the activity plans.

The Trust has used the GooRoo modelling tool to a greater extent as the basis for demand and capacity modelling for 2025/26. Diagnostic modalities have continued to use IMAS. In addition, the Trust's Senior Operational Modelling Lead has developed models to aid with producing plans to deliver new national RTT wait times requirements. UEC growth is aligned with ICB modelling.

3.1.1. The key assumptions on activity are:

- ‘Yes if’ plan – continue to deliver non-recurrent ERF mitigations from 2024/25 plus all new investment requests (£10m of ERF has been switched on),

- UEC delivery contingent on NCTR being 15%, as plan assumes all Trust actions have been undertaken to meet performance at this level of NCTR,

- A&E attendance growth 4% on top of Month 9 Forecast Outturn (5.6% Majors; 1.3% Minors); c.309 attendances per day,

- Non-Elective (NEL) admission growth 3%; split of 54% 0-day Length of Stay (LoS) / 46% 1+day-LoS,

- Core capacity of 878 beds with escalation to mitigate >100% occupancy,

- Target bed occupancy 93% (NEL 92%; EL 95%),

- Minimum 2 ring-fenced elective wards in the Brunel Building and Bristol Surgical Centre are ring fenced,

- Cancer performance metrics are for delivery in the final quarter, the plan assumes delivery in line with standards by this point. It is dependent upon SWAG funding being available at current levels.

3.1.2. Key Deliverables

- ED 4-hour: 78% by year end (March 2026) including 7.9% footprint uplift – improvement will be subject to robust system plans including NC2R reduction down to 15% by year end,

- RTT: Deliver 72% of patients waiting no more than 18-weeks by year end; deliver 78% 1st OPA within 18-weeks; continue to deliver no more than 1% of the wait list waiting >52-weeks,

- Diagnostics: continue to deliver 1% national standard with 0 x 13-week breaches,

- Cancer: 62-day combined delivery of 75% by year end; FDS 80% by year end.

3.1.3. Plan position NBT

The activity plan set out using the contract income currency within SLAM (the contract income monitoring system used by the Trust) is in Table 2 below.

	Activity			Income (£m)		
POD	*2019/20*	*2025/26*	*% of 2019/20*	*2019/20*	*2025/26*	*% of 2019/20*
Elective inpatients	14,148	15,714	111.1%	66.1	77.7	117.5%
Day Case	54,266	70,041	129.1%	51.4	70.5	137.2%
Total Elective	**68,414**	**85,755**	**125.3%**	**117.5**	**148.2**	**126.1%**
Outpatient First	113,085	137,125	121.3%	26.2	30.7	117.2%
Outpatient Procedure	46,154	63,855	138.4%	10.0	14.9	149.0%
Total ERF Outpatients	**159,238**	**200,980**	**126.2%**	**36.2**	**45.6**	**126.0%**
Total ERF	**227,652**	**286,735**	**126.0%**	**153.7**	**193.8**	**126.1%**
Outpatient Follow Up	289,234	283,008	97.8%	44.6	45	100.9%
NEL	98,689	112,640	114.1%	20.0	24.5	122.5%
A&E	67,387	85,151	126.4%	185.5	206.5	111.3%

Table 2

The activity baseline which the Trust will be measured against is SUS (national repository for healthcare data), which is different to SLAM but not how the Trust routinely reports income. Our assessment of the impact of the conversion from SLAM to SUS is in the below Table 3. Within the Trust's assessment based on SUS, it should be noted that CDC activity is included in the Day Case activity, as is other Endoscopy activity. This is not included in the Elective Recovery calculation in table 2 above.

POD	% of 2019/20 SUS
ED Attendances	114.1%
NEL Zero LoS	146.7%
NEL 1+day LoS	119.6%
OP First Attendance	123.0%
OP Follow UP	97.8%

OPPROC	138.4%
EL Day Case	129.1%
EL Inpatient	116.7%

Table 3

3.2. Performance

3.2.1. Elective Care

Whilst previous planning rounds, following the pandemic, have focussed on backlog clearance and reduction of the longest-waiting patients, the guidance for 2025/26 and in the Elective Reform publication, renews focus on overall compliance with the 18-week RTT standard.

The Trust has already delivered the minimum national requirements for both wait time for first activity and proportion of patients waiting over 18-weeks. Therefore, the Trust's plans are focussed on delivery of the 5% stretch target for both metrics.

The Trust will be expected to deliver a minimum of 72% of patients waiting less than 18-weeks for their treatment and a minimum of 78% of patients waiting less than 18-weeks for their first activity.

The Trust has developed plans that demonstrate the additionality in activity and improved productivity required to deliver these improvements. This is in addition to the opening of the Bristol Surgical Centre in 2025.

The Trust has also already delivered no more than 1% of the total wait list waiting over 52-weeks; plans for 2025/26 will ensure that delivery of this standard is sustained, and key focus will be on ensuring progress is continued at pace to enable delivery of the 18-week constitutional standard.

3.2.2. Cancer

Cancer targets for delivery by March 2026 are:

- *Faster Diagnosis – 80% of patients will be given a diagnosis within 28 days.*
- *75% will be treated within 62 days for cancer.*

The implementation and continuation of new pathways will support sustained improvements in faster diagnosis. For Skin, 11 PCNs are now delivering teledermatology referrals with further expansion planned in 2025. In Gynaecology, the new direct to test pathway launched in January 2025 will reduce demand on the cancer pathway and support earlier diagnosis.

The introduction of the Bristol Surgical Centre will provide some additional capacity and efficiency to deliver surgical interventions.

NBT will continue to use external funding to support delivery plans. The South West Cancer Alliance (SWAG) have not yet provided the non-recurrent funding profile for 2025/26. NBT will focus this funding on extending initiatives delivered in 2024/25 including pathology additionality, waiting list and other elective additionality. It is assumed that funding will be less than that available in 2024/25, however additional in year funding will continue to support all at

risk phases of the pathway to deliver performance improvements before year end.

3.2.3. Diagnostics

- *National wait time standard of no more than 1% of patients waiting >6-weeks for their diagnostic test.*

Whilst not explicitly covered in the operational planning guidance for 2025/26, it is understood that the expectation is for trusts to be back to compliance with the 1% national standard. The Trust plans to continue to deliver this requirement and maintain clearance of over 13 weeks.

- *Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.*

The Trust plans to deliver sufficient activity to deliver elective, cancer and diagnostic waiting times ambitions. The Trust's plan includes CDC activity and non-recurrent mitigations including insourcing/outsourcing of activity, including wating list initiatives and Independent Sector capacity. The use of these mitigations varies across modalities with some modalities now delivering within sustainable core capacity e.g. DEXA scans and Respiratory Physiology – Sleep Studies.

3.2.4. Productivity

NHS organisations will need to reduce their cost base by at least 1% and achieve 4% improvement in productivity, in order to deal with demand growth. This is a step change across all services. The Trust must demonstrate that all productivity and efficiency opportunities have been exhausted before considering where it is necessary to reduce or stop services, taking account of each organisation's own legal duties.

NHSE have published productivity and efficiency packs at a Trust level to support the identification of opportunities. Measures have been identified across nine areas including clinical and operational productivity and efficiency (see Appendix 3).

The Productivity Packs show NBT as an outlier, this is due to the use of the 2023/24 National Cost Collection as the basis for the calculation. There was an accounting change in 2023/24 relating to the PFI which was excluded from the Trust's control total to achieve breakeven. However, the impact appears to have been included in the metrics received, thus driving the position. The Trust is working with both regional and national colleagues to find a route to replicate the calculation with the PFI impact removed.

The Trust has reviewed the outputs of national data and discussed the approach through Finance Sustainability Board. Key areas of focus for the Trust will be temporary staffing, commercial procurement, and elective and outpatients. This will include driving improvements in operational and clinical productivity, with a specific focus on outpatients and theatre efficiency.

Progress has been made in recovering activity in the last year and improving some key productivity and efficiency metrics. Productivity, therefore, remains a critical component of the Trust's recovery and sustainability plans.

The Trust's approach continues to be data driven, using comparative and benchmarking information, including Getting it Right First Time (GIRFT), to highlight areas for improvement.

There remain some challenges for NBT in improving its productivity and efficiency, including our disproportionally high no criteria to reside position; workforce constraints; lack of anaesthetic rooms in Brunel Theatres and outsourcing of a significant amount of High-Volume Low Complexity (HVLC) cases to the independent sector. Despite these constraints, however, we have identified opportunities for improvement. These include:

- Through NBT's Outpatient Board, the Trust continues to progress projects supporting both the recovery and productivity and efficiency agenda. Continuing projects are focused on maximising outpatient room utilisation and reducing Did Not Attends (DNAs), with digital transformation as an enabler, to ensure NBT is making best use of its limited resources to provide the best patient care. An additional focus for 2025/26 will be on optimising outpatient clinic templates, with an initial focus on five specialties in quarter one before a rollout to other areas.

- Through the Theatre Efficiency Group, delivery of a comprehensive improvement plan focusing on improving Capped Theatre Utilisation. This work has improved the capped theatre time from 75% to 79% in this year. This has led to an improvement in the number of cases being delivered per day. A key area of efficiency will be when the Bristol Surgical Centre is functioning, this has been designed to be able to maximise GIRFT guidance on high volume lists. The organisation has a maturing Prehabilitation service which optimises patients prior to surgery and there are plans to increase the operating day in Gynaecology to maximise the use of the current estate.

3.2.5. Urgent Emergency Care (UEC)

As in 2024/25, improvements in performance in UEC metrics are dependent on:

- management of front door demand,
- streamlining and redirection,
- reducing time in department,
- improving timeliness of ambulance handovers,
- improving flow into and out of the bed base, and
- crucially, reducing the number of beds occupied by NC2R patients.

This is set in the context of continuing growth in ED attendances, particularly Majors, and remaining being an outlier regionally and nationally on NC2R.

The 2025/26 internal programme of work will continue to focus on two areas – the front door and flow and discharge. Governance and oversight of the implementation of agreed schemes will continue through the established UEC Transformation Programme Board, chaired by the Chief Operating Officer with further Executive Sponsorship from the Chief Medical Officer and Chief Nursing Officer.

Given the system wide nature of Urgent and Emergency Care, NBT representatives will also continue to pro-actively participate in system level governance structures, as required, and work with partners to support the implementation of the UEC and Home First Plan.

3.3. Workforce

National planning guidance for workforce sets out clear expectations to reduce workforce cost and whole time equivalent (wte) and for workforce to contribute towards improving productivity. Guidance sets out expectations to ensure:

- Optimisation of the substantive workforce, delivering reduction in spend (and use) of bank (10% reduction) and agency (30% reduction) and review support function establishment to return expenditure to April 2022 levels.
- Overall workforce does not exceed budgeted establishment from a WTE and pay perspective with delivery enabled by implementing workforce controls and improving productivity, closing the WTE and activity productivity gap.

Delivery is underpinned through the utilisation of available tools, such as eRostering and eJobPlanning, and in continuing progressing our strategic commitments to our People through delivery of the People Promise, the six national high impact Equality, Diversity and Inclusion actions, our Health, Wellbeing and Resilience plan and through targeted resourcing activity.

3.3.1. Assumptions and Modelling Approach

3.3.1.1. Supply

Our supply forecast is based on the underlying assumption that we can achieve, where required, supply rates from the last 12 months for clinical roles, with known exceptions applied, e.g., specific recruitment volumes for clinical professions; undergraduate pipelines, apprenticeships, targeted domestic recruitment, recruitment plans for hard to fill posts, resident doctor expansion and areas where deterioration in available supply is anticipated. Targeted analysis of supply for clinical professions has been worked up through the relevant People Governance routes, including Nursing Workforce Committee and AHP Workforce.

3.3.1.2. Retention

Our plan assumes current levels of turnover continue. Our plans continue to focus on improving our turnover position in targeted areas, particularly frontline clinical teams. However, given the considerable work over the past 12 months to improve staff retention, close our vacancy gaps and enhance staff experience. There is a risk with the focus on headcount reduction and

continued reduction in temporary staffing that we could start to see these positive retention trends impacted.

3.3.1.3. Substantive Workforce Growth

Our plan assumes growth in our substantive workforce where existing budgeted clinical vacancies are being filled or where there is an agreed and funded workforce expansion. The impact of the Bristol Surgical Centre on workforce demand and supply is the most significant area of workforce growth, currently 273 wte for NBT. In addition, re-investment of nursing temporary staffing budget into substantive staffing has been agreed to reflect safe staffing and headroom need, this aligns with planning guidance on productivity aimed at reducing the use of premium cost staff through establishment reviews. The final area of workforce growth is NHS England's national expansion of Resident Doctors with the Trust receiving 12 additional doctors from August 2026.

3.3.1.4. Workforce Cost Reduction

Recognising the need to reduce our workforce costs to meet national guidance and contribute to Trust savings requirements, our assumption is that we will deliver workforce reduction. To deliver the required savings our targeted reduction is 211 wte. This will manifest as a budget reduction of 211 wte and a substantive staff reduction of 180 wte (assuming that some of the 211 wte will be currently vacant posts). The mechanisms to underpin the delivery are being rapidly worked up and will be presented to the Executive Management Team for sign off. This includes a proposal for enhanced governance and oversight, strengthening the role of the Resourcing and Temporary Staffing Oversight Group established July 2024, chaired by the Chief People Officer. The group will play a pivotal role in terms of monitoring the impact of our workforce plans, particularly on delivery of the required cost savings and the impact of controls.

3.3.1.5. Temporary Staffing

NHS England planning priorities for 2025/26 require a reduction in bank and agency expenditure of 10% and 30% respectively of our overall spend on bank and agency in 2024/25. The 2025/26 plan assumes that the improvements will be delivered over the course of the year in reduced temporary staffing use. Delivery will be through additional controls, conversion of agency to bank and substantive, establishment reviews, work on rota design for Resident Doctors. In addition, we will identify opportunities through cost improvements, reviewing rates and opportunities for direct engagement of agency staff.

3.3.1.6. Workforce Productivity

Encompasses aspects directly relating to workforce use and cost and the specific aspects of the guidance are outlined in the productivity section above and throughout section 3.3.1.

3.3.2. Workforce Submission

The table in Appendix 4 shows the final submission alignment with national planning guidance and key wte changes in our anticipated workforce position for 2025/26.

3.3.3. Summary Key Performance Indicators (KPIs for Workforce)

NHS England focus on two workforce KPIs, Turnover and Sickness. Additional success measures focussing on agency and bank reduction and reduced spend on support functions have been described in the NHS England's guidance and described above in section 3.3.1 will be monitored in 2025/26.

There are additional success criteria in the planning guidance relating to the closure of the wte and activity productivity gap and the delivery of the NHS People Promise and six high impact Equality, Diversity and Inclusion actions. We will work to develop any additional measures, either required by NHS England or determined as required internally, to support monitoring of delivery against these criteria in 2025/26.

Our turnover target for 2024/25 (11.9%) has been achieved and is 11.6% in February 2025. Given the anticipated pressure on staff due to the additional workforce controls that will be in place next year, we assume no further improvement in turnover overall will be achieved in 2025/26. We continue to deliver our long-term retention plan aims and interventions with a focus on 2025/26 on culture, 'living our values', flexible working and career development and coaching to build long term careers in the Trust and will take a targeted approach to improvement focussing primarily on clinical and business critical roles.

Our sickness absence rate is currently above our 2024/25 targets (4.4%) at 4.6% in February 2025. Our draft target for sickness for 2025/26 remains 4.4%. Improvement has been delivered in 2024/25, but our rolling 12-month sickness position has 'plateaued' at 4.6% over the last six months. Retaining a target of 4.4% aligns with ongoing focus on improving staff Health and Wellbeing whilst recognising that further stretching targets may not be achievable due to ongoing and increasing pressures on the workforce driven by cost reduction requirements.

The risk to deliver these targets has been highlighted to the ICS through the planning process as part of a wider risk to staff retention, engagement and health and wellbeing.

Overall impact of anticipated pressures - there has been considerable work over the past 12 months to improve staff retention, close our vacancy gaps and enhance staff experience. There is a risk with the focus on headcount reduction and continued reductions in temporary staffing that we could start to see these positive trends impacted. We have mitigations to help address this, but with additional pressures due to patient acuity, increased demand on our services, and no criteria to reside, there is a risk that these trends could be negatively impacted.

There is a risk that headcount reduction and efficiencies across the acute sector result in periods of significant organisational change across our workforce and the potential need to make difficult decisions regarding

recruitment into vacancies and the potential for redundancies. We have robust organisational change policies and procedures to support this, and every effort will be made to avoid redundancies, and we are already working closely with partner organisations and prioritising redeployment across our services wherever possible. However, there is a need to ensure that appropriate approval mechanisms regionally/nationally are in place to support with this level of organisational change, and to ensure that we are supported to manage this in the most efficient and cost-effective way, e.g., consultation closure and in year savings delivery may be at risk due to current regional control on redundancy.

3.4. Finance

The Final plan to be submitted by BNSSG ICS is a breakeven position. The NBT position is also showing a breakeven position.

Within the NBT position is:

- £8.1m of provider deficit support income from the system (and per the Medium-Term Financial Plan).
- £7.7m of non-recurrent mitigations or income
- £16.7m of cost pressures recurrently funded
- Savings plan to deliver £40.6m in 2025/26 equating to 5% of turnover as agreed with ICB, made up of:
    - £36.4m of recurrent savings
    - £4.2m of non-recurrent savings

The Elective Recovery Funding recurrently added to baselines in 2023/24, in addition to further funding confirmed for 2025/26, is included within the 2025/26 plan. The Trust has worked with operational teams to prioritise this funding to ensure maximum delivery of targets.

The detailed Budget is in Appendix 5.

A waterfall to show the movement from the Underlying position to the final 2025/26 plan is shown in Appendix 6.

3.4.1. System Underlying position

Through the 2025/26 planning process each of the organisations within BNSSG has reviewed its underlying position.

The deterioration which NBT has seen due to the non-delivery of savings is reflected in UHBW, who have also not delivered savings recurrently in line with plans set out at the start of 2024/25.

Overall, the combination of non-delivery of provider and system savings, alongside other pressures seen in year, have resulted in the system deteriorating from a planned £68.3m underlying deficit to a £134.7m forecast underlying deficit.

This deficit will need to be recovered, and this aligns with the Trust's own plans to recover its element of the underlying deficit, initially through a combination

of non-recurrent and recurrent savings in 2025/26, with fully recurrent initiatives planned in future years.

3.4.2. NBT Underlying position

The NBT underlying position, calculated in December 2024, has deteriorated in year.

The key drivers of this have been:

- Non-delivery of full savings requirement of £28.7m in 2024/25.
- Short fall in 2024/25 pay award funding based on budgeted establishment of £2.5m.
- Non-pay inflation greater that the national Cost Uplift Factor £3.0m.
- Further pressures driven by increased activity on block contracts £6.5m.

Appendix 7 shows the route from the 2024/25 breakeven forecast outturn to the underlying position. Appendix 8 shows the movement from the 2023/24 to 2024/25 underlying positions.

3.4.3. Inflation

Inflation has been one of the most significant drivers in the past two financial years of the underlying position movement and this has only been partially funded nationally.

It should be noted that the 2025/26 pay inflation calculation has been made prior to any announcements on pay settlements and is in line with national planning assumptions. For Final planning, it is assumed that this will be fully funded and there is no financial pressure from the 2025/26 pay award.

The impact of the 2024/25 pay award has not been fully funded nationally. The pressure arises from the funding received for the pay award being calculated on staff in post on 31 March and not funded establishment. However, the ICB has allocated funding for this £2.5m pressure and is included in the Final Plan to offset the cost pressure.

3.4.4. Cost Pressures

A review of cost pressures has been undertaken and the updated Underlying Position reflects these, with funding made available within the final assessment.

This funding will cover the specifics driving the Underlying Position, in addition to any changes in budgets due to business cases and income sources which have changed in year.

3.4.5. Elective Recovery Funding

Elective Recovery Funding (ERF) will continue in 2025/26 however the funding arrangements are now capped. Based on published guidance no additional funding will be available for elective activity beyond that included in the commissioner allocations.

Core and additional ERF has been separately identified in ICB allocations. Distribution of additional ERF funding is based on the forecast outturn for Month 8 2024/25 with adjustments for the impact of Bristol Surgical Centre, scaled backed for performance over target set nationally.

Currently only the allocation for BNSSG and Specialised Commissioning has been made available and the Trust, with Associates yet to be confirmed. For BNSSG the allocation of £272.8m represents 113% of the 2019/20 baseline.

ERF for Bristol Surgical Centre (BSC) of £12m is separately identified as part of targeted investment funding (TIF) and £10m of funding has been prioritised to support the delivery of performance standards in RTT and Cancer.

3.4.6. PFI PDC Dividend Risk

The PDC Dividend is a charge by NHS England to cover the cost of NHS funds tied in assets (cost of capital). Normally, PFIs, as privately funded assets, do not incur this charge since they already bear private investment costs, including interest.

In 2024/25, the National Finance team introduced adjustments to estimate PDC charges if PFIs were publicly funded, aiming for fair comparisons. However, the NBT finance team argues this method is flawed as it overlooks existing private charges mentioned above. This change was only introduced late in the financial year.

For NBT this increase in PDC charge would be c£5m per annum.

NBT is collaborating with central NHSE finance teams to revise these calculations however the guidance currently received is to include this cost in the Trust's 2025/26 plan. As this is a cost pressure originating from an accounting change for which NBT has no control over NBT have also included additional funding to mitigate this cost. There is a risk that this funding will not be received and the PDC charges as stated above would still stand.

3.4.7. Savings

3.4.7.1. Savings delivered prior to 2025/26

The table below shows the level of savings which have delivered historically by the Trust.

Financial Year	Total CIP Delivered (£'m)	Recurrent (£'m)	Non-recurrent (£'m)	Full-Year Effect (£'m)	FYE % of Income
2015/16	27.3	26.3	1.0	29.2	5.0%
2016/17	26.1	25.0	1.1	24.4	5.0%
2017/18	36.8	29.4	7.4	32.8	6.0%
2018/19	26.3	15.3	11.0	17.5	3.0%
2019/20	22.1	15.4	6.7	18.6	3.0%
2020/21	2.5	2.5	0.0	2.5	0.4%
2021/22	3.5	3.5	0.0	3.5	0.5%

2022/23	6.5	6.5	0.0	6.5	0.8%
2023/24	18.2	18.2	0.0	18.2	2.3%
2024/25	22.1*	22.1	0.0	22.1	2.8%
2025/26	40.6.	36.4	4.2	40.6	5.0%

Table 4

*This is currently a forecasted Year-End position.

This demonstrates that whilst the level of savings delivered in recent years has been less than 3%, pre-Covid the Trust was delivering over 3% consistently. However as shown above this included non-recurrent savings no longer reported as CIP by the Trust, although an element of non-recurrent will be used to support 2025 / 26 delivery.

3.4.7.2. National and local requirements on savings delivery

The national requirement is for 2.0% of efficiency to be delivered by the Trust as part of the core efficiency. This is an increase from prior years where the national efficiency target was set at 1.1% and the Medium-Term Financial Plan (MTFP) was based on an assumption of a 1.1% national efficiency target.

3.4.7.3. Savings Approach for 2025/26

The Trust has developed savings plans to deliver £40.6m in 2025/26 equating to 5% of turnover which includes the increased national efficiency target. This is in line with the percentage that UHBW are expecting to deliver. Divisions and Directorates will continue to target 4% savings (£32.8m). The approach taken has been to ask each area to deliver 3.25% savings on its budget, excluding high-cost drugs and devices and Clinical Negligence Premiums. Additionally, there is a further ask for delivery of 0.75% through Trustwide initiatives, including Procurement, Digital and Medicines. The Trustwide savings will be delivered by the key corporate lead, with support from the clinical divisions.

Central actions will be taken to deliver the further 1% (£7.8m) required which may include non-recurrent savings. Actions supporting this delivery will include further negotiations with the PFI, as well as reviewing rates for Agency and Bank. The Central savings will be delivered by the key corporate lead and will unlikely need support from clinical divisions due to their nature.

The approach started in 2022/23 for the governance around the delivery of savings through the Exec-led Financial Sustainability Board. This will continue alongside the monitoring of delivery through Divisional Review meetings on a monthly basis.

Weekly reports are produced and circulated to Divisional Operations Directors, Finance Business Partners and scheme leads, using information from the Savings Tracker to accurately report movement.

The Tracker holds project information on each scheme to improve confidence in deliverability. Information consists of project start/finish date, SRO lead name, scheme lead name, risks/issues.

3.4.7.4. Final 2024/25 position

The delivery of savings at Month 11 is £21.1m, with a further £0.9m expected in Month 12. Any slippage beyond this would need to be added to the 2025/26 target and the clinical and corporate divisions have been made aware of this.

3.4.7.5. 2025/26 position for the Final return

The savings identified for the Final return is £36.4m, thus 90% of the £40.6m target.

Of this £12.7m has been worked up in detail by divisions, with further savings identified from the following areas and plans are either in place for being worked up to deliver this level:

- £4.0m Procurement
- £0.5m Digital Transformation
- £0.5m Medicines Management
- £1.5m Fee paying
- £1.5m Productivity (cost reduction)
- £1.0m Admin review
- £0.3m Commercial

Further work is being undertaken to assess and capture opportunities from corporate benchmarking.

3.4.7.6. Group Benefits and Savings

The impact of the work underway on Group benefits and savings have not been included for the final submission. The investment requirements and associated savings are equal in 2025/26 so these budgetary changes can be reflected in year.

3.4.8. Risks to the Income and Expenditure Position of the Trust in 2025/26 and mitigations to these

The key risk is the delivery of savings. £40.6m needs to be delivered to ensure that NBT hits the breakeven position. Where divisions are unable to fully recurrently deliver the level of savings in year, they will need non-recurrent mitigations to counter any current year impact.

No detailed income schedules have been received from Associate commissioners. There is a risk that without the full detail of income expected that there is a misalignment of expectations.

Whilst the impact of the cap on Elective Recovery Funding is worked through, the ability to fully model the performance and financial trade-off that might be required drives a risk in both areas.

At this stage, there remains limited information shared from Specialised Commissioning. Whilst Elective Recovery Funding figures have been shared, no confirmation around significant national funding has been made. NBT is currently assuming funding in line with the 2024/25 position in the absence of further detail. The relationship with Specialised Commissioning continues to

be positive, however there is pressure both on them and other areas of NHS England commissioning, to reduce costs and therefore they are scrutinising our spend, including drugs spend. The Trust will continue to work closely to with commissioners to minimise risks and to counter any challenges raised.

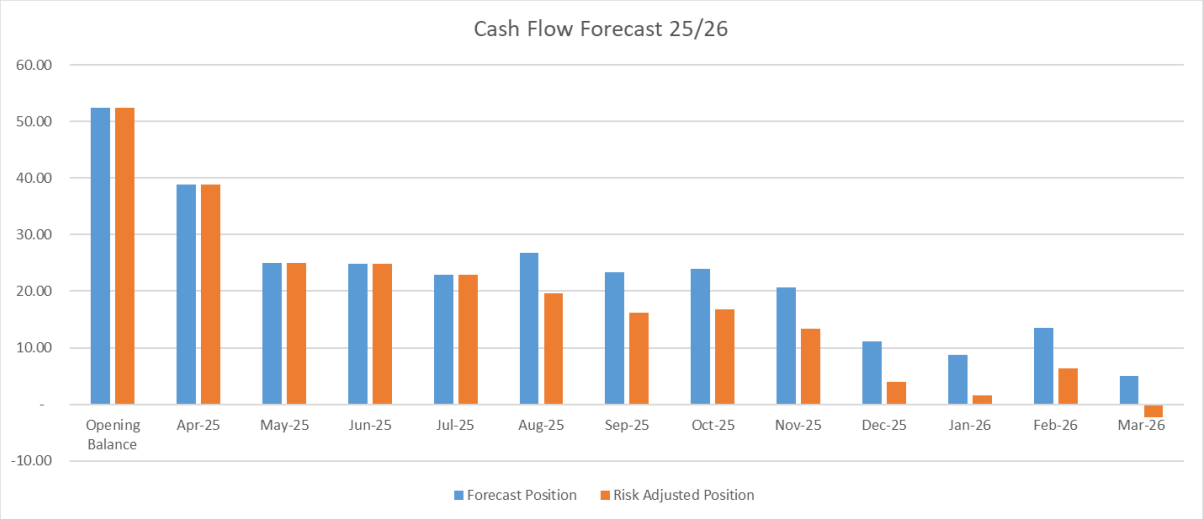
The Trust continues to work closely with the DH&SC on the impact of the 2023/24 change recognising PFI costs in relation to IFRS16. The Trust has recognised a pressure related to the calculation of Public Divided Capital in relation to the residual interest, as well as the inflationary impact on the PFI. Work will continue to model this for 2025/26 and reflect this within the position.

3.4.9. Cash

The cash balances for the Trust have been modelled in line with the planned I&E position and capital spend.

Cash is predicted to reduce in year. This is primarily driven by the payment of a high value invoices in the first quarter of the year relating to capital spend from the final quarter of 2024/25.

In addition, there are several impacts on cash due to technical non-cash income and expenditure items in particular the impact of the PFI (£7.2m).



Graph 1

The above graph shows a core cash forecast position giving a year-end cash balance of £5m and a risk adjusted position which shows the year-end cash position as £2m overdrawn.

In order to mitigate the risk of running out of cash and in a similar exercise to 2024/25, the Trust will work with the National team to obtain additional cash support in relation to shortfalls in cash due to PFI accounting. To this end the core position includes an assumption of £7.2m of cash support linked to the accounting of the PFI which is not included in the risk adjusted position.

Included within both models is an additional service payment for the PFI being paid in May.

The large decrease in cash in the first quarter in both scenarios is driven by the large value of capital invoices expected to be paid as a result of the high level of capital spend in March 2025 as mentioned above.

3.4.10. Capital

3.4.10.1. ICS Capital Prioritisation

Since 2023/24, the CDEL (Capital Departmental Expenditure Limit) is issued to the ICB to allocate across the organisations in the system rather than to individual Trusts. This means that there is no longer any element of the capital envelope which is owned by any individual organisation. In addition, any future asset disposals or national funding will be allocated by the ICB to the area of highest priority rather that going directly to the organisation which generates it.

The ICB has developed mechanisms for agreeing priorities and distributing capital across the system. This involves a broad range of stakeholders dealing with a relatively complex set of requirements and priorities as well as a high volume of potential schemes and a significantly over-subscribed capital budget.

3.4.10.2. NBT Funding position

Following the ICB process, the Trust currently has the following funding confirmed based on historic levels of depreciation:

	Value (£000)
Operational CDEL Envelope	23,742
Sustainability	2,233
Less System Brokerage – Agreed in 2024/25	(2,000)
Subtotal	23,975
Lease Capital	1,094
Total	**25,069**

Table 5

3.4.10.3. NBT capital allocation

There are a high level of commitments already identified against this envelope. The table 6 below shows the items that have already been approved at Capital Planning Group (CPG).

Further prioritisation is taking place to agree a full plan that matches current allocations.

Capital Project	Value (£000)
Bristol Surgical Centre	8,175
Level 0 CT Scanner	628
IR Lab 4 Replacement Bi Plane	355
Level 2 N Med	1,000
Cossham CT Scanner	1,000

Yate Plain Film Room	350
Cossham Plain Film Room	350
Hybrid Theatres	1,500
Mortuary Extension	1,500
SSD Washer Replacement	200
Pathology AHUs	2,426
NICU Ventilation	3,000
EPMA	662
Cyber Security Recovery, Protection & Backup Facility	36
High Speed Storage	85
PC Refresh	98
Replacement Capital Medical Equipment (CES)	1,010
PSDS Wave 3c (Excludes Salix spend)	850
Spend to be brought into 2024/25	(2,714)
Subtotal	**20,510**

Table 6

3.4.10.4. Over-programming

BNSSG has agreed an approach to overprogramming to ensure that any slippage is mitigated, and all capital allocations are fully utilised. To this end NBT will include a level of overprogramming as outlined in table 7 below.

Category	Depreciation Funding	Overprogramming	Sustainability Funding	Grand Total
Critical Infrastructure & Estates	5.8	3.2	0.0	9.0
Digital	1.0	1.1	0.0	2.2
Major Capital Schemes	7.2	0.0	0.0	7.2
Major Medical Equipment	5.2	0.0	0.0	5.2
Medical Equipment	0.6	3.0	0.0	3.6
Sustainability	0.9	0.0	2.0	2.8
Operational Capital	0.0	0.0	0.0	0.0
Lease	1.1	0.0	0.0	1.1
Grand Total	**21.7**	**7.4**	**2.0**	**31.1**

Table 7

3.4.10.5. National Capital Funding

In addition to the operational allocation based on historic depreciation, capital funding is available through national schemes. The allocation of this funding is to be prioritised at a ICB level for each organisation taking into account risks across the system. The Trust is actively engaging in this process.

The amounts of national funding provisionally allocated to the ICB are shown in the table 8 below. It is expected that there will be an additional allocation relating to digital schemes, but this is yet to be announced.

	Value (£000)
Return to Constitutional Standards – Diagnostics	500

Return to Constitutional Standards – Electives	13,750
Return to Constitutional Standards – UEC	10,250
Estates Safety	27,011
Total	**51,511**

Table 8

In order to maximise national funding received all items eligible for national funding are to be submitted even if they are already included in the operational capital plans shown above.

Once national funding has been awarded a risk-based prioritisation process will be carried out led by the ICB System Capital Board to allocate all remaining funds against unfunded items.

As a system, bids totalling £60.3m have been submitted against the £24.5m RtCS allocation and £37.4m against the Estates Safety allocation. The ICB Capital Board have decided to submit these lists in full rather than prioritise bids down to the level of the indicative allocations.

The below table 9 summarises the additional NBT schemes for which national funding has been bid for.

Category	Estates Safety	Diagnostics	Elective	UEC	Grand Total
Critical Infrastructure & Estates	7,086			5,000	12,086
Major Capital Schemes				1,341	1,341
Major Medical Equipment			4,800		4,800
Medical Equipment		596	90	700	1,386
Operational Capital		3,500		250	3,750
Grand Total	**7,086**	**4,096**	**4,890**	**7,291**	**23,363**

Table 9

4. Summary and Recommendations

To inform the Board of the detail of the NBT 2025/26 Operating Plan, as submitted to NHSE on 27 March 2025.

This paper was taken to NBT's Trust Board on 27 March 2025 to provide confirmation of:

- The Final position for NBT Business and Operational Planning for 2025/26. The plan will deliver a breakeven financial position and is compliant across performance metrics.

- The Joint Chief Executive and Hospital Managing Director approved the plan for submission to NHS England, in line with delegation from Trust Board, due to the timing of submission on the same day as the Board meeting.

- The amendment between the Headline and Final submission for key metrics to be submitted 27 March 2025.

- The approach to capital funding and allocation, including the over-programming.

- The risks included in the plan, and the approach to mitigating these.

- At that meeting the final budget for 2025/26 was approved, in advance of the start of the financial year.

Appendix 1: Board Assurance Framework

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.	Yes	Finance, Digital & Performance Committee (FDPC) received the draft Operating Plan in February which provided a comprehensive overview of the operational, workforce and financial plans at Headline submission stage. This was then reported upwards to Trust Board. Details of the Final submission to NHS England covering operational, workforce and financial plans have been scrutinised by the March FDPC and will be reported up to Trust Board.
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	Yes	Plans are developed from the bottom up - Divisional triumvirate develop plans to meet system and nationally led requirements. All savings plans are subject to quality assessment and cost pressures have received Executive Team sign off.
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	Yes	The principle of living within our means and to deliver a compliant plan against the national priorities are fundamental in the prioritisation decisions made by the Board.
A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.	Yes	Whilst QEIAs are not part of the development of the organisation's plans, they are embedded into the business case review and approval of CIPs, to ensure any planned changes have been assessed in both quality and equality impacts.
The organisation's plan was developed with appropriate input from and engagement with system partners.	Yes	System Finance, workforce and operational discussions contribute towards the Trust's planning position throughout the process.

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	Yes	Finance, Digital & Performance Committee (FDPC) received the Draft Operating Plan in February which provided a comprehensive overview of the operational, workforce and financial plans at Headline submission stage. This was then reported upwards to Trust Board. Details of the Final submission to NHS England covering operational, workforce and financial plans have been scrutinised by the March FDPC and will be reported up to Trust Board.
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.	Yes	Detail of the savings required are set out in this paper, along with actions to deliver the required level. This is reflected in the operational, workforce and financial plans.
The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.	Yes	Risks/Issues log are well understood both at a Trust and a system level. These are included in this report.
The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.	Yes	Finance, Digital & Performance Committee (FDPC) received the Draft Operating Plan in February which provided a comprehensive overview of the operational, workforce and financial plans at Headline submission stage. This was then reported upwards to Trust Board. Details of the Final submission to NHS England covering operational, workforce and financial plans have been scrutinised by the March FDPC and will be reported up to Trust Board.

Appendix 2: Health Inequalities focus

Priority focus	Guidance	2025/26 NBT Priorities and approach
Data insights and sharing	Reforming Elective Care: • *demonstrable improvements in the completeness and accuracy of coding and recording practices, including ethnicity and housing status coding, by using relevant SNOMED codes*	• Ethnicity recording – continue to aim for 80%+ of RTT waiting list. Remains a Top 10 data DQ for each division • Exploring with ICB/UHBW a consistent approach to sharing and recording of data on housing status
Elective waiting times	Reforming Elective Care: • *undertake quarterly reviews of local waiting list data (children and young people and adults) to better understand areas of inequality, looking at deprivation and ethnicity and using wider Core20PLUS5 approaches* • *embed health inequalities data into performance reporting with a quarterly review at board level*	• Inequalities Performance dashboard available to all specialties and Clinical Divisions for their review and consideration being given to Board level reporting via deep dives at the appropriate committees • Assessment at Trust level shows no adverse 52+ week waits for Core20 and adverse additional average waiting time of 3 days for Core20 (down from 2 weeks additional in June 2024) • Board subcommittees to consider deep dive sessions on inequalities as part of performance reviews
Outpatient access	Reforming Elective Care: • *develop and monitor action plans to reduce inequalities in access and quality of Care*	• All large outpatient specialties (10k+ per year) to set improvement target for DNA rate for IMD quintile 1 and Global Majority patient cohorts relative to overall DNA rate (i.e. to reduce DNAs and narrow the gap)
Prevention	System priorities: • Tackling Tobacco Dependency (TTD) in maternity and inpatient settings (system ambition to reduce smoking prevalence below 5% by 2030) • Healthy weight declaration being finalized	• Roll out and embed admissions forms with smoking status, Very Brief Advice and referral to TTD • Commit to Healthy Weight Declaration and develop action plan

Appendix 3: Productivity Pack

Measure	Measure description	National Published Opportunity £m	Trust Restated National Opportunity £m	Trust Targeted Opportunity £m	Trust Cash Releasing Opportunity £m	Provider Response	Actions in place
1	Non elective overnight stays	20.4	4.5	4.5		- Internal processes reviewed to speed up to point of referral however success is determined on community provision to support NCTR. - Internal review against other acute trauma centres, Trust not outlier.	- UEC project around LOS to explore further opportunities.
2	A&E and SDEC	2.4	2.4	2.4		- Complexities of patients seen as major trauma centre. - Internal review against other acute trauma centres, Trust not outlier.	-Further review to understand opportunities.
3	Elective Opportunity	18.0	3.9	1.0	0.5	- Elective position under cap next year. - Projects in motion on areas such as theatre efficiency.	- Better understanding of the opportunity through business planning. - May be more productivity improvements compared to cash releasing.
4	Outpatient Opportunity	64.3	2.0	2.0	1.0	- Requested calculation to understand methodology. - Recognise opportunity and discussions within Finance and Operational colleagues to agree next steps.	- Outpatient NCC activity assessed, and top 10 specialities identified. - discussions with Ops to agree neared with divisions.

Measure	Measure description	National Published Opportunity £m	Trust Restated National Opportunity £m	Trust Targeted Opportunity £m	Trust Cash Releasing Opportunity £m	Provider Response	Actions in place
5	Other Acute Activity	3.7	3.7	3.7	3.7	- Aligns with target set for support services division	
6	Temporary Staffing	8.8	8.8	2.5	2.5	- Agency spend is currently 1.5% of overall spend and significant action has been taken to reduce run rate. - Further opportunities under review in line with national guidance.	-Target further 30-40% reduction in agency in line with guidance, review against agency rules and changes in supplier for nursing and scientific. -Further controls across all temporary staffing.
7	Corporate Services	5.8	5.8	0.5	0.5	- Analysis completed across HR, IT and procurement. - In 23/24, for HR £3.1m related to international recruitment that was NR. IT teams has fluctuation in spend linked to capital projects. Further reviews in place.	- Review to understand position using the most current financial year and further discussions in areas of HR, IT, procurement and finance. - Opportunities to further review as part of group model discussions.
8	Medicines	1.5	1.5	0.4	0.4	- Ustekinumab started in November 24 and 100% switch expected by March 25. - Limited opportunity in 2025/26 unless further biosimilars.	- Continue to review as part of updates in guidance.
9	Commercial	5.1	5.1	4.0	4.0	- Adjusted target based on provider view, £3.7m already identified.	- Picked up through procurement CIP route.
	Total	**130.0**	**37.7**	**21.0**	**12.6**		

Appendix 4: Workforce final submission and NBT's Contribution towards national guidance

	Mar-25	Mar-26	Variance
Establishment	**9,970**	**9,976**	**6**
Total Substantive	**9,525**	**9,605**	**80**
Total Bank	**673**	**613**	**-60**
Total Agency	**59**	**52**	**-7**
Total Workforce	**10,258**	**10,270**	**12**
Of Which on Maternity Leave	*247*	*247*	
Over Establishment	-41	-47	

Key Workforce Change	Headline submission	Final submission
Elective Recovery - Bristol Surgical Centre Impact	Out	In – 273 wte
Headcount Reduction (wte and activity productivity gap, optimise substantive workforce, return spending on support functions to Apr-22 levels)	Out	In – 211 wte (31 wte existing vacancies and 180 wte staff in post)
Temporary Staffing Spend Reduction (Reduce temporary staffing spend - 30% Agency and 10% Bank spend reduction)	Out	In
Substantive Growth in Clinical Roles (optimise substantive workforce)	Yes – 136 wte	Yes – 87 wte
Over Establishment – Total Workforce (Workforce is maintained within the overall funded position (WTE and pay))	Yes – 160 wte	Yes – 71 wte

Additional Material Supply Adjustments

- NHS England Resident Doctor expansion has been reflected (2 Anaesthetics, 1 Intensive Care, 1 Renal, 2 Histopathology and, 6 Foundation Doctors) from August 2025.
- Reinvestment of temporary staffing budget to uplift substantive nursing establishments by 50 wte to recognise safe staffing and headroom requirements and to offset bank use once the posts are recruited to.

- Temporary staffing assumes the improvement seen year to date reflect in our month 8 and month 11 position continues and each profession then contributes equally to a further reduction to deliver the required 10% reduction in bank and 30% reduction in agency expenditure in 2025/26.

NBT's Contribution towards national guidance - Wider People Factors

Guidance requires Trusts to '**Systematically implement all elements of the People Promise to improve the working lives of all staff and increase staff retention and attendance and implement the 6 high impact actions to improve equality, diversity and inclusion. The evidence is clear that engaged, motivated staff improve productivity and patient outcomes'.** We are already significantly progressed as an exemplar organisation in terms of the People Promise with national recognition for improvement in 2024. We also approved a refreshed Trust EDI plan in 2024 which incorporated the six high impact EDI actions published by NHS England.

People Promise – we are an exemplar organisation for People Promise implementation and have been nationally recognised by NHS Employers as one of the ten most improved organisations for staff engagement in 2024. Recognising the NHS England Planning priority to '**Systematically implement all elements of the People Promise to improve the working lives of all staff and increase staff retention and attendance and implement the 6 high impact actions to improve equality, diversity and inclusion. The evidence is clear that engaged, motivated staff improve productivity and patient outcomes'.** Significant work we have undertaken to enhance staff engagement and experience, we saw improvements in all our People Promise staff survey scores last year and achieved the highest score in the Southwest for most recommended place to work**.**

'We do not Accept' – we have delivered a successful 'we do not accept campaign' and are working to build on this success into 2025/26, we have agreed the key priority of continuing to enhance our organisational culture. We have a range of successful initiatives and interventions, and this is being consolidated into '*Living our Values',* which aims to embed the positive behaviours underpinning our Trust values. We will do this by making clear the expectations of our values and how they relate to behaviours including compassion, fairness, listening and learning. We will re-frame and simplify for staff, our support, guidance, systems, training and interventions for developing, building and maintaining a compassionate, civil and inclusive workplace culture.

Equality, Diversity and Inclusion - In November 2023, a new, 3-year EDI Plan was developed and agreed, which replaced the previous EDI Strategy "Valuing You". The 2023-2026 EDI Plan took account of 2022-23 EDI data and performance, our Patient First Strategy 'Proud to Belong' and the newly released NHSE EDI Improvement Plan with its 6 high impact areas. The Plan aimed to be ambitious, organisationally owned and practical, with clear metrics, regular progress reviews and opportunities to update as appropriate every 6 months. We reviewed the NHSE High Impact actions alongside our existing programmes of work and against where our own EDI data showed us that we need to improve. This led us to develop four key themes, which would be our core EDI areas of focus:

Since the development and implementation of our plan we have seen some positive improvements in many areas, particularly when looking at WDES and the experiences of our disabled staff. We have also seen improvements in our gender pay gap and in some of our WRES indicators, particularly in comparison with the national average position. We continue to review our data (qualitative and quantitative), report progress against the specific actions within the plan and refresh these as necessary.

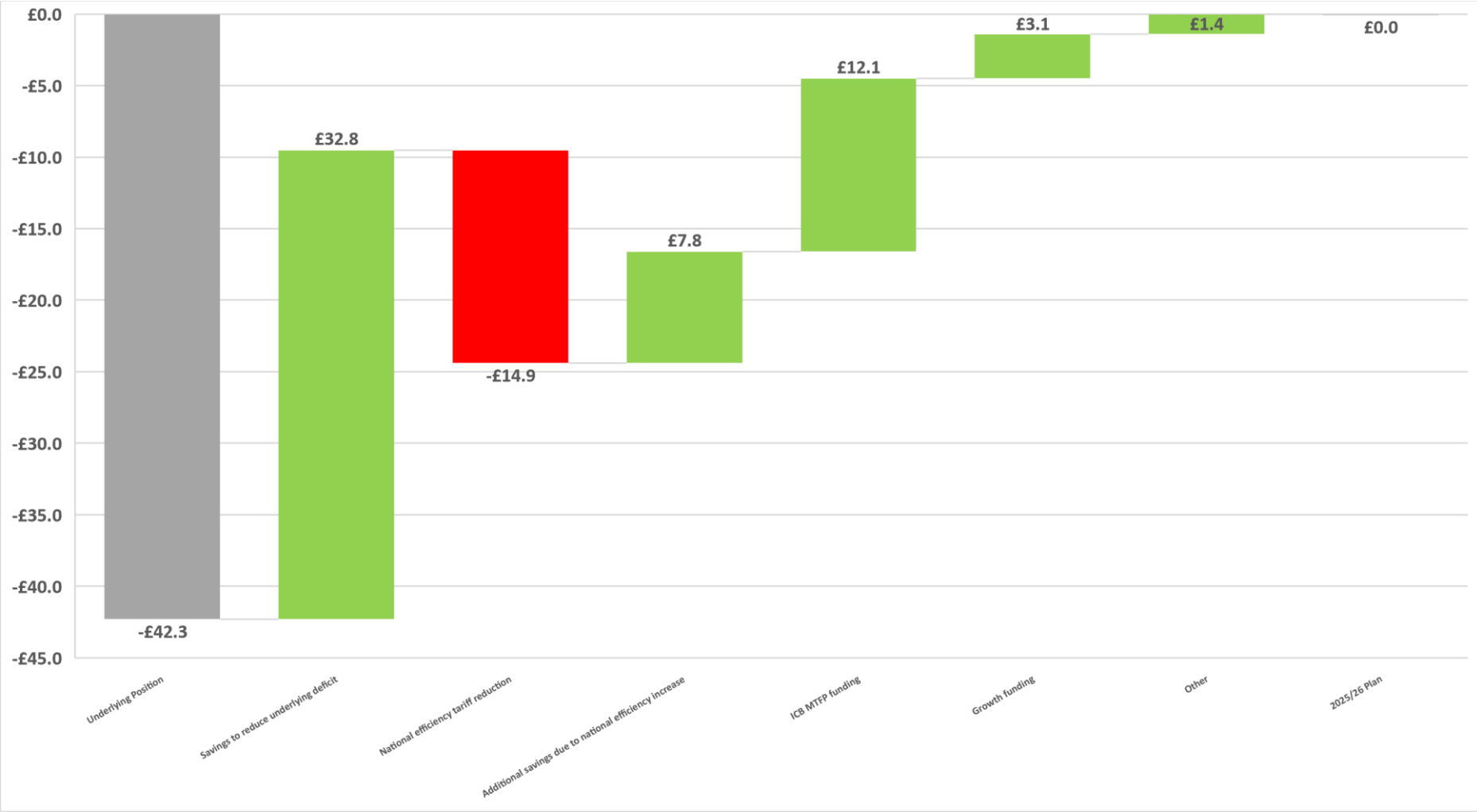
Commitment to our Community – As one of the largest employers here in Bristol, we are committed to having a truly diverse workforce that is representative of our local communities because we know that this enables us to deliver our aim of outstanding patient experience. We are tackling this as a key improvement priority under our patient first improvement approach. Our commitment is to increase employment opportunities for those who live locally, with a focus on ethnically diverse groups and in particular areas which are impacted by socio-economic disadvantage and experiencing inequalities. We have delivered a programme of work in 2024/25 which forms the foundation to our focus for 2025/26 including supporting candidates with active applications through the interview/onboarding process and ensuring our recruitment process is fair, using a patient first problem solving methodology and the aim of producing a toolkit for managers and ultimately improving our disparity ratio.

Health and Wellbeing - Sickness whilst target not achieved we have delivered statistically significant improvement in Trust absence rates and our wider Health and Wellbeing programme (aligned to our Clinical Strategy) continues to have a wide impact on staff engagement and attendance. Our 2025/26 Health and Wellbeing plan will continue to support staff to remain healthy and continue to provide outstanding patient care. We have developed a Staff Health and Wellbeing Plan 2025 to 2028 aligned to our People Strategy, Long Term Retention Plan and Clinical Strategy. The plan contains workstreams that will connect with our Hospital Group partners UHBW and will focus on four priority areas, Embed a culture of Staff Health and Wellbeing, Support Essential Health and Wellbeing, Improve Staff Physical Health and Wellbeing, Improve Staff Mental Health and Wellbeing. The plan also includes two golden threads linked to ICB workstreams, Health Inequalities and Trauma Informed Practice.

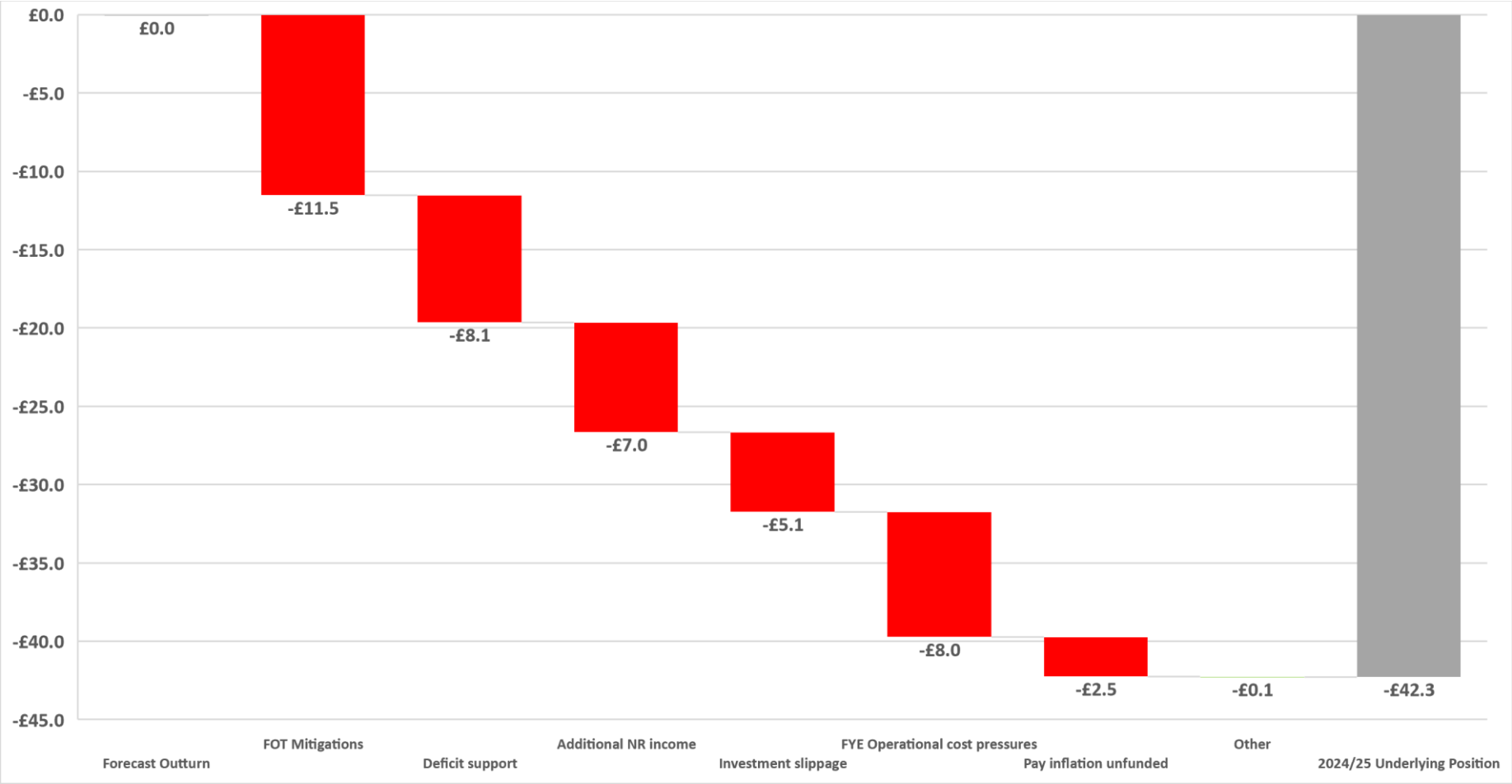
Appendix 5 Final Budget 2025/26

(£'m)	Contract Income	Other Income	Pay	Non-Pay	Surplus/(Deficit)
2024/25 Plan	**804.5**	**90.6**	**(552.0)**	**(343.1)**	**0.0**
2024/25 Non-recurrent items	(10.2)	(12.4)	(2.8)	(9.4)	(34.8)
Budget changes in year	34.7	11.3	(29.0)	(6.8)	10.2
2024/25 Recurrent Budget (Month 9)	**829.0**	**89.5**	**(583.8)**	**(359.2)**	**(24.6)**
Cost pressures	0.0	2.7	(0.2)	(19.7)	(17.2)
Other	5.0	9.4	(11.6)	(3.4)	(0.6)
Underlying position	**834.0**	**101.5**	**(595.5)**	**(382.3)**	**(42.3)**
Efficiencies	(14.9)	0.0	26.8	13.9	25.8
Pay and Non-pay inflation	30.8	0.0	(26.0)	(9.0)	(4.2)
Elective Recovery	31.2	(6.3)	(13.5)	(9.0)	2.5
Investments	0.0	0.0	(1.3)	0.0	(1.3)
Other	11.0	0.3	(4.8)	(4.7)	1.8
2025/26 Recurrent exit budget	**892.2**	**95.5**	**(614.3)**	**(391.1)**	**(17.7)**
Non-recurrent Contract Income	4.9	0.0	(1.0)	(2.0)	1.9
Non-recurrent budgets	8.1	2.5	(3.1)	5.7	13.3
Non-recurrent System mitigations	2.5	0.0	0.0	0.0	2.5
2025/26 Budget	**907.7**	**98.0**	**(618.3)**	**(387.4)**	**(0.0)**

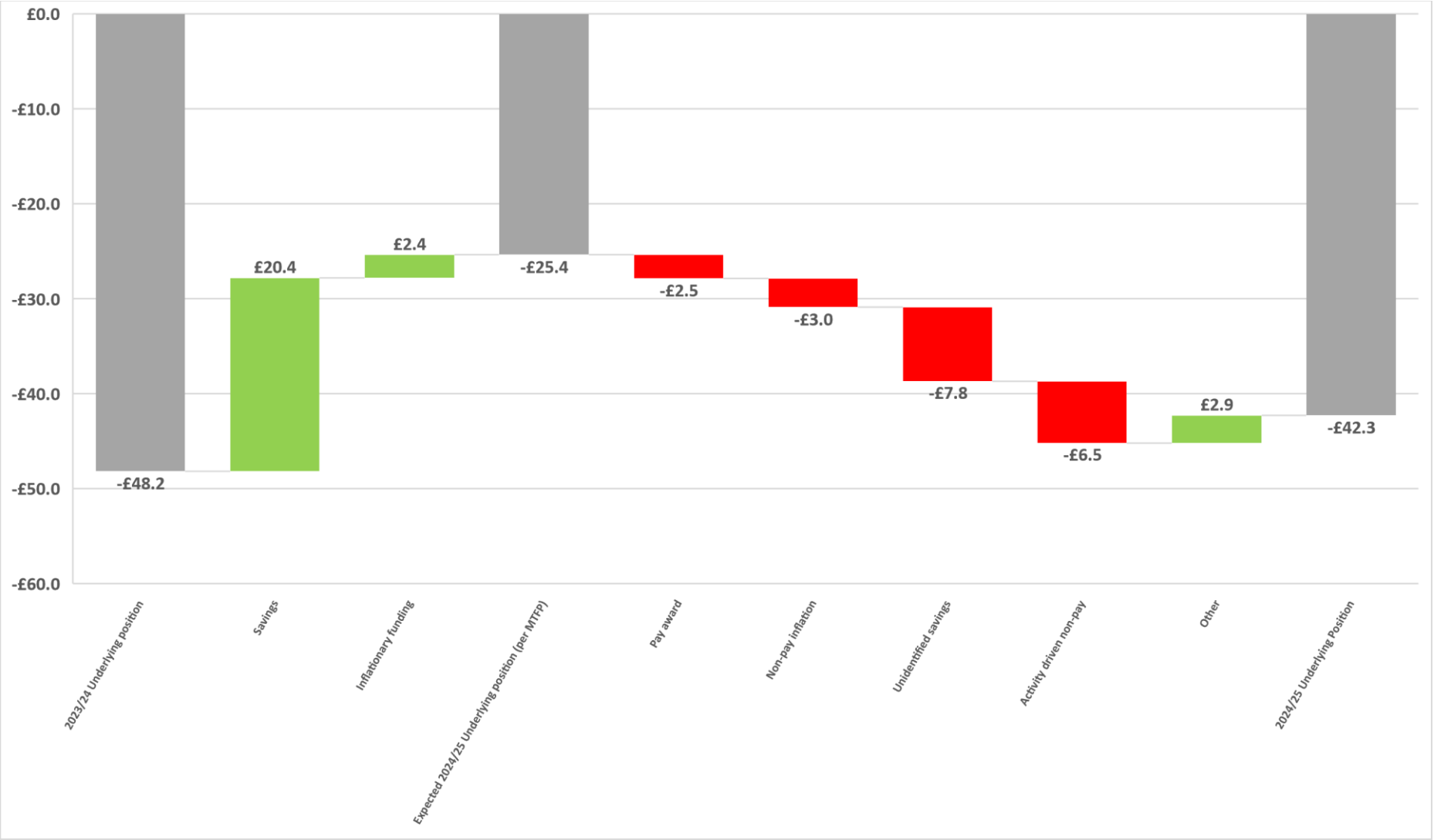
Appendix 6 Financial Underlying Position to 2025/26 Final Plan



Appendix 7 2024/25 Forecast Outturn to Underlying Position



Appendix 8 2023/24 Underlying to 2024/25 Underlying Position



North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public		
Date of Meeting:	08 April 2025		
Report Title:	Group Board Assurance Framework Q1 2025/26		
Report Author:	Sarah Wright, Head of Risk Management, UHBW		
Report Sponsor:	Eric Sanders, Joint Chief Corporate Governance Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		
	The Board Assurance Framework (BAF) provides a structured overview of the principal risks facing an organisation, supporting the Board in identifying, assessing, and mitigating risks effectively.		

Key Points to Note

- The Group Board Assurance Framework (BAF) has been developed by integrating the existing BAFs from UHBW and NBT, ensuring a unified approach to principal risk reporting across the Group.
- Principal risks from both organisations have been reviewed, consolidated, and aligned with the Group's separate Trust-level strategic priorities. Four existing risks have been reclassified as corporate/Trust level risks to better reflect their operational impact and ensure they are managed at the appropriate level. To support this approach, the BAF Task & Steering Group has met twice to review the proposed structure, categorisation, and alignment of risks.
- In discussions with the Executive teams before presentation to the Boards, two potential risk areas were highlighted to be considered:
    - The first risk related to the ongoing changes to the Department of Health & Social Care, NHS England and Integrated Care Boards, and how this might impact on the delivery of the Trusts strategic priorities. It is proposed that as the impact of these changes is not yet known, that the Trusts keep this under review and assess the risk again in the future.
    - The second risk related to the high levels of patients classified as No Criteria to Reside and the impact on the delivery of the Trusts priorities. In review of the proposed principal risks, and underlying corporate risks and trust level risks, this risk is already described and its impact assessed. It is therefore not proposed that this is a separate risk. The risk will be kept under consideration and adjusted if the situation changes.
    - A comprehensive assessment of the Net Zero Carbon agenda will be undertaken to evaluate the potential risks associated with delivery, funding, and regulatory compliance. This will include consideration of both strategic and operational implications across the Group. In line with the existing risk management process, any significant risks identified through this assessment that meet the escalation criteria will be added to the Corporate Risk Register to ensure appropriate oversight and mitigation.

Strategic and Group Model Alignment
This report and its recommendations align with the Trust's strategic direction by ensuring that risk management remains embedded within decision-making processes and supports the delivery of the Patient First methodology. The BAF is a key governance tool that strengthens the Group's ability to proactively manage risks that could impact the achievement of its strategic priorities. The principal risks are aligned with Strategic Priorities, ensuring that their impact on the achievement of objectives is systematically identified, assessed, and mitigated. The integration of UHBW and NBT's BAFs into a joint framework supports the ambition to form a Hospital Group by ensuring a cohesive and standardised approach to risk oversight across both organisations. The collaborative approach to managing principal risks reinforces system-wide alignment and enables more effective joint decision-making, shared learning, and resource optimisation.
Risks and Opportunities
Risks • If the BAF is not actively used by Board members, there is a risk that strategic risks are not adequately considered in decision-making, leading to gaps in mitigation. • If risks are not identified or assessed effectively, the BAF may not provide an accurate reflection of the Group's risk landscape, limiting its value as a governance tool. • While the BAF provides high-level oversight, it must be complemented by operational risk management, real-time performance data (IQPR), and robust governance processes to ensure effective risk mitigation. • The risk management processes of the two Trusts are not yet fully aligned, meaning differences in approach, terminology, and scoring methodologies may cause confusion or inconsistencies in risk reporting and escalation. **Opportunities** • The BAF provides clear visibility of principal risks, enabling the Board to make informed decisions that proactively address strategic challenges. • Aligning the BAF with the IQPR and corporate risk register enhances Board and committee oversight. • Embedding the BAF into executive discussions helps foster a proactive risk-aware culture, encouraging leaders to actively engage with risk management rather than viewing it as a compliance exercise.
Recommendations
• The Boards are asked to **approve** the Group Board Assurance Framework (BAF), which consolidates the principal risks from UHBW and NBT into a unified framework aligned with the Group's strategic priorities. This approval will ensure a consistent and structured approach to risk oversight, enabling the Board to effectively monitor, assess, and mitigate strategic risks. • The Boards are asked to **note** the ongoing work to align risk management processes between UHBW and NBT, including a planned review of risk appetite, and to continue refining the BAF to support effective decision-making and assurance.

History of the paper	
BAF Task & Finish Group	13 March 2025
Executive Committees (BOTH)	26 March 2025
Appendices:	Appendix 1 – Board Assurance Framework

1. Purpose

The Board Assurance Framework (BAF) provides a structured overview of the principal risks facing an organisation, supporting the Board in identifying, assessing, and mitigating risks effectively. It integrates risk escalation, controls, and assurance mechanisms to offer a comprehensive view of an organisation's risk landscape, ensuring informed decision-making and strategic oversight.

As a dynamic document, the BAF is regularly reviewed to remain aligned with evolving priorities and the external environment. The review process includes:

- Updates from sub-groups of the Executive Committees to assess risk status and emerging challenges.
- Executive Committee oversight to validate risk scoring, assess control effectiveness, and ensure mitigation measures are appropriate.
- Board and committee scrutiny to provide assurance, challenge risk management approaches, and support strategic decision-making.

By embedding risk considerations into strategic planning and operational decision-making, the BAF helps direct resources and drive continuous improvement.

2. Background

The development of a Group Board Assurance Framework (BAF) marks a key step in supporting the formation of a Hospital Group between UHBW and NBT. Historically, both Trusts maintained separate BAFs, each aligned to their individual strategic objectives and governance arrangements. However, as collaboration between the two organisations has progressed, the need for a consistent, integrated approach to strategic risk management has become increasingly important.

To support this, the BAF Task & Steering Group, comprising Executive and Non-Executive Directors from both Trusts, along with the Directors of Corporate Governance has met on two occasions to review and align the principal risks from each Trust. As part of this process:

- Existing principal risks from both Trusts have been reviewed, consolidated, and reformatted
- 4 risks are proposed to be reclassified as corporate/Trust-level risks, to ensure they are managed at the appropriate level: Fire Safety (UHBW), Change Management (UHBW), Ambulance Handover and Patient Flow (NBT), Net Zero Carbon (NBT)
- UHBW's Emergency Planning principal risk is proposed for retirement, with no other associated risks currently meeting the criteria for corporate risk.
- A new principal risk focused on Compliance has been introduced to reflect increasing complexity in meeting statutory, regulatory, and governance obligations:

UHBW's Principal Risks	NBT's Principal Risks	Group Principal Risk
Quality		Quality
Workforce	Workforce	Workforce
Financial	Underlying Financial Position	Finance
Estate Infrastructure	Retained Estate	Estate
Fire Safety		
Capacity & Performance	Timely Access to Care	Performance
	Patient flow & Ambulance Handover	
Digital & Cyber Security	Cyber attack	Digital
Change Management		
Emergency Planning		
	Net Zero Carbon	
		Compliance

In discussions with the Executive teams before presentation to the Boards, two potential risk areas were highlighted to be considered.

- The first risk related to the ongoing changes to the Department of Health & Social Care, NHS England and Integrated Care Boards, and how this might impact on the delivery of the Trusts strategic priorities. It is proposed that as the impact of these changes is not yet known, that the Trusts keep this under review and assess the risk again in the future.
- The second risk related to the high levels of patients classified as No Criteria to Reside and the impact on the delivery of the Trusts priorities. In review of the proposed principal risks, and underlying corporate risks and trust level risks, this risk is already described and its impact assessed. It is therefore not proposed that this is a separate risk. The risk will be kept under consideration and adjusted if the situation changes.
- A comprehensive assessment of the Net Zero Carbon agenda will be undertaken to evaluate the potential risks associated with delivery, funding, and regulatory compliance. This will include consideration of both strategic and operational implications across the Group. In line with the existing risk management process, any significant risks identified through this assessment that meet the escalation criteria will be added to the Corporate Risk Register to ensure appropriate oversight and mitigation.

3. Principal Risks

Principal risks are a risk or combination of risks that can seriously affect the performance or reputation of an organisation. These risks have the potential to threaten the achievement of the organisation's strategic objectives, they are distinct from operational risks as they have a broad impact across the organisation and require strategic oversight to ensure effective mitigation.

Principal risks are identified through an ongoing risk assessment and analysis processes and are monitored at the highest level of governance by the organisation's Board of Directors.

Principal risks in the NHS are dynamic and will evolve over time rather than disappear entirely. As healthcare needs, regulatory requirements, financial pressures, workforce challenges, and technological advancements change, risks will shift in focus and priority. While some risks may be effectively mitigated to reduce their impact, new challenges will emerge, requiring ongoing assessment and adaptation. The Board Assurance Framework (BAF) ensures that these risks are continuously reviewed, allowing the organisation to remain proactive in managing uncertainties and safeguarding strategic objectives. By maintaining a structured approach to risk oversight, the BAF enables the organisation to respond to emerging threats while ensuring that mitigations remain effective and aligned with the Group's evolving priorities.

4. Impact on Strategic Priorities

Each principal risk is mapped against the Trust's strategic priorities to determine the extent of its potential impact. Where the impact is high, it indicates a significant challenge in delivering the associated objective.

The BAF ensures that these risks are actively monitored and addressed through structured mitigation plans using the Trusts adopted methodology of 'Patient First', supporting the Trust's ability to deliver high-quality care, financial sustainability, and operational resilience.
The BAF categorises the impact of each principal risk on strategic objectives using a three-tier scale:

- **High** - A significant challenge requiring mitigation to avoid adverse consequences.
- **Moderate** - A measurable but manageable challenge to achieving objectives.
- **Low** - Does not significantly threaten strategic priorities.

As a temporary step, the strategic priorities of UHBW and NBT have been combined into a single list under six shared headings, to illustrate the alignment and how a joint approach might appear:

UHBW's Strategic Priorities	NBT's Strategic Priorities	Heading on BAF
Experience of Care		Quality
Patient Safety	High-Quality Care	Quality
Timely Care		Timely Care
Our People	People	People
Innovate & Improve	Innovate to Improve	Innovation
Our Resources	Sustainability	Resources
	Commitment to Community	Commitment to Community

As the joint strategic priorities for the Hospital Group are formally agreed, the overarching headings will be updated to reflect the finalised priorities. Once these are confirmed, the impact of each principal risk on the strategic priorities will be reassessed and updated.

5. Causal and Contributory Factors

Principal risks are influenced by a combination of causal and contributory factors. Causal factors are the underlying reasons why a risk exists, such as workforce shortages, financial constraints, or outdated infrastructure. Contributory factors are conditions that may amplify the risk, including ineffective processes, lack of training, or external regulatory changes.

Understanding these factors allows the Board to design targeted interventions that address both the root causes and exacerbating elements of each risk, ensuring a more comprehensive approach to risk management.

6. Controls

Controls to mitigate risks are implemented and monitored through the Group's governance mechanisms. These controls are assessed to determine their adequacy and effectiveness:

- **Adequate Controls** - Controls are in place and functioning effectively to mitigate the risk to an acceptable level. There may still be areas for improvement, but there are no significant gaps in mitigation.
- **Inadequate Controls** - Significant gaps are identified in the effectiveness of the controls, limiting their ability to mitigate the risk. These gaps may relate to insufficient implementation, lack of robust oversight, or deficiencies in governance processes.

Ongoing review of controls ensures that risks are managed effectively, with actions taken to address gaps and enhance mitigation where required.

7. Assurance

Assurance is the process by which the Board receives sufficient evidence to build confidence that systems are working effectively and that risks are being managed appropriately. Assurance is critical to effective governance as it provides confidence based on documented and verified information, rather than assumption.

- **Assurance** - Demonstrates that something is true or happening as expected through evidence, data, and oversight. It provides the Board with confidence in decision-making and governance.
- **Reassurance** - Relies on professional expertise, trust, and opinion rather than documented evidence. While reassurance can be helpful, it does not provide the same level of certainty as assurance.

The BAF provides structured assurance by triangulating key elements, including risk information, controls, assurances, and gaps in controls. By consolidating this information, the BAF enables the Board to maintain oversight of risk management effectiveness and take informed decisions on risk mitigation where necessary.

The level of assurance noted is based on the Three Lines of Defence model, a widely used tool for managing risk and assurance. The first line consists of operational management, which owns and manages risks on a day-to-day basis. The second line provides oversight, support, and challenge through functions such as risk management, governance, and compliance. The third line offers independent assurance, typically provided by internal audit or trusted external parties, giving an objective view of how effectively risks are being managed across the organisation.

8. Corporate Risk Register (CRR) / Trust level Risks (TLR)
Aligned to each principal risk are the key operational risks identified by each Trust to provide a comprehensive view of the Group's risk landscape. These are significant risks that, while not strategic in nature, have the potential to impact the organisation's ability to function effectively. Their inclusion ensures that the Board has visibility of key operational challenges that may require escalation or strategic intervention. This approach enables a more integrated risk management process, ensuring alignment between operational risk controls and strategic oversight.

Risks are escalated through a structured assessment and review process undertaken by sub-groups of the Executive Committee. Risks are assessed based on their potential impact area, with escalation decisions made according to the following criteria:

- Risks that have an impact across the entire Group may be escalated to the CRR
- Where similar risks are identified across multiple divisions or directorates, an overarching Corporate Risk may be raised to ensure a coordinated response.
- Risks that primarily affect individual services and can be managed through operating plans may remain at the service level.

This structured approach ensures that risks are managed at the right level, allowing for strategic oversight of critical risks while maintaining operational control and ownership of service level risks.

9. Integrated Quality and Performance Report (IQPR)
The BAF is closely aligned with the IQPR to ensure a comprehensive approach to risk management and performance oversight:

- The BAF aligns principal risks with strategic priorities, ensuring that risk management remains focused on the organisation's long-term goals.
- The IQPR maps each Key Performance Indicator (KPI) and Key Risk Indicator (KRI) to the Corporate Risk Register, ensuring that performance data directly informs risk assessment.
- A quarterly review process ensures that all relevant corporate risks are reflected in the IQPR and that performance challenges are appropriately linked to risk oversight.

10. Summary
This report presents the joint Board Assurance Framework (BAF), which integrates the principal risks from UHBW and NBT into a single, aligned framework. The BAF has been developed through a structured review process, ensuring that risks are mapped to the Group's strategic priorities and aligned with the Integrated Quality and Performance Report (IQPR) to enhance risk oversight.

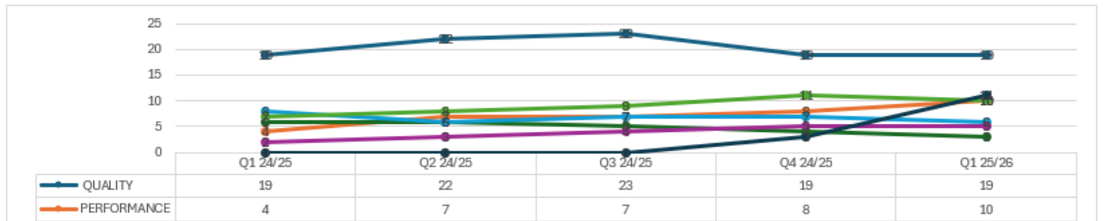
11. Recommendations

- The Boards are asked to **approve** the Group Board Assurance Framework (BAF), which consolidates the principal risks from UHBW and NBT into a unified framework aligned with the Group's strategic priorities. This approval will ensure a consistent and structured approach to risk oversight, enabling the Board to effectively monitor, assess, and mitigate strategic risks.

- The Boards are asked to **note** the ongoing work to align risk management processes between UHBW and NBT, including a planned review of policy and risk appetite, and the continued refinement of the BAF to support effective decision-making and assurance.

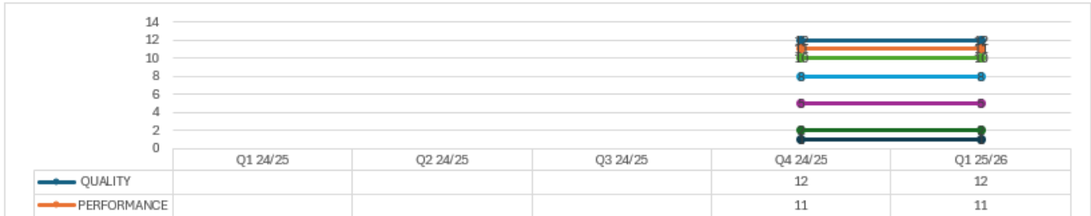
BOARD ASSURANCE FRAMEWORK			Impact on Delivery of Strategic Priority						Linked Corporate Risks	
Principal Risk	Executive Lead	Change to Impact	Quality	Timely Care	People	Innovation	Resources	Commitment to Community	UHBW	NBT
Risk 1. QUALITY	Chief Nurse & Chief Medical Officer	↔	HIGH	HIGH	HIGH	HIGH	MODERATE	MODERATE	19	12
Risk 2. PERFORMANCE	Chief Operating Officer	↑	HIGH	HIGH	MODERATE	HIGH	HIGH	MODERATE	10	11
Risk 3.WORKFORCE	Chief People Officer	↑	MODERATE	HIGH	HIGH	HIGH	HIGH	LOW	2	2
Risk 4. ESTATE	Chief Finance Officer	↔	HIGH	HIGH	HIGH	HIGH	HIGH	MODERATE	6	8
Risk 5. FINANCE	Chief Financial Officer	↑	HIGH	HIGH	HIGH	MODERATE	HIGH	MODERATE	5	5
Risk 6. DIGITAL	Chief Digital Information Officer	↔	MODERATE	HIGH	MODERATE	MODERATE	MODERATE	HIGH	10	10
Risk 7. COMPLIANCE	Chief Corporate Governance Officer	↔	MODERATE	HIGH	HIGH	MODERATE	MODERATE	MODERATE	11	1

UHBW - Corporate Risks linked to Principal Risk – Number of linked risks over time



	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
QUALITY	19	22	23	19	19
PERFORMANCE	4	7	7	8	10
WORKFORCE	6	6	5	4	3
ESTATE	8	6	7	7	6
FINANCE	2	3	4	5	5
DIGITAL	7	8	9	11	10
COMPLIANCE	0	0	0	3	11

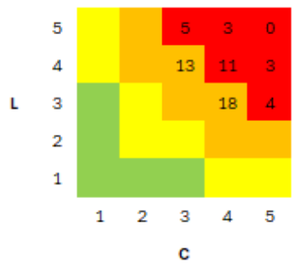
NBT - Trust Level Risks linked to Principal Risk – Number of linked risks over time



	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
QUALITY				12	12
PERFORMANCE				11	11
WORKFORCE				2	2
ESTATE				8	8
FINANCE				5	5
DIGITAL				10	10
COMPLIANCE				1	1

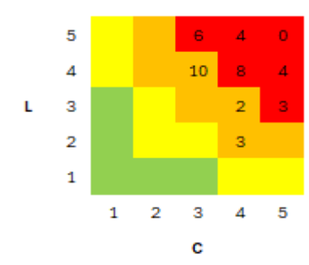
UHBW - Corporate Risk Register - heatmap

	High Risk	Very High Risk	Total
Patient Safety	6	8	14
Statutory	11	3	14
Quality	6	6	12
Business	2	6	8
Financial	3	2	5
Environmental	2	0	2
Health & Safety	1	0	1
Workforce	0	1	1
Total	31	26	57



NBT - Trust Level Risk Register - heatmap

	High Risk	Extreme Risk	Total
Patient Safety	10	4	14
Service Delivery	3	10	13
Patient Experience	0	5	5
Financial	2	3	5
Statutory Duty, Compliance	2	1	3
Health and Safety	1	1	2
Performance	0	1	1
Total	18	25	43



Report Overview

This page summerises Board Assurance Framework (BAF). It includes:

- An overview of the impact assessments, highlighting the level of impact each principal risk has on strategic priorities.
- Changes to impact assessments, indicating whether the significance of each Principal Risk has shifted.
- A summary of corporate and Trust-Level Risks linked to each Principal Risk, by assessment domain.
- A comparison of risk heatmaps from UHBW and NBT, providing a visual representation of corporate and trust-level risks across both organisations.

Board Assurance Framework – Principal Risk 1. QUALITY			Impact on Delivery of Strategic Priority					
Executive Leads	Chief Nursing Officer, Chief Medical Officer		Quality	Timely Care	People	Innovation	Resources	Commitment to Community
Board Committee	Quality Committee		HIGH	HIGH	HIGH	HIGH	MODERATE	MODERATE

Principal Risk Description

Increasing service demand, workforce shortages, financial constraints, and operational pressures, combined with the complexity of clinical pathways, create challenges in maintaining high standards of care and clinical safety.

The ability to maintain high-quality care is also affected by limitations in funding, restricting the Trust's ability to replace essential clinical equipment and upgrade facilities, which may lead to increased downtime, suboptimal patient care, and further operational inefficiencies.

There is also a heightened risk of hospital-acquired infections, prolonged recovery times, and avoidable complications, if staffing levels and resources are stretched.

Failure to uphold quality standards may result in health inequalities, diminished patient satisfaction, reputational damage, and difficulties in staff recruitment and retention. Regulatory scrutiny, legal liabilities, and financial consequences could arise if the Trust does not effectively mitigate these risks.

Causal & Contributory Factors

- Resource Constraints (BOTH)
- Lack of Standardisation (BOTH)
- Failure to address systemic issues (BOTH)
- Communication Breakdowns (BOTH)
- Ineffective feedback mechanisms (BOTH)
- Aging equipment (BOTH)
- Insufficient investment in infrastructure (BOTH)
- Lack of robust digital infrastructure and processes (UHBW)

Sources of Assurance

Internal

- Patient Safety Reports (BOTH)
- Integrated Quality & Performance Reports (BOTH)
- Safe Staffing Reports (BOTH)
- Complaint and Patient Experience Reports (BOTH)
- Pulse Surveys and Annual Staff Survey Reports (BOTH)
- Freedom To Speak Up Feedback Reports (BOTH)
- Maternity Quality Assurance Reports (BOTH)
- Clinical Accreditation Programme (UHBW)
- Deep dive reports into services (UHBW)

External

- Internal Audit Reports (BOTH)
- Care Quality Commission Reports (BOTH)

External Assurance – Third Line of Defence

Existing Controls

- Clinical audits, patient safety initiatives, and incident reporting (BOTH)
- Staff reruitment, retention and training and education programs (BOTH)
- Policies and guidelines (BOTH)
- Infection prevention protocols (BOTH)
- Elective recovery plans (BOTH)
- Communication, patient surveys, and structured engagement (BOTH)
- ICS-led patient flow initiatives, NHS funding access, and regional coordination for urgent and emergency care (BOTH)

Inadequate

Gaps in Controls

- Insufficient training uptake due to staff availability (BOTH)
- Reliance on temporary staffing (BOTH)
- Limited capacity in community and primary care services (BOTH)
- Need for external funding to support major infrastructure improvements (BOTH)
- Lack of robust digital infrastructure and processes (UHBW)
- Lack of robust Business Intelligence function (UHBW)
- Lack of centralised medical equipment repository (UHBW)
- Lack of capital rolling replacement programme for equipment (UHBW)

Planned Mitigation

- Joint Clinical Strategy, Healthy Weston phase 2 and the UHBW Elective Strategy (BOTH) Experience of Care Strategy (UHBW)
- Implementation of Careflow Medicines Management (UHBW)
- Deteriorating Patient Programme and Implementation of Martha's rule.(UHBW)
- Mental Health Across UHBW Corporate Project (UHBW)
- Implement the Community Diagnostics Centre expansion (NBT)
- Increase elective surgical capacity through the new Bristol Surgical Centre (NBT)
- Engage with ICS to secure additional community capacity for patient discharge (NBT)

UHBW Corporate Risks

6744	Patients attending with Stroke will not receive specialist treatment	↔	20
7449	Failure to effectively procure and maintain fit-for-purpose equipment	↑	16
6677	Non-compliant behaviours for effective IPC practice amongst staff	↑	16
7566	That staff fatigue impacts performance and patient safety	↑	16
7919	That sepsis is not considered, recognised and responded to	↑	16
7633	Reliance on paper-based medication prescribing	↔	16
2264	Delays in commencing induction of labour	↔	16
2614	Patient care and experience is affected due to being cared for in extra	↑	15
588	Patient deterioration is not recognised and responded to	↔	15
856	Emotional & mental health needs of C&YP may not be met	↔	15
6691	That medicines are not stored securely	↔	12
5942	Failure to record patients communication requirements	↔	12
6013	Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia's	↔	12
418	Routine radiology reports are not signed off/ acknowledged timely	↔	12
1598	Patients suffer harm or injury from preventable falls	↔	12
1702	Communication needs of patients with disability or sensory impairment	↔	12
2680	Complainants experience a delay in receiving a call back	↔	12
3452	Patient Safety Improvement Programme aims are not met	↔	12
7980	Non-compliance with statutory and regulatory safeguarding duties	↑	12

NBT Trust Level Risks

1760	Hybrid clinical noting leads to delayed or inaccurate decision making	↑	20
1800	Patient record systems do not robustly identify known allergies	↔	20
1681	Aging Imaging equipment reaching end of life may fail	↔	16
1697	Transfer of medically fit patients requiring Mental Health services	↔	15
1704	Sub-optimal delivery of Stroke Care to patients	↔	15
1881	Care of Medical Outlying Patients	↔	15
1970	Anaesthesia, Surgery, Critical Care and Renal Patients cared for in extra	↔	15
1972	Neurosciences and Musculoskeletal Patients cared for in extra capacity	↔	15
1699	Absence of a Core 24 service in BNSSG delays Mental Health Act	↔	12
1831	Insufficient resourcing of the Vascular Access Service iimpacts service	↔	12
1982	Lack of anaesthetic support Endoscopic Retrograde	↔	12
2041	Aging nurse call system in Women and Children's sector	↔	12

Current Position

- This section will be used to provide a quarterly update on any changes to the principal risk, its impact on objectives or changes to corporate risks.
- The two Board Assurance Frameworks (BAFs) from North Bristol Trust (NBT) and University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) have been reviewed, and key elements from both have been used to populate the new template.
- Each element has been assigned to either NBT, UHBW, or BOTH, depending on its relevance and applicability across the hospital group.
- It is expected that strategic priorities will be reviewed and consolidated, with assurances provided to the joint group board, ensuring applicability across both Trusts.
- This version is for presentation purposes only, and a full review of the contents will be undertaken by the executive leads and the relevant operational groups.

Board Assurance Framework – Principal Risk 2. PERFORMANCE			Impact on Delivery of Strategic Priority					
Executive Leads	Chief Operating Officer		Quality	Timely Care	People	Innovation	Resources	Commitment to Community
Board Committee	Quality Committee		HIGH	HIGH	MODERATE	HIGH	HIGH	MODERATE

Principal Risk Description

A combination of factors, including a high number of patients with no criteria to reside, constrained community and primary care capacity, and workforce pressures, is limiting patient flow across our hospitals. This contributes to delays in care, overcrowding, and increased stress on staff. Patients face prolonged wait times, which can worsen clinical outcomes, while overcrowding heightens the risk of infection spread.

The inability to discharge patients in a timely manner directly impacts bed availability, leading to delays in Emergency Departments, including breaches of key targets such as timely treatment and ambulance handovers. Stretched resources also elevate the risk of errors, compromising patient safety.

Failure to meet operational targets results in poor patient experience, potential harm, and reputational damage to the Trust. Additionally, reduced productivity and service inefficiencies exacerbate health inequalities.

Causal & Contributory Factors

- Poor coordination between different parts of the healthcare system (BOTH)
- Access to primary care and capacity of social care to support discharge (BOTH)
- Growing and aging population increases the need for healthcare services (BOTH)
- Sudden surges in demand due to outbreaks of illness (BOTH)
- Limited bed capacity and space in emergency departments and wards (BOTH)

Sources of Assurance

Internal

- Integrated Quality & Performance Reports (BOTH)
- True North Timely Care Quality Report (UHBW)
- Finance & Performance Committee deep-dives into operational performance (NBT)

External

- Internal Audit Reports on performance and Data Quality Framework
- CQC Inspection Reports

External – Third Line of Defence

Existing Controls

- Bed management and pre-emptive transfer planning (BOTH)
- Same Day Emergency Care Departments (SDEC) prevents admission (BOTH)
- Integrated discharge, planning and Transfer of Care Hub (BOTH)
- NHS@Home to prevent admission and facilitate discharge (BOTH)
- Extra capacity locations identified (BOTH)
- Telemedicine (BOTH)
- System working (BOTH)
- Repatriation Policy (NBT)
- RTT Recovery Plan (NBT)
- UEC Board and Improvement Plan (NBT)
- Protected Elective Capacity and Waiting List Incentives (NBT)

Inadequate

Gaps in Controls

- Ability to staff extra capacity locations (BOTH)
- Ability to discharge in a timely manner (BOTH)
- Inability to ring fence critical care beds for elctive procedures due to emergency admissions (BOTH)
- Ability to measure productivity (UHBW)
- Not yet seeing evidence that investment in “Discharge 2 Assess” initiative is delivering planned improvements to discharge numbers or reducing proportion of patients with no criteria to reside (NBT)

Planned Mitigation

- Proactive Hospital Project (UHBW)
- Improving Outpatients Productivity and Efficiency Project (UHBW)
- Improving theatres productivity and efficiency Project (UHBW)
- Ready for discharge Breakthrough Objective (UHBW)
- Community Diagnostics Centre (NBT)
- Bristol Surgical Centre due to come online in May 2025 (NBT)
- Opportunities for additional Elective Care Capacity in BNSSG via national Targeted Investment Fund (NBT)
- Working with ICS via the system Chief Executive group and the D2A Board to identify bridging strategies and short-term mitigations to compensate for delayed D2A impact. (e.g., Transfer of care hub (NBT)
- Ongoing escalation via the ICS to secure temporary additional community capacity to relieve pressures (NBT)

UHBW Corporate Risks

423	That demand for inpatient admission exceeds available bed capacity	↔	20
7769	Patients in the Trusts ED’s may not receive timely and effective care	↔	20
2244	Long waits for Outpatient follow-up appointments	↔	20
6782	Non-compliance with the 28 day Faster Diagnosis cancer standard	↔	16
6320	That there is inadequate Clinical Site Management resource overnight	↔	15
5532	Non-compliance with the 31 day cancer standard	↔	12
801	That elements of the NHS Oversight Framework are not met	↔	12
5520	That health inequalities are exacerbated for patients on waiting lists	↔	12
1035	Access to critical care beds for BNSSG and tertiary catchment areas	↓	12
7875	Business as usual is disrupted due to Group Model implementation	↔	12

NBT Trust Level Risks

1940	Delays in patient flow through the hospital impact timely treatment	↔	20
1840	Patients in the Trusts ED’s may not receive timely and effective care	↔	20
1704	Stroke Service Performance	↔	15
1697	Delayed transfers of care for patients requiring a mental health bed	↔	15
1701	Capacity of tier3 Weight Management Service	↔	15
1881	Medical outliers	↔	15
1970	Surgical outliers	↔	15
1972	Use of MSK wards as extra capacity	↔	15
523	Urology Service waiting list	↔	12
1812	Gynaecology cancer referrals failing to meet the 28-day fast diagnosis	↔	12
1831	Capacity of the Vascular Access Service	↔	12

Current Position

- This section will be used to provide a quarterly update on any changes to the principal risk, its impact on objectives or changes to corporate risks.
- The two Board Assurance Frameworks (BAFs) from North Bristol Trust (NBT) and University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) have been reviewed, and key elements from both have been used to populate the new template.
- Each element has been assigned to either NBT, UHBW, or BOTH, depending on its relevance and applicability across the hospital group.
- It is expected that strategic priorities will be reviewed and consolidated, with assurances provided to the joint group board, ensuring applicability across both Trusts.
- This version is for presentation purposes only, and a full review of the contents will be undertaken by the executive leads and the relevant operational groups.

Board Assurance Framework – Principal Risk 3. WORKFORCE			Impact on Delivery of Strategic Priority					
Executive Leads	Chief People Officer		Quality	Timely Care	People	Innovation	Resources	Commitment to Community
Board Committee	People Committee		MODERATE	HIGH	HIGH	HIGH	HIGH	LOW

Principal Risk Description	Causal & Contributory Factors	Sources of Assurance
Sustaining a capable, engaged, and resilient workforce is essential to delivering the Group's long-term strategic objectives. Demand for workforce capacity is expected to rise steadily particularly in hard-to-fill specialist roles driven by service expansion, population growth, and the shift toward new models of care. The Group operates in a highly competitive labour market, with high living costs and limited transport infrastructure reducing the appeal of city centre hospital sites for some candidates. At the same time, national constraints on the training pipeline, growing expectations for flexible and values-led careers, and the need for inclusive, future-focused leadership present further challenges in aligning the workforce to future service needs. Ensuring visible progress on equality, diversity, and inclusion remains vital for building a culture where all colleagues feel valued, supported, and able to thrive, particularly in a diverse urban population. Shifts in government priorities or NHS-wide restructuring could intensify financial constraints potentially leading to greater restrictions on recruitment and the continuation of headcount controls across the Group. These pressures could result in greater instability, increased reliance on temporary staffing, and a diminished ability to deliver safe, high-quality care across the Group in the years to come.	• Increasing demand for services along with budget constraints (BOTH) • Challenges associated with shortages of specialists nationally (BOTH) • Fixed Agenda for Change reward structure (BOTH) • Tempory staffing costs and market forces (BOTH) • Insufficient training provision and uptake (BOTH) • Workload and work related stress (BOTH) • Dr rotation allocation (BOTH) • Capacity of HEI's and FE's to develop workforce plan (BOTH) • Inconsistent culture and experience across staff groups (BOTH) • Pipeline, leadtimes and funding for developing the workforce (BOTH) • Industrial action (BOTH)	Internal • Staff Survey Results Reporting (BOTH) • Compliance Reports with standards related to staffing levels and safety (BOTH) • Integrated Quality & Performance Report contains people metrics (BOTH) • Workforce planning reports (BOTH) • Freedom to Speak up process and reports (BOTH) • Guardian of safe working reports (BOTH) • National Violence and Aggression Prevention Standards (BOTH) • Deliverables of People Strategy Reports (UHBW) • People Committee deep-dives and performance reviews (NBT) External • People themed Internal Audit Reports (BOTH) • CQC reports contain feedback on workforce (BOTH) • NHSE Quality visits to Education (BOTH) • Annual site visits from HEI's of sudent experiences and placements (BOTH) • Gender pay-gap report and WRES/WDES data Reports (BOTH) • British Safety Council Audit and Safer Learning Environmental Charter (UHBW)

External Assurance – Third Line of Defence

Existing Controls	Gaps in Controls	Planned Mitigation
• Collaborative recruitment across the Group and shared bank (BOTH) • Workforce planning and information, data on exit interviews (BOTH) • Job planning and E-Rostering (BOTH) • People and Workforce Strategies and retention plans (BOTH) • Traineeship and apprenticeships programmes (BOTH) • Staff Health Checks, Wellbeing and Flexible Working offers (BOTH) • Equality, Diversity, and Inclusion Plan and Anti-racism work (BOTH) • Education Strategy (UHBW) • Funded Nurse Retention Programme • High cost agency and temporary spend working groups (UHBW) • HELM Programme (NBT)	• Competition between providers across the BNSSG and the wider South West for the same staff (BOTH) • Differentialsacross the region in grading between similar roles (BOTH) • Pro-equity and Anti Racism statement is in development (UHBW) • Understanding the productivity of our workforce (UHBW) • Ability to forecast future threats to local supply of workforce (UHBW) • Current workforce plan for medical roles needs to be refreshed to include hard to fill posts, alternative roles, options for reducing high cost agency and locums and international pipeline (UHBW) • Long term plan financial and student allocations are unknown (UHBW)	• The People Strategy year 3 delivery plan includes initiatives to Reduce agency spend, Meet stability index of 85%, Comply with Local Medical Committee offer of 75%, Deliver H&S governance and systems and Develop 3 new career pathways for Admin & Clerical, Health Care Scientists and Pharmacy staff (UHBW) • Medical Workforce programme (UHBW) • Delivering the pro-equity promise breakthrough Objective (UHBW) • The People Benefit Strand of the Hospital Group Benefits Case will focus on ensuring aligned and complementary workforce arrangements between the two Acute Trusts and across the wider system (NBT) • Talent acquisition team are providing targeted support to affected specialties (NBT)

Inadequate

UHBW Corporate Risks				NBT Trust Level Risks				Current Position
7566	Risk that staff fatigue impacts performance and patient safety	↑	16	1979	Workforce shortages in specialist medical roles	↔	16	• This section will be used to provide a quarterly update on any changes to the principal risk, its impact on objectives or changes to corporate risks. • The two Board Assurance Frameworks (BAFs) from North Bristol Trust (NBT) and University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) have been reviewed, and key elements from both have been used to populate the new template. • Each element has been assigned to either NBT, UHBW, or BOTH, depending on its relevance and applicability across the hospital group. • It is expected that strategic priorities will be reviewed and consolidated, with assurances provided to the joint group board, ensuring applicability across both Trusts. • This version is for presentation purposes only, and a full review of the contents will be undertaken by the executive leads and the relevant operational groups.
422	Patients and staff experience violent or aggressive behaviour	↔	12	374	Patients and staff experience violent or aggressive behaviour	↔	15	
674	Use of agencies who are non-compliant with national pricing caps	↔	12					

Board Assurance Framework – Principal Risk 4. ESTATE			Impact on Delivery of Strategic Priority					
Executive Leads	Chief Finance Officer		Quality	Timely Care	People	Innovation	Resources	Commitment to Community
Board Committee	Finance & Estates Committee		High	High	High	High	High	Moderate

Principal Risk Description	Causal & Contributory Factors	Sources of Assurance
The hospital group faces a significant risk due to aging estate infrastructure, with UHBW's older buildings requiring modernisation and NBT's retained estate nearing the need for major refurbishment. Limited decant space, competing priorities, and restrictions on capital expenditure, including CDEL limits, may delay essential upgrades and maintenance, increasing the likelihood of unplanned service failures, equipment malfunctions, and regulatory non-compliance. If buildings become unsafe or unusable, clinical services may be disrupted or forced to close, impacting patient care, operational performance, and staff morale. This could compromise patient safety, disrupt clinical services, and negatively impact staff morale and patient experience.	• Aging Infrastructure (UHBW) • Deferred Maintenance (UHBW) • Technological Obsolescence (UHBW) • Inadequate Funding (BOTH) • Lack of Strategic Planning (BOTH) • Regulatory Compliance Issues (BOTH) • Environmental Factors (BOTH) • Capital Expenditure Restriction (BOTH) • Staffing Shortages (BOTH)	Internal • Strategic Estates Plan (BOTH) • Capital Planning Reports (BOTH) • Premises Assurance Model (PAM) Reports (BOTH) • Estates Returns Information Collection (ERIC) Benchmarking reports (BOTH) • Health & Safety and Compliance Reports (BOTH) • Performance Reviews (BOTH) External • Internal Audit Reports (BOTH) • Regulatory Inspections and Third-Party Assessments (BOTH) • Quality Assurance Programs (BOTH) • Certification Programs (BOTH) External Assurance – Third Line of Defence

Existing Controls	Gaps in Controls	Planned Mitigation
• Fire Safety and Remediation Plans (UHBW) • Capital Planning and Investment (BOTH) • Estate Management and Maintenance (BOTH) • Health, Safety, and Compliance Functions (BOTH) • Risk Management and Contingency Planning Functions (BOTH) • Technology and Innovation (BOTH) • Sustainability and Environmental Initiatives (BOTH) • Collaboration and Strategic Partnerships (BOTH) Inadequate	• Technology integration (UHBW) • Lack of full Condition Survey (UHBW) • Lack of comprehensice Asset Registers (UHBW) • Incomplete Planned Prevantative Maintance (PPM) Programme (UHBW) • Data and information management (UHBW) • Resource allocation (BOTH) • Availability of decant space (BOTH) • Workforce skills and training (BOTH) • Workforce capacity (BOTH)	• Joint Estates Strategy to develop interim plan (UHBW) • Heygroves Theatres refurbishment (UHBW) • Neonatal Intensive Care Unit (NICU) Fire Safety (UHBW) • Bristol Eye Hospital (BEH) Theatres (UHBW) • Estates and W&C teams are assessing unresolved risks beyond available CDEL, identifying mitigation measures, and outlining business continuity plans for high-risk services (NBT) • Elective Care Centre to provide contingency in the event of catastrophic failure of other theatres (NBT)

UHBW Corporate Risks				NBT Trust Level Risks				Current Position
3472	That the Trust fails to deliver the ICS Green Plan	↔	20	545	Air-conditioning failure in data centre causes IT service failure	↔	16	• This section will be used to provide a quarterly update on any changes to the principal risk, its impact on objectives or changes to corporate risks. • The two Board Assurance Frameworks (BAFs) from North Bristol Trust (NBT) and University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) have been reviewed, and key elements from both have been used to populate the new template. • Each element has been assigned to either NBT, UHBW, or BOTH, depending on its relevance and applicability across the hospital group. • It is expected that strategic priorities will be reviewed and consolidated, with assurances provided to the joint group board, ensuring applicability across both Trusts. • This version is for presentation purposes only, and a full review of the contents will be undertaken by the executive leads and the relevant operational groups.
7130	The Trust is unable to fund the strategic estate programme	↔	16	1572	Pathology Air Handling Unit	↔	15	
7131	That the strategic estate programme is not delivered	↔	16	1587	Pathology Chiller Failure	↔	15	
5325	BHOC services are compromised due to estate condition	↔	16	2016	Delays of required building works in the Mortuary compound	↔	15	
6112	Estates backlog maintenance may not be adequately funded	↑	15	1946	Condition of WACH Estate	↔	12	
5540	The Trust infrastructure is inadequate for extreme weather	↓	12	2041	Aging nurse call system in Women and Children's sector	↔	12	
				1716	lack of storage, desk and operational space in Pharmacy	↔	12	
				TBC	Insufficient capital funding to replace fossil fuel boilers			

Board Assurance Framework – Principal Risk 5. FINANCE			Impact on Delivery of Strategic Priority					
Executive Leads	Chief Finance Officer		Quality	Timely Care	People	Innovation	Resources	Commitment to Community
Board Committee	Finance & Estates Committee		HIGH	HIGH	HIGH	MODERATE	HIGH	MODERATE

Principal Risk Description	Causal & Contributory Factors	Sources of Assurance	
Failure to achieve financial sustainability due to an inability to meet elective activity targets, productivity targets, cost improvement targets, and/or manage cost pressures may lead to budget deficits. At NBT, the underlying deficit increases the risk of regulatory intervention, including heightened scrutiny, stricter reporting requirements, and potential limitations on decision-making authority. A deteriorating financial position across the Group could also result in service reductions, compromised patient access and care, additional headcount controls, recruitment constraints, and reduced financial autonomy, with greater oversight from the System and Regulators. These factors collectively impact the ability to operate effectively, maintain stakeholder confidence, and invest in future service and organisational improvements.	• Insufficient revenue funding from the ICB and Specialised Commissioners • Insufficient CDEL and/or cash for capital investment • Underlying financial challenge • Increasing demand, with fixed and/or limited growth funding • Workforce supply challenges, with premium costs or contained capacity • Operational inefficiencies and negative productivity • Estate configuration, condition and infrastructure maintenance • Political priorities • Macro-economic conditions • Technological advancements • Public expectations	Internal • Monthly reporting to Finance Committee and onwards to the Board • Monthly reporting of CIP/ERF at PFIG (with ICB/NHSE review) • Intenal and External Audit submissions to Audit Committee • Report from Local counter fraud service • Capital plan monitoring at Trust Capital Group and Capital Progam Steering Group. • ICB review through BNSSG Performance and Recovery Board and BNSSG Finance, Estates & Digital Committee. External • Model Hospital Benchmarking Reports • Internal Audit Reports • External Audit Reports and Value for Money Review	External Assurance – Third Line of Defence

Existing Controls		Gaps in Controls	Planned Mitigation
• Internal budget Planning and Oversight (BOTH) • Regular financial reporting at divisional and Trust level (BOTH) • ICS Directors of Finance (DoF) Group and System Planning Processes (BOTH) • Procurement controls (BOTH) • Financial escalation frameworks (BOTH) • Divisional Performance Management (BOTH) • Investment Prioritisation (BOTH) • Financial Forecasting and Scenario PlanningRe (BOTH) • Local counter fraud service (BOTH) • Weekly CIP Monitoring Reports (NBT) • Business Case Review Group (NBT) • Monthly Financial Returns and review with NHSE (NBT)	Inadequate	• Failure to achieve CIP targets on a recurring basis (BOTH) • Overspending on pay budgets due to over-establishment and premium workforce costs (UHBW) • Negative productivity (as measured by NHSE) and linking elective recovery investment (of more inputs) with elective activity delivery (UHBW) • Review of previous investments to ensure benefits realised (UHBW) • Being at or close to funded establishment means timely delivery of CIP becomes more important and reallocating resources to meet operational needs becomes a priority to avoid incurring additional temporary staffing costs (NBT) • Business Planning for 2025/26 is underway. The initial savings requirement is 4%, which equates to £32.4m. However, further savings will be required to cover the 0.9% increase in the national efficiency target (£7.8m). Currently £27m plans have been identified (NBT)	• Driving Productivity and Financial Improvement project (UHBW) • Digital procurement, stores & materials management transformation project (UHBW) • Medical Workforce Programme, reducing premium spend project (UHBW) • Waste reduction: savings identified on a recurring basis (paused) (UHBW) • Divisions, Transformation and Trustwide teams need to develop plans to allow CIP schemes to be delivered (NBT) • Additional controls to be applied to manage both substantive recruitment and committing additional temporary staffing costs (NBT)

UHBW Corporate Risks				NBT Trust Level Risks			
416	The Trust fails to fund the Trust's Strategic Capital Programme	↔	20	1777	Negative financial impact from decarbonisation targets and carbon	↔	20
5645	The Trust fails to achieve its stated Clean Air Hospital Framework 2025	↔	12	1887	Risk to delivery of recurrent savings	↔	20
6494	Specialised commissioning structures (delegation) impacts income	↔	12	1896	Risk of unfunded cost pressures	↔	16
5375	That the Trust doesn't deliver the in-year financial plan	↔	12	TBC	Procurement of goods which represent 54% of carbon emissions		
674	Use of agencies who are non-compliant with national pricing caps	↔	12	TBC	Focus on in-year savings does not enable sustainability investment		

Current Position

- This section will be used to provide a quarterly update on any changes to the principal risk, its impact on objectives or changes to corporate risks.
- The two Board Assurance Frameworks (BAFs) from North Bristol Trust (NBT) and University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) have been reviewed, and key elements from both have been used to populate the new template.
- Each element has been assigned to either NBT, UHBW, or BOTH, depending on its relevance and applicability across the hospital group.
- It is expected that strategic priorities will be reviewed and consolidated, with assurances provided to the joint group board, ensuring applicability across both Trusts.
- This version is for presentation purposes only, and a full review of the contents will be undertaken by the executive leads and the relevant operational groups.

Board Assurance Framework – Principal Risk 6. DIGITAL			Impact on Delivery of Strategic Priority					
Executive Lead	Chief Digital Information Officer		Quality	Timely Care	People	Innovation	Resources	Commitment to Community
Board Committee	Digital Committee		Moderate	High	Moderate	Moderate	Moderate	High

Principal Risk Description

A lack of digital maturity, oversight, and coordination across the group, combined with an aging infrastructure at UHBW requiring significant investment, increases the risk of an insecure and unstable digital environment. This could result in siloed and incomplete data, poor system interoperability, and an inconsistent user experience.

Systems that are not fully accessible or joined up across sites may limit access to critical information, creating operational challenges, inefficiencies, and delays in decision-making.

A significant cyber-attack or prolonged IT system failure could further compromise patient safety, disrupt business continuity, and impact the ability to deliver critical services. The consequences include data breaches, privacy violations, financial and regulatory repercussions, and reputational damage, ultimately eroding confidence in the Trust's digital resilience.

Causal & Contributory Factors

- Limited and fragmented investment in digital infrastructure has led to a variety of systems, presenting challenges in maintenance, future-proofing, performance, and alignment with evolving cybersecurity standards (UHBW)
- Delays in investment and prioritisation of replacing end-of-life software have resulted in a reliance on unsupported systems(UHBW)
- Business Intelligence (BI) capabilities are affected by data silos, continued use of paper records, and inconsistent data quality(UHBW)
- The existence of shadow IT complicates the coordination of digital systems, making it harder to consolidate information and ensure security (BOTH)
- The capacity for digital transformation is spread thin due to competing priorities and the complexity of managing multiple initiatives (BOTH)

Sources of Assurance

Internal

- HIMSS Infrastructure Adoption Model Assessment has scored our digital infrstructure capability at 4 out of 7 (UHBW)
- DSPT Self-Assessment and Audit Report (BOTH)

External

- Internal Audit reports of the Trust's Information Security Policies, Cyber-Security Action Plan, and Business Continuity Plans in the Trust's digital supply chain (BOTH)
- Annual IT Health Check (BOTH)
- Digital Maturity Assessment (BOTH)
- HIMSS Electronic Medical Record Adoption Model BOTH)

External Assurance – Third Line of

Existing Controls

- Digital Security Policies, Procedures and audits (BOTH)
- Regular scanning for vulnerabilities or attacks and antivirus software (BOTH)
- Disaster recovery backup in place and business continuity plans (BOTH)
- Timely server and software updates and patch application (BOTH)
- CareFlow Clinical Workspace (BOTH)
- Connecting Care (BOTH)
- Clinical Risk Management System for Digital Systems (BOTH)
- Digital Hospital Programme Board and its supporting bodies (UHBW)
- New procurement process for introduction of Digital systems (BOTH)
- NHSE cyber security alerting and briefing programme 'CareCert' (BOTH)
- NHSE South West Regional Cyber Security Group (BOTH)

Inadequate

Gaps in Controls

- The Information Asset Register is incomplete, making it difficult to confirm full compliance with Information Security Policies (UHBW)
- Contract management for digital systems is currently limited (UHBW)
- Business Intelligence (BI) reporting tools are not user-friendly or advanced enough to meet the needs of users (UHBW)
- The data quality function is limited (UHBW)
- A significant portion of shadow IT and some Digital Services systems do not yet comply with the clinical risk management system (BOTH)
- Servers are operating on unsupported systems (BOTH)
- The current infrastructure and insufficient alignment of core IT systems is not equipped to support joint working across the Group (BOTH)

Planned Mitigation

- Digital Strategy Year 1 delivery plan (UHBW)
- Careflow Medicines Management Project (UHBW)
- Implementation of tools to proactively monitor network activity and quickly identify and respond to any changes to normal activity (NBT)
- Improvement or replacement the existing back-up solution (NBT)
- Ongoing remediation work for areas highlighted by the vulnerability scanner (NBT)
- Remove or mitigate 146 Windows 2012 servers from the estate (NBT)
- Development of an assessment process with the Trust auditors to investigate cyber resilience of the supply chain with procurement (NBT)
- The BNSSG Cyber Security Governance Group has been established to focus on governance reporting across the ICS and considering converging Cyber Security toolsets (NBT)

UHBW Corporate Risks

7051	Risk that bespoke Homegrown Solutions limits future development	↔	16
7633	Reliance on paper-based medication prescribing	↑	16
291	Trust IT infrastructure does not meet the needs of a Digital hospital	↔	15
292	Risk that the Trust is impacted by a cyber incident	↔	15
6299	That patients may not have migrated from Millenium to Medway &/or	↔	15
7034	That the Trust has unsupported server operating systems in use	↔	15
6431	Inability to upload patient data from Careflow Connect to EPR	↔	12
3115	Clinical decision making may be based upon incomplete information	↔	12
6129	That inappropriate access to systems is undetected	↔	12
1374	Risk that obsolete network components are not replaced	↔	12

NBT Trust Level Risks

1760	continued use of hybrid clinical noting (paper and electronic notes)	↑	20
1800	Trust systems do not record the allergy ststus of patients	↔	16
545	Building 180 data centre will overheat and IT Services will fail	↔	16
2040	BloodTrack Tracking system is at end of life	↔	16
2076	Withdrawal of 'My Medical Record' (MMR) system	↔	16
1692	Promega Tecan is having episodes of unplanned downtime/design flaws	↔	12
1373	Vulnerability found in the Log4j software component	↔	12
1868	Access controls of Bristol Centre for Enablement 'Best' system	↔	12
1333	The Philips ICCA ICU system does not allow immediate patching	↔	12
1842	Cyber Attack via emails that contain malware	↔	12

Current Position

- This section will be used to provide a quarterly update on any changes to the principal risk, its impact on objectives or changes to corporate risks.
- The two Board Assurance Frameworks (BAFs) from North Bristol Trust (NBT) and University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) have been reviewed, and key elements from both have been used to populate the new template.
- Each element has been assigned to either NBT, UHBW, or BOTH, depending on its relevance and applicability across the hospital group.
- It is expected that strategic priorities will be reviewed and consolidated, with assurances provided to the joint group board, ensuring applicability across both Trusts.
- This version is for presentation purposes only, and a full review of the contents will be undertaken by the executive leads and the relevant operational groups.

Board Assurance Framework – Principal Risk 7. COMPLIANCE			Impact on Delivery of Strategic Priority					
Executive Leads	Chief Corporate Governance Officer		Quality	Timely Care	People	Innovation	Resources	Commitment to Community
Board Committee	Audit Committee		MODERATE	HIGH	HIGH	MODERATE	MODERATE	MODERATE

Principal Risk Description	Causal & Contributory Factors	Sources of Assurance	
Failure to comply with regulatory requirements, statutory duties, and NHS governance standards may lead to enforcement actions, financial penalties, reputational damage, and reduced public and stakeholder confidence. The complexity of operating as a Group introduces challenges in maintaining consistent compliance across both Trusts, particularly in areas such as data protection, health and safety, safeguarding, financial governance, and clinical regulations. Variability in local implementation of policies, differing regulatory interpretations, and resource constraints may contribute to non-compliance. Failure to meet Care Quality Commission (CQC), NHS England, and other regulatory requirements could result in enforcement actions, special measures, or increased scrutiny, impacting operational effectiveness and strategic priorities. Inadequate compliance mechanisms may also lead to legal liabilities, workforce implications, and compromised patient safety. Ensuring robust oversight, aligned governance frameworks, and clear accountability across the Group is critical to mitigating this risk.	• Frequent updates to NHS, CQC, and statutory requirements (BOTH) • Limited specialist compliance staff and training (BOTH) • Variability in applying policies across sites (BOTH) • Competing priorities deprioritising compliance activities (BOTH) • Third-party providers failing to meet regulatory standards (BOTH) • Delays in updating policies and unclear ownership (UHBW) • Differences in policies and governance create inconsistencies (UHBW) • Lack of integrated digital systems for compliance oversight (UHBW) • Lack of awareness and training on compliance requirements (UHBW)	Internal • Health & Safety Reports (BOTH) • CQC Action plans in response to inspections (BOTH) • Premesis Assurance Model reports (BOTH) • Safeguarding Reports (BOTH) • IQPR containg compliance with NHS England Oversight Framework Report (BOTH) • DSP Toolkit (BOTH) • Equality, Diversity & Inclusion Compliance (BOTH) • NICE Compliance (BOTH) • Environmental & Sustainability Compliance Report (BOTH) External • Internal audit reports (BOTH) • Reports from CQC, MHRA and other regulatory bodies (BOTH)	External Assurance – Third Line of Defence

Existing Controls		Gaps in Controls	Planned Mitigation
• Regular monitoring of compliance with accountability at Board level (BOTH) • Specialist teams oversee key statutory areas and report compliance with related standards into operational groups (BOTH) • Clear accountability for compliance across operational, clinical, and corporate functions (BOTH) • Policies and procedures covering regulated activities (BOTH) • Regular staff training on key compliance areas, including GDPR, safeguarding, health and safety, and safeguarding and targeted training for high-risk roles (e.g., clinicians, data handlers) (BOTH) • Processes for reporting and escalating compliance breaches (BOTH) • Confidential freedom to speak up channels for staff to report compliance concerns without fear of retaliation (BOTH)	Inadequate	• Complexity leads to no single, clear reference of obligations (BOTH) • Opportunities to improve training engagement (UHBW) • Inconsistent implementation and monitoring of policies (UHBW)	• Fire Safety Programme (UHBW) • Objective to improve completion weekly fire evacuation checks (UHBW) • Neonatal Intensive Care Unit (NICU) Fire Safety project (UHBW)

UHBW Corporate Risks				NBT Trust Level Risks			
972	Non-Compliance with Regulatory Reform Order 2005	↔	20	2016	Mortuary Compliance with Human Tissue Act	↔	15
3830	Incomplete fire compartmentation	↔	20				
3826	Departmental Risk Assessments by non-competent persons	↔	12				
5564	WGH fire doors do not meet current certification standards	↔	12				
6085	StMH wet riser is not sufficient for firefighting needs	↔	12				
6202	Fire alarm cause & effect is not programmed correctly	↔	12				
3827	Incomplete Risk Assessments for plant rooms	↓	12				
801	That elements of the NHS Oversight Framework are not met	↔	12				
6691	That medicines are not stored securely	↔	12				
7980	Non-compliance with statutory and regulatory safeguarding duties	↑	12				
2695	Risk that the Trust fails to establish and maintain robust governance	↔	12				

Current Position

- This section will be used to provide a quarterly update on any changes to the principal risk, its impact on objectives or changes to corporate risks.
- The two Board Assurance Frameworks (BAFs) from North Bristol Trust (NBT) and University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) have been reviewed, and key elements from both have been used to populate the new template.
- Each element has been assigned to either NBT, UHBW, or BOTH, depending on its relevance and applicability across the hospital group.
- It is expected that strategic priorities will be reviewed and consolidated, with assurances provided to the joint group board, ensuring applicability across both Trusts.
- This version is for presentation purposes only, and a full review of the contents will be undertaken by the executive leads and the relevant operational groups.

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public		
Date of Meeting:	8 April 2025		
Report Title:	Board Workplan and Committee Terms of Reference		
Report Author:	Eric Sanders, Joint Chief Corporate Governance Officer Xavier Bell, Joint Chief of Staff Lucy Thorp, Teneo Jamie Foster, Hill Dickinson LLP		
Report Sponsor:	Eric Sanders, Joint Chief Corporate Governance Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X	**X**	
	To present proposed changes to the Board workplan and Committee Terms of Reference for approval.		

Key Points to Note *(Including any previous decisions taken)*

Following agreement for the Boards of University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and North Bristol NHS Trust (NBT) to meet in common, as part of the governance arrangements to support working as a group, work has been undertaken to review the current Board workplans. The process has included identifying the source of each report, and reviewing whether the items are core Board business, or if they can be delegated to Committees or Executives. The new Board workplan is presented in Appendix 1 for discussion.

The consequential knock on to Committee workplans is also being considered and will be discussed with executive leads and Committee Chairs.

The review has highlighted several reports which could be delegated or considered at the Board Day (i.e. outside of the formal meetings) and these are outlined in Appendix 2. There are also several inclusions proposed to recognise that the Board will need to have oversight of the Joint Clinical Strategy and the Group Benefits Case.

Following a discussion with the Chief Nurses, it has been agreed to provide full reports on maternity compliance to the Board twice per annum, with monthly reporting into the Quality & Outcomes Committees. Escalation will be via the Committee Chair's reports, and via the NED Maternity Champion/Executive Lead.

Work has also been undertaken to revise all the Board Committee Terms of Reference in readiness for the Committees to meet in common from April. The Terms of Reference have been discussed with Executives and Non-Executives and have been simplified to ensure there is clarity in expectations from the Board. The documents have also been informed through discussions with other Groups to ensure they align with current good practice.

The Terms of Reference will be considered and updated as a suite of documents to recognise that the Committees must work together to provide assurance to the Board. This also acknowledges the complex nature of healthcare provision and the size and complexity of the Group.

The proposed membership of the Committees is included in Appendix 10 for approval by the Board. The Board should note that specific titles have not been included in the Terms of Reference to ensure that there is agility in considering which Board members maybe best placed to attend meetings.

In the spirit of continuous improvement, all documents will be kept under regular review to ensure that they remain effective and adding value to the Boards.
Strategic and Group Model Alignment
These documents directly support the Board's ambition to form a Group, and these documents support the new governance model being implemented.
Risks and Opportunities
For the Group Board (Board in common) to operate effectively, it will need to delegate some items to its committees or the Executives to discuss and approve. This means that the whole Board may not be fully sighted on the same level as detail as before and must rely on prompt and effective escalation of issues if necessary. The documents support a new way of working which will free up the Board's time for more strategic and future focused discussion, focusing only on the things the Board can do.
Recommendation
This report is for **Approval** The Boards are asked to: • Approve the revised Board workplan, noting the detail of the items to be considered elsewhere included in Appendix 2 and agree to undertake a regular review as the Board starts to operate in common. • Approve the review Governance Structure and the Terms of Reference for the Committees • Approve the proposed membership of the Committees as outlined in Appendix 10
History of the paper (details of where paper has <u>previously</u> been received)
N/A

Appendices:	Appendix 1 – Revised Board Workplan Appendix 2 – Summary of key changes to the Board workplan Appendix 3 – Group Governance Structure Appendices 4 - 9 – Committee Terms of Reference *Appendix 10 – Proposed Committee Membership*

Board of Directors
Combined Annual Cycle of Business 2025/26

	Source	Health NHS Board - Roles and Building Blocks	Sponsor	Author	Type	8th April 2025	13th May 2025	10th June 2025 BOARD DAY	8th July 2025	12th August 2025 BOARD DAY	9th September 2025	14th October 2025 BOARD DAY	11th November 2025	9th December 2025 BOARD DAY	13th January 2026	10th February 2025 BOARD DAY	10th March 2026
Preliminary Business																	
Apologies for absence		N/A	Verbal		Information			ICB Strategy 10 Year Plan Health Inequalities		TBC		WECA Strategy Risk Appetite		A rotation of topics including Patient Experience, People, Research and Strategic, operational planning and risk		A rotation of topics including Patient Experience, People, Research and Strategic, operational planning and risk	
Declarations of interest	SOs	N/A	Verbal		Information												
Minutes of the last meeting	SOs	N/A	Joint Chair	Head of Corporate Governance / Deputy Trust Secretary	Approval												
Matters arising and action log	SOs	N/A	Joint Chair	Head of Corporate Governance / Deputy Trust Secretary	Approval												
Staff Story	Internal	Context	Chief People Officer	Various	Information												
Patient Story	Good practice	Context	Chief Nurse and Midwife/Chief Nurse	Patient & Public Involvement Lead	Information												
Questions from the Public	SOs	N/A	Joint Chair	Head of Corporate Governance / Deputy Trust Secretary	Information												
Strategic																	
Joint Chief Executive's Report	Good practice	Context	Joint Chief Executive	Joint Chief Executive	Information												
Joint Chair's Report	Good practice	Context	Joint Chair	Joint Chair	Information												
Combined Committee Chairs' Reports / Integrated Governance Report including Register of Seals	Good practice	Accountability	Joint Chair	Joint Chief Corporate Governance Officer	Information												
Review of Joint Clinical Strategy, Trust Strategies and Patient First Priorities	Good practice	Strategy	Joint Chief Executive	TBC	Approval												
Benefits Case Delivery Review	Good practice	Strategy	Joint Chief Executive	TBC	Information												
System, Regional and National Context Update	Good practice	Context	Joint Chief Executive	Joint Chief of Staff	Information												
Operational Plan	SOs, Code of Governance	Intelligence	Executive Directors	TBC	Approval		Approval										Approval
Quality and Performance																	
Integrated Quality and Performance Report	Code of Governance	Intelligence	Joint Chief Executive	Head of Performance Reporting	Assurance												
Non-Executive Safety Visit Summaries	Good practice	Intelligence	Joint Chair	Head of Corporate Governance and Non-Executive Directors	Assurance												
Maternity Assurance Report:	Ockenden	Intelligence	Chief Nurse and Midwife/Chief Nurse	Heads of Midwifery	Assurance										CNST Compliance sign off		
Nurse Staffing Report	National requirement	Intelligence	Chief Nurse and Midwife/Chief Nurse	Deputy Chief Nurses	Assurance												
Learning from Deaths Quarterly Report	National requirement - National Guidance on Learning from	Intelligence	Chief Medical Officers	Deputy Medical Directors	Assurance				Q4		Q1		Q2		Q3		
Governance																	
Board Assurance Framework	Code of Governance	Intelligence	Joint Chief Corporate Governance Officer	Head of Risk Management	Assurance												
Emergency Preparedness	Legislative	Intelligence	Chief Operating Officers	Deputy Chief Operating Officers	Assurance												Annual
Modern Slavery Statement	Legislative	Ensure Accountability	Director of Corporate Governance	Head of Corporate Governance	Approval				Annual								
Annual Review of Governance - Board and Committee Self Reviews - Cycles of Business - Terms of Reference - Constitution and Standing Orders, including SFIS - Annual Review Codes of Conduct for the Board and Council of Governors	Constitution and Standing Orders	Ensure Accountability	Joint Chief Corporate Governance Officer	Head of Corporate Governance	Approval		Annual										
Finance																	
Financial Plan & Budget	Code of Governance	Intelligence	Chief Financial Officer/Chief Finance Officer	Director of Operational Finance	Approval												Approval
Business Cases, as required in line with Scheme of Delegation	Constitution	Ensure Accountability	Joint Chief Executive	Various	Approval												
Annual Report and Accounts	Constitution	Ensure Accountability	Chief Executive and Chief Financial Officer	Director of Operational Finance and Head of Corporate Governance	Approval				Possible separate meeting								
People Management																	
Medical Revalidation	Legislative	Intelligence	Chief Medical Officers	TBC	Assurance								Annual				
Freedom to Speak Up	National guidance	Intelligence	FTSU Executive Lead	FTSU Guardians	Assurance				Annual								
Concluding business																	
Any other urgent business		N/A	Joint Chair	n/a	Information												
Date of next meeting		N/A	n/a	n/a	Information												

	Private Meeting
	Public Meeting
	Both

Appendix 2 - Summary of Changes to the Board Cycle

1. **Notes:**

- Board cycle to be kept under regular review and adjusted as necessary
- Committees and Executive Directors to escalate any urgent or thematic issues for the Boards attention outside of the cycle, either direct or via the Committee upward report
- Some items have been grouped together on the new Board cycle for ease of reference e.g. governance items

2. **Potential Board Day Topics:**

• WECA Strategy and impact on Group Strategy/Priorities • Developments of the Group Digital Strategy • Patient Experience including relevant surveys	• Strategy review and refresh (JCS, Trust Strategies and Patient First) including risk appetite • Research • Our People – staff survey, Equality, Diversity and Inclusion, education etc.

3. **Items to be added to the current Board Cycle:**

Item	**Rationale**
Review of Joint Clinical Strategy, Trust Strategies and Patient First Priorities	Core Board business to consider and approve changes to the key strategies of the Group.
Update on the delivery of the Group Benefits Case	Need to monitor and track delivery of the key benefits

4. **Items to be removed from the current NBT/UHBW Board Cycle.**

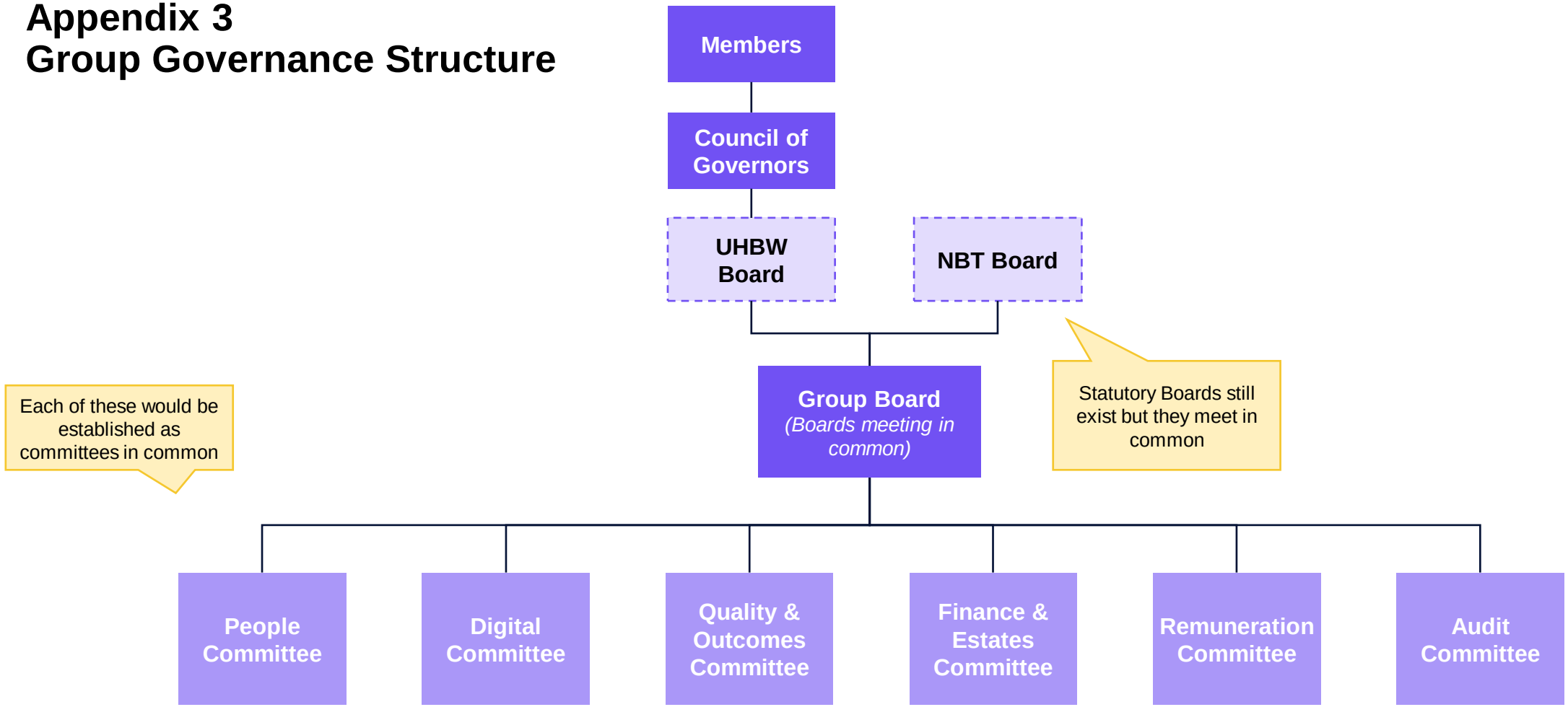
Item	**Moved to**	**Rationale**
Approval of the Strategy	N/A	Replaced with a review of the Joint Clinical Strategy, Trust Strategies, and Patient First Priorities

Item	Moved to	Rationale
Sustainability Strategy and Annual Sustainability Reporting	N/A	Included in the annual report
Estates Update including Strategic Capital Update	Finance and Estates Committee	Core function of the Committee
Trust Level Enabling Strategy Updates (NBT)	NBT Management Board	To be considered at the Hospital Management Team
Winter Plan	Quality and Outcomes Committee	Key part of quality and operational assurance
Green Plan	Board Day	More time is required for the Board to discuss and debate this topic, which the Board Day will allow.
Maternity Serious Incidents (by exception)	Quality and Outcomes Committee and include in the IQPR	Core function of the Committee
Annual Infection Prevention Control Report	Quality and Outcomes Committee	Not a statutory requirement to be presented to the Board. It must be publicly available.
Annual Patient Experience Report	Board Day	More dedicated time to consider a range of patient experience sources of data and information
Annual Patient Complaints Report	Quality and Outcomes Committee	No specific requirement to be presented to the Board. Themes from complaints to form part of the patient experience session on a Board Day.
Annual National Adult Inpatient Survey	Board Day and Quality and Outcomes Committee	More dedicated time to consider a range of patient experience sources of data and information. QOC to consider any strategic themes which are identified as survey results are received.
Children and Young People's Survey (BI-ENNIEL)		
Annual Under 16 Cancer Patient Experience Survey		

Item	Moved to	Rationale
Annual Cancer Patient Experience Survey		
National Urgent and Emergency Care Survey		
National Maternity Survey		
Safeguarding Annual Report	Quality and Outcomes Committee	To be considered at QOC and issues escalated to the Board as necessary.
Annual Safe Working Hours Guardian Report	People Committee	Allow more detailed discussion and triangulation with other sources of information
Quality Accounts	Quality and Outcomes Committee	No requirement for Board sign off.
Research and Innovation Report	Board Day	Annual Joint Research report to Board Development Session.
NIHR CRN Annual Plan and Annual Report	N/A	No longer required under the new contract
CHD Network Annual Report (hosted body report)	N/A	No longer required
Annual Review of Directors Interests	N/A	Standing link to be included on each agenda
Annual Review of Risk Appetite Statement	Board Day	Time for more detailed consideration of risk
Corporate Governance Statement Self Assessments Certification	N/A	No longer required.
Governors' Log of Communications	N/A	Circulate for information outside of meetings.
Professionals Under Investigation (NBT)	NBT Management Team	Not core Board business, and not a regulatory requirement that its reported to Board.

Item	Moved to	Rationale
Finance Report	Finance and Estates Committee and IQPR	Detail to be discussed at the Finance and Estates Committee, with monthly reporting into the IQPR.
Capital Investment Policy	Audit Committee	Core element of internal control systems
Treasury Management Policy	Audit Committee	Core element of internal control systems
Equality and Diversity Annual Report	Board Day	To consider in conjunction with other key staff data and information
National Staff Survey Results	Board Day	To consider in conjunction with other key staff data and information

Appendix 3
Group Governance Structure



North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

People Committee

Terms of Reference

1. Constitution

1.1. The People Committee is constituted as a standing Committee of each of the University Hospitals Bristol and Weston NHS Foundation Trust Board of Directors and the North Bristol NHS Trust Board of Directors (hereafter collectively referred to as "the Boards"). The People Committee (hereafter referred to as "the Committee") operates as Committees in Common of both Boards.

1.2. The Committee has no executive powers, other than those specifically delegated by the Boards in these Terms of Reference which are incorporated within the Trusts' Standing Orders.

2. Purpose

2.1. The Committee is responsible for assuring the Boards on matters concerning all aspects of delivery that relate to workforce supply, development and wellbeing and the delivery of education.

2.2. The scope of the Committee covers:

- **Workforce:** workforce strategy and planning; workforce supply (recruitment and retention); workforce health and wellbeing; learning and development; leadership development; culture and organisational development; HR systems, policies and processes; Equality, Diversity and Inclusion (EDI); workforce engagement; Freedom to Speak Up (FTSU); and workforce risk.
- **Education:** Group Learning and Workforce strategy and the delivery of thereof.

3. Duties

3.1. Workforce

- Receive, scrutinise, shape and approve the trusts' Group People Strategy.
- Ensure that the trusts have an appropriate annual workforce plan which aligns with the trusts' broader business plan.
- Receive and scrutinise updates relating to Our People Patient First priorities.
- Monitor delivery of the trusts' people strategy(s), ensuring that the desired outcomes are achieved.
- Monitor key performance indicators relating to workforce supply, development and wellbeing.
- Monitor and take assurance against the trusts' approach to Equality, Diversity and Inclusion (EDI), including reviewing the trusts' performance against nationally mandated standards and corresponding action plans.
- Ensure that cultural improvement is a priority for the trusts, and that the approach and initiatives connected to cultural improvement are effective.
- Ensure that the trusts continue to develop and embed an open and safe culture towards Speaking Up, including by receiving FTSU exception reports/ escalations.
- Receive exception reports and escalations from the Guardian of Safe Working Hours.
- Ensure that the trusts' approach and initiatives connected to the promotion of staff health and wellbeing are aligned to workforce needs and embody the culture and values of the trusts.
- Ensure there is a positive and open culture to staff engagement and that there are appropriate processes in place for engaging and communicating with staff at all levels.

- To receive and review the findings of the annual National NHS Staff Survey and ensure the implementation and effectiveness of resultant action plans.

3.2. Education

- Receive, scrutinise, shape and approve the trusts' Group Learning and Workforce Development Strategy.
- Monitor delivery of the trusts' education strategy(s), ensuring that the desired outcomes are achieved.
- Monitor key performance indicators relating to education.

3.3. Review and monitor strategic risks within the Committee's area of responsibility, as set out in the Board Assurance Framework (BAF).

3.4. The Committee shall collectively undertake the statutory duties of the Non-Executive Director Champion Role related to Security Management – Violence and Aggression

3.5. In carrying out these duties, the Committee will:

- Work collaboratively with the other Committees and on behalf of the Board to test and seek assurance from a range of perspectives on the key risks affecting the trusts to ensure coordinated and comprehensive oversight of cross-cutting themes; and
- Work collaboratively with system partners to improve the supply and development of the whole health and care workforce in BNSSG.

4. Membership

4.1. Members of the Committee shall be appointed by the Board and shall comprise:

- Two Non-Executive Directors from each Board, one of whom shall be appointed as the Committee Co-Chair
- At least two Executive Directors from each Board.

4.2. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5. Quorum and Attendees

5.1. The quorum necessary for the transaction of business shall be:

- At least one Non-Executive Director
- At least two Executive Directors

6. Frequency

6.1. The Committee shall meet a minimum of 6 times per annum.

6.2. Additional meetings may be called at the request of the Chair.

7. Authority

7.1. The Committee is authorised:

- to investigate any activity within its terms of reference
- to seek any information required from any employee of the Trusts in order to perform its duties, and to direct all employees to cooperate with any requests made by the Committee
- to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and
- to call any employee to be questioned at a meeting of the Committee as and when required
- to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary

8. Meeting administration

8.1. The Trust Secretariat shall act as the secretary of the Committee

8.2. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members

9. Reporting

9.1. An exception report will be provided to the Boards via the Committee Chair – highlighting business transacted and making any recommendations as deemed appropriate within the remit of the Committee.

9.2. The Committee will conduct an annual review of its effectiveness.

Version XX

Date Approved: XX

Date of Next Review Date: XX

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Digital Committee

Terms of Reference

1. Constitution

1.1. The Digital Committee is constituted as a standing Committee of each of the University Hospitals Bristol and Weston NHS Foundation Trust Board of Directors and the North Bristol NHS Trust Board of Directors (hereafter collectively referred to as "the Boards"). The Digital Committee (hereafter referred to as "the Committee") operates as a Committee in Common of both Boards.

1.2. The Committee has no executive powers, other than those specifically delegated by the Boards in these Terms of Reference which are incorporated within the Trusts' respective Standing Orders.

2. Purpose

2.1. The Committee is responsible for assuring the Boards on matters concerning all aspects of, digital strategy, the operational delivery of digital services and delivery of the digital transformation programmes across both Trusts.

2.2. The scope of the Committee covers:

- Digital strategy and transformation, digital systems, policy and operational performance, cyber security, digital risks

3. Duties

3.1. Digital strategy & transformation

- Receive, scrutinise, shape and approve the trusts' digital strategy(s).
- Monitor delivery of the trusts' digital strategy(s), ensuring that the desired outcomes are achieved.
- Ensure that the trusts have appropriate digital plans which aligns with the trusts' broader business plan.
- To review and monitor strategic risks within the Committee's area of responsibility, as set out in the Group Board Assurance Framework.

3.2. Digital systems, policy and operational performance

- Ensure the trusts have robust and effective digital policies and processes in place, including cyber security, information governance and records management.
- Monitor key performance indicators relating to operational digital and IMT performance.

3.3. Business cases and capital expenditure

- Receive, scrutinise, shape and approve significant digital capital/revenue business cases, in line with the delegated authorisations set out in the Trusts' respective Standing Financial Instructions and Schemes of Reservation and Delegation.
- Monitor key performance indicators and benefits realisation relating to significant digital capital/revenue investments.

3.4. In carrying out these duties, the Committee will:

- Work collaboratively with system partners to improve the alignment of digital systems and processes within BNSSG; and

- Liaise with other Committees to ensure coordinated and comprehensive oversight of cross-cutting themes.

4. Membership

4.1. Members of the Committee shall be appointed by the Board and shall comprise:

- Two Non-Executive Directors from each Board, one of whom shall be appointed as the Committee Co-Chair
- At least two Executive Directors from each Board.

4.2. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5. Quorum and Attendees

5.1. The quorum necessary for the transaction of business shall be:

- At least one Non-Executive Director from each Board
- At least two Executive Directors

6. Frequency

6.1. The Committee shall meet a minimum of 6 times per annum.

6.2. Additional meetings may be called at the request of the of the Chair.

7. Authority

7.1. The Committee is authorised:

- to investigate any activity within its terms of reference
- to seek any information required from any employee of the Trusts in order to perform its duties, and to direct all employees to cooperate with any requests made by the Committee
- to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and
- to call any employee to be questioned at a meeting of the Committee as and when required
- to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary

8. Meeting administration

8.1. The Trust Secretariat shall act as the secretary of the Committee

8.2. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members

9. Reporting

9.1. An exception report will be provided to the Boards via the Committee Chair – highlighting business transacted and making any recommendations as deemed appropriate within the remit of the Committee.

9.2. The Committee will conduct an annual review of its effectiveness.

Version XX

Date Approved: XX

Date of Next Review Date: XX

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Quality and Outcomes Committee

Terms of Reference

1. Constitution

1.1. The Quality and Outcomes Committee is constituted as a standing Committee of each of the University Hospitals Bristol and Weston NHS Foundation Trust Board of Directors and the North Bristol NHS Trust Board of Directors (hereafter collectively referred to as "the Boards"). The Quality and Outcomes Committee (hereafter referred to as "the Committee") operates as Committees in Common of both Boards.

1.2. The Committee has no executive powers, other than those specifically delegated by the Boards in these Terms of Reference which are incorporated within each Trust's Standing Orders.

2. Purpose

2.1. The Committee is responsible for assuring the Boards on matters concerning all aspects of quality, safety, experience and performance, to ensure the delivery of safe and effective care to patients.

2.2. The scope of the Committee covers:

- **Quality and safety:** quality strategy and reporting, quality improvement, clinical governance and escalation, clinical risk, clinical audit, patient safety, safe staffing, Infection Prevention and Control (IPC), safeguarding, clinical effectiveness, safe and effective prescribing and administration of medicines, health inequalities, NHS SOF – Quality of Care and Outcomes.
- **Patient experience:** patient and public engagement, complaints (and compliments), serious incidents and never events, local and national patient experience surveys, Equality, Diversity and Inclusion (EDI - patient-focused).
- **Performance:** target setting and action planning, operational performance monitoring (e.g., against care access standards), activity recovery, performance benchmarking and reporting, learning mechanisms, Emergency Planning Resilience and Response (EPRR), NHS SOF – Access.

3. Duties

3.1. <u>Quality and safety</u>

- Receive, scrutinise, shape and approve the trusts' quality strategy(s)
- Monitor progress and achievement of the trusts' quality strategy, priorities and quality-related action plans, and provide an informed opinion to the Boards on the sustainability of objectives.
- Receive and scrutinise the trusts' annual quality reports prior to submission to the trusts' Boards for approval.
- Support the trusts' objective to strive for continuous quality improvement and oversee the trusts' approach to quality improvement is robust and embedded across the trusts.
- Monitor the impact of the trusts' clinical strategy, transformation and cost improvement programmes on the quality and safety of patient care.
- Review the suitability and implementation of risk mitigation plans with regards to their potential impact on safety and care quality.
- Oversee that the trusts have robust and effective clinical governance arrangements in place to support compliance with regulatory standards and external sources of assurance, including the receipt of draft and final reports, oversight of action plans and other statutory undertakings.

- Oversee compliance with all relevant healthcare standards, including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of healthcare professionals.
- Be assured of safe and effective prescribing and administration of medicines.
- Receive, scrutinise and approve the clinical audit plan and receive assurance on progress against the plan and related programmes.
- Support the trusts' objective to reduce health inequalities amongst its patients and community.
- Oversight of the NHS System Oversight Framework themes of Quality of Care and Outcomes.
- Consider and examine activity models to ensure consistency and to provide assurance on critical assumptions.
- Consider and examine operational performance.

3.2. Patient experience

- Support the trusts to actively engage with patients, staff, the public and other relevant stakeholders on care experiences, and take into account, as appropriate, views and information from these sources in guiding trusts' quality strategy(s) and priorities.
- Receive and scrutinise reports on complaints and patient experience, identifying key themes, trends and learnings – including oversight of actions plans arising from serious incidents, complaints and never events.
- Identify opportunities to improve outcomes and experiences for patients through innovative practice and partnerships.
- Review the results and outcomes of local and national patient experience surveys.
- Receive and review the Equality and Diversity Annual Report, with a particular focus on patient experience and quality of care.

3.3. Performance

- Oversight of target setting, as relates to quality, safety and experience KPIs, including ensuring a comprehensive suite of metrics are in place bringing together key national and local targets, and due consideration is given to relevant regional and national benchmarking statistics.
- Undertake additional scrutiny and deep dives into performance where there is consistent non-delivery against plans.
- Oversee the trusts' performance around Emergency Care and Elective Care and seek assurance that the risks to delivery are known, robust action plans are in place to address these issues and that the implementation of these plans are resulting in intended outcomes.
- Oversight of the NHS System Oversight Framework theme - Access.
- Seek assurance on the robustness of the trusts' Emergency Planning Resilience and Response (EPRR) framework, including receiving the annual NHS England assurance report, and testing compliance of business continuity arrangements across the trusts.

3.4. Review and monitor strategic risks within the Committee's area of responsibility, as set out in the Board Assurance Framework (BAF).

3.5. The Committee shall collectively undertake the statutory duties of the Non-Executive Director Champion Role related to:

- Hip Fracture, Falls and Dementia

- Learning from Deaths
- Safety and Risk
- Palliative Care and End of Life
- Health and Safety
- Children and Young People
- Resuscitation
- Emergency Preparedness
- Safeguarding

3.6. In carrying out these duties, the Committee will:

- Extend the Boards' monitoring and scrutiny of standards of quality, safety, experience and performance of services across both trusts, make recommendations to the Boards on opportunities for improvement and support these opportunities where identified;
- Seek sources of evidence from management groups at trust, divisional and sub-divisional level on which to base informed opinions regarding the standards detailed above;
- Work collaboratively with the other Committees and on behalf of the Board to test and seek assurance from a range of perspectives on the key risks affecting the trusts to ensure coordinated and comprehensive oversight of cross-cutting themes; and
- Work collaboratively with system partners to improve the quality and safety of clinical services, care experience and reduce health inequalities across BNSSG.

4. Membership

4.1. Members of the Committee shall be appointed by the Board and shall comprise:

- Two Non-Executive Directors from each Board, one of whom shall be appointed as the Committee Co-Chair
- At least two Executive Directors from each Board.

4.2. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5. Quorum and Attendees

5.1. The quorum necessary for the transaction of business shall be;

- At least one Non-Executive Director
- At least two Executive Directors

6. Frequency

6.1. The Committee shall meet a minimum of 6 times per annum.

6.2. Additional meetings may be called at the request of the Chair.

7. Authority

7.1. The Committee is authorised:

- to investigate any activity within its terms of reference,
- to seek any information required from any employee of the Trusts in order to perform its duties, and to direct all employees to cooperate with any requests made by the Committee,
- to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and

- to call any employee to be questioned at a meeting of the Committee as and when required
- to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8. Meeting administration

8.1. The Trust Secretariat shall act as the secretary of the Committee.

8.2. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members.

9. Reporting

9.1. An exception report will be provided to the Boards via the Committee Chair – highlighting business transacted and making any recommendations as deemed appropriate within the remit of the Committee.

9.2. The Committee will conduct an annual review of its effectiveness.

Version XX

Date Approved: XX

Date of Next Review Date: XX

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Finance and Estates Committee

Terms of Reference

1. Constitution

1.1. The Finance and Estates Committee is constituted as a standing Committee of each of the University Hospitals Bristol and Weston NHS Foundation Trust Board of Directors and the North Bristol NHS Trust Board of Directors (hereafter collectively referred to as "the Boards"). The Finance and Estates Committee (hereafter referred to as "the Committee") operates as Committees in Common of both Boards.

1.2. The Committee has no executive powers, other than those specifically delegated by the Boards in these Terms of Reference which are incorporated within each Trust's Standing Orders.

2. Purpose

2.1. To seek and receive assurance on the stewardship of each Trust's finances and estates, including but not limited to financial planning, financial performance, investment decisions and benefits realisation, and development and implementation of an estate's strategy, to ensure the delivery of long-term financial sustainability.

2.2. The scope of the Committee covers:

- **Financial Strategy:** annual budget, financial performance, capital investment programme, financial risk, financial relationships, Board Assurance Framework document.
- **Investment:** financial performance benchmarks, Capital Investment Policy, compliance, Project Initiation Documents, capital investments and divestments, business cases.
- **Estates and Facilities:** estates strategy, estate risks, regulatory compliance.

3. Duties

3.1. Financial Strategy

To consider and examine on behalf of the Board of Directors:

- The annual budget;
- Key Trust and Divisional financial performance indicators;
- Progress to deliver the capital investment programme, in line with recommendations from the Capital Programme Steering Group;
- Risks associated with financial plans (finance risk);
- Financial relationships with the Trust's Commissioners;
- Financial performance and productivity metrics applied by NHS England;
- Financial performance forecasts;
- Financial aspects of the Board Assurance Framework document; and
- Business cases classed as 'major' or 'high' risk; making recommendations for approval or rejection to the Board.

3.2. Investment

- Set financial performance benchmarks and monitor the performance of investments;

- Review proposed revisions to the Capital Investment Policy for approval by the Trust Board of Directors each year;
- Seek and consider evidence of organisational compliance with the Capital Investment Policy;
- Review and approve business cases in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.

3.3. Estates and Facilities

- To support the development and implementation of an Estates Strategy, and be assured about its delivery;
- To be assured that the Trust is aware of and acting on estates risks, in particular those relating to fire safety;
- To receive assurances in relation to regulatory compliance; and

3.4. The Committee will also consider relevant high risk internal audit reports and seek updates on progress to close recommendations.

4. Membership

4.1. Members of the Committee shall be appointed by the Board and shall comprise:

- Two Non-Executive Directors from each Board, one of whom shall be appointed as the Committee Co-Chair
- At least two Executive Directors from each Board.

4.2. If a member is unable to attend a meeting of the Committee, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues under discussion. The deputy should be approved by the Chair in advance of the relevant meeting.

5. Quorum and Attendees

5.1. The quorum necessary for the transaction of business shall be;

- At least two Non-Executive Director
- The Chief Financial Officer or nominated deputy
- At least one other Executive Director, or nominated deputy

5.2. The following individuals will attend (but are not members of) the Committee:

- Director of Corporate Governance

5.3. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Director of Operational Finance
- Director of Estates & Facilities

6. Frequency

6.1. The Committee shall meet a minimum of 6 times per annum.

6.2. Additional meetings may be called at the request of the Chair.

7. Authority

7.1. The Committee is authorised to:

- Review, monitor, and where appropriate, investigate any matter within its terms of reference, and seek such information from any employee of the Trust as it requires to facilitate this activity.

- Obtain whatever advice it requires, including external professional or legal advice if deemed necessary (as advised by the Director of Corporate Governance). In so doing, it may require directors and other officers, or independent specialists to attend meetings to provide such advice.

8. Meeting administration

8.1. The Trust Secretariat shall co-ordinate secretariat services to the Committee.

8.2. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members.

9. Reporting

9.1 The Chair of the Committee shall report to the Board of Directors on the activities of the Committee and shall make whatever recommendations the Committee deems appropriate (on any area within the Committee's remit where disclosure, action or improvement is considered necessary).

9.2 The Chair shall provide a report on the activities of the Committee at each meeting of the Audit Committee.

9.3 The Committee shall prepare a statement for inclusion in the Annual Report about its activities.

9.4 The Committee will conduct an annual review of its effectiveness.

Version XX

Date Approved: XX

Date of Next Review Date: XX

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Remuneration and Nomination Committee

Terms of Reference

1. Constitution

1.1. The Remuneration and Nomination Committee is constituted as a standing Committee of each of the University Hospitals Bristol and Weston NHS Foundation Trust Board of Directors and the North Bristol NHS Trust Board of Directors (hereafter collectively referred to as "the Boards"). The Remuneration and Nomination Committee (hereafter referred to as "the Committee") operates as Committees in Common of both Boards.

1.2. The Committee executive powers, other than those specifically delegated by the Boards in these Terms of Reference which are incorporated within each Trust's Standing Orders.

2. Purpose

2.1. The Committee is responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service.

2.2. The scope of the Committee covers:

- **Nomination:** composition of the Board, succession planning, appointment process, continuation in office of executive directors, significant commitments and conflicts of interest.
- **Renumeration:** remuneration policy, individual remuneration packages, levels of remuneration, terms and conditions of office of the Trust's Executive Directors, performance targets, expenses claims, severance payments.

3. Duties

3.1. Nomination

- Review as required the structure, size, composition, and diversity of the Board, and provide input to the formal board evaluation process.
- Provide assurance to the Board that there is appropriate succession planning in place for executive directors and the organisational level below.
- Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy.
- Be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise.
- Before any appointment is made to the executive team, evaluate the balance of skills, knowledge, experience and diversity and in the light of the evaluation, review a description of the role and capabilities required for a particular appointment.
- Ensure that the appointment process is designed to attract the best candidates, through the use of a range of open advertising or the services of external advisers to facilitate the search. The Committee will seek to provide assurance that candidates fully reflect a wide range of backgrounds and the Trust's commitment to equality, diversity and inclusion and that the recruitment process will consider candidates on merit and against objective criteria.
- The Committee will be consulted with regarding any temporary or interim arrangements for appointing executive directors.

- Approve any matters relating to the continuation in office of any executive director at any time including the suspension or termination of service of an executive director as an employee of the Trust subject to the provisions of the law and their service contract.
- Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.
- Ensure there is a process in place that proposed Board appointees disclose any business interests that may result in a conflict of interest prior to the appointment and that any future business interests that could result in a conflict are reported.
- Ensure that the Trust has an appropriate policy in place to check that proposed Board appointees and existing Board members comply with the requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

3.2. Renumeration

- Establish and keep under review a remuneration policy in respect of all Very Senior Managers.
- When setting the remuneration policy for Very Senior Managers, ensure it is in line with pay and employment conditions across the Trust and the wider NHS, and that it is benchmarked against other trusts of comparable scale and complexity.
- Within the terms of the agreed policy and in consultation with the Chief Executive, approve the total individual remuneration package of each Very Senior Manager.
- In accordance with all relevant laws, regulations and trust policies, approve and keep under review the terms and conditions of office of Very Senior Managers, including:
    - Salary, including any performance-related pay or bonus;
    - Provisions for other benefits, including pensions and cars;
    - Allowances;
    - Payable expenses;
    - Compensation payments.
- In adhering to all relevant laws, regulations and Trust policies establish levels of remuneration which are sufficient to attract, retain and motivate Very Senior Managers of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust.
- Approve the performance targets for any performance related pay schemes and authorise payments against those targets.
- The Committee will receive a report from the Chair of the Trust Board on the outcome of the annual assessment of the performance of the Chief Executive prior to its submission to NHS Improvement. The Committee will consider this outcome when reviewing changes to the Chief Executive's remuneration.
- The Committee will receive a report from the Chief Executive on the outcome of the annual assessment of the performance of the individual executive directors and will consider this outcome when reviewing changes to individual director's remuneration levels.
- Monitor and assess the output of the evaluation of the performance of individual Executive Directors, and consider this output when reviewing changes to remuneration levels.

- Advise upon and oversee contractual arrangements for Very Senior Managers, including but not limited to termination payments to avoid rewarding poor performance.

- Where appropriate, authorise any severance payments including redundancy payments, settlements and compromise agreements as determined within current NHS rules, ensuring that they are fair to both the individual and the organisation.

- Oversee compliance when appointing board members at salaries above the upper limits as set out in national NHS guidance.

- When appointing interim board members and senior officials to fill roles with significant responsibility, ensure compliance with national NHS guidance.

4. Membership

4.1. Members of the Committee shall comprise:

- The Joint Chair of NBT and UHBW
- All Non-Executive Directors of each Board

4.2. In the absence of the Joint Chair or where the Joint Chair has a conflict of interest, the Vice Chair of each Trust will chair the meeting in respect of each Trust's Committee. In the absence of the Vice Chair, another Non-Executive Director will be nominated by the Joint Chair in respect of each Trust's Committee.

5. Quorum and Attendees

5.1. The quorum necessary for the transaction of business shall be;

- The Chair of the Committee
- At least 3 Non-Executive Directors

5.2. In addition to members of the Committee, the following shall normally attend all meetings, at the invitation of the Committee:

- Chief Executive Officer
- Chief People Officer
- Director of Corporate Governance/ Trust Secretary

6. Frequency

6.1. The Committee shall meet a minimum of 3 times per annum.

6.2. Additional meetings may be called at the request of the Chair.

7. Authority

7.1. The Committee is authorised:

- to act within its terms of reference
- to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.
- to obtain such internal information as is necessary and expedient to the fulfilment of its functions. All members of staff are directed to co-operate with any request made by the Committee.

8. Meeting administration

8.1. The Trust Secretariat shall act as the secretary of the Committee.

8.2. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members.

9. Reporting

9.1. The Committee shall make whatever recommendations to the Trust Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

9.2. The Chair on behalf of the Committee shall make a statement in the annual report about its activities and the process used to decide remuneration.

9.3. The Committee will conduct an annual review of its effectiveness.

Version XX

Date Approved: XX

Date of Next Review Date: XX

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Audit Committee

Terms of Reference

1. Constitution

1.1. The Audit Committee is constituted as a standing Committee of each of the University Hospitals Bristol and Weston NHS Foundation Trust Board of Directors and the North Bristol NHS Trust Board of Directors (hereafter collectively referred to as "the Boards"). The Audit Committee (hereafter referred to as "the Committee") operates as Committees in Common of both Boards.

1.2. The Committee has no executive powers, other than those specifically delegated by the Boards in these Terms of Reference which are incorporated within each Trust's Standing Orders.

2. Purpose

2.1. The Committee is responsible for assuring the Board on matters concerning:

- Governance including financial governance, corporate governance and clinical and non-clinical audit
- Risk management, and
- Internal control - seeking assurance from internal and external audit and counter fraud.

3. Duties

3.1. Governance, Risk Management and Internal Control

The Committee will;

- Seek assurance that the Trust's activities are efficient, effective and represent value for money – including reviewing the establishment and maintenance of an effective system of internal control that supports the achievement of the Trust's objectives
- Seeking assurance that the Trust complies with regulation and information is triangulated with independent sources prior to recommendation to the Board for approval.
- Test the effectiveness of the use of the Board Assurance Framework
- Seek assurance that appropriate governance arrangements have been implemented to support the organisation operating in the emerging Integrated Care Systems and Integrated Care Partnerships

3.2. Internal Audit

The Committee will:

- Ensure there is an effective internal audit function that meets the relevant audit standards and provides appropriate independent assurance to the Committee, Chief Executive and Board.
- Receive and review the Head of Internal Audit Opinion, prior to Board approval

3.3. External Audit

The Committee will:

- In accordance with the Local Audit and Accountability Act 2014, establish an 'Auditor Panel' to advise on the appointment of external auditors (membership of the panel will be approved by the Board). For an NHS Trust, the Panel shall recommend the appointment of external auditors to the Board. For an NHS Foundation Trust, the Panel shall make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the Trust's External Auditor.

- Review and monitor the work and findings of the external auditor and consider the implications and management's responses to their work.
- Consider of the provision of the external audit service - including the performance, cost, seeking assurance that the audit function remains independent, and of any questions of resignation and dismissal
- Agree the Letter of Representation before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management response
- Agree any non-audit services conducted – agreeing acceptable thresholds and safeguards. Any such work will be disclosed within the Annual Report

3.4. Financial Reporting

The Committee will

- Receive assurances from management on financial matters
- Monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance
- Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board

3.5. Whistleblowing /Freedom to Speak Up

The Committee will, on a three yearly basis

- Review the effectiveness of the Trust's arrangements for its employees to raise concerns
- Ensure that arrangements allow proportionate and independent investigation of such matters and appropriate follow up action

3.6. Counter Fraud

The Committee will

- Satisfy itself that the Trust has adequate arrangements in place for countering fraud, bribery and corruption
- Review the outcomes of counter fraud work and investigations- seeking assurance that management are addressing any gaps in internal controls and are progressing actions to meet recommendations made
- Ensure that the Trust has appropriate policies and procedures for all work related to fraud, bribery and corruption

3.7. Other Assurance Functions

The Committee will:

- Review the findings of other significant assurance reviews, both internal and external to the Trust, and consider the implications for the governance of the Trust (e.g. from regulators /inspectors etc)
- Receive updates on progress made towards the achievement of clinical audits and receive the Annual Clinical Audit Report and Annual Audit Plan
- Receive the Trust's Charity Annual Accounts and Report

4. Membership

4.1. Members of the Committee shall be appointed by the Board and shall comprise;

- Non-Executive Director Chair
- the Non-Executive Director Chairs of the Board's Committees

4.2. At least one of whom shall have recent and relevant financial experience.

4.3. The Chair of the Trust Board shall not be a member of the Committee.

4.4. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5. Quorum and Attendees

5.1. The quorum necessary for the transaction of business shall be:

- 2 Non-Executive Directors (including the Chair or their designated deputy)

5.2. The following officers will have an open invitation to each meeting, unless otherwise informed by the Committee Chair (or when the Committee meets privately):

- Chief Executive
- Chief Finance Officer
- Representatives from Internal Audit, External Audit and Counter Fraud
- Director of Corporate Governance
- Independent Freedom to Speak Up Guardian (FTSU)

5.3. The Head of Internal Audit, representative of external audit, Counter Fraud Specialist and FTSU Guardian have a right of direct access to the Chair of the Committee.

6. Frequency

6.1. The Committee shall meet:

- At least on a quarterly basis at appropriate times in the reporting and audit cycle and otherwise as required.
- In private with external and internal audit representatives without any member of the executives present on at least one occasion each year

6.2. The Chief Executive, external auditors or internal auditors may request an additional meeting if they consider that one is necessary.

7. Authority

7.1. The Committee is authorised:

- to investigate any activity within its terms of reference
- to seek any information required from any employee of the Trust in order to perform its duties, and to direct all employees to cooperate with any requests made by the Committee
- to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and
- to call any employee to be questioned at a meeting of the Committee as and when required
- to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8. Meeting administration

8.1. The Trust Secretariat shall act as the secretary of the Committee

8.2. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members

9. Reporting

9.1. An exception report will be provided to the Board via the Committee chair – highlighting business transacted and making any recommendations as deemed appropriate within the remit of the Committee.

9.2. Following scrutiny, the Committee will recommend to the Board the approval of the Accounts, Annual Report, Annual Governance Statement, Letter of Representation, Quality Account and the Annual Clinical Audit report.

9.3. The Committee shall make necessary recommendations to the Board on areas relating to the appointment, re-appointment and removal of auditors and terms.

9.4. The Committee will conduct an annual review of its effectiveness.

Version XX

Date Approved: XX

Date of Next Review Date: XX

Appendix 10 – Proposed Committee Membership

Note this is based on current Committee membership, with the exception of the Digital Committee which is new.

Membership	Non-Executive		Executive	
	UHBW	NBT	UHBW	NBT
People Committee	Linda Kennedy (Chair) Marc Griffiths Roy Shubhabrata Rosie Benneyworth Arabel Bailey	Kelvin Blake (Chair) Kelly Macfarlane Jane Khawaja	Chief People Officer Chief Medical Officer Chief Financial Officer Executive Managing Director, WGH	Chief People Officer Chief Nursing Officer Chief Medical Officer Chief Finance Officer
Digital Committee	Roy Shubhabrata (Chair) Arabel Bailey	Richard Gaunt (Chair) Shawn Smith	Chief Digital Information Officer Chief Financial Officer Chief Nurse and Midwife	Chief Digital Information Officer Chief Finance Officer Chief Medical Officer
Quality & Outcomes Committee	Sue Balcombe (Chair) Marc Griffiths Rosie Benneyworth Susan Hamilton (Associate)	Sarah Purdy (Chair) Kelly Macfarlane Shawn Smith	Chief Nurse and Midwife Chief Medical Officer Chief Operating Officer	Chief Nurse Chief Medical Officer Chief Operating Officer
Finance & Estates Committee	Martin Sykes (Chair) Anne Tutt Roy Shubhabrata Arabel Bailey	Richard Gaunt (Chair) Kelly Macfarlane Kelvin Blake	Chief Financial Officer Chief Digital Information Officer Chief Operating Officer	Chief Finance Officer Chief Operating Officer Chief Digital Information Officer
Remuneration	Joint Chair (Chair) All NEDS	Joint Chair (Chair) All NEDS	N/A	N/A
Audit Committee	Ann Tutt (Chair) Committee Chairs	Shawn Smith (Chair) Richard Gaunt Kelvin Blake	N/A	N/A
Charity Committee		Richard Gaunt (Chair) Kelvin Blake		Chief Finance Officer Chief People Officer Chief Nursing Officer

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public		
Date of Meeting:	8 April 2025		
Report Title:	Key Governance Documents		
Report Author:	Eric Sanders, Joint Chief Corporate Governance Officer Xavier Bell, Joint Chief of Staff Jamie Foster, Hill Dickinson LLP Catherine Cookson, Head of Finance – Financial Services and Assurance, UHBW Patrick O'Brien, Assistant Director of Finance, NBT		
Report Sponsor:	Ingrid Barker, Joint Chair		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		
	To present the Trust's Standing Orders and Standing Financial Instructions to the Boards for approval.		

Key Points to Note *(Including any previous decisions taken)*

A thorough and robust review of the UHBW Constitution, NBT Standing Orders and both Trusts' Standing Financial Instructions has been completed to support the implementation of the Group.

The review has been supported by Hill Dickinson LLP and colleagues from finance.

The Boards have already considered the changes to the Standing Orders for the Board of Directors in the UHBW Constitution and Standing Orders for NBT at its meeting on 5 February 2025, and these are now presented for approval in public.

Following discussions with Governors, the Standing Orders for the Council of Governors have also been updated to ensure they are consistent with the same for the Board of Directors.

A set of principles has informed the review to ensure clarity, consistency and where possible, simplicity in the documentation to support operation as a Group.

The Chief Financial and Chief Finance Officers have been involved in the review of the Standing Financial Instructions, and the Trust's Audit Committee Chairs have been updated on the process and approach.

The changes are legally compliant, and no new risks have been identified because of the review and changes made. The implementation of the changes will be reviewed to ensure no unintended consequences arise. If issues are identified, then these will be flagged to the Board alongside any proposed changes.

Strategic and Group Model Alignment

The alignment of the Trusts' governance documents will support the delivery of the group governance arrangements, to ensure that arrangements for decision making are consistent. It also recognises that there are some areas which need to be different, and these are clearly identified in the documents.

Risks and Opportunities
The comprehensive review has made a large number of changes to the documents, and these will need to be communicated to key individuals to ensure they are aware of the changes. There are no new significant risks created or identified because of the review. The main opportunity is to ensure alignment of governance across the Trusts to support the delivery of the Group Benefits Case and Joint Clinical Strategy.
Recommendation
This report is for **Approval.** The UHBW Board is asked to: • Approve the UHBW Standing Orders for the Board of Directors, Standing Orders for the Council of Governors and the Standing Financial Instructions The NBT Board is asked to: • Approve the NBT Standing Orders and Standing Financial Instructions

History of the paper (details of where paper has <u>previously</u> been received)	
Board to Board	5 February 2025
Appendices:	Appendix 1 – UHBW Standing Orders for the Board of Directors Appendix 2 - UHBW Standing Orders for the Council of Governors Appendix 3 – NBT Standing Orders Appendix 4 – Aligned Standing Financial Instructions - UHBW Appendix 5 - Aligned Standing Financial Instructions - NBT

1. Purpose

1.1 To present the following key governance documents to the Boards for approval in support of the group governance arrangements:

- UHBW Standing Orders for the Council of Governors and Standing Orders for the Board of Directors
- NBT Standing Orders
- UHBW and NBT Standing Financial Instructions

2. Background

2.1 The Trusts, as two separate legal entities, with different legal forms, have different governing documents which describe how the organisations will operate. As an NHS Foundation Trust, UHBW has a Constitution, which incorporates the Standing Orders (SOs). NBT as an NHS Trust only requires a set of Standing Orders. Both Trusts then have Standing Financial Instructions (SFIs).

2.2 Both the Constitution and the NBT SOs must meet the legal requirements as set out in the NHS Act 2006 and 2012, and other legislation, as well as their Establishment Orders.

2.3 The Standing Financial Instructions are for Trusts to determine and have no direct legislative requirements.

3. Review Principles

3.1 To inform the review, the following principles were followed:

- The documents would be aligned so they were as consistent as possible.
- Only in exceptional circumstances would the Trusts deviate from an aligned approach i.e. by the nature of their legal form.
- Documents would be simplified where possible.
- The documents would be aligned so that all sections were numbered the same, so could easily be cross referenced.
- Unnecessary detail would be removed from these documents and included in the Scheme of Delegation or Trust policies.
- Once implemented, the documents will be subject to regular review to ensure they are meeting the requirements of the Group.

4. Summary of the Review Process

4.1 In order to update the documents, the following process has been completed with the support of Jamie Fister, Partner, Hill Dickinson LLP.

Constitution and Standing Orders

4.2 The Directors of Corporate Governance with Jamie Foster considered the two documents and identified that the UHBW Standing Orders (SOs) were a clearer and simpler version on which to base the NBT SOs.

4.3 The documents were then compared and updated to reflect current legislative requirements and best practices, as well as to further simplify in line with the agreed principles.

4.4 The proposed changes were presented to the Board in Common on 5 February 2025 and a summary shared with the Governors. The changes were broadly as follows:

- Adopting consistent definitions
- Alignment of notice periods for calling meetings of the Board(s)
- Recognition that decisions are rarely taken by vote, and that consensus decisions are sought in the first instance
- Streamlining wording on “declarations of interest”, with reference to the current NHSE guidance on this topic (avoiding the risk that the SOs fall out of date as the guidance is updated)

4.5 Changes were supported by the Boards and the Governors.

4.6 Jamie Foster has confirmed that the changes made to the documents meet current legislative requirements.

4.7 Following feedback from the Governors on the Standing Orders for the Board of Directors, the same changes to how timescales were referenced has also been made to the Standing Orders for the Council of Governors.

4.8 The final version of the UHBW Standing Orders for the Board of Directors, the Standing Orders for the Council of Governors, and NBT Standing Orders are presented in Appendix 1, 2 and 3 respectively. If the UHBW Board approve the Standing Orders, the changes will be presented to the Council of Governors for approval. No further action is required for the NBT SOs following approval by the NBT Board.

Standing Financial Instructions (SFIs)

4.9 The review of the SFIs has been more complicated due to the size, complexity and greater variation in the two sets of SFIs. The Directors of Corporate Governance, with colleagues in finance, reviewed the existing SFIs and agreed to use the NBT version as the base, given they were simpler and clearer.

4.10 The document was then reviewed and updated to reflect current legislation, particularly in relation to procurement, key elements from the UHBW SFIs were included, and more general updates in line with the principles were agreed.

4.11 Several meetings were held to consider each section and paragraph in turn and ensure that both UHBW and NBT colleagues were supportive of the amendments. In addition, meetings were also held with the Trusts Chief Financial Officers to agree the approach and update on progress. Finally, a discussion was held with the Trust’s Audit Chairs to ensure they were sighted on the approach and were assured by the process undertaken.

4.12 There are a large number of changes to the SFIs and therefore it is not possible to describe these in detail, however the changes are not deemed to be high risk nor to significantly change how the organisations operate; rather, they simplify, streamline, and align arrangements.

4.13 The final version of the Standing Financial instructions is presented in Appendix 3. Please note that only one version is presented to the Board as the same version applies to both organisations.

4.14 It is important to consider that all the documents will need to be regularly reviewed to ensure they are achieving the desired outcomes and are supporting the delivery of the

group governance arrangements. If any issues are identified, these will be reported to the Board with proposed changes,

5. Recommendations

5.1 The UHBW Board is asked to:

- Approve the UHBW Standing Orders for the Board of Directors, Standing Orders for the Council of Governors and the Standing Financial Instructions

5.2 The NBT Board is asked to:

- Approve the NBT Standing Orders and Standing Financial Instructions

UHBW CONSTITUTION ANNEX 5 STANDING ORDERS DIRECTORS

JANUARY 2025

Note:

This is an updated version of UHBW's Standing Orders, which forms part of UHBW's Constitution.

NBT's Standing Orders are in the same format and the numbering is aligned in both NBT's and UHBW's documents. UHBW-specific terms appear at the end of sections.

ANNEX 5: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

INTRODUCTION

University Hospitals Bristol and Weston NHS Foundation Trust (the Trust) is a public benefit corporation established under the National Health Service Act 2006.

These Standing Orders form part of the Trust's Constitution in accordance with the 2006 Act.

1 INTERPRETATIONS AND DEFINITIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive).

1.2 For convenience, and unless the context otherwise requires, the terms and expressions contained within the Interpretations and Definitions section of the Constitution at page 4 are incorporated and are deemed to have been repeated here verbatim for the purposes of interpreting words contained in this Annex 5 and in addition:

2006 ACT	means the National Health Services Act 2006.
2022 ACT	means the Health and Care Act 2022.
ACCOUNTING OFFICER	means the officer with responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matter, in accordance with the 2006 Act.
AUDIT COMMITTEE	means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework.
CHIEF EXECUTIVE OFFICER	is the chief officer of the Trust and the Accounting Officer and holds the role of Joint Chief Executive of both University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust.

COMMISSIONING	means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
COMMITTEE	means a committee or sub-committee appointed by the Trust
COMMITTEE MEMBERS	shall be persons formally appointed by the Trust to sit on or to chair specific committees.
CONTRACTING AND PROCURING	means the systems for 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.
DIRECTORS	means the Executive Directors and the Non-Executive Directors
EXECUTIVE DIRECTOR	means is an officer of the Trust.
FUNDS HELD ON TRUST	means 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 Schedule 6, paragraph 8 of the 2006 Act. Such funds may or may not be charitable.
GROUP	means the hospital group established by the Trust and North Bristol Trust.
HOSPITAL MANAGING DIRECTOR	means the Executive Director who provides day-to-day leadership and line management of the executive team, reporting to the Chief Executive Officer.
NHS ENGLAND	means the body which is responsible for the oversight of NHS Foundation Trusts.
NOMINATED OFFICER	means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and standing financial instructions.
NON-EXECUTIVE DIRECTOR	means a person who is appointed to the Board of Directors who is not an Executive Director.
OFFICER	means an employee of the Trust or any other person holding a paid appointment or office with the Trust.
SFIs	means Standing Financial Instructions
SOs	means Standing Orders
VOLUNTARY ORGANISATION	means a body, other than a public or local authority, the activities of which are not carried on for profit.

2 **THE BOARD**

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.3 The power of the Trust shall be exercised in public or private session as provided for in SO item 4.

2.4 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Schedule of Matters reserved to the Board and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3 MEMBERSHIP OF THE BOARD

3.1 The terms of the Trust's Constitution shall apply.

4 MEETINGS OF THE BOARD

4.1 **Admission of the Public and the Press** – The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

4.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO item 4.1 above, the Chair (or Vice 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 such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "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".

4.3 The Board of Directors may agree further provisions in respect of the admission of the public and the press, to be set out in a policy.

4.4 **Observers at Board Meetings** – The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

4.4.1 The Trust may appoint Associate Non-Executive Directors to the Board of Directors on such terms as the Board of Directors may direct. Associate Non-Executive Directors) will attend Board of Director meetings and relevant Committee meetings at the discretion of the Chair and will play an active role in such meetings by providing advice and appropriate challenge across the range of Trust healthcare services and supporting business areas. For the avoidance of doubt, Associate Non-Executive Directors are not formally appointed as members of the Board of Directors and, should circumstances arise, will not be eligible to vote.

4.5 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committees. Such permission shall be granted only upon resolution of the Trust.

4.6 **Calling of Meetings** – Ordinary meetings of the Board shall be held at such times and places as the Board determines.

4.7 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

4.8 **Notice of Meetings** – Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or

sent by post to the usual place of residence of such Director or sent electronically to the usual e-mail address of the director, or circulated via an agreed online board paper portal, so as to be available to them at least three working days before the meeting.

4.9 Want of service of the notice on any Director shall not affect the validity of a meeting.

4.10 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO item 4.20.1.

4.11 Agendas will normally be sent to members of the Board five working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three working days before the meeting, save in emergency. Failure to serve such a notice on more than three Directors will invalidate 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.

4.12 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least three working days before the meeting.

4.13 **Setting the Agenda** – The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders).

4.14 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least five working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than five working days before a meeting may be included on the agenda at the discretion of the Chair.

4.15 **Chair of Meeting** – At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and they are present, shall preside. If the Chair and Vice Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

4.16 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

4.17 **Notices of Motion** – A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least five working days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chief Executive shall insert in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. Subject to SO item 4.20.1, this paragraph shall not prevent any motion being moved during the meeting without notice on any business mentioned on the agenda.

4.18 **Withdrawal of Motion or Amendments** – A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.19 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall be made in writing by the Director who gives it and four other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if they

consider it appropriate. This Standing Order item 4.19 shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

4.20 **Motions** – A motion may be proposed by the Chair or any Director present at the meeting. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

Emergency Motions

4.20.1 Subject to the agreement of the Chair and SO item 4.21 below, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda (by reason of SO item 4.8 and SO item 4.11), up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

4.21 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

4.21.1 an amendment to the motion.

4.21.2 the adjournment of the discussion or the meeting.

4.21.3 that the meeting proceeds to the next business*.

4.21.4 the appointment of an ad hoc committee to deal with a

specific item of business.

4.21.5 that the motion be now put*.

4.21.6 that a Director be not further heard*.

4.21.7 that the public be excluded pursuant to SO item 4.1,

and in the case of sub-paragraphs denoted by (*) above, to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote.

4.22 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

4.23 The Chair may (at their discretion) refuse to admit any motion of which notice was not given in accordance with SO item 4.17, other than a motion relating to:

4.23.1 the reception of a report.

4.23.2 consideration of any item of business before the Trust

Board.

4.23.3 the accuracy of minutes.

4.23.4 that the Board proceed to next business.

4.23.5 that the Board adjourn.

4.23.6 that the question be now put.

4.24 **Chair's Ruling** – Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the

material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matter shall be final.

4.25 **Voting** – The Board shall aim to make decisions through discussion and by consensus. It is not a requirement for all decisions to be subject to a vote. The Chair of the meeting at which any particular decision is to be taken shall be responsible for determining whether a vote is required and what form this will take. Where the Chair determines that a vote should take place, the decision put to a vote shall be determined by a majority of the votes of the Chair and Directors present and voting on the question and, in the case of the number of votes for and against being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

4.26 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 also be used if the Chair so directs, or it is proposed and seconded by any of the Directors present.

4.27 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.28 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

4.29 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

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

4.31 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.

4.32 **Minutes** – The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

4.33 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.34 Minutes shall be circulated in accordance with Director wishes. Where providing a record of a meeting in public the minutes shall be made available to the public.

4.35 **Joint Directors** – Where the Office of a Director is shared jointly by more than one person:

4.35.1 either or both of those persons may attend or take part in meetings of the Board.

4.35.2 if both are present at a meeting, they should cast one vote if they agree.

4.35.3 in the case of disagreements, no vote should be cast.

4.35.4 the presence of either or both of those persons should count as the presence of one person for the purposes of SO item 4.42 (Quorum).

4.36 **Suspension of Standing Orders** – Except where it would contravene any statutory provision or any provision in the Constitution or any direction made by the Secretary of State for Health and Social Care or NHSE, any one or more of the Standing Orders may be suspended at any

meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and at least two-thirds of those present vote in favour of suspension.

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

4.38 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

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

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

4.41 **Record of Attendance** – The names of the Chair and Directors present at the meeting shall be recorded in the minutes. 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.

4.42 **Quorum** – No business shall be transacted at a meeting unless at least one half of the whole number of the voting Chair and Directors appointed are present (including at least two Non-Executive Directors and one Executive Director, and a majority of Non-Executive Directors).

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

4.44 If the Chair or Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 7 or 8) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board considers the recommendations of the Remuneration and Nominations Committee).

5 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 Subject to the Constitution, or any relevant statutory provision and any directions as may be given by the Secretary of State for Health and Social Care, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions in each case subject below to such restrictions and conditions as the Trust thinks fit:

5.1.1 By a committee or sub-committee.

5.1.2 Appointed by virtue of Standing Order item 6.1 or 6.2 below, or by an Officer of the Trust.

5.1.3 By another body, subject to Standing Order item 5.2 below.

5.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. Upon delegation to committees, sub committees or Officers or third parties, the Trust retains full responsibility.

5.3 **Emergency Powers** – The powers which the Board has retained to itself within these Standing Orders (Standing Order item 2.4) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

5.4 **Delegation to Committees** – The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees,

or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.5 **Delegation to Officers** – Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust 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 an accountability to the Trust.

5.6 **Scheme of Delegation:** The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board as indicated above.

5.7 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Financial Officer to provide information and advise the Board in accordance with statutory or NHS England requirements. Outside these requirements, the roles of the Chief Financial Officer shall be accountable to the Chief Executive for operational matters.

5.8 The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

5.9 **Overriding Standing Orders** – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6 COMMITTEES

6.1 Subject to the Constitution, (and to any guidance issued by the Department of Health and Social Care or by NHS England), the Trust may appoint committees of the Trust, or together with one or more other bodies as defined in the 2022 Act, appoint joint committees.

6.2 A committee or joint committee appointed under SO item 6.1 may, subject to such directions as may be given by the Trust or other health service bodies in question, appoint sub-committees consisting wholly or partly of members of the committee or joint committee (whether or not they are members of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

6.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees, joint committees and sub-committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee, joint committee or sub-committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. There is no requirement to hold meetings of committees, joint committees and sub-committees established by the Trust in public.

Each such committee, joint committee and sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

6.4 The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute or assist it in the exercise of its powers. It may delegate powers to such committees only if the membership consists wholly of Directors.

6.5 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

6.6 The Board shall approve the appointments to each of the committees, joint committees and sub-committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee, joint committee or sub-committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

6.7 Where the Board is required to appoint persons to a committee, joint committee or sub-committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Constitution, the Terms of Reference and any applicable regulations and directions.

6.8 The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

7 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

7.1 **Declaration of Interests** – The Constitution, the 2006 Act, the Code of Governance for NHS provider trusts and the Managing conflicts of interest in the NHS guidance, as updated or superseded from time to time, require the Board Directors to declare interests which are relevant and material to the NHS board of which they are a Director. All existing Board Directors and other decision-making staff should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

7.2 Interests are as defined in NHSE's Managing conflicts of interest in the NHS guidance.

7.3 At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

7.4 Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

7.5 If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Director of Corporate Governance. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.6 **Register of Interests** – The Chief Executive will ensure that a Register of Interests is established to record formal declarations of interests of Board Directors. In particular, the register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order item 7.1.

7.7 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding 12 months will be incorporated.

7.8 The Register will be available to the public in accordance with paragraph 36 and 37 of the Constitution.

7.9 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact the Corporate Governance Team for clarification.

7.10 With the exception of the requirement to report interests in the Annual Report (Standing Order 7.4), 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).

8 DISABILITY OF CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

8.1 Subject to the following provisions of this Standing Order, if the Chair or 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 or 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.

8.2 The Board may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

8.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

8.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO item 8.5, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

8.4.1 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

8.4.2 they are a partner/associate 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;

8.4.3 and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

8.5 The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

8.5.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

8.5.2 of an interest in any company, body or person with which they are connected as mentioned in SO item 8.4 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.

8.6 Where the Chair or a Director has 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 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 body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit them from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

8.7 This SO item 8 applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a Director of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

9 STANDARDS OF BUSINESS CONDUCT POLICY

9.1 Staff should comply with national guidance concerning standard of business conduct including as applicable NHS England's "Standards of Business Conduct for NHS Staff", as may be updated or superseded from time to time.

9.2 **Interests of staff** - All staff shall declare any relevant and material interest, including those described in Standing Order 7. 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.

9.3 **Interest of Officers in Contracts** – If it comes to the knowledge of an Officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they themselves are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive or the Director of Corporate Governance of the fact that they are interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

9.4 An Officer should also declare to the Chief Executive any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

9.5 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

9.6 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.

9.7 **Canvassing of and Recommendations by, Directors in Relation to Appointments** – Canvassing of Directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of Standing Order item 9 shall be included in application forms or otherwise brought to the attention of candidates.

9.8 A Director of the Board shall not solicit for any person any

appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order item 9 shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

9.9 **Relatives of Directors or Officers** – Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

9.10 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

9.11 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

9.12 Where the relationship to a Director of the Trust is disclosed, the Standing Order headed `Disability of Chair and Directors in proceedings on account of pecuniary interest' (SO item 8) shall apply.

10 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

10.1 **Custody of Seal** – The Common Seal of the Trust shall be kept by the Chief Executive or designated Officer in a secure place.

10.2 **Sealing of Documents** – The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers. Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Directors; OR, one Director and the Director of Corporate Governance; OR two senior managers (not being from the originating department) duly authorised by the Chief Executive, and shall be attested by them.

10.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Financial Officer (or an Officer nominated by him) and authorised and countersigned by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate).

10.4 **Register of Sealing** – An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board at least quarterly. (The report shall contain details of the seal number, a description of the document and the date of sealing).

11 SIGNATURE OF DOCUMENTS

11.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

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

11.3 Unless there is a requirement for sealing, the Chief Executive or nominated officers shall also be authorised, by resolution of the Board, to execute any agreement or other document (the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority) as a deed on behalf of the Trust by signing in the physical presence of an attesting witness. Before any deed relating to building, engineering, property, or capital is executed as a deed in this way, it must be approved and signed by the Chief Financial Officer (or an Officer nominated by him) and authorised and countersigned by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate).

11.4 Unless there is a specific requirement for a physical seal or wet ink signature, any signature under SO Item 11.1, 11.2 or 11.3 above may be provided in electronic form and shall not be invalid on this basis.

12 MISCELLANEOUS

12.1 **Standing Orders to be given to Directors and Officers** – It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within Standing Orders and standing financial instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

12.2 **Documents having the standing of Standing Orders** – standing financial instructions (including provisions as to tendering and contract procedures, disposals and in-house services), Schedule of Matters reserved to the Board and Scheme of Delegation, the Policy on the Register of Interests, Gifts and Hospitality and the Staff Disciplinary and Appeals Procedures

document shall be read in conjunction with the Standing Orders. The Board may also, from time to time, agree and approve policy statements/procedures which will apply to all, or specific groups of staff employed by the Trust.

12.3 **Review of Standing Orders** – Standing Orders shall be reviewed annually by the Board and any requirements for amendments must be directed to both the Board of Directors and the Council of Governors. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

12.4 The Board may confirm contracts to purchase from a voluntary organisation or a local authority using appropriate powers under the 2006 Act and shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with this Act.

ANNEX 4: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

INTERPRETATION AND DEFINITIONS

1.1 In these Standing Orders (SOs), the provisions relating to Interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning and in addition:

2006 ACT	means the National Health Services Act 2006.
ACCOUNTING OFFICER	means the officer with responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matter, in accordance with the 2006 Act.
APPOINTED GOVERNORS	means the Governors who are appointed in accordance with the Constitution.
CHIEF EXECUTIVE OFFICER	means the chief officer of the Trust and the Accounting Officer and holds the role of Joint Chief Executive of both University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust.
COMMITTEE	means a committee or sub-committee appointed by the Trust.
COUNCIL OF GOVERNORS	means the council comprising the Elected Governors and the Appointed Governors.
DIRECTORS	means the Executive Directors and the Non-Executive Directors.
ELECTED GOVERNORS	means the Governors who are elected in accordance with the Constitution.
EXECUTIVE DIRECTOR	means is an officer of the Trust.
NON-EXECUTIVE DIRECTOR	means a person who is appointed to the Board of Directors who is not an Executive Director.
SOs	means Standing Orders.
STAFF CONSTITUENCY	means the staff constituency constituted in accordance with the Constitution.

MEETINGS OF THE COUNCIL OF GOVERNORS

Calling Meetings:

1.2 Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Trust's website. Notice shall be presumed to have been served two days after posting and one day after being sent out via email or portal. The Secretary shall ensure that within the meeting cycle of the Council of

Governors, general meetings are called at appropriate times to consider matters as required by the 2006 Act and the Constitution.

1.3 If the Chair fails to call a meeting of the Council of Governors after a requisition for that purpose, signed by at least one-third of the whole number of the Council of Governors has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them at the Trust's Headquarters, such one third or more members of the Council of Governors may forthwith call a meeting.

1.4 **Admission of the Public and the Press**– The meetings of the Council of Governors shall be open to members of the public and press unless the Council of Governors decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Council of Governors following the exclusion of members of the public and/or press shall be confidential to the members of the Council of Governors. Governors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

1.5 In the event that the public and press are admitted to all or part of a meeting by reason of SO item 1.4 above, the Chair (or Vice 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 such as to ensure that the Council's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Council of Governors resolving "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".

1.6 The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Council of Governor meetings.

1.7 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Council of Governors. Such permission shall be granted only upon resolution of the Trust.

1.8 The Council of Governors may agree further provisions in respect of the admission of the public and the press, to be set out in a policy.

1.9 **Chair of Meetings** – The Chair of the Trust, or in their absence, the Vice Chair, is to preside at meetings of the Council of Governors.

1.10 The Vice Chair may preside at meetings of the Council of Governors in the following circumstances:

1.10.1 When there is a need for someone to have the authority to chair any meeting of the Council of Governors when the Chair is not present.

1.10.2 On those occasions when the Council of Governors is considering matters relating to Non-Executive Directors and it would be inappropriate for the Chair to preside.

1.10.3 When the remuneration, allowance and other terms and conditions of the Chair are being considered.

1.10.4 When the appointment of the Chair is being considered, should the current Chair be a candidate for re-appointment.

1.10.5 On occasions when the Chair declares a pecuniary interest that prevents them from taking part in the consideration or discussion of a matter before the Council of Governors.

1.11 **Setting the Agenda –** The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

1.12 **Agenda** – A Governor desiring a matter to be included on an agenda shall specify the question or issue to be included by request in writing to the Chair or Secretary at least five working days before Notice of the meeting is given. Requests made less than five working days before the Notice is given may be included on the agenda at the discretion of the Chair. Agendas will normally be sent to members of the Council of Governors five working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three working days before the meeting, save in emergency.

1.13 **Notices of Motion** – A Governor desiring to move or amend a motion shall send a written notice thereof at least five working days before the meeting to the Chair or Secretary, who shall insert in the agenda for the meeting all notices so received subject to the Notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without Notice on any business mentioned on the agenda, subject to the Chair's discretion.

1.14 **Withdrawal of Motion or Amendments** – A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

1.15 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall be in writing by the Governor who gives it and also four other Governors. When any such motion has been disposed of by the Council of Governors, it shall not be competent for any Governor other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

1.16 **Motions** – The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

1.17 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

1.17.1 An amendment to the motion.

1.17.2 The adjournment of the discussion or the meeting.

1.17.3 That the meeting proceed to the next business.

1.17.4 That the motion be now put.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

1.18 **Chair's Ruling** – Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

1.19 Save as permitted by law, at any meeting the person presiding shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive).

1.20 **Voting** – Save as otherwise provided in the Constitution and/or the 2006 Act, if the Chair so determines or if a Governor requests, a question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a casting vote.

1.21 All questions put to the vote shall, at the discretion of the person presiding, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

1.22 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

1.23 If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

1.24 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

1.25 **Minutes** – The Minutes of the proceedings of a matter shall be drawn up and submitted for agreement at the next ensuing meeting.

1.26 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

1.27 **Suspension of Standing Orders** – Except where this would contravene any statutory provision, or any provision of the Constitution, any one or more of the SOs may be suspended at any meeting provided that at least two thirds of the Council of Governors are present, including one Public Governor and one Staff Governor, and that a majority of those present vote in favour of suspension.

1.28 A decision to suspend SOs shall be recorded in the minutes of the meeting.

1.29 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Governors.

1.30 No formal business may be transacted while SOs are suspended.

1.31 **Record of Attendance** – the names of the Governors present at the meeting shall be recorded in the minutes.

1.32 **Quorum** – A meeting of the Council of Governors shall be quorate and quoracy shall require that there shall be present at the meeting not less than 50% of all Governors and of those not less than 51% shall be Elected Governors (excluding those Governors representing the Staff Constituency).

1.33 A Governor who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Governor will count towards the quorum of the meeting. If a Governor has declared a pecuniary interest in any matter, the Governor must leave the meeting room, and will not count towards the quorum of the meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing or a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

1.34 Subject to SOs in relation to interests, any Director or their nominated representatives shall have the right to attend meetings of the Council of Governors and, subject to the overall control of the Chair, to speak to any item under consideration.

COMMITTEES

1.35 The Council of Governors shall exercise its functions in general meeting and shall not delegate the exercise of any function or any power in relation to any function to a committee.

DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

1.36 **Declaration of Interests** – in accordance with the Constitution, Governors are required to declare formally any direct or indirect pecuniary interest and any other interest which is relevant and material to the business of the Trust. The responsibility for declaring an interest is solely that of the Governor concerned.

1.37 A Governor must declare to the Secretary:

1.37.1 any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust, and

1.37.2 any interests which are relevant and material to the business of the Trust.

1.38 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time setting out any interests required to be declared in accordance with the Constitution or these SOs and delivering it to the Secretary within 28 days of a Governor's election or appointment or otherwise within seven days of becoming aware of the existence of a relevant or material interest. The Secretary shall amend the Register of Interests upon receipt of notification within three working days.

1.39 If a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if they have declared a pecuniary interest, they shall not take part in the consideration or discussion of the matter. The provisions of this paragraph are subject to paragraph

1.40 Interests are as defined in NHSE's Managing conflicts of interest in the NHS guidance.

1.41 Any travelling or other expenses or allowances payable to a Governor in accordance with this Constitution shall not be treated as a pecuniary interest.

1.42 Subject to any other provision of this Constitution, a Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

1.42.1 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

1.42.2 they are a partner, associate or employee of any person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the same.

1.43 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

1.43.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

1.43.2 of an interest in any company, body, or person with which they are connected as mentioned in paragraphs 4.2, 4.5 and 4.7, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

1.44 Where a Governor:

1.44.1 has 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

1.44.2 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

1.44.3 if 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 that class;

1.45 the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty discloses their interest.

1.46 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of these SOs to be also an interest of the other.

1.47 If Governors have any doubt about the relevance of an interest, this should be discussed with the Corporate Governance Team.

1.48 **Register of Interests –** the Corporate Governance Team shall record any declarations of interest made in a Register of Interests kept by the Trust in accordance with paragraph 36 of the Constitution. Any interest declared at a meeting shall also be recorded in the minutes of the meeting.

1.49 The register will be available for inspection by members of the public free of charge at all reasonable times. A person who requests it is to be provided with a copy or extract from the register. If the person requesting a copy or extract is not a member of the Trust, then a reasonable charge may be made for doing so.

STANDARDS OF BUSINESS CONDUCT

1.50 **Policy –** in relation to their conduct as a Governor of the Trust, each Governor must comply with the Code of Conduct for Governors. In particular, the Trust must be impartial and honest in the conduct of its business and its office holders and staff must remain beyond suspicion. Governors are expected to be impartial and honest in the conduct of official business.

1.51 **Interest of Governors in Contracts** – if it comes to the knowledge of a Governor that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust, they will at once give notice in writing to the Corporate Governance Team of the fact that that they are interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

1.52 A Governor shall not solicit for any person any appointment in the Trust.

REMUNERATION

1.53 Governors are not to receive remuneration.

PAYMENT OF EXPENSES TO GOVERNORS

1.54 The Trust will pay travelling expenses to Governors at the prevalent NHS Public Transport rate for attendance at General Meetings of the Governors, or any other business authorised by the Corporate Governance Team as being under the auspices of the Council of Governors.

1.55 Expenses will be authorised and reimbursed through the Director of Corporate Governance's office on receipt of a completed and signed expenses form provided by the Corporate Governance Team.

1.56 A summary of expenses paid to Governors will be published in the Trust's Annual Report.

MISCELLANEOUS

1.57 **Review of Standing Orders** – These Standing Orders shall be reviewed annually by the Council of Governors and any requirements for amendments must be approved by both the Board of Directors and the Council of Governors.

1.58 **Vice Chair** – In relation to any matter concerning the Council of Governors or a Governor outside of a meeting of the Council of Governors which arises, the Vice Chair may exercise such power as the Chair would have in those circumstances.

1.59 **Notice** – Any written notice required by these SOs shall be deemed to have been given on the day the notice was sent to the recipient.

1.60 **Confidentiality** – A Governor shall not disclose any matter reported to the Council of Governors notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors shall resolve that it is confidential.

COUNCIL OF GOVERNORS: NOMINATIONS AND APPOINTMENTS COMMITTEE

1.61 The Chair and other Non-Executive Directors shall be appointed following a process of open competition conducted in accordance with a policy to be agreed by the Council of Governors.

1.62 The Council of Governors shall establish a committee of its members to be called the Nominations and Appointments Committee ("the Committee") to discharge those functions in relation to the selection of the Chair and Non-Executive Directors described in Terms of Reference to be approved by the Council of Governors.

NORTH BRISTOL NHS TRUST STANDING ORDERS

JANUARY 2025

Note:

This is a new version of NBT's Standing Orders. It is based on UHBW's format, which is simpler than NBT's current format. There is no required template for NHS Trust Standing Orders.

Some detail from NBT's current Standing Orders has not been included – please see comments and accompanying document for further detail.

The numbering is aligned in both NBT's and UHBW's Standing Orders. NBT-specific terms appear at the end of sections.

INTRODUCTION

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) 1999.

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).

1 INTERPRETATIONS AND DEFINITIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive).

2006 ACT	means the National Health Services Act 2006.
2022 ACT	means the Health and Care Act 2022.
ACCOUNTABLE OFFICER	means 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.
AUDIT COMMITTEE	means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework.
CHIEF EXECUTIVE OFFICER	is the chief officer of the Trust and the Accountable Officer and holds the role of Joint Chief Executive of

	both North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust.
COMMISSIONING	means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
COMMITTEE	means a committee or sub-committee appointed by the Trust
COMMITTEE MEMBERS	shall be persons formally appointed by the Trust to sit on or to chair specific committees.
CONTRACTING AND PROCURING	means the systems for 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.
DIRECTORS	means the Executive Directors and the Non-Executive Directors
EXECUTIVE DIRECTOR	means an officer of the Trust, being up to five voting members of the Trust Board in number, appointed in accordance with the NHS Trusts (Membership and Procedure) Regulations 1990. The remainder will not be eligible to vote on the Trust Board.
GROUP	means the hospital group established by the Trust and University Hospitals Bristol and Weston NHS Foundation Trust.
HOSPITAL MANAGING DIRECTOR	means the Executive Director who provides day-to-day leadership and line management of the executive team, reporting to the Chief Executive Officer.
NHS ENGLAND	means the body which is responsible for the oversight of NHS Trusts and has delegated authority from the Secretary of State for Health and Social Care for the appointment of the Non-Executive Directors, including the Chair of the Trust.
NOMINATED OFFICER	means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and standing financial instructions.
NON-EXECUTIVE DIRECTOR	means a person appointed by the Secretary of State for Health and Social Care to help the Trust Board to deliver its functions.
OFFICER	means an employee of the Trust or any other person holding a paid appointment or office with the Trust.
SFIs	means Standing Financial Instructions.
SOs	means Standing Orders.

VOLUNTARY ORGANISATION	means a body, other than a public or local authority, the activities of which are not carried on for profit.

2 **THE BOARD**

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be held in the name of the Trust as corporate trustee. Further:

2.2.1 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.

2.2.2 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 and Social Care. Accountability for non-charitable funds held on trust is only to the Secretary of State for Health and Social Care.

2.3 The power of the Trust shall be exercised in public or private session as provided for in SO item 4.

2.4 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Schedule of Matters reserved to the Board and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

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

3 **MEMBERSHIP OF THE BOARD**

3.1 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.

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

3.2.1 one appointee nominated to be the Vice-Chair;

3.2.2 one appointee nominated to be the (shadow) Senior Independent Director;

3.2.3 in accordance with the Establishment Order, one appointee from the University of Bristol, in recognition of the Trust's status as a teaching hospital;

3.2.4 one or more appointees who have recent relevant financial experience.

Appointees can fulfil more than one of the roles identified.

3.3 The Executive Directors shall include:

3.3.1 Chief Executive Officer;

3.3.2 Chief Finance Officer, or equivalent;

3.3.3 Chief Medical Officer or Chief Nursing Officer;

3.3.4 Such other Executive Directors as may be appointed.

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

3.5 **Appointment of the Chair and Directors.** The Chair and Non-Executive Directors of the Trust are appointed by NHSE, on behalf of the Secretary of State for Health and Social Care. The tenure and termination and suspension of office shall be in accordance with the NHS Trusts (Membership and Procedure) Regulations 1990 (as amended).

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

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

3.8 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 3 as one person.

3.9 **Vice-Chair:** 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.

3.10 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.

3.11 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.

3.12 **Functions and roles of the Chair and Directors.** 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.

3.13 **Tenure of office.** Terms 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 NHS Trusts (Membership and Procedure) Regulations 1990 (as amended) and as directed by NHSE, under its delegated authority from Secretary of State for Health and Social Care.

4 MEETINGS OF THE BOARD

4.1 **Admission of the Public and the Press** – The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

4.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO item 4.1 above, the Chair (or Vice 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 such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "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".

4.3 The Board of Directors may agree further provisions in respect of the admission of the public and the press, to be set out in a policy.

4.4 **Observers at Board Meetings** – The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

4.4.1 The Trust may appoint Associate Non-Executive Directors to the Board of Directors on such terms as the Board of Directors may direct. Associate Non-Executive Directors will attend Board of Director meetings and relevant Committee meetings at the discretion of the Chair and will play an active role in such meetings by providing advice and appropriate challenge across the range of Trust healthcare services and supporting business areas. For the avoidance of doubt, Associate Non-Executive Directors are not formally appointed as members of the Board of Directors and, should circumstances arise, will not be eligible to vote.

4.5 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committees. Such permission shall be granted only upon resolution of the Trust.

4.6 **Calling of Meetings** – Ordinary meetings of the Board shall be held at such times and places as the Board determines.

4.7 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting. 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.

4.8 **Notice of Meetings** – Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or sent by post to the usual place of residence of such Director or sent electronically to the usual e-mail address of the director, or circulated via an agreed online board paper portal, so as to be available to them at least three working days before the meeting.

4.9 Want of service of the notice on any Director shall not affect the validity of a meeting.

4.10 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO item 4.20.1.

4.11 Agendas will normally be sent to members of the Board five working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three working days before the meeting, save in emergency. Failure to serve such a notice on more than three Directors will invalidate 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.

4.12 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least three working days before the meeting.

4.13 **Setting the Agenda** – The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders).

4.14 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least five working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than five working days before a meeting may be included on the agenda at the discretion of the Chair.

4.15 **Chair of Meeting** – At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and they are present, shall preside. If the Chair and Vice Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

4.16 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

4.17 **Notices of Motion** – A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least five working days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chief Executive shall insert in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. Subject to SO item 4.20.1, this paragraph shall not prevent any motion being moved during the meeting without notice on any business mentioned on the agenda.

4.18 **Withdrawal of Motion or Amendments** – A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.19 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall be made in writing by the Director who gives it and four other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if they consider it appropriate. This Standing Order item 4.19 shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

4.20 **Motions** – A motion may be proposed by the Chair or any Director present at the meeting. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

Emergency Motions

4.20.1 Subject to the agreement of the Chair and SO item 4.21 below, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda (by reason of SO item 4.8 and SO item 4.11), up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

4.21 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

4.21.1 an amendment to the motion.

4.21.2 the adjournment of the discussion or the meeting.

4.21.3 that the meeting proceeds to the next business*.

4.21.4 the appointment of an ad hoc committee to deal with a

specific item of business.

4.21.5 that the motion be now put*.

4.21.6 that a Director be not further heard*.

4.21.7 that the public be excluded pursuant to SO item 4.1,

and in the case of sub-paragraphs denoted by (*) above, to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote.

4.22 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

4.23 The Chair may (at their discretion) refuse to admit any motion of which notice was not given in accordance with SO item 4.17, other than a motion relating to:

4.23.1 the reception of a report.

4.23.2 consideration of any item of business before the Trust

Board.

4.23.3 the accuracy of minutes.

4.23.4 that the Board proceed to next business.

4.23.5 that the Board adjourn.

4.23.6 that the question be now put.

4.24 **Chair's Ruling** – Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the

material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matter shall be final.

4.25 **Voting** – The Board shall aim to make decisions through discussion and by consensus. It is not a requirement for all decisions to be subject to a vote. The Chair of the meeting at which any particular decision is to be taken shall be responsible for determining whether a vote is required and what form this will take. Where the Chair determines that a vote should take place, the decision put to a vote shall be determined by a majority of the votes of the Chair and Directors present and voting on the question and, in the case of the number of votes for and against being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

4.26 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 also be used if the Chair so directs, or it is proposed and seconded by any of the Directors present.

4.27 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.28 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

4.29 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

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

4.31 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.

4.32 **Minutes** – The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

4.33 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.34 Minutes shall be circulated in accordance with Director wishes. Where providing a record of a meeting in public the minutes shall be made available to the public.

4.35 **Joint Directors** – Where the Office of a Director is shared jointly by more than one person:

4.35.1 either or both of those persons may attend or take part in meetings of the Board.

4.35.2 if both are present at a meeting, they should cast one vote if they agree.

4.35.3 in the case of disagreements, no vote should be cast.

4.35.4 the presence of either or both of those persons should count as the presence of one person for the purposes of SO item 4.42 (Quorum).

4.36 **Suspension of Standing Orders** – Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHSE, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, [including one Executive Director and one Non-Executive Director], and at least two-thirds of those present vote in favour of suspension.

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

4.38 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

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

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

4.41 **Record of Attendance** – The names of the Chair and Directors present at the meeting shall be recorded in the minutes. 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.

4.42 **Quorum** – No business shall be transacted at a meeting unless at least one half of the whole number of the voting Chair and Directors appointed are present (including at least two Non-Executive Directors and one Executive Director).

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

4.44 If the Chair or Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see

Standing Order 7 or 8) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board considers the recommendations of the Remuneration and Nominations Committee).

5 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 Subject to any relevant statutory provision and any directions as may be given by the Secretary of State for Health and Social Care, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions in each case subject below to such restrictions and conditions as the Trust thinks fit:

5.1.1 By a committee or sub-committee.

5.1.2 Appointed by virtue of Standing Order item 6.1 or 6.2 below, or by an Officer of the Trust.

5.1.3 by another body, subject to Standing Order item 5.2 below.

5.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. Upon delegation to committees, sub committees or Officers or third parties, the Trust retains full responsibility.

5.3 **Emergency Powers** – The powers which the Board has retained to itself within these Standing Orders (Standing Order item 2.4) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

5.4 **Delegation to Committees** – The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.5 **Delegation to Officers** – Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust 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 an accountability to the Trust.

5.6 **Scheme of Delegation:** The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board as indicated above.

5.7 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Financial Officer to provide information and advise the Board in accordance with statutory or NHS England requirements. Outside these requirements, the roles of the Chief Financial Officer shall be accountable to the Chief Executive for operational matters.

5.8 The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

5.9 **Overriding Standing Orders** – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the

Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6 COMMITTEES

6.1 Subject any guidance issued by the Department of Health and Social Care or by NHS England, the Trust may appoint committees of the Trust, or together with one or more other bodies as defined in the 2022 Act, appoint joint committees.

6.2 A committee or joint committee appointed under SO item 6.1 may, subject to such directions as may be given by the Trust or other health service bodies in question, appoint sub-committees consisting wholly or partly of members of the committee or joint committee (whether or not they are members of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

6.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees, joint committees and sub-committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee, joint committee or sub-committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. There is no requirement to hold meetings of committees, joint committees and sub-committees established by the Trust in public.

6.4 Each such committee, joint committee and sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

6.5 The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute or assist it in the exercise of its powers.

6.6 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

6.7 The Board shall approve the appointments to each of the committees, joint committees and sub-committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee, joint committee or sub-committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

6.8 Where the Board is required to appoint persons to a committee, joint committee or sub-committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Terms of Reference and any applicable regulations and directions.

6.9 The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

7 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

7.1 **Declaration of Interests** – The 2006 Act, NHSE’s Code of Governance for NHS provider trusts and NHSE’s Managing conflicts of interest in the NHS guidance, as updated or superseded from time to time, require the Board Directors to declare interests which are relevant and material to the NHS board of which they are a Director. All existing Board Directors and other decision-making staff should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

7.2 Interests are as defined in NHSE's Managing conflicts of interest in the NHS guidance.

7.3 At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

7.4 Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

7.5 If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Director of Corporate Governance. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.6 **Register of Interests** – The Director of Corporate Governance will ensure that a Register of Interests is established to record formal declarations of interests of Board Directors. In particular, the register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order item 7.1.

7.7 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding 12 months will be incorporated.

7.8 The Register will be available to the public.

7.9 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact the Corporate Governance Team for clarification.

7.10 With the exception of the requirement to report interests in the Annual Report (Standing Order 7.4), 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).

8 DISABILITY OF CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

8.1 Subject to the following provisions of this Standing Order, if the Chair or 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 or 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.

8.2 The Board may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

8.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

8.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO item 8.5, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

8.4.1 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

8.4.2 they are a partner/associate 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;

8.4.3 and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

8.5 The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

8.5.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

8.5.2 of an interest in any company, body or person with which they are connected as mentioned in SO item 8.4 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.

8.6 Where the Chair or a Director has 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 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 body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit them from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

8.7 This SO item 8 applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a Director of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

9 STANDARDS OF BUSINESS CONDUCT POLICY

9.1 Staff should comply with national guidance concerning standard of business conduct including as applicable NHS England's "Standards of Business Conduct for NHS Staff", as may be updated or superseded from time to time.

9.2 **Interests of staff** - All staff shall declare any relevant and material interest. 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.

9.3 **Interest of Officers in Contracts** – If it comes to the knowledge of an Officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they themselves are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive or the Director of Corporate Governance of the fact that they are interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

9.4 An Officer should also declare to the Chief Executive any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

9.5 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

9.6 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.

9.7 **Canvassing of and Recommendations by, Directors in Relation to Appointments** – Canvassing of Directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of Standing Order item 9 shall be included in application forms or otherwise brought to the attention of candidates.

9.8 A Director of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order item 9 shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

9.9 **Relatives of Directors or Officers** – Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

9.10 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

9.11 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

9.12 Where the relationship to a Director of the Trust is disclosed, the Standing Order headed `Disability of Chair and Directors in proceedings on account of pecuniary interest' (SO item 8) shall apply.

10 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

10.1 **Custody of Seal** – The Common Seal of the Trust shall be kept by the Chief Executive in a secure place.

10.2 **Sealing of Documents** – 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 the Standing Financial Instructions. 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."

10.3 **Bearing witness of the affixing of the Seal:** 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….".

10.4 **Register of Sealing** – An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. 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.

11 SIGNATURE OF DOCUMENTS

11.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

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

11.3 Unless there is a requirement for sealing, the Chief Executive or nominated officers shall also be authorised, by resolution of the Board, to execute any agreement or other document (the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority) as a deed on behalf of the Trust by signing in the physical presence of an attesting witness.

11.4 Unless there is a specific requirement for a physical seal or wet ink signature, any signature under SO Item 11.1, 11.2 or 11.3 above may be provided in electronic form and shall not be invalid on this basis.

12 MISCELLANEOUS

12.1 **Standing Orders to be given to Directors and Officers** – It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within Standing Orders and standing financial instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

12.2 **Documents having the standing of Standing Orders** – standing financial instructions (including provisions as to tendering and contract procedures, disposals and in-house services), Schedule of Matters reserved to the Board and Scheme of Delegation, the Policy on the Register of Interests, Gifts and Hospitality and the Staff Disciplinary and Appeals Procedures document shall be read in conjunction with the Standing Orders. The Board may also, from time to time, agree and approve policy statements/procedures which will apply to all, or specific groups of staff employed by the Trust. The decision to approve such policies and procedures shall be recorded in an appropriate Trust Board minute to be read in conjunction with these Standing Orders.

12.3 **Review of Standing Orders** – Standing Orders shall be reviewed annually by the Board and any requirements for amendments must be directed to both the Board of Directors and the Council of Governors. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

12.4 The Board may confirm contracts to purchase from a voluntary organisation or a local authority using appropriate powers under the 2006 Act and shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with this Act.

12.5 **Variation of Standing Orders:** These Standing Orders shall be varied only if:

12.5.1 A notice of motion under Standing Order 4.17 has been given and

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

12.5.3 at least two-thirds of the directors who are eligible to vote are present and

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

12.6 Standing Order 12.5 (this Standing Order) may not be varied.

12.7 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.

12.8 Where financial limits are varied the Chief Finance Officer will advise the Audit Committee, and internal and external audit.

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS

Notes:

These new SFIs use NBT's SFIs as the base. NBT's are simpler, so some detail from UHBW's existing SFIs has not been replicated in here. Key changes are highlighted. Note that the SFIs, unlike the SOs, do not form part of the Constitution.

Numbering is aligned in both Trust SFIs. Trust-specific additions to each SFIs appear at the end of sections so as to preserve alignment, or via addition of 'A' after the relevant number.

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 **Director of Corporate Governance** shall advise them. In the case of the Standing Financial Instructions they will be advised by the **Chief Financial 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 including in relation to capital) 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 **Group** means the hospital group established by North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust.

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 provides support services to North Bristol NHS Trust, or any equivalent replacement provider.

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 reenactment for the time being in force.

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 Delegation (Appendix 3).

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 and Social Care or NHS England applicable to the Trust. Any uncertainty regarding the application of these SFIs should be discussed with the **Chief Financial 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. The SFIs do not provide detailed procedural advice and should be read in conjunction with the relevant departmental guidance and the financial procedure notes (available on the intranet or via the Finance Department). The **Chief Financial Officer and Information** must approve all detailed financial procedures.

Compliance with these SFIs

2.7 These SFIs prevail over any division and service guidance or procedural documents in the event of any conflicts between the SFIs and any such guidance. They also prevail over any guidance or instruction issued by other organisations conducting business with the Trust. **All staff** should notify the **Chief Financial 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 Financial 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 Financial Officer** to the next formal meeting of the Audit Committee for referring action or ratification.

Responsibilities and delegations

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

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 Trust (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 Accounting Officer of the Trust and:

2.12.1 is legally accountable to the Secretary of State for Health and Social Care and NHS England 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 and holds overall executive responsibility for the Trust's activities

2.12.3 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 Delegation (Appendix 3).

2.14 **The Chief Financial 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.

Hosting Arrangements

2.16 Where the Trust hosts an organisation with a separate management board, the financial transactions supporting the day-to-day business of the organisation shall be strictly in accordance with the Trust's Standing Financial Instructions, policies, and procedures. Responsibility for decision making, planning, and reporting will be delegated in accordance with the hosting agreement or as specified in the Scheme of Delegation.

Temporary suspension of procedures in exceptional circumstances

2.17 The **Trust Board** shall allow the SFIs to be suspended temporarily in exceptional circumstances, where the circumstance is:

2.17.1 a Trust wide problem, rather than a directorate specific issue.

2.17.2 of sufficient scale that failure to act quickly and decisively would put the Trust at significant financial and reputational risk.

2.17.3 unforeseen and rapidly developing.

2.17.4 such that following normal procedures would hinder the recovery of the situation.

3 Financial framework

3.1 The **Chief Financial Officer** shall ensure that members of the Board are aware of the financial aspects of NHS England's applicable 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 be developed by the **Chief Financial Officer** and **other Executive Directors** and will include:

4.1.1 An annual financial plan, which takes into account financial targets and forecast limits of available resources, in accordance with the requirements of NHS England and for submission to NHS England.

4.1.2 An annual budget and supporting operational plans (including capital plans as applicable, in accordance with section 13 of these SFIs).

4.2 The plans will be approved before the start of each financial year.

Chief Financial Officer

4.3 **All staff who have been given delegated authority** to manage and administer budgets shall be expected to contribute to the preparation of the annual financial plan, budget and other plans.

5 Management of the financial resource

5.1 The **Chief Executive** shall require directors and **delegated 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 **delegated authorised budget managers** 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**.

5.4 Delegation and associated responsibilities must be clearly communicated. Control of budgets shall be exercised in accordance with these Standing Financial Instructions and supplementary guidance issued by the **Chief Financial Officer**.

5.5 Except where otherwise approved by the **Chief Executive**, taking account of advice of the **Chief Financial Officer and Information**, budgets shall be used only for the purpose for which

they were provided and any budgeted funds not required for their designated purposes shall transfer to the Trust's reserves, unless covered by the delegated powers of virement.

5.6 Expenditure for which there is no provision in an approved budget and is not subject to funding under the delegated powers of virement, or approved procedures for new funding obtained during the year, may only be incurred if authorised by the **Chief Executive**.

Setting the annual financial plan

5.7 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 as developed by the **Chief Financial Officer** in accordance with Standing Financial Instructions 4.1. 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 and Social Care.

5.8 The **Chief Financial Officer** shall be responsible overall for the design and delivery of the annual integrated financial budget plan.

5.9 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.

5.10 **Budget holders** shall provide all financial, statistical and other relevant information, including service, capacity, workforce and efficiency plans, as required by the **Chief Financial Officer** to enable budgets to be compiled.

5.11 **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

5.12 The **Chief Financial Officer** shall be responsible overall for the design and delivery of adequate systems of financial budgetary control. These systems will include processes for:

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

5.12.2 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.

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

5.12.4 monitoring and reporting financial performance against plans and forecasts.

5.12.5 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**.

5.13 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.

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

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

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

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

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

5.16.3 trends and projections.

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

5.17 The **Chief Financial Officer** shall ensure that budget holders are provided with training on an ongoing basis, advice and support from suitably qualified finance staff, to enable them to perform their budget management role adequately.

5.18 The **Chief Financial Officer** shall be required to compile and submit to the **Trust Board** such financial estimates and forecasts, on both revenue and capital account, as may be required.

5.19 The **Chief Financial Officer** shall keep the **Trust Board** informed of:

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

5.19.2 financial consequences of changes in Trust policy.

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

5.20 The **Chief Financial Officer** shall 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 Financial Officer** shall:

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

6.1.2 prepare and submit annual financial returns and reports to the DHSC and NHS England as required and certified in accordance with current guidelines.

6.1.3 submit periodic monitoring and financial returns to external organisations, such as NHS England, 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 and NHS England.

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 and NHS England requirements and guidance.

6.4 The Trust's annual report and statutory accounts must be presented to the **Trust Board** for approval.

6.5 The annual report and accounts and the auditor's report must be presented at a meeting of the **Council of Governors** in accordance with the NHS England's timetable.

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

7.1 The **Chief Financial 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 A contract or agreement must be in place for all income due to the Trust for the provision of goods or services to a third party. The nature of the contract or agreement will depend on the goods or services being provided. The **Chief Financial Officer** is responsible for signing all contracts and agreements with delegated responsibilities given within the Scheme of Delegation.

7.3 Employees responsible for agreeing the prices of goods and services provided by the Trust should ensure that they cover all costs, including overheads. Support should be sought from the finance department as required. Appropriate, independent professional advice shall be taken on matters of valuation. Prices and charges shall be reviewed at least annually. This paragraph applies equally to:

- the sale of goods and services
- support to commercial research trials and projects
- pricing of non-patient care service agreements with other bodies.

7.4 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

7.5 The **Chief Financial Officer** shall:

7.5.1 follow the up to date DHSC's guidance and regulations for setting prices for providing NHS services.

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

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

7.6 The **Chief Financial Officer** shall approve all property and non-clinical equipment leases, property rentals and tenancy agreements. The **Director of Estates and Facilities** shall advise on these arrangements.

7.7 **All employees** shall inform the **Chief Financial 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

7.8 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. Where the Trust makes arrangements for the provision of services by non-NHS providers, the **Chief Executive** is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided.

7.9 The **Chief Financial Officer** shall provide up to date advice on:

7.9.1 Standard NHS contractual terms and conditions, issued by NHS England.

7.9.2 costing and pricing of services.

7.9.3 payment terms and conditions.

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

7.10 The **Chief Financial Officer** shall ensure that SLAs and other contractual and extra-contractual arrangements:

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

7.10.2 are financially sound; and that any contractual arrangement pricing at marginal cost are approved by the **Chief Financial Officer** and reported to the **Trust Board**.

7.11 The **Chief Financial 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.

7.12 **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

7.13 All applications for research funding shall be considered and approved by the research 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**.**

7.14 The agreement covering any undertaking of research shall recognise the Trust's policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the relevant research project.

Concession agreements

7.15 The **Chief Financial Officer**, advised by the **Director of Estates and 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 Financial Officer** shall authorise all concession agreements entered into by the Trust.

8 Procurement, tendering and contracting procedure

8.1 The Trust is permitted to enter into contracts within the statutory powers delegated to it. The procedure for setting contracts shall comply with those powers and these SFIs, in particular this section 8 and sections 9 and 10, all of which should be read together. Delegated powers of authorisation are granted to Trust officers according to the Scheme of Delegation. 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 Financial Officer** is responsible for signing all contracts and agreements with delegated responsibilities given within the Scheme of Delegation.

8.2 All contracts made shall ensure best value for money using the Trust's procurement service provider and processes established by the **Chief Financial Officer.** For each contract a **Trust Officer who is a delegated budget holder** shall be nominated and hence responsible for overseeing and managing the contract on behalf of the Trust.

8.3 The **Chief Financial Officer** is responsible for making arrangements for the purchase of goods and services:

8.3.1 On a non-contracted basis in accordance with the requisitions processes set out in section 10 of these Standing Financial Instructions and the delegated authorities set out in the Scheme of Delegation, and

8.3.2 On a contracted based in accordance with this section 8 of these Standing Financial Instructions and the delegated authorities set out in the Scheme of Delegation.

Legislation and guidance regarding public procurement

8.4 The Trust shall comply with all relevant procurement legislation and guidance, including any advertising and award requirements.

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

Competitive tendering

8.6 The **Chief Financial Officer** shall be responsible for ensuring compliance with applicable procurement law and guidance, and for advising the **Board** regarding matters in relation to which discretion is permitted or required including for the setting of thresholds in addition to those prescribed by procurement law. Additional detail relating to the Trust's procedures for complying with procurement law and discretionary matters shall be incorporated in these Standing Orders through the Scheme of Delegation; and shall be reviewed at least annually.

8.7 The **Trust Board** shall ensure that competitive tenders, or quotations are invited, in line with the thresholds required by procurement law and as set out in the Scheme of Delegation, for:

8.7.1 the supply of goods, materials and manufactured articles.

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

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

8.8 The **Trust Board** shall allow for exceptions to the requirement for formal tendering procedures in accordance with procurement law.

8.9 Subject to compliance with procurement law, the **Trust Board** shall allow for the requirement for formal tendering procedures to be waived in certain circumstances, for example where:

- the **Chief Executive** decides that formal tendering procedures would not be practicable
- available timescales due to unforeseen circumstances genuinely mean that competitive tendering is not a realistic option, in accordance with procurement law requirements. 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, in accordance with procurement law requirements. 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, in accordance with procurement law requirements
- there is a clear benefit to be gained from maintaining continuity with an earlier supply in accordance with procurement law requirements. In such cases, the benefits of such continuity must outweigh any potential advantage to be gained from competitive tendering

Note that section 8.4 takes precedence over the above list of 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 the Scheme of Delegation.

8.10 The **Chief Financial 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 that procedural guidance from BWPC 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 all relevant procurement legislation and guidance, and in accordance with the Scheme of Delegation (Appendix 3).

8.11.2 Tenders and quotations expressly state suppliers’ obligations to comply with all relevant legislation.

8.11.3 Tender processes and rules are in accordance with up-to-date and relevant specialist guidance, including government procurement policy notes.

8.11.4 It maintains a record of competitive tenders and subsequent contract awards.

8.11.5 Award notices are published for all contracts where required by procurement law.

8.11.6 Procurement Strategy reports are created for all contracts with a total value as set by the **Chief Financial Officer** in accordance with the Scheme of Delegation

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.

8.13 The **Chief Financial 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 the thresholds set under SFI 8.12 (in accordance with the Scheme of Delegation).

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.

8.14 The **Chief Financial 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 (including in particular SFI 8).

9.1.2 UK procurement legislation and guidance,.

9.1.3 any relevant directions issued, or recognised by, the DHSC and NHS England.

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 and arrange for execution of each contract on behalf of the Trust

Longer term commitments

9.4 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 Delegation, in advance of any commitment being made.

Healthcare Service Agreements

9.5 The **Chief Financial 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 procurement law.

In-house services

9.6 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 procurement law and guidance are applied correctly, including:

9.6.1 setting clearly defined specifications for the service.

9.6.2 clear separation between the in-house service provider tender team and the Trust's commissioning team.

9.6.3 independent evaluation process.

9.7 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 Management of 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 Financial 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 Delegation.

Requisitioning and ordering goods and services

10.4 The **Chief Financial 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 Delegation.

10.4.2 recognition of the Trust's approved supply arrangements, including, but not limited to the following:

- recognised Trust wide procurement systems
- other recognised controlled ordering systems for specific service areas providing that they can evidence a secure audit trail
- framework agreements made by the Trust, or by BWPC, 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 Financial 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 Financial 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 Financial 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 Financial 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 government's Fair Payment Code).

10.9 Where applicable, such requirements will be specified in any SLA with the Shared Business Service provider.

10.10 The **Chief Financial Officer** shall:

10.10.1 ensure the prompt payment of all properly authorised accounts and claims.

10.10.2 maintain an adequate system of verification, recording and payment of all amounts payable, including relevant thresholds.

10.10.3 identify procedures to follow for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

10.10.4 maintain instructions to employees regarding the handling and payment of accounts within the Finance Department.

Prepayments and payments on account

10.11 The **Chief Financial 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 Financial 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 procurement law and guidance, 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 Financial 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 (Scheme of Delegation) and where required by applicable investment policies, all planned (including Capital funded) procurements 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 total contract cost of an amount as specified in the Scheme of Delegation, (a cost overrun) then this shall be approved in accordance with the Scheme of Delegation.

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 Financial 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 Delegation. 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 Financial 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 agree appropriate remuneration and terms of service for the **Chief Executive**, other directors and any staff remunerated via Very Senior Manager 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 monitor and evaluate the performance of individual directors and other staff on Very Senior Manager arrangements

11.2.3 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.

11.3A The **Council of Governors** will decide the remuneration and allowances and other terms of office of the **Chair** and **Non-Executive Directors**.

Other employees

11.4 The **Chief People Officer** shall consider and approve proposals 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 Financial 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 Financial Officer** shall ensure that the arrangements for providing the payroll service are supported by:

11.9.1 adequate internal controls and audit review procedures

11.9.2 timetables for submission of properly authorised time records and other notifications

11.9.3 arrangements to make payment on agreed dates

11.9.4 arrangements for allowed methods of payment, and

11.9.5 that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.10 The **Chief People Officer** shall:

11.10.1 agree the final determination of pay and allowances.

11.10.2 agree appropriate (contracted) terms and conditions.

11.11 **Delegated authorised budget 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 Financial 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 All senior staff must be on the payroll of the Trust or the other trust in the Group unless there are exceptional temporary circumstances, which will require the **Chief Executive's** approval. This includes all Trust Board members and staff with significant financial responsibility.

11.14 The **Chief People Officer** 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 the off-payroll working rules.

11.15 All Trust officers responsible for procuring services from self-employed individuals shall ensure that they comply with the procedures established.

12 Insurance, including risk pooling schemes administered by the NHS Litigation Authority

12.1 The **Trust Board** shall determine the Trust's arrangements for insurance cover, including the option to insure through the risk pooling schemes administered by the NHS Litigation Authority (under its operating name 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 Financial 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 Financial Officer** shall determine the level of insurance cover to be held by the Trust.

13 Capital investment, private financing, fixed asset registers and security of assets

13.1 The **Chief Financial 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 Financial 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 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

13.5 The **Chief Financial Officer** shall review the costs and revenue analysis, including revenue consequences included in the business case

13.6 For approved capital schemes, the **Chief Financial Officer** shall:

13.6.1 issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.6.2 agree arrangements for managing stage payments.

13.6.3 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.

13.7 Where appropriate, the Trust's **Procurement Service** shall advise the **Chief Financial Officer**, on the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

13.8 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 Delegation:

13.8.1 specific authority to commit expenditure.

13.8.2 authority to proceed to tender.

13.8.3 approval to accept a successful tender.

Asset Register

13.9 The **Chief Financial 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 every three years on a rolling basis for assets.

13.10 The **Chief Financial Officer** shall maintain procedures for verifying additions and amendments to the assets recorded in the asset register. These procedures and records will include:

13.10.1 additions to the fixed asset register clearly identified to an appropriate budget manager.

13.10.2 properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties.

13.10.3 records of costs incurred within the Trust, on stores, requisitions and labour including appropriate overheads.

13.10.4 lease agreements in respect of assets held under a finance leases.

13.11 The **Chief Financial 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.

13.12 The **Chief Financial Officer** shall approve procedures for:

13.12.1 applying depreciation charges and indexation valuation adjustment to assets, using methods and rates as specified in the guidance issued by the DHSC.

13.12.2 reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

Security of assets

13.13 The **Chief Financial Officer** shall maintain procedures for controlling the security of assets, including fixed assets, cash, cheques and negotiable instruments. The procedures will include:

13.13.1 recording managerial responsibility for each asset

13.13.2 identification of additions and disposals

13.13.3 identification of all repairs and maintenance expenses

13.13.4 physical security of assets

13.13.5 periodic verification of the existence of, condition of, and title to, assets recorded

13.13.6 identification and reporting of all costs associated with the retention of an asset

13.13.7 reporting, recording and safekeeping of cash, cheques, and negotiable instruments

13.14 **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.

13.15 Where practical, assets should be marked as Trust property. Disposals and condemnations

13.16 The **Chief Financial Officer** shall prepare procedures for the disposal of assets including condemnations and ensure that these are notified to budget managers. The procedures will include arrangements to be followed for:

13.16.1 condemning and disposing of unserviceable and redundant assets.

13.16.2 maintaining records of assets disposed of, including confirmation of destruction of condemned assets.

13.16.3 specific processes to be followed in instances where assets are passed on for future use to another organisation.

13.16.4 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.

13.17 The appropriate **asset management lead** responsible for the decision to dispose of an asset shall advise the **Chief Financial Officer** of the estimated market value of the asset, taking account of professional advice where appropriate.

14 Bank accounts and Government Banking Service accounts

14.1 The **Trust Board** shall approve the banking arrangements for the Trust.

14.2 Where applicable, the **Chief Financial Officer** is responsible for producing a Treasury Management Policy, in accordance with any relevant guidance from NHS England, for **Trust Board** approval.

14.3 The **Chief Financial 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 DHSC.

14.4 The **Chief Financial Officer** shall:

14.4.1 establish and maintain necessary commercial bank accounts and Government Banking Service (GBS) accounts.

14.4.2 advise the Trust's bankers, formally in writing, of the conditions under which each account will be operated (the bank mandate).

14.4.3 seek to limit the use of commercial bank accounts and the value of cash balances held within them.

14.4.4 conduct the Trust's main banking services and financial transactions using accounts provided by the GBS.

14.5 Only the **Chief Financial Officer**, or their nominated representative, is authorised to open, operate and control a bank account, where monies owned by the Trust, including where applicable 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.

14.6 The **Chief Financial Officer** shall:

14.6.1 ensure that payments made from bank or GBS accounts do not exceed the amount credited to the account.

14.6.2 monitor compliance with DHSC guidance on the level of cleared funds.

14.6.3 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

14.7 The **Chief Financial Officer** shall prepare detailed instructions on the operation of bank and GBS accounts which shall include:

14.7.1 the conditions under which each bank and GBS account is to be operated.

14.7.2 details of those authorised to sign cheques or other orders drawn on the Trust's accounts.

14.7.3 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

14.8 The **Chief Financial 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.

14.9 The **Chief Financial 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 Financial 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 Financial 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 or cheques for private purposes.

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 Financial 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 for Health and Social Care and authorised by the **Board** and in accordance with the Trust's Treasury Management Policy, where applicable.

16 Management of debtors

16.1 The **Chief Financial Officer** shall manage debts in accordance with the Trust's Treasury Management Policy, and where not applicable the **Chief Financial 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 Financial 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 Financial 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 Financial 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 Where applicable, the **Chief Financial 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 DHSC and in accordance with the Trust's Treasury Management Policy. The **Chief Financial Officer** shall also provide periodic reports to the Board concerning the PDC debt and all loans as applicable.

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 Financial Officer**.

18.3 The **Chief Financial 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 DHSC.

18.3.2 the **Trust Board** is made aware of all short term borrowings at the next meeting.

18.4 The **Finance and Estates Committee** shall ensure that all proposed long-term borrowing is consistent with the Trust's financial plans; and is approved by the **Trust Board**.

18.5 Where applicable for an NHS Foundation Trust, the Trust can obtain a working capital facility from the commercial banking sector. Short term borrowing should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, comply with the Trust's Treasury Management Policy and all guidance issued by NHS England.

19 Losses and special payments

19.1 The **Chief Financial 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, as set out in the Scheme of Delegation. 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 Financial Officer** shall determine the nature and/or value of losses which must be reported immediately to the **Chief Financial 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 Financial 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 Financial 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 the relevant policy.

19.4 The **Trust Board** shall approve a scheme of delegation for the approval and authorisation of the write off of losses, compensations and ex-gratia payments, within the limits delegated to it by the Department of Health and Social Care and NHS England. Write offs includes the abandonments of claims and the charging of fruitless payments.

19.5 The **Audit Committee** shall receive regular reports from the **Chief Financial Officer** of losses, compensations and ex-gratia payments made, with details of all cases for which the **Trust Board**'s specific approval is required.

19.6 The **Chief Financial Officer** and where applicable 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 in accordance with relevant law and guidance.

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 Financial 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 'Charitable funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the NHS, the objects of which are for the benefit of the NHS in England.

21.2 The charitable trusts associated with the University Hospitals Bristol and Weston NHS Foundation Trust are administered by the Trustees of Bristol & Weston Hospitals Charity (hereafter called the Trustees). The Trustees have their own systems of accounting and financial control and operate separate bank accounts to the Trust. Charitable funds should not be confused with those operated by the Trust.

21.3 All gifts, donations and proceeds of fund-raising activities which are intended for the Trust's benefit shall be handed to either the Trustees or to the Trust's cashier who will bank the money and transfer funds and donor's intention or area of benefit as appropriate. Any charitable funds paid in through the Trust's cashier must be clearly identified as such to ensure it is separated from the Trust's exchequer funds.

21.4 The **CFO** shall be required to advise the **Trust Board** on the financial implications of any proposal for fund-raising activities which the Trust may initiate, sponsor, or approve.

21.5 The Trustees will designate a fund advisor for each fund held who must comply with the written procedures issued by the charitable trusts regarding the use of these funds.

21.6 Expenditure of any funds held in trust shall be conditional upon:

21.6.1 the expenditure being within the terms of the appropriate fund

21.6.2 meeting the delegated limits in accordance with the Scheme of Delegation.

21.6.3 the prior approval of the Trust's Capital Programme Steering Group being obtained for items falling within the capital definition

21.6.4 being authorised by the fund advisor in writing, or by a person to whom the fund advisor has delegated authority having advised the Trustees in writing

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 relevant DHSC and NHS England guidelines.

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 Digital and data security

23.1 The **Chief Digital and Information Officer** shall be responsible for the accuracy and security of the 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 relevant data protection legislation.

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 Financial 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 Financial 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 Financial 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 Financial Officer** shall periodically seek assurances that adequate controls are in operation.

Risk assessment

23.6 The **Chief Digital and 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 NHS England (to the **Chief Financial Officer** in the first instance).

25.3 It is the responsibility of the **Chief Financial 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 Financial 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 Financial 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 as applicable from time to time.

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, as required by DHSC and NHSE.

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 Financial 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 NHS internal audit standards as applicable from time to time.

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 Financial Officer**. The reporting system for internal audit shall be agreed between the **Chief Financial 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 such matters as required by DHSC and NHSE and the **Trust Board**.

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 Financial Officer** must be notified immediately.

25.14 In obtaining third party assurance from other 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 Council of Governors Representative at a general meeting of the Council of Member Representatives and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and reported to the Audit Committee and Council of Governors Representatives.

25.16 The Trust will ensure that the external auditor complies with the Audit Code for NHS Foundation Trusts at the date of appointment and on and on-going basis throughout the term of appointments.

25.17 The **Council of Governors** shall determine the terms of the contract for the provision of the External Audit.

25.18 The Audit Committee will receive and agree the External Auditor's annual plan.

Counter Fraud and Bribery

25.19 In line with their responsibilities the Trust **Chief Executive** and **Chief Financial Officer** shall ensure compliance with relevant directions and guidance on countering fraud and corruption within the NHS;

25.20 The **Chief Financial Officer** shall ensure that:

25.20.1 the Trust's Counter Fraud and Bribery Policy is maintained and remains up to date;

25.20.2 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.

25.21 The appointed **Local Counter Fraud Specialist** shall report to the **Chief Financial Officer** and shall work with staff in NHS Counter Fraud Authority, when required;

25.22 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;

25.23 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 Financial Officer** or via the NHS Fraud and Bribery Reporting Line.

25.24 All reported concerns will be treated in the strictest confidence and professionally investigated in accordance with the Fraud Act 2006 and Bribery Act 2010.

25.25 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

25.26 The **Chief Financial 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 DHSC and NHS England.

25.27 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.

26 Acceptance of Gifts by Staff and Other Standards of Business Control

26.1 The **Chief Executive** shall ensure that a Register of Interests, Gifts and Hospitality is established to formally record declarations of interests, gifts and hospitality made by Trust staff, and as the **Accountable Officer** has ultimate responsibility for ensuring the Trust has appropriate policies in place in respect of conflicts of interest and the acceptance of gifts or other benefits in kind conferring an advantage to a member of staff. These policies should be consistent with the Standards of Business Conduct for NHS Staff.

26.2 The **Director of Corporate Governance** of the Trust is responsible for implementing the Trust's Register of Interests, Gifts and Hospitality Policy across Clinical Divisions and Trust Headquarters and ensuring all Trust employees are aware of these Trust policies and the restrictions in relation to accepting gifts, inducements, benefits in kind or other personal advantage that could be considered to be bribes under the Bribery Act 2010.

Gifts

26.3 Casual gifts offered by contractors or others may be construed to be connected with the performance of duties so as to constitute an offence under the Bribery Act 2010 and therefore all such gifts should be declined. Business articles with little intrinsic value (of less than £50 per gift) such as diaries, calendars, pens etc. need not be refused, nor small tokens of gratitude from patients or their relatives.

26.4 Any gift accepted of value greater than £50 should be declared in writing to the Trust Secretary via the Register of Interests, Gifts, and Hospitality. If several small gifts worth a total of over £100 are received by an individual from the same or closely related source in a twelve-month period, these should also be declared on the Register of Interests, Gifts, and Hospitality.

26.5 Gifts offered to an individual where the value exceeds £50 should be declined. In exceptional circumstances and with the agreement of the line manager, the matter may be referred to the Trust Secretary for a decision as to whether the gift can be accepted.

26.6 Under no circumstances may staff accept cash or vouchers, even below the £50.00 threshold. Gifts of cash made to a ward or department are deemed to be charitable donations and should be dealt with as described in section 21. No further declaration is required.

26.7 All gifts to staff must be accepted in line with the Trust's Register of Interests, Gifts and Hospitality Policy.

Hospitality

26.8 Suppliers must not attempt to influence business decision making by offering hospitality to trust staff. Modest hospitality provided it is normal and reasonable in the circumstances may be accepted (e.g., lunches in the course of a working visit). If in doubt, advice should be sought from the employee's line manager or relevant Director.

26.9 Any offers of inappropriate hospitality should be notified to the **Trust secretary** for appropriate action.

26.10 All hospitality to staff must be accepted in line with the Trust's Register of Interests, Gifts and Hospitality Policy.

Sponsorship

26.11 Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks approval in advance from their line manager. Approval must depend on whether acceptance will, or could be believed to, compromise current or future purchasing decisions in any way.

26.12 The sponsorship of Trust events by existing suppliers to the Trust is acceptable subject to informing the **Trust Board Secretary** of the agreement for recording the details in the Register of Gifts, Hospitality and Sponsorship. Where the sponsor does not have a contract for supplies or services with the Trust, the Procurement Department should be consulted. The Trust **Director of Corporate Governance** be informed. In all such cases there must be no favouritism shown to any one supplier in a way that could later be challenged by a competitor. Where this could be the case the same opportunity to sponsor events should be offered to the other interested parties.

26.13 Some suppliers offer training as a part of supplying equipment, and this should be fully reflected through the contract entered into with the relevant organisation. In such cases no disclosure to the Trust **Director of Corporate Governance** is necessary.

26.14 The Trust shall not enter into commercial or charitable sponsorship arrangements which link such sponsorship to the supply of goods or services from any particular source.

26.15 Employees must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to concessionary agreements negotiated with companies by the Trust, or the NHS, or by recognised staff interests, on behalf of all staff for example, staff benefit schemes.

ENDS

NORTH BRISTOL NHS TRUST

STANDING FINANCIAL INSTRUCTIONS

Notes:

These new SFIs use NBT's SFIs as the base. NBT's are simpler, so some detail from UHBW's existing SFIs has not been replicated in here. Key changes are highlighted. Note that the SFIs, unlike the SOs, do not form part of the Constitution.

Numbering is aligned in both Trust SFIs. Trust-specific additions to each SFIs appear at the end of sections so as to preserve alignment, or via addition of 'A' after the relevant number.

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 **Director of Corporate Governance** shall advise them. In the case of the Standing Financial Instructions they will be advised by the **Chief Financial 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 including in relation to capital) 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 **Group** means the hospital group established by North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust.

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 provides support services to North Bristol NHS Trust, or any equivalent replacement provider.

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 reenactment for the time being in force.

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 Delegation (Appendix 3).

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 and Social Care or NHS England applicable to the Trust. Any uncertainty regarding the application of these SFIs should be discussed with the **Chief Financial 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. The SFIs do not provide detailed procedural advice and should be read in conjunction with the relevant departmental guidance and the financial procedure notes (available on the intranet or via the Finance Department). The **Chief Financial Officer and Information** must approve all detailed financial procedures.

Compliance with these SFIs

2.7 These SFIs prevail over any division and service guidance or procedural documents in the event of any conflicts between the SFIs and any such guidance. They also prevail over any guidance or instruction issued by other organisations conducting business with the Trust. **All staff** should notify the **Chief Financial 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 Financial 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 Financial Officer** to the next formal meeting of the Audit Committee for referring action or ratification.

Responsibilities and delegations

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

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 Trust (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 Accounting Officer of the Trust and:

2.12.1 is legally accountable to the Secretary of State for Health and Social Care and NHS England 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 and holds overall executive responsibility for the Trust's activities

2.12.3 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 Delegation (Appendix 3).

2.14 **The Chief Financial 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.

Hosting Arrangements

2.16 Where the Trust hosts an organisation with a separate management board, the financial transactions supporting the day-to-day business of the organisation shall be strictly in accordance with the Trust's Standing Financial Instructions, policies, and procedures. Responsibility for decision making, planning, and reporting will be delegated in accordance with the hosting agreement or as specified in the Scheme of Delegation.

Temporary suspension of procedures in exceptional circumstances

2.17 The **Trust Board** shall allow the SFIs to be suspended temporarily in exceptional circumstances, where the circumstance is:

2.17.1 a Trust wide problem, rather than a directorate specific issue.

2.17.2 of sufficient scale that failure to act quickly and decisively would put the Trust at significant financial and reputational risk.

2.17.3 unforeseen and rapidly developing.

2.17.4 such that following normal procedures would hinder the recovery of the situation.

3 Financial framework

3.1 The **Chief Financial Officer** shall ensure that members of the Board are aware of the financial aspects of NHS England's applicable 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 be developed by the **Chief Financial Officer** and **other Executive Directors** and will include:

4.1.1 An annual financial plan, which takes into account financial targets and forecast limits of available resources, in accordance with the requirements of NHS England and for submission to NHS England.

4.1.2 An annual budget and supporting operational plans (including capital plans as applicable, in accordance with section 13 of these SFIs).

4.2 The plans will be approved before the start of each financial year.

Chief Financial Officer

4.3 **All staff who have been given delegated authority** to manage and administer budgets shall be expected to contribute to the preparation of the annual financial plan, budget and other plans.

5 Management of the financial resource

5.1 The **Chief Executive** shall require directors and **delegated 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 **delegated authorised budget managers** 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**.

5.4 Delegation and associated responsibilities must be clearly communicated. Control of budgets shall be exercised in accordance with these Standing Financial Instructions and supplementary guidance issued by the **Chief Financial Officer**.

5.5 Except where otherwise approved by the **Chief Executive**, taking account of advice of the **Chief Financial Officer and Information**, budgets shall be used only for the purpose for which

they were provided and any budgeted funds not required for their designated purposes shall transfer to the Trust's reserves, unless covered by the delegated powers of virement.

5.6 Expenditure for which there is no provision in an approved budget and is not subject to funding under the delegated powers of virement, or approved procedures for new funding obtained during the year, may only be incurred if authorised by the **Chief Executive**.

Setting the annual financial plan

5.7 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 as developed by the **Chief Financial Officer** in accordance with Standing Financial Instructions 4.1. 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 and Social Care.

5.8 The **Chief Financial Officer** shall be responsible overall for the design and delivery of the annual integrated financial budget plan.

5.9 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.

5.10 **Budget holders** shall provide all financial, statistical and other relevant information, including service, capacity, workforce and efficiency plans, as required by the **Chief Financial Officer** to enable budgets to be compiled.

5.11 **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

5.12 The **Chief Financial Officer** shall be responsible overall for the design and delivery of adequate systems of financial budgetary control. These systems will include processes for:

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

5.12.2 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.

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

5.12.4 monitoring and reporting financial performance against plans and forecasts.

5.12.5 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**.

5.13 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.

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

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

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

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

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

5.16.3 trends and projections.

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

5.17 The **Chief Financial Officer** shall ensure that budget holders are provided with training on an ongoing basis, advice and support from suitably qualified finance staff, to enable them to perform their budget management role adequately.

5.18 The **Chief Financial Officer** shall be required to compile and submit to the **Trust Board** such financial estimates and forecasts, on both revenue and capital account, as may be required.

5.19 The **Chief Financial Officer** shall keep the **Trust Board** informed of:

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

5.19.2 financial consequences of changes in Trust policy.

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

5.20 The **Chief Financial Officer** shall 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 Financial Officer** shall:

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

6.1.2 prepare and submit annual financial returns and reports to the DHSC and NHS England as required and certified in accordance with current guidelines.

6.1.3 submit periodic monitoring and financial returns to external organisations, such as NHS England, 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 and NHS England.

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 and NHS England requirements and guidance.

6.4 The Trust's annual report and statutory accounts must be presented to the **Trust Board** for approval.

6.5 The annual report and accounts and the auditor's report must be presented at a meeting of the **Council of Governors** in accordance with the NHS England's timetable.

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

7.1 The **Chief Financial 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 A contract or agreement must be in place for all income due to the Trust for the provision of goods or services to a third party. The nature of the contract or agreement will depend on the goods or services being provided. The **Chief Financial Officer** is responsible for signing all contracts and agreements with delegated responsibilities given within the Scheme of Delegation.

7.3 Employees responsible for agreeing the prices of goods and services provided by the Trust should ensure that they cover all costs, including overheads. Support should be sought from the finance department as required. Appropriate, independent professional advice shall be taken on matters of valuation. Prices and charges shall be reviewed at least annually. This paragraph applies equally to:

- the sale of goods and services
- support to commercial research trials and projects
- pricing of non-patient care service agreements with other bodies.

7.4 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

7.5 The **Chief Financial Officer** shall:

7.5.1 follow the up to date DHSC's guidance and regulations for setting prices for providing NHS services.

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

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

7.6 The **Chief Financial Officer** shall approve all property and non-clinical equipment leases, property rentals and tenancy agreements. The **Director of Estates and Facilities** shall advise on these arrangements.

7.7 **All employees** shall inform the **Chief Financial 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

7.8 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. Where the Trust makes arrangements for the provision of services by non-NHS providers, the **Chief Executive** is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided.

7.9 The **Chief Financial Officer** shall provide up to date advice on:

7.9.1 Standard NHS contractual terms and conditions, issued by NHS England.

7.9.2 costing and pricing of services.

7.9.3 payment terms and conditions.

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

7.10 The **Chief Financial Officer** shall ensure that SLAs and other contractual and extra-contractual arrangements:

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

7.10.2 are financially sound; and that any contractual arrangement pricing at marginal cost are approved by the **Chief Financial Officer** and reported to the **Trust Board**.

7.11 The **Chief Financial 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.

7.12 **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

7.13 All applications for research funding shall be considered and approved by the research 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**.**

7.14 The agreement covering any undertaking of research shall recognise the Trust's policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the relevant research project.

Concession agreements

7.15 The **Chief Financial Officer**, advised by the **Director of Estates and 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 Financial Officer** shall authorise all concession agreements entered into by the Trust.

8 Procurement, tendering and contracting procedure

8.1 The Trust is permitted to enter into contracts within the statutory powers delegated to it. The procedure for setting contracts shall comply with those powers and these SFIs, in particular this section 8 and sections 9 and 10, all of which should be read together. Delegated powers of authorisation are granted to Trust officers according to the Scheme of Delegation. 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 Financial Officer** is responsible for signing all contracts and agreements with delegated responsibilities given within the Scheme of Delegation.

8.2 All contracts made shall ensure best value for money using the Trust's procurement service provider and processes established by the **Chief Financial Officer.** For each contract a **Trust Officer who is a delegated budget holder** shall be nominated and hence responsible for overseeing and managing the contract on behalf of the Trust.

8.3 The **Chief Financial Officer** is responsible for making arrangements for the purchase of goods and services:

8.3.1 On a non-contracted basis in accordance with the requisitions processes set out in section 10 of these Standing Financial Instructions and the delegated authorities set out in the Scheme of Delegation, and

8.3.2 On a contracted based in accordance with this section 8 of these Standing Financial Instructions and the delegated authorities set out in the Scheme of Delegation.

Legislation and guidance regarding public procurement

8.4 The Trust shall comply with all relevant procurement legislation and guidance, including any advertising and award requirements.

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

Competitive tendering

8.6 The **Chief Financial Officer** shall be responsible for ensuring compliance with applicable procurement law and guidance, and for advising the **Board** regarding matters in relation to which discretion is permitted or required including for the setting of thresholds in addition to those prescribed by procurement law. Additional detail relating to the Trust's procedures for complying with procurement law and discretionary matters shall be incorporated in these Standing Orders through the Scheme of Delegation; and shall be reviewed at least annually.

8.7 The **Trust Board** shall ensure that competitive tenders, or quotations are invited, in line with the thresholds required by procurement law and as set out in the Scheme of Delegation, for:

8.7.1 the supply of goods, materials and manufactured articles.

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

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

8.8 The **Trust Board** shall allow for exceptions to the requirement for formal tendering procedures in accordance with procurement law.

8.9 Subject to compliance with procurement law, the **Trust Board** shall allow for the requirement for formal tendering procedures to be waived in certain circumstances, for example where:

- the **Chief Executive** decides that formal tendering procedures would not be practicable
- available timescales due to unforeseen circumstances genuinely mean that competitive tendering is not a realistic option, in accordance with procurement law requirements. 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, in accordance with procurement law requirements. 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, in accordance with procurement law requirements
- there is a clear benefit to be gained from maintaining continuity with an earlier supply in accordance with procurement law requirements. In such cases, the benefits of such continuity must outweigh any potential advantage to be gained from competitive tendering

Note that section 8.4 takes precedence over the above list of 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 the Scheme of Delegation.

8.10 The **Chief Financial 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 that procedural guidance from BWPC 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 all relevant procurement legislation and guidance, and in accordance with the Scheme of Delegation (Appendix 3).

8.11.2 Tenders and quotations expressly state suppliers’ obligations to comply with all relevant legislation.

8.11.3 Tender processes and rules are in accordance with up-to-date and relevant specialist guidance, including government procurement policy notes.

8.11.4 It maintains a record of competitive tenders and subsequent contract awards.

8.11.5 Award notices are published for all contracts where required by procurement law.

8.11.6 Procurement Strategy reports are created for all contracts with a total value as set by the **Chief Financial Officer** in accordance with the Scheme of Delegation

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.

8.13 The **Chief Financial 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 the thresholds set under SFI 8.12 (in accordance with the Scheme of Delegation).

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.

8.14 The **Chief Financial 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 (including in particular SFI 8).

9.1.2 UK procurement legislation and guidance,.

9.1.3 any relevant directions issued, or recognised by, the DHSC and NHS England.

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 and arrange for execution of each contract on behalf of the Trust

Longer term commitments

9.4 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 Delegation, in advance of any commitment being made.

Healthcare Service Agreements

9.5 The **Chief Financial 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 procurement law.

In-house services

9.6 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 procurement law and guidance are applied correctly, including:

9.6.1 setting clearly defined specifications for the service.

9.6.2 clear separation between the in-house service provider tender team and the Trust's commissioning team.

9.6.3 independent evaluation process.

9.7 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 Management of 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 Financial 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 Delegation.

Requisitioning and ordering goods and services

10.4 The **Chief Financial 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 Delegation.

10.4.2 recognition of the Trust's approved supply arrangements, including, but not limited to the following:

- recognised Trust wide procurement systems
- other recognised controlled ordering systems for specific service areas providing that they can evidence a secure audit trail
- framework agreements made by the Trust, or by BWPC, 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 Financial 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 Financial 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 Financial 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 Financial 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 government's Fair Payment Code).

10.9 Where applicable, such requirements will be specified in any SLA with the Shared Business Service provider.

10.10 The **Chief Financial Officer** shall:

10.10.1 ensure the prompt payment of all properly authorised accounts and claims.

10.10.2 maintain an adequate system of verification, recording and payment of all amounts payable, including relevant thresholds.

10.10.3 identify procedures to follow for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

10.10.4 maintain instructions to employees regarding the handling and payment of accounts within the Finance Department.

Prepayments and payments on account

10.11 The **Chief Financial 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 Financial 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 procurement law and guidance, 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 Financial 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 (Scheme of Delegation) and where required by applicable investment policies, all planned (including Capital funded) procurements 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 total contract cost of an amount as specified in the Scheme of Delegation, (a cost overrun) then this shall be approved in accordance with the Scheme of Delegation.

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 Financial 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 Delegation. 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 Financial 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 agree appropriate remuneration and terms of service for the **Chief Executive**, other directors and any staff remunerated via Very Senior Manager 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 monitor and evaluate the performance of individual directors and other staff on Very Senior Manager arrangements

11.2.3 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.

11.3A The **Council of Governors** will decide the remuneration and allowances and other terms of office of the **Chair** and **Non-Executive Directors**.

Other employees

11.4 The **Chief People Officer** shall consider and approve proposals 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 Financial 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 Financial Officer** shall ensure that the arrangements for providing the payroll service are supported by:

11.9.1 adequate internal controls and audit review procedures

11.9.2 timetables for submission of properly authorised time records and other notifications

11.9.3 arrangements to make payment on agreed dates

11.9.4 arrangements for allowed methods of payment, and

11.9.5 that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.10 The **Chief People Officer** shall:

11.10.1 agree the final determination of pay and allowances.

11.10.2 agree appropriate (contracted) terms and conditions.

11.11 **Delegated authorised budget 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 Financial 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 All senior staff must be on the payroll of the Trust or the other trust in the Group unless there are exceptional temporary circumstances, which will require the **Chief Executive's** approval. This includes all Trust Board members and staff with significant financial responsibility.

11.14 The **Chief People Officer** 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 the off-payroll working rules.

11.15 All Trust officers responsible for procuring services from self-employed individuals shall ensure that they comply with the procedures established.

12 Insurance, including risk pooling schemes administered by the NHS Litigation Authority

12.1 The **Trust Board** shall determine the Trust's arrangements for insurance cover, including the option to insure through the risk pooling schemes administered by the NHS Litigation Authority (under its operating name 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 Financial 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 Financial Officer** shall determine the level of insurance cover to be held by the Trust.

13 Capital investment, private financing, fixed asset registers and security of assets

13.1 The **Chief Financial 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 Financial 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 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

13.5 The **Chief Financial Officer** shall review the costs and revenue analysis, including revenue consequences included in the business case

13.6 For approved capital schemes, the **Chief Financial Officer** shall:

13.6.1 issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.6.2 agree arrangements for managing stage payments.

13.6.3 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.

13.7 Where appropriate, the Trust's **Procurement Service** shall advise the **Chief Financial Officer**, on the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

13.8 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 Delegation:

13.8.1 specific authority to commit expenditure.

13.8.2 authority to proceed to tender.

13.8.3 approval to accept a successful tender.

Asset Register

13.9 The **Chief Financial 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 every three years on a rolling basis for assets.

13.10 The **Chief Financial Officer** shall maintain procedures for verifying additions and amendments to the assets recorded in the asset register. These procedures and records will include:

13.10.1 additions to the fixed asset register clearly identified to an appropriate budget manager.

13.10.2 properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties.

13.10.3 records of costs incurred within the Trust, on stores, requisitions and labour including appropriate overheads.

13.10.4 lease agreements in respect of assets held under a finance leases.

13.11 The **Chief Financial 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.

13.12 The **Chief Financial Officer** shall approve procedures for:

13.12.1 applying depreciation charges and indexation valuation adjustment to assets, using methods and rates as specified in the guidance issued by the DHSC.

13.12.2 reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

Security of assets

13.13 The **Chief Financial Officer** shall maintain procedures for controlling the security of assets, including fixed assets, cash, cheques and negotiable instruments. The procedures will include:

13.13.1 recording managerial responsibility for each asset

13.13.2 identification of additions and disposals

13.13.3 identification of all repairs and maintenance expenses

13.13.4 physical security of assets

13.13.5 periodic verification of the existence of, condition of, and title to, assets recorded

13.13.6 identification and reporting of all costs associated with the retention of an asset

13.13.7 reporting, recording and safekeeping of cash, cheques, and negotiable instruments

13.14 **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.

13.15 Where practical, assets should be marked as Trust property. Disposals and condemnations

13.16 The **Chief Financial Officer** shall prepare procedures for the disposal of assets including condemnations and ensure that these are notified to budget managers. The procedures will include arrangements to be followed for:

13.16.1 condemning and disposing of unserviceable and redundant assets.

13.16.2 maintaining records of assets disposed of, including confirmation of destruction of condemned assets.

13.16.3 specific processes to be followed in instances where assets are passed on for future use to another organisation.

13.16.4 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.

13.17 The appropriate **asset management lead** responsible for the decision to dispose of an asset shall advise the **Chief Financial Officer** of the estimated market value of the asset, taking account of professional advice where appropriate.

14 Bank accounts and Government Banking Service accounts

14.1 The **Trust Board** shall approve the banking arrangements for the Trust.

14.2 Where applicable, the **Chief Financial Officer** is responsible for producing a Treasury Management Policy, in accordance with any relevant guidance from NHS England, for **Trust Board** approval.

14.3 The **Chief Financial 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 DHSC.

14.4 The **Chief Financial Officer** shall:

14.4.1 establish and maintain necessary commercial bank accounts and Government Banking Service (GBS) accounts.

14.4.2 advise the Trust's bankers, formally in writing, of the conditions under which each account will be operated (the bank mandate).

14.4.3 seek to limit the use of commercial bank accounts and the value of cash balances held within them.

14.4.4 conduct the Trust's main banking services and financial transactions using accounts provided by the GBS.

14.5 Only the **Chief Financial Officer**, or their nominated representative, is authorised to open, operate and control a bank account, where monies owned by the Trust, including where applicable 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.

14.6 The **Chief Financial Officer** shall:

14.6.1 ensure that payments made from bank or GBS accounts do not exceed the amount credited to the account.

14.6.2 monitor compliance with DHSC guidance on the level of cleared funds.

14.6.3 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

14.7 The **Chief Financial Officer** shall prepare detailed instructions on the operation of bank and GBS accounts which shall include:

14.7.1 the conditions under which each bank and GBS account is to be operated.

14.7.2 details of those authorised to sign cheques or other orders drawn on the Trust's accounts.

14.7.3 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

14.8 The **Chief Financial 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.

14.9 The **Chief Financial 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 Financial 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 Financial 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 or cheques for private purposes.

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 Financial 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 for Health and Social Care and authorised by the **Board** and in accordance with the Trust's Treasury Management Policy, where applicable.

16 Management of debtors

16.1 The **Chief Financial Officer** shall manage debts in accordance with the Trust's Treasury Management Policy, and where not applicable the **Chief Financial 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 Financial 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 Financial 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 Financial 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 Where applicable, the **Chief Financial 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 DHSC and in accordance with the Trust's Treasury Management Policy. The **Chief Financial Officer** shall also provide periodic reports to the Board concerning the PDC debt and all loans as applicable.

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 Financial Officer**.

18.3 The **Chief Financial 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 DHSC.

18.3.2 the **Trust Board** is made aware of all short term borrowings at the next meeting.

18.4 The **Finance and Estates Committee** shall ensure that all proposed long-term borrowing is consistent with the Trust's financial plans; and is approved by the **Trust Board**.

18.5 Where applicable for an NHS Foundation Trust, the Trust can obtain a working capital facility from the commercial banking sector. Short term borrowing should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, comply with the Trust's Treasury Management Policy and all guidance issued by NHS England.

19 Losses and special payments

19.1 The **Chief Financial 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, as set out in the Scheme of Delegation. 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 Financial Officer** shall determine the nature and/or value of losses which must be reported immediately to the **Chief Financial 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 Financial 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 Financial 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 the relevant policy.

19.4 The **Trust Board** shall approve a scheme of delegation for the approval and authorisation of the write off of losses, compensations and ex-gratia payments, within the limits delegated to it by the Department of Health and Social Care and NHS England. Write offs includes the abandonments of claims and the charging of fruitless payments.

19.5 The **Audit Committee** shall receive regular reports from the **Chief Financial Officer** of losses, compensations and ex-gratia payments made, with details of all cases for which the **Trust Board**'s specific approval is required.

19.6 The **Chief Financial Officer** and where applicable 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 in accordance with relevant law and guidance.

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 Financial 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 'Charitable funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the NHS, the objects of which are for the benefit of the NHS in England.

21.2 The charitable trusts associated with the University Hospitals Bristol and Weston NHS Foundation Trust are administered by the Trustees of Bristol & Weston Hospitals Charity (hereafter called the Trustees). The Trustees have their own systems of accounting and financial control and operate separate bank accounts to the Trust. Charitable funds should not be confused with those operated by the Trust.

21.3 All gifts, donations and proceeds of fund-raising activities which are intended for the Trust's benefit shall be handed to either the Trustees or to the Trust's cashier who will bank the money and transfer funds and donor's intention or area of benefit as appropriate. Any charitable funds paid in through the Trust's cashier must be clearly identified as such to ensure it is separated from the Trust's exchequer funds.

21.4 The **CFO** shall be required to advise the **Trust Board** on the financial implications of any proposal for fund-raising activities which the Trust may initiate, sponsor, or approve.

21.5 The Trustees will designate a fund advisor for each fund held who must comply with the written procedures issued by the charitable trusts regarding the use of these funds.

21.6 Expenditure of any funds held in trust shall be conditional upon:

21.6.1 the expenditure being within the terms of the appropriate fund

21.6.2 meeting the delegated limits in accordance with the Scheme of Delegation.

21.6.3 the prior approval of the Trust's Capital Programme Steering Group being obtained for items falling within the capital definition

21.6.4 being authorised by the fund advisor in writing, or by a person to whom the fund advisor has delegated authority having advised the Trustees in writing

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 relevant DHSC and NHS England guidelines.

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 Digital and data security

23.1 The **Chief Digital and Information Officer** shall be responsible for the accuracy and security of the 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 relevant data protection legislation.

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 Financial 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 Financial 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 Financial 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 Financial Officer** shall periodically seek assurances that adequate controls are in operation.

Risk assessment

23.6 The **Chief Digital and 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 NHS England (to the **Chief Financial Officer** in the first instance).

25.3 It is the responsibility of the **Chief Financial 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 Financial 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 Financial 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 as applicable from time to time.

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, as required by DHSC and NHSE.

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 Financial 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 NHS internal audit standards as applicable from time to time.

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 Financial Officer**. The reporting system for internal audit shall be agreed between the **Chief Financial 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 such matters as required by DHSC and NHSE and the **Trust Board**.

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 Financial Officer** must be notified immediately.

25.14 In obtaining third party assurance from other 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 Council of Governors Representative at a general meeting of the Council of Member Representatives and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and reported to the Audit Committee and Council of Governors Representatives.

25.16 The Trust will ensure that the external auditor complies with the Audit Code for NHS Foundation Trusts at the date of appointment and on and on-going basis throughout the term of appointments.

25.17 The **Council of Governors** shall determine the terms of the contract for the provision of the External Audit.

25.18 The Audit Committee will receive and agree the External Auditor's annual plan.

Counter Fraud and Bribery

25.19 In line with their responsibilities the Trust **Chief Executive** and **Chief Financial Officer** shall ensure compliance with relevant directions and guidance on countering fraud and corruption within the NHS;

25.20 The **Chief Financial Officer** shall ensure that:

25.20.1 the Trust's Counter Fraud and Bribery Policy is maintained and remains up to date;

25.20.2 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.

25.21 The appointed **Local Counter Fraud Specialist** shall report to the **Chief Financial Officer** and shall work with staff in NHS Counter Fraud Authority, when required;

25.22 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;

25.23 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 Financial Officer** or via the NHS Fraud and Bribery Reporting Line.

25.24 All reported concerns will be treated in the strictest confidence and professionally investigated in accordance with the Fraud Act 2006 and Bribery Act 2010.

25.25 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

25.26 The **Chief Financial 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 DHSC and NHS England.

25.27 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.

26 Acceptance of Gifts by Staff and Other Standards of Business Control

26.1 The **Chief Executive** shall ensure that a Register of Interests, Gifts and Hospitality is established to formally record declarations of interests, gifts and hospitality made by Trust staff, and as the **Accountable Officer** has ultimate responsibility for ensuring the Trust has appropriate policies in place in respect of conflicts of interest and the acceptance of gifts or other benefits in kind conferring an advantage to a member of staff. These policies should be consistent with the Standards of Business Conduct for NHS Staff.

26.2 The **Director of Corporate Governance** of the Trust is responsible for implementing the Trust's Register of Interests, Gifts and Hospitality Policy across Clinical Divisions and Trust Headquarters and ensuring all Trust employees are aware of these Trust policies and the restrictions in relation to accepting gifts, inducements, benefits in kind or other personal advantage that could be considered to be bribes under the Bribery Act 2010.

Gifts

26.3 Casual gifts offered by contractors or others may be construed to be connected with the performance of duties so as to constitute an offence under the Bribery Act 2010 and therefore all such gifts should be declined. Business articles with little intrinsic value (of less than £50 per gift) such as diaries, calendars, pens etc. need not be refused, nor small tokens of gratitude from patients or their relatives.

26.4 Any gift accepted of value greater than £50 should be declared in writing to the Trust Secretary via the Register of Interests, Gifts, and Hospitality. If several small gifts worth a total of over £100 are received by an individual from the same or closely related source in a twelve-month period, these should also be declared on the Register of Interests, Gifts, and Hospitality.

26.5 Gifts offered to an individual where the value exceeds £50 should be declined. In exceptional circumstances and with the agreement of the line manager, the matter may be referred to the Trust Secretary for a decision as to whether the gift can be accepted.

26.6 Under no circumstances may staff accept cash or vouchers, even below the £50.00 threshold. Gifts of cash made to a ward or department are deemed to be charitable donations and should be dealt with as described in section 21. No further declaration is required.

26.7 All gifts to staff must be accepted in line with the Trust's Register of Interests, Gifts and Hospitality Policy.

Hospitality

26.8 Suppliers must not attempt to influence business decision making by offering hospitality to trust staff. Modest hospitality provided it is normal and reasonable in the circumstances may be accepted (e.g., lunches in the course of a working visit). If in doubt, advice should be sought from the employee's line manager or relevant Director.

26.9 Any offers of inappropriate hospitality should be notified to the **Trust secretary** for appropriate action.

26.10 All hospitality to staff must be accepted in line with the Trust's Register of Interests, Gifts and Hospitality Policy.

Sponsorship

26.11 Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks approval in advance from their line manager. Approval must depend on whether acceptance will, or could be believed to, compromise current or future purchasing decisions in any way.

26.12 The sponsorship of Trust events by existing suppliers to the Trust is acceptable subject to informing the **Trust Board Secretary** of the agreement for recording the details in the Register of Gifts, Hospitality and Sponsorship. Where the sponsor does not have a contract for supplies or services with the Trust, the Procurement Department should be consulted. The Trust **Director of Corporate Governance** be informed. In all such cases there must be no favouritism shown to any one supplier in a way that could later be challenged by a competitor. Where this could be the case the same opportunity to sponsor events should be offered to the other interested parties.

26.13 Some suppliers offer training as a part of supplying equipment, and this should be fully reflected through the contract entered into with the relevant organisation. In such cases no disclosure to the Trust **Director of Corporate Governance** is necessary.

26.14 The Trust shall not enter into commercial or charitable sponsorship arrangements which link such sponsorship to the supply of goods or services from any particular source.

26.15 Employees must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to concessionary agreements negotiated with companies by the Trust, or the NHS, or by recognised staff interests, on behalf of all staff for example, staff benefit schemes.

ENDS

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public – 8 April 2025

Reporting Committee	**UHBW Quality and Outcomes Committee**
Chaired By	**Sue Balcombe – Non-Executive Director**
Executive Lead	**Deirdre Fowler - Chief Nurse & Midwife**

For Information

The IQPR was reviewed and continued high levels of bed occupancy and beds occupied by patients with No Criteria to Reside was noted. Performance against planned care trajectories was reviewed and improvements in 6-week diagnostics noted. Positive improvements in the number of patients with MRSA and a reduction in the number of falls was welcome. Urgent care demand remains high, and performance challenged but an improvement in 12 hour waits in ED was also noted.

Performance against Patient First priorities highlighted that theatre utilisation rates are being maintained, and that the implementation of the Marthas rule pilot continues to go well with metrics being developed and initial feedback being largely positive.

The committee received an update on the specialist commissioning process and discussions including an update on vulnerable services. A more detailed discussion is planned for the May meeting.

The Clinical Quality Group escalated concerns regarding the number of incidents of violence and aggression in the surgical division. More work is underway to understand if this is due to increased reporting or another cause.

Positive improvements in admission avoidance was noted in BHOC who have developed a new virtual ward model which is making a real impact.

The safer staffing fill rate this month was 107% with turnover reducing. The Safer Nursing Care Audit using the new tool for acuity and dependency was completed in February.

The Maternity spotlight report highlighted the work of the Birth Choices clinic which is currently being piloted. In recognition that an increasing number of women are choosing to give birth “off guidance”, the programme aims to improve awareness of parents rights and knowledge and understanding of the options that are currently available to them. The importance of maintaining effective communication with the public via social media was noted.

For Board Awareness, Action or Response

University Hospitals Bristol and Weston NHS Foundation Trust

Following discussions at the last Trust board meeting, the Quality Impact Process for new developments, cost improvements and unfunded cost pressures was reviewed to include the policy, escalation process and reporting process up to the committee.

The committee received the Quarter three complaints report and noted that from 1st April the designation of formal complaints will be brought into alignment with North Bristol Trust with everything else recorded as PALS. Planned work to bring together the findings and actions following complaints with Patient Experience has been brought forward to Quarter four and will be subject to a deep dive discussion at committee in June to ensure that there is a good understanding of trends, themes and associated learning.

Key Decisions and Actions

Progress against the Trusts CQC Action Plan was reviewed and the committee agreed that seven actions could be closed. 25 new actions have been added to the plan following the inspection of the ED department in Bristol.

Additional Chair Comments

The committee remains concerned that the level of beds occupied by patients who meet the No Criteria to Reside threshold remains too high and continues to have an adverse impact on the ability of the Trust to deliver the required quantity and quality of care. Welcome progress was noted in Weston with regards to pathway 2 beds supported by Trust therapists, but it remains clear that the ability of the Trust to deliver agreed performance levels is dependent on the system helping us to achieve the target of 15% NCTR.

Update from ICB Committee

N/A

Date of next meeting:	**Tuesday 29th April**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public – 8 April 2025

Reporting Committee	**People Committee – March 2025 meeting**
Chaired By	**Linda Kennedy, Non-Executive Director**
Executive Lead	**Emma Woods, Chief People Officer and Deputy Hospital Managing Director**

For Information

The People Strategy comprises four key pillars of **Growing for the Future, New Ways of Working, Inclusion and Belonging and Looking After Our People**.

The focus in March's meeting was in three key areas: Growing For the Future, Inclusion and Belonging, and New ways of working.

Growing for the Future:

Education Update

This report provides a very high level update on the group benefits realisation plan which is looking at 3 key objectives:

- The development of a group Learning & Workforce Development Strategy
- Developing a single learning & workforce development portfolio
- Supporting the transition of the learning and development provision at NBT to sit under one Single Executive lead, the Chief People Officer.

Benefits achieved – reduction of the August medical education induction reducing from two days to one, releasing time to care for patients. Passporting of training across the group. Next steps are an away day for all L&WD managers to explore opportunities for further collaboration.

Inclusion and Belonging

National Staff survey Results 2024

The report provides an update since receipt of preliminary results, providing highlights of the Trust National Staff Survey, in comparison to the trusts benchmark group, Acute & Acute and Community Trusts:

Highlights:

- The national results are divided into 9 themes, the Trust are performing positively in all nine themes.
- Four People Promise themes had a significant increase compared to 2023.
- Out of the 103 questions which make up the People Promise asked in the Staff Survey, 100 were above the national acute average in our benchmarking group, and 62 questions improved year on year for the Trust.

University Hospitals Bristol and Weston NHS Foundation Trust

- The most notable strengths are that colleagues are advocates of the organisation, as well as there being positive relationships between colleagues and teams, and the confidence to speak up about concerns.
- UHBW had the best result, performing as the highest scoring Trust amongst the benchmarking group on the following questions: 5c 'relationships at work are unstrained' (53.5%) and 11e 'have felt pressure from manager to come to work when not feeling well enough' (14.7%).

The group model comparison results can be summarised as follows:

- In comparison UHBW (59.4) performance across all the people promise themes was higher in total than NBT. (58.9)
- In terms of nine themes NBT scored the same on two themes engagement and morale, and higher performing on `We are always learning`
- We are always learning has two sub scores Development and Appraisal. UHBW scores higher for Development and NBT performs more positively for Appraisal, identified as shortfall for UHBW as appraisal compliance.
- Staff engagement scores are aligned for both Trust at 7.1

The priorities from the Staff Survey feedback are aligned to the People Strategy milestones and People Patient First measures as follows:

- A programme of work to improve Appraisal compliance outcomes and align group model approach.
- Improve the Staff Survey measures for teams, as reported as most declined scores in the preliminary results January 2025.

New ways of working

The People Systems update.
Key updates are;

- **Medical e-rostering** roll out has continued and now falls under the Medical Workforce programme, a mission critical project. There has been very positive progress in the use of Healthroster for leave and absence recording and also Locum's Nest for locum payments. Focus into the new financial year will be on achieving at least Level 1 for the nationally set Levels of Attainment framework.
- **E-job planning** implementation is complete with a recent focus on responsibilities for signing off job plans to meet reporting requirements and ensure accuracy of pay going into the new financial year.
- **AfC e-rostering** has seen the roll out of annual leave and absence recording to all areas in Trust and also an uptake in the use of the Loop app following the sunsetting of previous software. Updates on actions are provided in the

report. The team is fully resourced to progress future workstreams and maintain business as usual processes.

- There is an **E-forms project** underway to replace the aging and unsupported inhouse system. Recommendations have been approved, and the project is moving into design phase.
- The Trust has recently undergone it's second **ESR assessment** to continue to prepare and action plan for future national changes to the HR and payroll system.
- Through the People Systems Group, work has been undertaken to develop a **HR data warehouse** which will collect, store and organise employee related data from various sources.
- Work continues to ensure there is a system fit for purpose to **track all learners** in the organisation.

A project has commenced, jointly with NBT, led by Digital Services to develop the functional specification and gap analysis of the RL Datix System. A report of findings and recommendations will be reported back to Executives of both Trusts by May 2025, to inform any **procurement exercise**. Medical Rostering are a key stakeholder for the project and will allocate resource to undertake the work.

For Board Awareness, Action or Response

There are two points to raise for awareness:

1. A proposal to review the Board Assurance Framework (BAF) principal risk description for Risk 2 – Workforce was discussed.

The current principal risk description is:

'There is a risk that our colleagues employment experience is not consistently excellent, and the Trust is unable to develop, engage or empower colleagues.

This may lead to poor retention and difficulty in attracting new staff, exacerbating the shortage of appropriately skilled and experienced professionals and increasing the cost of temporary staffing.

This situation could increase workloads, create skill gaps, decrease staff motivation, reduce a sense of belonging and ultimately impact the quality of care and patient outcomes'.

This description has been in place for some time, and the four pillars of the People Strategy have addressed and improved a number of areas around colleague experience. In addition, the people mission critical and corporate objectives from Patient First have focussed on key areas of the employment experience and the staff survey results have also demonstrated improvements.

It has been agreed to review the description and consideration be given to the following:

- The need to align the risk to the group so it remains contemporary, and the development of the Group People Strategy will enable appropriate actions to mitigate the risk.
- The current description needs to be cognisant of the current environment, and the impact of not only change management, but consideration of potential flight risks, which may include changes in the NHS and a challenging financial landscape.
- Consideration of potential workforce reductions and the impact on workloads
- Review the links and work programmes aligned with NHSE and the ICB to ensure the recent announcements about these organisations do not adversely impact on the People Strategy.

2. Digital Agenda – People Systems

The inability to progress improvements in transformation and increase productivity for a range of People System developments. The balance of investment predominantly sits outside of workforce requirements and therefore reduces the impact it can have within the People teams to innovate and reduce the time it takes to undertake labour intensive tasks, or work arounds in outdated systems.

Key Decisions and Actions

The committee were briefed and updated on the Annual Workforce Plan submission in the following areas:

- Workforce KPI performance, of the 21 workforce metrics set in March 2024, all except appraisal compliance and bank minimum usage were achieved in March 2025. The bank metric will be set as a maximum target going forward and will be monitored via People Learning and Development Group.
- People Learning and Development Group approved the workforce metrics for 25-26 on 26th February. The metrics for bank and agency FTE usage have been updated subsequently as the plan has been finalised.
- The final annual plan submission was due on 27th March, details were still being finalised at the date of submission of the People Committee papers, Tuesday 18th March. The final submission was shared with People Committee, via a presentation and described the fundamental driver of the workforce plan has been the need to deliver a breakeven financial plan that will enable providers to retain greater autonomy over their own workforce.

University Hospitals Bristol and Weston NHS Foundation Trust

The workforce triangulates with the financial and operational planning assumptions and the submission is completed in close alignment with planning and finance colleagues.

The committee approved the plan and the revised workforce targets for 2025/26.

Additional Chair Comments

Happy to see progress being made across all People areas and especially pleased to see the Employee Engagement survey results. I am supportive of the updates being made to the Risk Description, as I feel that this better reflects the current position, with specific consideration being given to the implementation of the Group Model.

Update from ICB Committee

Jaya Chakrabarti (Chair) provided an update on the current ICB situation regarding the 50% reduction in ICB running and programme costs. We are awaiting more information on what may happen next. Nothing has been formally received since the announcement made two weeks ago; it is anticipated that we won't hear anything for the next few weeks. The ICB will continue to deliver requirements meantime. The challenges that this brings were acknowledged and discussed.

Date of next meeting:	**22 May 2025**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public – 8 April 2025

Reporting Committee	**UHBW Finance, Digital & Estates Committee**
Chaired By	**Martin Sykes, Non-Executive Director**
Executive Lead	**Neil Kemsley, Chief Financial Officer and Neil Darvill, Joint Chief Digital Information Officer**

For Information

Finance

The committee reviewed the March version of the Trust finance and operations plan for 2025/26 and on behalf of the Board approved the plan for submission. The submitted plan showed a planned financial breakeven after the achievement of £53m of savings. The committee reviewed the assumptions and risks within the plan, key risks including:

- Delivery of the £53m savings programme.
- A failure to reduce the numbers of patients with no criteria to reside.
- Higher than planned growth in emergency admissions.
- Formal agreement of contracts with commissioners.
- Areas of quality and safety risk including fragile services.

The committee reviewed the month 11 (February) finance report noting a £1.9m in-month improvement to a £2.5m year-to-date deficit.

The committee reviewed a pre-submission report relating to the 2024/25 National Cost Collection. The committee approved the costing plan (in accordance with NHSE requirements) and also reviewed data from the earlier submissions ranging from 2019/20 to 2023/24.

Digital

The committee received a report on the Trust's digital progress – noting in particular the continuing plan for the rollout of electronic prescribing (on track) and the addition of Single Sign On (SSO) to next year's plan.

Digital risks were reviewed with the latest progress against Cyber Security and clinical coding being noted.

Estates

The committee received an update on estates compliance – noting the progress made and the ongoing development of more robust reporting systems.

A strategic estates review was also presented setting out the latest position on strategic capital schemes and the approach to prioritisation of capital schemes for 2025/26.

University Hospitals Bristol and Weston NHS Foundation Trust

Date of next meeting:	29th April 2025

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public		
Date of Meeting:	8 April 2025		
Report Title:	Integrated Quality and Performance Report (IQPR)		
Report Author:	David Markwick, Director of Performance James Rabbitts, Head of Performance Reporting Anne Reader/Julie Crawford, Head/Deputy Head Quality (Patient Safety) Alex Nestor, Deputy Director of Workforce Development Laura Brown, Head of HR Information Services (HRIS) Kate Herrick, Head of Finance Cathy Caple, Deputy Director of Improvement & Innovation Melanie Jeffries, Head of Improvement	Lisa Whitlow, Director of Performance Paul Cresswell, Director of Quality Governance Juliette Hughes, Deputy Chief Nursing Officer Benjamin Pope, Associate Director for Workforce Planning, People Systems and Data Simon Davies, Assistant Director of Finance	
Report Sponsor:	Responsive - Jane Farrell, Chief Operating Officer Quality, Safety & Effectiveness – Deirdre Fowler, Chief Nurse and Midwife Becky Maxwell Interim Chief Medical Officer Our People – Emma Wood, Chief People Officer Finance – Neil Kemsley, Chief Financial Officer	Responsive – Nicholas Smith, Interim Chief Operating Officer Quality, Safety & Effectiveness – Steven Hams, Chief Nursing Officer Tim Whittlestone, Chief Medical Officer Our People – Peter Mitchell, Interim Chief People Officer Finance – Elizabeth Poskitt, Interim Chief Financial Officer	
Purpose of the report:	**Approval**	**Discussion**	**Information**
			✓
	To provide an overview of NBT and UHBW's performance across Urgent and Planned Care, Quality, Workforce and Finance domains.		
Key Points to Note *(Including any previous decisions taken)*			
This is the first presentation of the NBT and UHBW consolidated IQPR for the first Board meeting in common.			
Strategic and Group Model Alignment			
This report aligns to the objectives in the CQC domains of Safe, Effective, Caring, Responsive and Well Led.			

Risks and Opportunities	
Risks are listed in the report against each performance area.	
Recommendation	
This report is for Information	
History of the paper (details of where paper has <u>previously</u> been received)	
UHBW Quality and Outcomes Committee received a previous iteration of this paper on 25 March 2025.	
Appendices:	PDF - NBT PQSM data for April-25 Joint Board (Feb 2025) PDF – UHBW PQSM data for April-25 Joint Report (Feb 2025)

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Integrated Quality and Performance Report

Month of Publication April 2025
Data up to February 2025

North Bristol NHS Trust

Contents

University Hospitals Bristol and Weston NHS Foundation Trust

North Bristol NHS Trust

Key to KPI Variation and Assurance Icons

University Hospitals Bristol and Weston NHS Foundation Trust

Assurance						Variation				
P*	P	?	F	F-	No icon	H	L	C	H	L
Consistently Passing Target	Meeting or Passing Target for at least Six Months	Inconsistent Passing and Falling Short of Target	Falling Short of Target for at least Six Months	Consistently Falling Short of Target	No Assurance Icon as No Specified Target	Special Cause of Improving Variation due to Higher or Lower Values		Common Cause Variation - No Significant	Special Cause of Concerning Variation due to Higher or Lower Values	

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (**L**) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (**H**) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (**L**) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (**H**) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Escalation Rules: SPC charts for metrics are only included in the IQPR where the combination of icons for that metric has triggered a Business Rule – see page at the end for detailed description.

Further Reading / Other Resources

The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link:
NHS England » Making data count

Scorecards Explained

Type of Metric; either Breakthrough Objective, Corporate Project or Constitutional Standard/Key Metric.

Name of Metric/KPI.

The most recent data period - this will be the last complete month for the majority, but some metrics are reported one or more

The target, where applicable, for the most recent month. This may be the national target or internal target / planned trajectory.

This icon indicates the assurance for this metric (see above key for summary or see Appendix for full detail).

Response taken based on the Metric Type and the Assurance and Variation Icon for the latest month (see Appendix for full detail). Action is either Note Performance, Escalation Summary, Counter Measure Summary or Highlight

Metric Type	CQC Domain	Experience of Care Metric	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Constitutional Standards and Key Metrics	Caring	Monthly Inpatient Survey - Standard of Care	Sep 24	93.2%	94.1%	90.1%	F	C	Escalation Summary

The CQC Domain the indicator is covered by. See CQC Website for more information: The five key questions we ask - Care Quality

The actual performance for the most recent month.

The actual performance for the previous month.

This icon indicates the variance for this metric (see above key or see Appendix for full detail).

Business Rules and Actions

Assurance						Variation				
P*	P	?	F	F-	No icon	H	L	C	H	L
Consistently Passing Target	Meeting or Passing Target for at least Six Months	Inconsistent Passing and Falling Short of Target	Falling Short of Target for at least Six Months	Consistently Falling Short of Target	No Assurance Icon as No Specified Target	Special Cause of Improving Variation due to Higher or Lower Values		Common Cause Variation - No Significant	Special Cause of Concerning Variation due to Higher or Lower Values	

SPC charts for metrics are only included in the IQPR where the combination of icons for that metric has triggered a Business Rule – see page at end for detailed description.

Metrics that fall into the **blue categories** above will be labelled as **Note Performance**. The SPC charts and accompanying narrative will not be included in this iteration.

Metrics that fall into the **orange categories** above will be labelled as **Escalation Summary** and an SPC chart and accompanying narrative provided

Executive Summary – Group Update

Responsive

Urgent Care

Four-hour performance remained challenged at both Trusts in February with NBT reporting at 59.4% and UHBW at 63.8% for all attendance types. Despite this performance, NBT ranked third out of 11 AMTC providers. In addition, there are also challenges in delivering the 12-hour total time in the department and ambulance handover metrics.

There is commonality in the drivers of this position across both Trusts - a combination of increasing demand, high bed occupancy and reduced patients flow out of the hospitals. These circumstances are creating a challenging clinical, operational and performance environment.

The System ambition to reduce the NC2R percentage to 15% remains unachieved. This ambition was central to the Trusts being able to deliver the 78% ED 4-hour performance requirement for March 2025. As yet, there is no evidence this ambition will be realised. Community-led D2A programme remains central to ongoing improvement. In the meantime, internal hospital flow plans continue to be developed and implemented across all sites.

Elective Care

NBT has been successful in delivering its 65-week RTT commitments against the national September-2024 requirements. Due to national challenges with Dental and supply of Cornea Graft material, at the end of February, UHBW reported 26 patients waiting more than 65-weeks for treatment. The Trust continues to develop and implement strategies to address the remaining patients at risk of breaching 65-weeks and both Trusts expect to eliminate 65-week waits during March.

At NBT, having reached the milestone of reducing 52-week waits to below 1,000 in September, there has been another significant reduction during February, taking the position under 400. The Trust has now set its own ambition to reduce 52-week wait breach volumes to less than 1% by the end of this year. This ambition is beyond national target requirements and is on track to deliver. Similarly, at UHBW, the number of patients waiting 52-weeks continues to fall each month, reducing from 5,800 to 824 in the last 18 months and an anticipated year-end position of c640 (c1.15%) against the operational planning trajectory of 862.

Diagnostics

For the seventh consecutive month, NBT's diagnostic performance has achieved the national constitutional standard – going beyond the target of no more than 5% breaching six-week waits. The actual breach rate in February was less than 1%. The Trust also remains compliant with the maximum 13-week wait with no patients waiting beyond 13-weeks. UHBW has also experienced an improvement in diagnostic performance during February, reporting 13.3%, recovering from an unforeseen deterioration in January (19.7%). UHBW has a continued focus on diagnostic recovery plans throughout March and is anticipating further improvement during the month, striving to move closer to the year-end target of 95%.

Cancer Wait Time Standards

Both Trusts continue to be compliant with the FDS-28-Day standard. UHBW also continues to deliver the 31-Day and 62-Day standards, having done so for the last nine months and expect to continue during the final two-months of the year. At NBT, the 62-Day Combined position has also reported improvements since September 2024 but deteriorated in January 2025. The work previously undertaken has been around improving systems and processes, and maximising performance in the high-volume tumor sites. To achieve the overall 62-Day breach standard this year, NBT will now focus on improvements in some of the most challenging pathways/backlogs - including the high volume and high-complexity Urology pathway (in particular, robotic prostatectomy). As reported previously, due to the backlog activity, the 62-Day position was expected to show a deterioration in January and February before recovering into March. As the backlog clearance work concludes, plans for sustaining the position will be enacted which will require slightly lower levels of additional activity. On this basis, the NBT is expecting to meet its commitments to secure its PTL, FDS and the 62-Day target by March 2025, as per the national requirement.

Executive Summary – Group Update

Quality, Safety and Effectiveness

Patient Experience

Patient Safety & Clinical Effectiveness

NBT has not seen any MRSA HCAI cases for the past four consecutive months, leaving the year-to-date (YTD) position remaining at four cases. UHBW had no additional cases of MRSA in February and YTD has seen seven cases recorded. The MRSA decolonisation of patient's pathway has been updated and is now in place at UHBW and the way skin cleansing is delivered, prior to the insertion of peripheral IV lines, has changed and this is rolling out across the Trust to help reduce the MRSA risk.

At NBT C. Difficile cases have exceeded the nationally set trajectory. C. Difficile ward rounds are to commence to reduce incidence of cases, and the central IPC team continue to provide focused education, especially targeted in areas of repeat infection. UHBW continues to do very well, below trajectory in February and quality improvement work to reduce the C. Difficile infection risk remains in progress.

VTE risk assessment compliance at both Trusts remains fairly static. The new digital prescribing system (CMM) is due to launch in 2025/26 across both organisations, which is anticipated to significantly increase compliance with the risk assessment completion.

During February 2025 NBT had a rate of 5.6 medication incidents per 1000 bed days which is below the 6–month average of 5.8 for this measure. The level of medication incidents causing moderate or severe harm or death was 0% this month with no incidents falling into this category. The work of the 'Medicines Safety Forum' continues – this is a multidisciplinary group whose aim is to focus on gaining a better understanding of medicines safety challenges and subsequently supporting staff to address these. UHBW had a rate of 8.61 medication incidents per 1,000 bed days in February, which is below the 6-month average of 8.77 for this measure. Medication incidents are reviewed by the UHBW medication safety team and individual incidents are managed by the department where the incident occurred. Incidents are identified for enhanced learning response according to the Patient Safety Investigation Response Plan (PSIRP), noting that, for medication incidents the criteria for enhanced learning is an omitted/delayed dose of a high-risk medication.

Both Trust's SHMI indicator continues to show special cause improving variation, which provides a positive assurance, and our insight will be further enhanced through the Mortality Improvement Programme which operates across the Hospital Group. This programme is enhancing our links with Medical Examiner Scrutiny, deepening our insights into our mortality and morbidity surveillance data and support specialty-led quality improvement initiatives.

Patient & Carer Experience

At NBT, delivery of the Year 2 workplan for the Patient & Carer Experience Strategy remains positive, with the majority of planned commitments successfully completed, or compliant with targeted improvements. Progress was reviewed at the March 2025 Patient & Carer Experience Committee and the forward plan approved for 2025/26, which is the final year of NBT's current strategy.

The complaint response rate compliance at NBT marginally decreased from 80% in January to 78%, below the target rate of 90%. Out of 45 complaints due, 35 were closed within the agreed timescale, 6 were closed outside the agreed timescale, and 4 remained open at the time of reporting. The Complaints and PALS Manager meets weekly with divisional Patient Experience teams to discuss cases due and those overdue. This provides an opportunity to discuss complexities and agree resolution. All complaints & PALS concerns continue to be acknowledged within the agreed timeframes. Timeliness of responses to formal and informal complaints at UHBW is showing improvement towards the 90% target in January 2025 compared to December 2024 at 54.4% and 86.5% respectively – UHBW is currently reporting this metric in arrears from NBT. Alignment work between NBT and UHBW continues, supporting both the Single Managed Service Programme and Group development.

The overall Friends and Family Test score for UHBW's maternity service was 96.5% in February 2025 which is above the latest published (January 2025) national average FFT score for Maternity (91%). Whilst the Maternity FFT has no target, it is displaying special cause variation with seven consecutive months below the mean.

Executive Summary – Group Update

Our People

Finance

Our People

Turnover at NBT is 11.6% in February, remaining below the NBT target of 11.9% for 2024/25. For UHBW, turnover reduced to 10.8% against a target of 12% and compared to 11.1% in the previous month. Vacancy rate has increased in both Trusts in February with particular impact of recruitment controls at NBT continuing.

NBT agency spend is 1.0% of total pay spend in February significantly below the target of 3.2% and is anticipated to reduce further as we continue to focus on temporary staffing use and spend through the Resourcing and Temporary Staffing Oversight group in 2025/26. UHBW agency usage is also low at 0.6% (84.1 FTE) against a target of 1.0% maximum and remains a priority focus area as reflected in the UHBW Patient First Corporate Projects, with increased focus on reducing medical usage.

For NBT, sickness remains at 4.6% which is above the target of 4.4%. This target will remain in place for 2025/26. However, UHBW sickness absence has reduced to 4.4% against the 4.9% target and compared to 4.7% the previous month.

Essential training compliance is >90% at both Trusts.

Finance

In Month 11 (February) both Trusts have delivered a surplus against their plans. NBT delivered a £2.3m surplus, which is £1.5m better than plan. UHBW delivered a £1.9m surplus against the plan of break-even. Year-to-date (YTD), the NBT position is a £1.0m adverse variance against a planned £0.8m deficit driven primarily by the impact of in year CIP delivery across pay and non-pay, and various non-pay pressures within Divisions. The cumulative UHBW YTD position at the end of the month is a net deficit of £2.5m (£4.4m net deficit last month) against a breakeven plan. The cumulative UHBW YTD net deficit is 0.2% of total operating income. Significant operating expenditure variances in the UHBW YTD position include: the shortfall on savings delivery; premium pay pressures and over-establishment mainly relating to nursing and medical staff; higher than planned pass-through costs (matched by additional patient care income) and the impact of unfunded non-pay inflation.

The NBT cash position at Month 11 is £56.9m, a reduction of £5.7m from Month 12 2023/24. This is driven by the underlying deficit and capital spend. The Trust has delivered £21.1m of completed cost improvement programme (CIP) schemes at Month 11, an increase of £3.5m from Month 10. There are a further £0.9m of schemes in implementation and planning that need to be developed, and none in the pipeline.

UHBW YTD pay expenditure is c3% higher than plan. Medical staffing costs in the Women's & Children's Division and nursing costs continue to cause significant overspends across Surgery, Specialised and Women's & Children's Division with continuing over-establishment and high nursing pay costs in total across substantive, bank and agency staff.

Responsiveness

Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Responsive	ED % Spending Under 4 Hours in Department	NBT	Feb-25	59.4%	71.4%	59.8%	F	L	Escalation Summary
		UHBW	Feb-25	63.8%	71.8%	66.0%	F	C	Escalation Summary
Responsive	ED % Spending Over 12 Hours in Department	NBT	Feb-25	12.2%	2.0%	11.9%	F-	H	Escalation Summary
		UHBW	Feb-25	7.4%	2.0%	8.5%	F	H	Escalation Summary
Responsive	ED 12 Hour Trolley Waits (from DTA)	NBT	Feb-25	536	0	545	F	H	Escalation Summary
		UHBW	Feb-25	664	0	909	F-	H	Escalation Summary
Responsive	No Criteria to Reside	NBT	Feb-25	20.7%	15.0%	21.5%	F-	L	Escalation Summary
		UHBW	Feb-25	22.0%	13.0%	21.4%	F-	H	Escalation Summary
Responsive	Ambulance Handover Delays (under 15 minutes)	NBT	Feb-25	19.9%	65.0%	21.0%	F-	C	Escalation Summary
		UHBW	Feb-25	27.0%	65.0%	21.5%	F-	C	Escalation Summary
Responsive	Ambulance Handover Delays (under 30 minutes)	NBT	Feb-25	45.9%	95.0%	46.9%	F-	L	Escalation Summary
		UHBW	Feb-25	56.6%	95.0%	47.5%	F-	C	Escalation Summary
Responsive	Ambulance Handover Delays (over 60 minutes)	NBT	Feb-25	723	0	710	F-	H	Escalation Summary
		UHBW	Feb-25	816	0	1226	F-	C	Escalation Summary

Assurance						Variation		
P*	P	?	F	F-	No icon	H L	C	H L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation	Common Cause (natural) Variation	Concerning Variation

Responsiveness

Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Responsive	Total RTT Pathways 52 weeks	NBT	Feb-25	345	528	434	P	N/A	Note Performance
		UHBW	Feb-25	824	993	938	P	N/A	Note Performance
Responsive	Total RTT Pathways 65 weeks	NBT	Feb-25	4	0	4	P	N/A	Note Performance
		UHBW	Feb-25	26	0	62	F	N/A	Escalation Summary
Responsive	Diagnostics % Over 6 Weeks	NBT	Feb-25	0.6%	0.98%	0.88%	P	L	Note Performance
		UHBW	Feb-25	13.3%	5.4%	19.7%	F-	L	Escalation Summary
Responsive	Cancer 28 Day Faster Diagnosis	NBT	Jan-25	77.8%	77.1%	82.1%	P	H	Note Performance
		UHBW	Jan-25	77.0%	77.0%	77.9%	P	H	Note Performance
Responsive	Cancer 31 Day Diagnosis to Treatment	NBT	Jan-25	88.1%	94.1%	92.2%	?	C	Escalation Summary
		UHBW	Jan-25	96.4%	96.0%	97.7%	P	H	Note Performance
Responsive	Cancer 62 Day Referral to Treatment	NBT	Jan-25	66.6%	70.3%	74.5%	?	C	Escalation Summary
		UHBW	Jan-25	74.2%	70.0%	76.4%	P	H	Note Performance

Assurance						Variation		
P*	P	?	F	F-	No icon	H L	C	H L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation	Common Cause (natural) Variation	Concerning Variation

Responsiveness

UEC – Emergency Department Metrics

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

ED Percentage Spending Under 4 Hours in Department

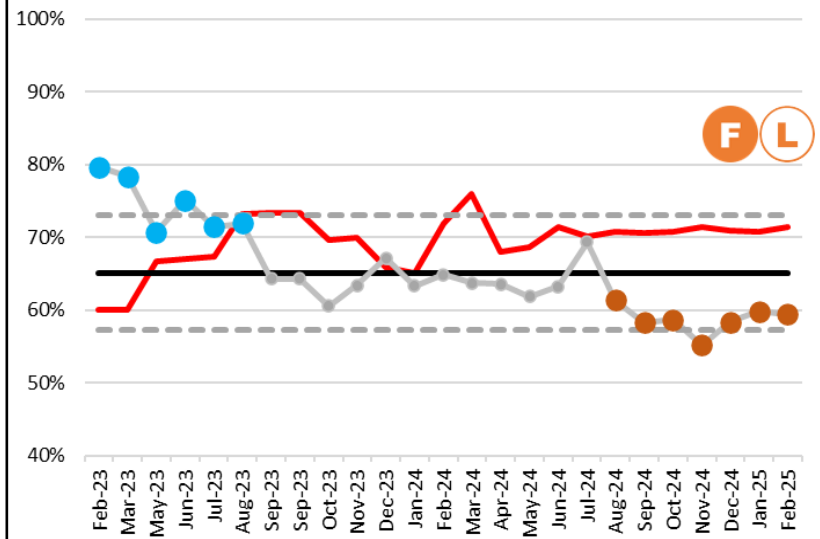
Latest Month
Feb-25

Target
71.4%

Latest Month's Position
59.4%

Performance / Assurance
Special Cause Concerning Variation Low, where down is deterioration and last six data points are less than target

Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



Summary

What does the data tell us?
The percentage of patients spending under 4 hours in ED for the month of February was similar to the previous month's position at 59.4% Year-on-year ED attendances have been increasing; for 2024/25 to-date, attendances have been 1.24% higher than the same period last year.

Actions being taken to improve
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).

Impact on forecast
As yet, no significant progress in reducing No Criteria to Reside (NC2R) problems against System ambition.
Since the month of December, significant rise in Flu and respiratory infection presentations.
In addition to respiratory presentations, the Trust experienced outbreaks of Norovirus with an inevitable impact on patient flow.

ED Percentage Spending Under 4 Hours in Department

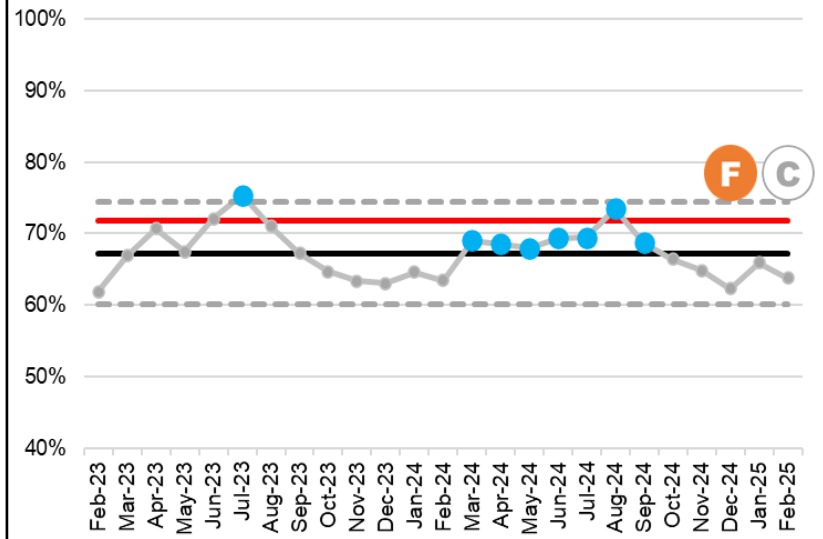
Latest Month
Feb-25

Target
71.8%

Latest Month's Position
63.8%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration.

Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)



Summary

What is the data telling us?
A slight deterioration on the previous month's performance in February against the ED 4-hour standard at 63.8% (66% January), noting that performance is aggregated across the four ED sites, and attendances continue to grow in year; attendances 3.7% higher than Apr-Feb 2023/24.
Patients requiring beds in a side room due to infections, plus significant challenges with No Criteria To Reside (NC2R) in January and February have impeded flow with a commensurate impact on ED 4-hour performance for BRI (48%) and Weston (62%) sites in particular.

Actions being taken to improve
Ongoing mobilisation of ED improvement plans across both BRI and Weston. This includes workforce reconfiguration to augment and better align senior decision makers to peak times IN & OOH, in addition to optimising SDEC utilisation and front door redirection models. Whole hospital review of ED 'quality standards' continues, with a specific focus on 'specialty reviews' and outward flow from ED. The departments also working closely with SWAST, community and primary care partners to maximise admissions avoidance schemes e.g. Frailty – Assessment & Coordination of Urgent & Emergency Care (F-ACE). NB UHBW currently leading the parallel development with Paediatrics (P-ACE)

Impact on forecast
Despite the challenges outlined, it is anticipated that focused efforts through March will improve the Trust position, aiming to achieve c76% (c69% for Type1/Type 2 only) by month end. YTD = 74%

Responsiveness

UEC – Emergency Department Metrics

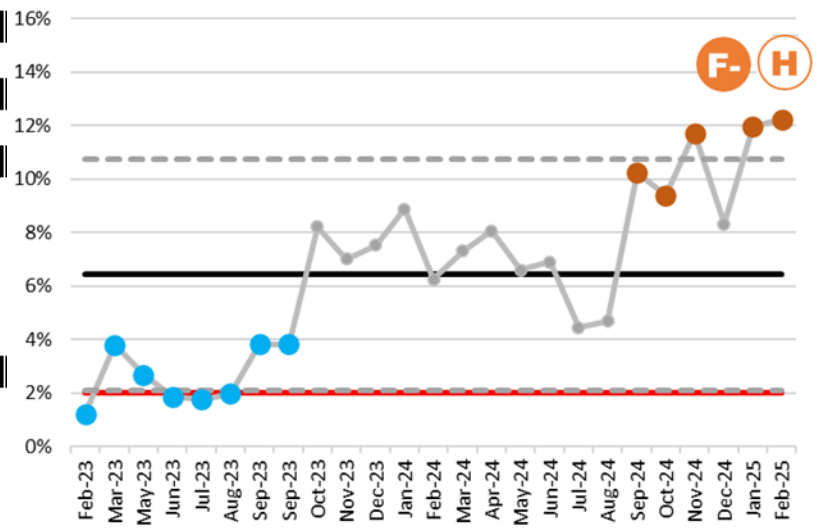
North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

ED Percentage Spending Over 12 Hours in Department

Latest Month
Feb-25
Target
2.0%
Latest Month's Position
12.2%
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit

Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



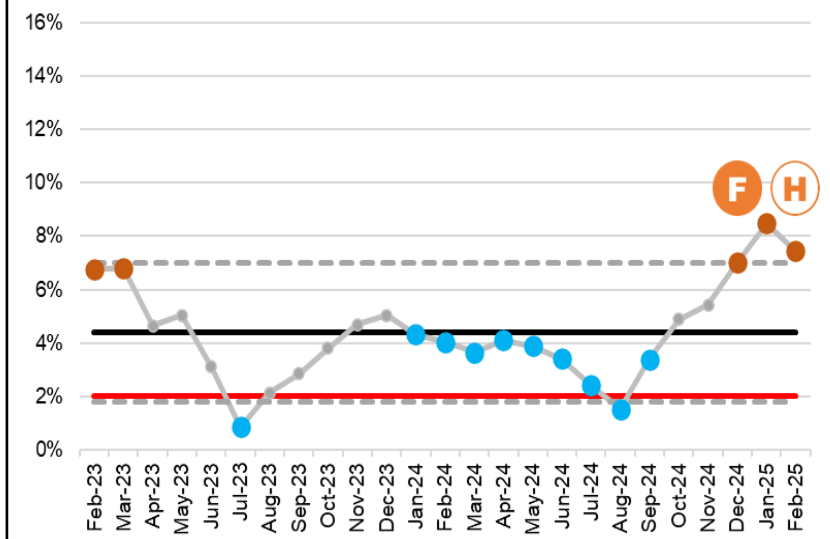
Summary

What does the data tell us?
The percentage of patients spending over 12 hours in ED for the month of February was slightly higher than the previous month at 12.23%.

Actions being taken to improve
See previous slide.

Impact on forecast
See previous slide.

ED Percentage Spending Over 12 Hours in Department



Latest Month
Feb-25
Target
2.0%
Latest Month's Position
7.4%
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration and last six data points are greater than or equal to target.
Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

Summary

What does the data tell us?
The percentage of patients spending over 12 hours in ED for the month of February (7.4%) was an improvement on the previous month at 8.5%

Actions being taken to improve
Note previous slide.

Additionally, ED 12-hour performance data is being reviewed by all divisions/specialties across BRI/Weston sites in support of a trust-wide approach to reducing 12-hour waits through improved responsiveness to requests for Specialty Reviews, in addition to improved support into ED in Out of hours periods.

Impact on forecast
The focused efforts through March are anticipated to result in an improved position to c5% during the month.

Responsiveness

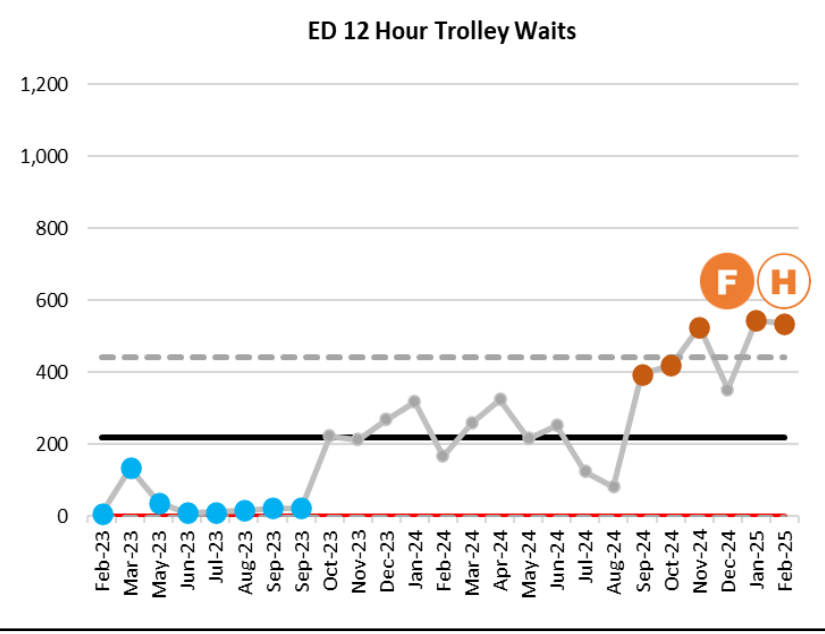
UEC – Emergency Department Metrics

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

ED 12 Hour Trolley Waits

Latest Month
Feb-25
Target
0
Latest Month's Position
536
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration and last six data points are greater than or equal to target
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



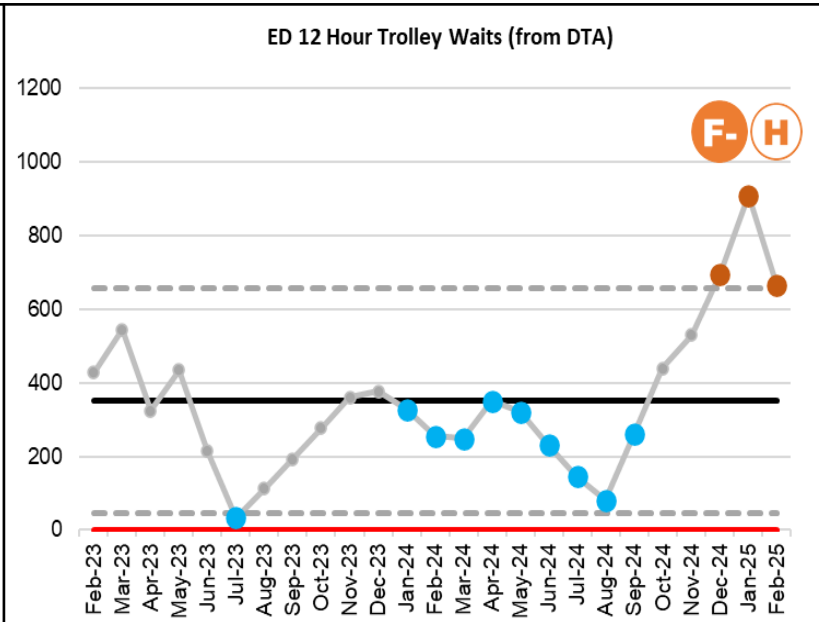
Summary

What does the data tell us?
The number of 12 Hour trolley decreased slightly on the previous month but remains high.

Actions being taken to improve
See previous slide.

Impact on forecast
See previous slide.

ED 12 Hour Trolley Waits



Latest Month
Feb-25
Target
0
Latest Month's Position
664
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit.
Corporate Risk
Corporate Risk 910 - That patients in BRI ED do not receive timely and effective care (20)

Summary

What does the data tell us?
The number of 12 Hour trolley waits has decreased on the previous month but remains high.

Actions being taken to improve
Note actions from previous two slides.

Impact on forecast
Along with improvements noted against the 4-hour and 12-hour standard, it is anticipated that 12-hour trolley waits will reduce in March as a result of the enhanced focus and re-launch of the ED Quality Standards in relation to “Speciality Reviews” in particular

North Bristol NHS Trust

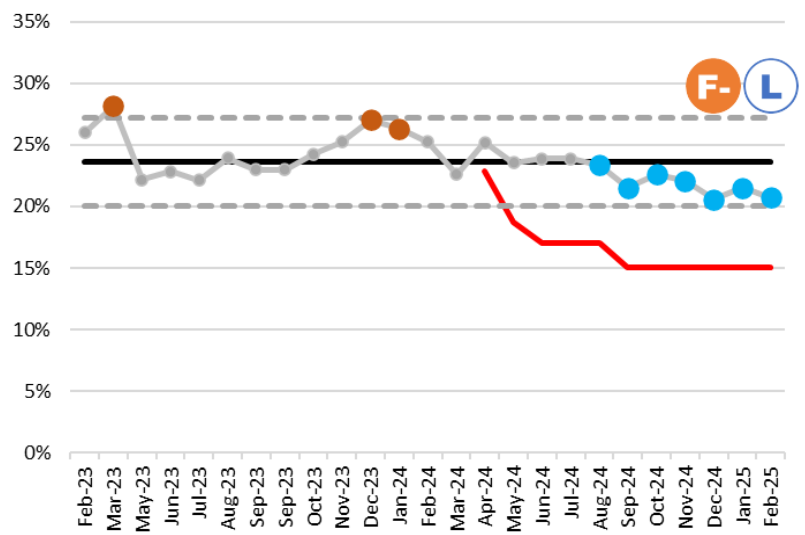
Responsiveness

UEC – No Criteria To Reside

University Hospitals Bristol and Weston NHS Foundation Trust

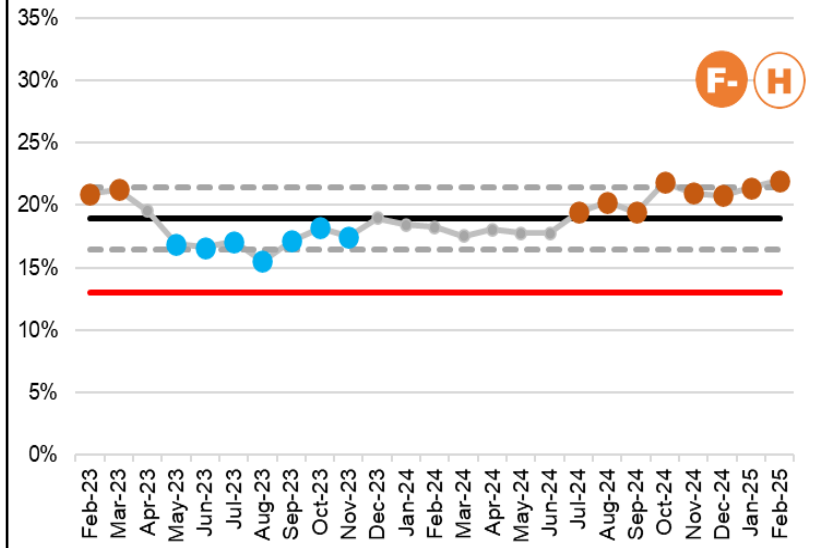
Percentage of Inpatients with No Criteria to Reside

Latest Month
Feb-25
Target
15.0%
Latest Month's Position
20.7%
Performance / Assurance
Special Cause Improving Variation Low, where down is improvement but target is less than lower limit
Trust Level Risk
No Trust Level Risk



No Criteria To Reside - Beds Occupied

Latest Month
Feb-25
Target
13.0%
Latest Month's Position
22.0%
Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit.
Corporate Risk
Corporate Risk 423 - Risk that demand for inpatient admission exceeds available bed capacity (20).
Corporate Risk 2614 Risk that patient care and experience is affected due to being cared for in extra capacity locations (15)



Summary

What does the data tell us?
Although there has been a slight downward trend in NC2R, there has not been progress in reducing this to the 15% System ambition target.

Actions being taken to improve
Executive and CEO-level escalation regarding NC2R impact - commitment secured from system partners for focussed work with revised reduction ambition. Additional capacity requirements developed by COOs across the System with CEO funding agreement reached. Awaiting capacity provision.
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.
New demand and capacity work being undertaken by system partners to refresh D2A model to support NC2R reduction ambition .
COO escalating Stroke NC2R. Further escalation arranged with System partners.

Impact on forecast
As yet, no significant progress in reducing NC2R problems against System ambition.

Summary

What does the data tell us?
The No Criteria to Reside (NC2R) position worsened slightly in February (22%) compared to the previous month (21.4%), continuing to impact flow through hospital sites. NB Weston 30.6%; BRI 19.4%

Actions being taken to Improve:
Executive and CEO-level escalation regarding NC2R impact - commitment secured from system partners for focussed work with revised reduction ambition. Additional capacity requirements developed by COOs and additional beds secured. A review of ongoing provision into 2025/26 (cessation or continuation) is underway given the NCTR position has remained largely unchanged & further improvement required before community bed contraction can be tolerated.
Focus continues on 'internal delays', across all partner organisations, seeking to improve the visibility and synergy between acute and community capacity and focus improvement efforts in the right place.
In addition, working with NHS@Home to further maximise their capacity to support reduction in discharge cancellations, and promote 'step up' as well as 'step down' as a means of balancing flow.

Impact on forecast:
Whilst the System ambition of reducing NC2R to 15% (11% at BRI; 19% at Weston) remains unmet, LoS reduction across all patient pathways at UHBW is noted during 2024/25, against the 2022/23 baseline period (25% reduction in Non-elective LoS at Weston and 11% reduction at BRI).

North Bristol NHS Trust

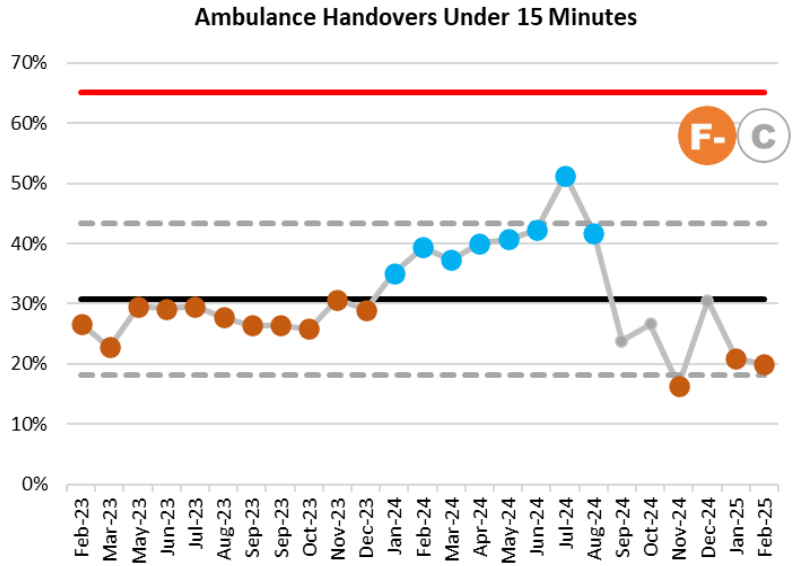
Responsiveness

UEC – Ambulance Handover Delays

University Hospitals Bristol and Weston NHS Foundation Trust

Ambulance Handovers Under 15 Minutes

Latest Month
Feb-25
Target
65.0%
Latest Month's Position
19.9%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



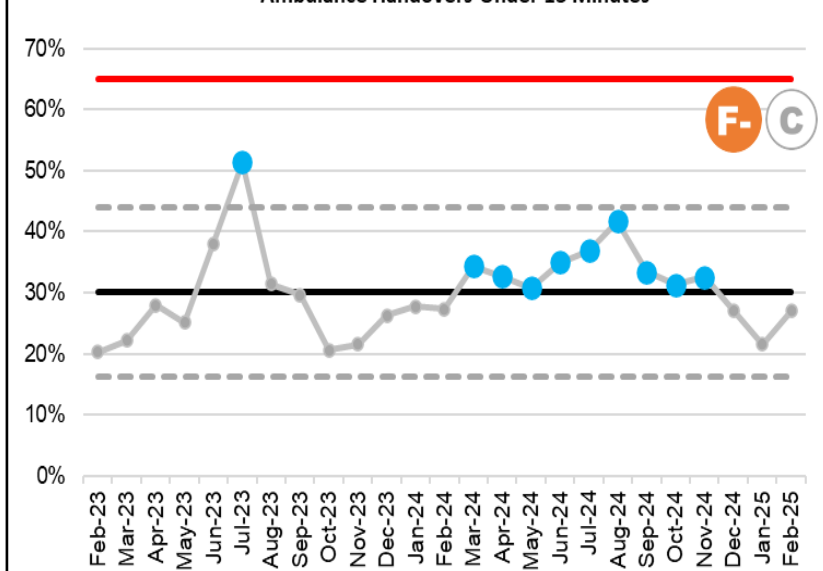
Summary

What does the data tell us?
Significant year-on-year improvement in lost ambulance handover time – but previous months have proved more challenging.

Actions being taken to improve
Internal UEC programme actions on handover processes, together with the 'continuous flow' model led by the Chief Nursing Officer has delivered further improvement.

Impact on forecast
As yet, no significant progress in reducing NC2R problems against System ambition.
Since the month of December, significant rise in Flu and other respiratory infection presentations, and more recently, Norovirus.

Ambulance Handovers Under 15 Minutes



Latest Month
Feb-25
Target
65.0%
Latest Month's Position
27.0%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit and down is deterioration.
Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

Summary

What is the data telling us?
Whilst UHBW has seen an improved position in February (27% vs 21.5% in January) and a notable year-on-year improvement, more recent months have been more challenged, largely impacted by lack of physical capacity and staffing numbers available to complete timely handovers.

Actions being taken to improve
The current improvement plan and Standard Operating Procedure for ambulance handover is under review in partnership with SWAST and clinical teams, with the aim of embedding and strengthening those schemes that are adding value – e.g. new cohort plan and rapid handover arrangements - and using a data driven approach to re-evaluating periods when most challenged. NB Largely OOH.

Impact on forecast
Whilst the progress in reducing NC2R remains challenged, it is anticipated that mitigations in place will contribute to an improved position in March.

North Bristol NHS Trust

Responsiveness

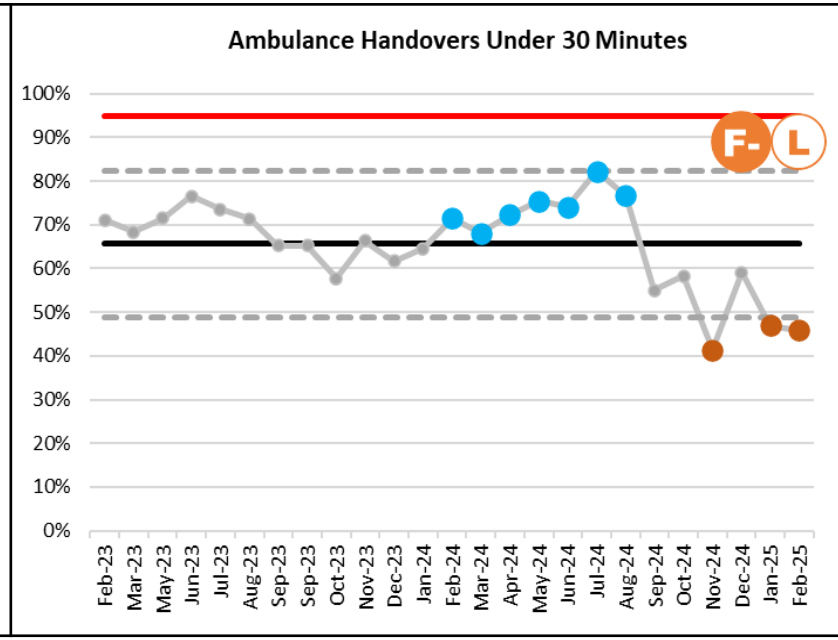
UEC – Ambulance Handover Delays

University Hospitals Bristol and Weston NHS Foundation Trust

Ambulance Handovers Under 30 Minutes

Latest Month
Feb-25
Target
95.0%
Latest Month's Position
45.9%
Performance / Assurance
Special Cause Concerning Variation Low, where down is deterioration and target is greater than upper limit

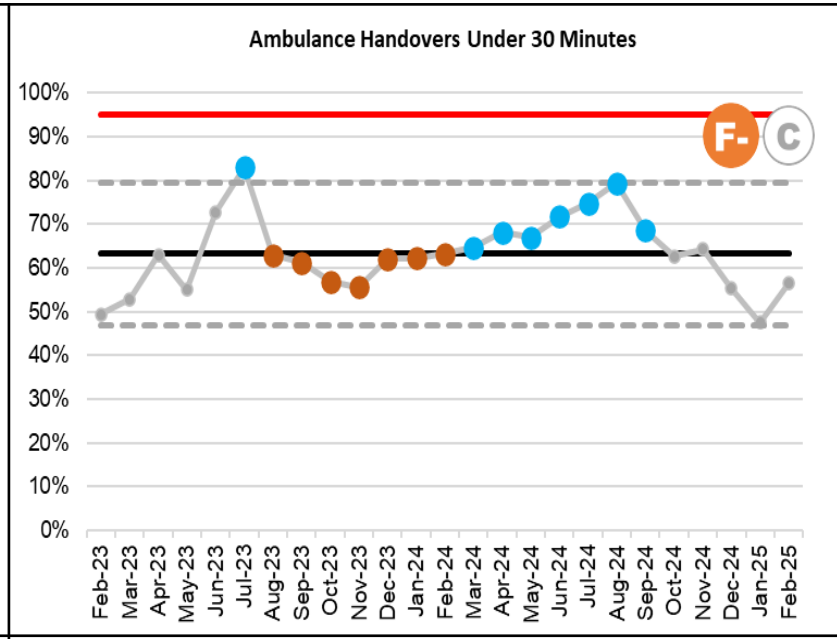
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



Summary

See Previous Slide for Ambulance Handover Summary

Ambulance Handovers Under 30 Minutes



Latest Month
Feb-25
Target
95.0%
Latest Month's Position
56.6%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit and down is deterioration.

Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

Summary

See Previous Slide for Ambulance Handover Summary

Responsiveness

UEC – Ambulance Handover Delays

Ambulance Handovers Over 1 Hour

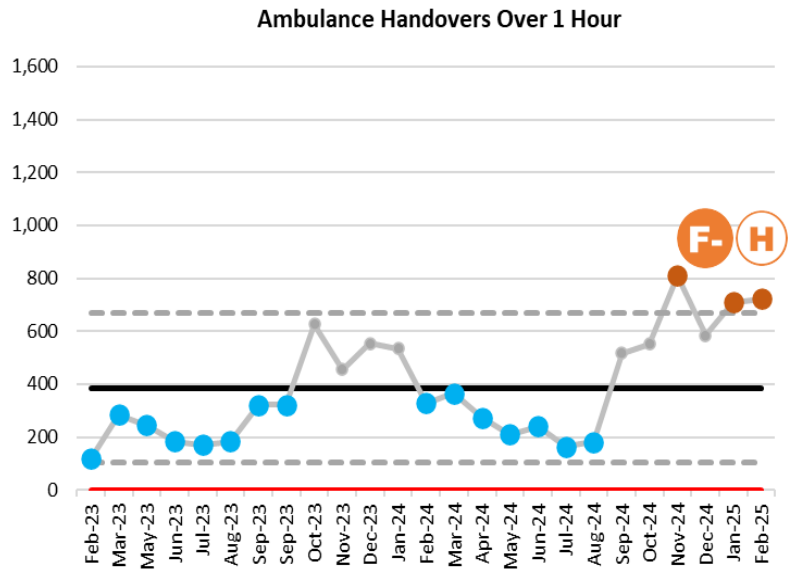
Latest Month
Feb-25

Target
0

Latest Month's Position
723

Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit

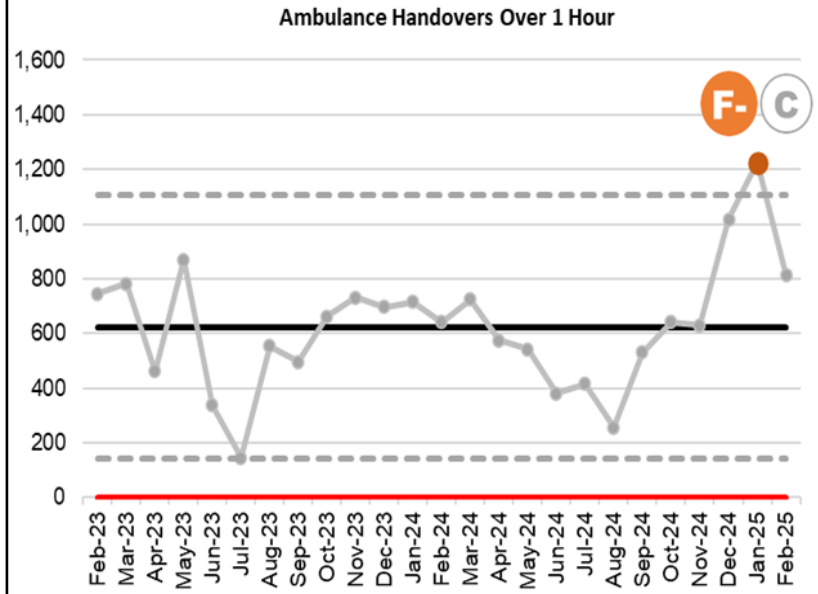
Trust Level Risk
1940 - risk that patients will not be treated in an optimum timeframe, impact on both performance and quality (20).



Summary

See Previous Slides for Ambulance Handover Summary

Ambulance Handovers Over 1 Hour



Latest Month
Feb-25

Target
0

Latest Month's Position
816

Performance / Assurance
Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration.

Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20)

Summary

See Previous Slides for Ambulance Handover Summary

North Bristol NHS Trust

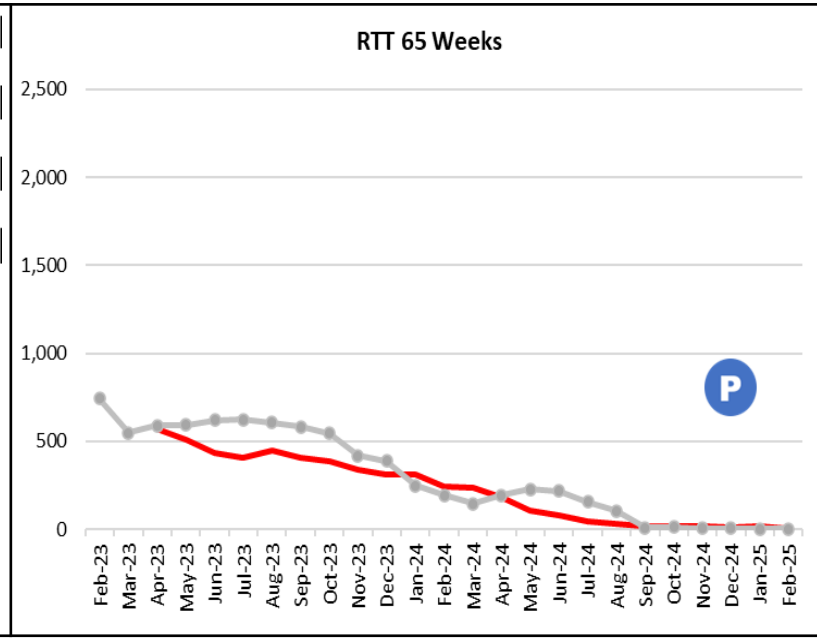
Responsiveness

Planned Care – Referral To Treatment

University Hospitals Bristol and Weston NHS Foundation Trust

Total RTT Pathways 65+ Weeks

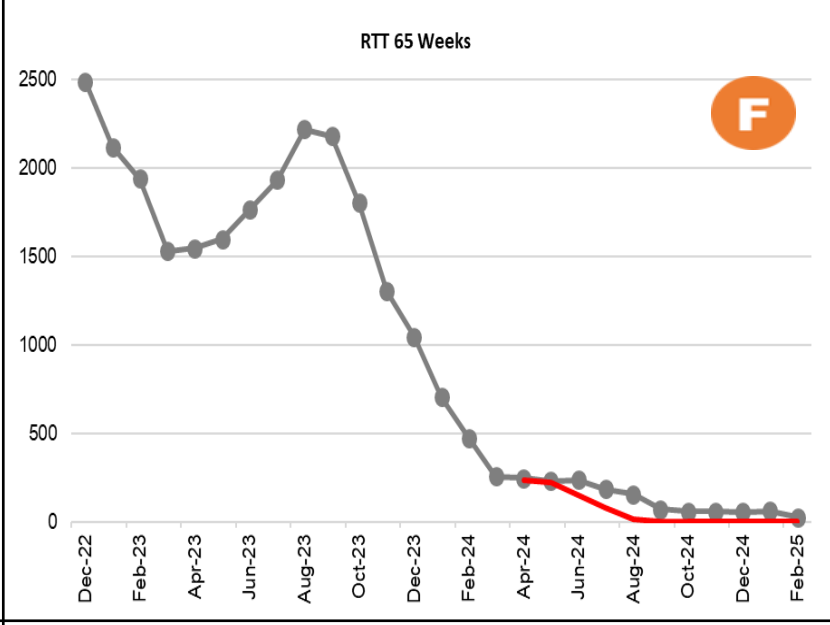
Latest Month
Feb-25
Target
6
Latest Month's Position
4
Trust Level Risk
No Trust Level Risk



Summary

No narrative required as per business rules.

Total RTT Pathways 65+ Weeks



Latest Month
Feb-25
Target
0
Latest Month's Position
26
Corporate Risk
Risk 801 - Elements of the NHS Oversight Framework are not met (12)

Summary

What is the data telling us?
At the end of February 26 patients were waiting more that 65 weeks (12 in Dental services and 14 Cornea Graft); a significant improvement on January position (62 patients). NB Formal NHSE dispensation for Corneal Graft given national supply issues out-with trust control. The Dental challenges illustrative of the national picture, hence NHSE agreement to a best-case year end 24/25 elimination plan.

Actions being taken to improve
The Trust is successfully delivering against the year end Dental elimination plan. Actions include a combination of service redesign, internal training and augmentation to better align resources to the scale of the demand challenge, underpinned ultimately with support from In sourcing and the Independent Sector for certain procedures. The national shortage of cornea graft material continues, and when material is made available, there is sufficient capacity to treat patients.

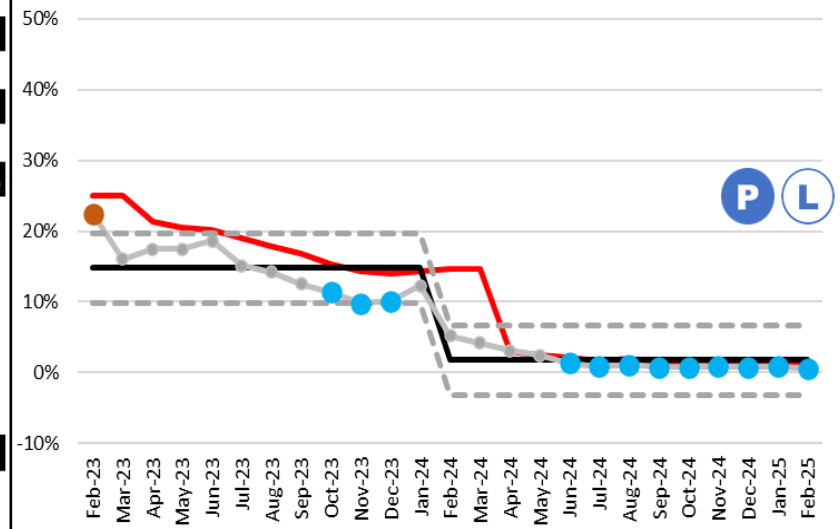
Impact on Forecast
The Trust is forecasting full elimination of 65-week waits by end of March, in addition to exceeding it's 52-week target.

Responsiveness

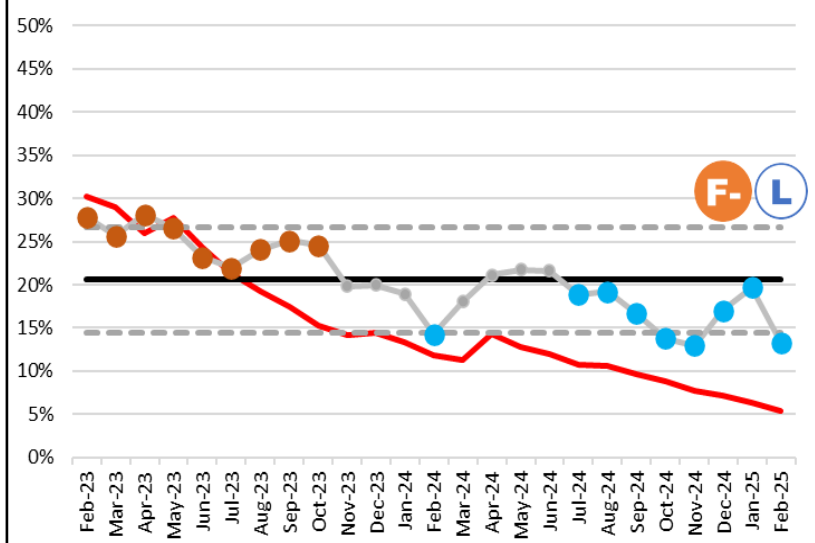
Planned Care – Diagnostics

Diagnostics Percentage Over 6 Weeks

Latest Month	Target	Latest Month's Position	Performance / Assurance	Trust Level Risk
Feb-25	1.0%	0.6%	Special Cause Improving Variation Low, where down is improvement and last six data points are less than target	No Trust Level Risk



Diagnostics Percentage Under 6 Weeks (15 Key Tests)



Latest Month	Target	Latest Month's Position	Performance / Assurance	Corporate Risk
Feb-25	5.4%	13.3%	Special Cause Improving Variation Low, where down is improvement but target is less than lower limit	Risk 801 - Elements of the NHS Oversight Framework are not met (12)

Summary

No narrative required as per business rules.

Summary

What is the Data Telling Us?

Despite a challenging winter period, February saw a strong recovery in six-week wait diagnostic performance (13.3% in February vs 19.7% in January), with improvement most noted for MRI, Endoscopy and Echocardiography.

Actions being taken to improve

Adult MRI: Enhanced bank rates remain in use. The outsourced mobile diagnostic unit has been approved to operate beyond 2024/25 into Q1 of 2025/26 to sustain performance gains.
CT Cardiac: Outsourcing, initiated in November 2024, will continue throughout 2024/25.
Community Diagnostic Centre's (CDCs): Digital integration with imaging modalities is now complete, allowing direct CDC patient booking. Work is ongoing to maximize utilisation and refine referral management processes.

Impact on Forecast

The above actions aim to sustain diagnostic performance improvements into March 2025.
Modalities are developing 2025/26 plans to improve productivity, secure funding, and address ongoing capacity shortfalls, ensuring resilience against rising diagnostic demand.

Responsiveness

Planned Care – Cancer Metrics

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Cancer – 31 Day Diagnosis to Treatment

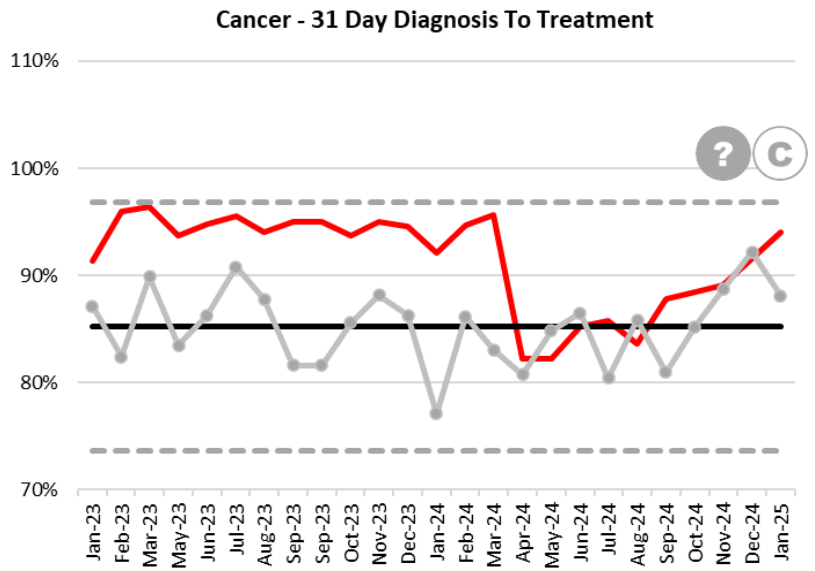
Latest Month
Jan-25

Target
94.1%

Latest Month's Position
88.1%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation

Trust Level Risk
988 - There is a risk that cancer patients will not be treated in the required timeframe due to insufficient capacity (15).



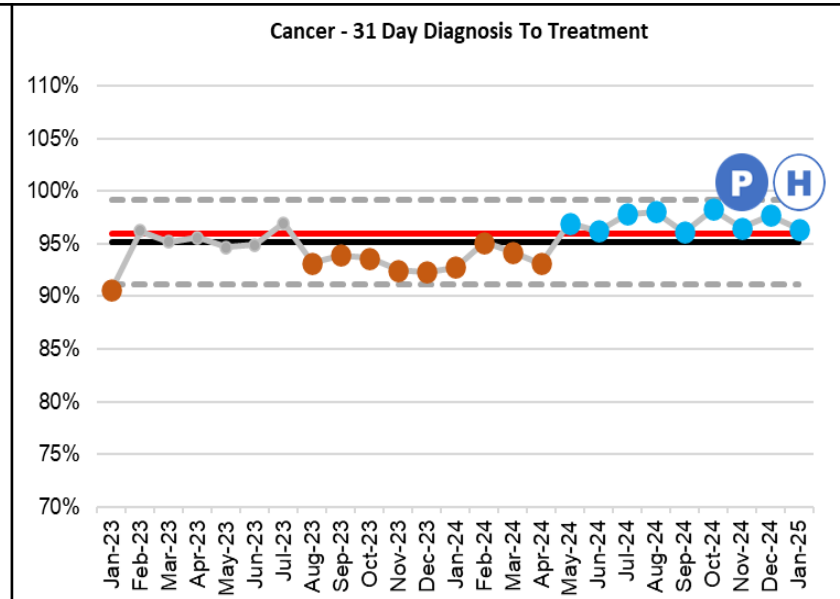
Summary

What does the data tell us?
There was deterioration against the 31-Day standard. Whilst the Trust delivered more treatments overall, there were more reported breaches within both first treatment and subsequent surgery.

Actions being taken to improve
Additionality in Urology Robotic Assisted Laparoscopic Prostatectomy is required to clear local and tertiary workload (first treatment and subsequent treatments).
Additionality in clinic has reduced the wait from decision to treat to surgery in Breast. This work will continue into Q4.

Impact on forecast
February will be a recovery month for NBT and this will negatively impact the 31-Day position.

Cancer – 31 Day Diagnosis to Treatment



Latest Month
Jan-25

Target
96.0%

Latest Month's Position
96.4%

Performance / Assurance
Special Cause Improving Variation High, where up is improvement and last six data points are greater than or equal to target.

Corporate Risk
Corporate Risk 5532 - Non-compliance with the 31 day cancer standard (12)

Summary

No narrative required as per business rules.

North Bristol NHS Trust

Responsiveness

Planned Care – Cancer Metrics

University Hospitals Bristol and Weston NHS Foundation Trust

Cancer – 62 Day Combined Standard

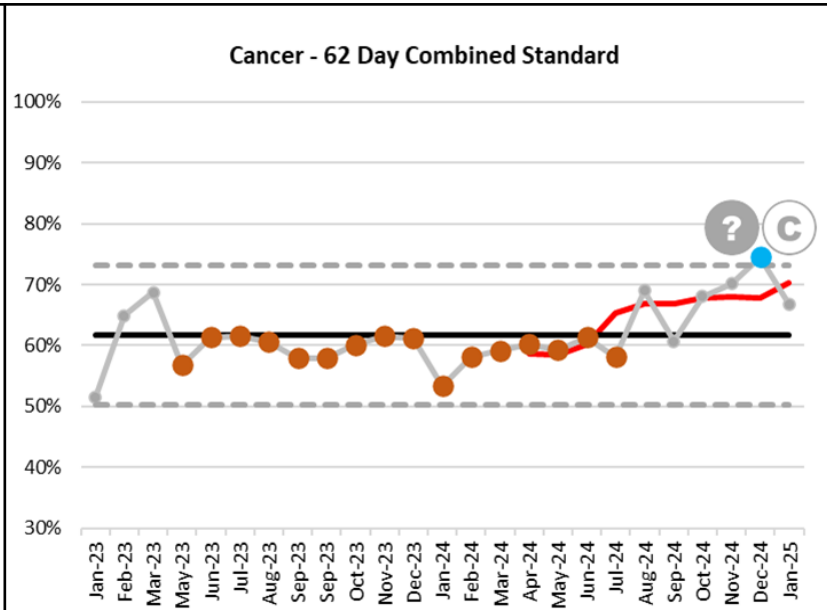
Latest Month
Jan-25

Target
70.3%

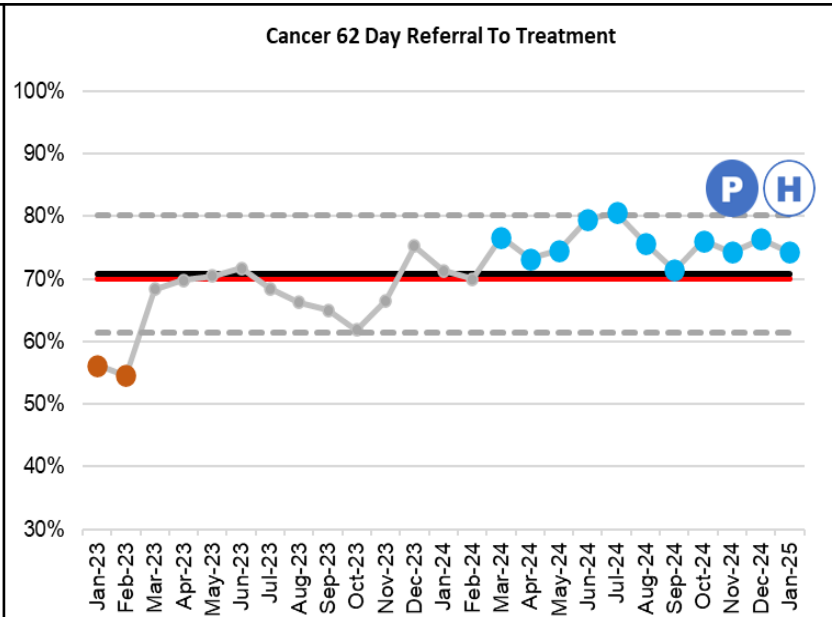
Latest Month's Position
66.6%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation

Trust Level Risk
988 - There is a risk that cancer patients will not be treated in the required timeframe due to insufficient capacity (15).



Cancer – 62 Day Referral to Treatment



Latest Month
Jan-25

Target
70.0%

Latest Month's Position
74.2%

Performance / Assurance
Special Cause Improving Variation High, where up is improvement and last six data points are greater than or equal to target.

Corporate Risk
No Corporate Risk

Summary

What does the data tell us?
There was deterioration against the 62-Day standard. This was a known risk moving into January. Whilst the Trust delivered more treatments, there were more reported breaches. This was driven by capacity challenges, delays in diagnostics and patient choice.

Actions being taken to improve
Additionality in Urology Robotic Assisted Laparoscopic Prostatectomy is required to clear local and tertiary workload. Backlog clearance will continue throughout February and March.
The Breast surgical backlog clearance has delivered improvements in 62-Day throughout Q3. This work will continue into Q4.

Impact on forecast
The Trust's 62-Day PTL backlog increased over the Christmas period to >240 and as the backlog is cleared there will be an impact on performance. February will be a recovery month for NBT. As of the 10th March the PTL backlog was significantly reduced at 147.

Summary

No narrative required as per business rules.

North Bristol NHS Trust

Quality, Safety & Effectiveness

Scorecard

University Hospitals Bristol and Weston NHS Foundation Trust

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Safe	Pressure Injuries Per 1,000 Beddays	NBT	Feb-25	0.3	No Target	0.2	N/A	C	Note Performance
		UHBW	Feb-25	0.2	0.4	0.1	P*	C	Note Performance
Safe	MRSA Hospital Onset Cases	NBT	Feb-25	0	0	0	F	C	Escalation Summary
		UHBW	Feb-25	0	0	0	F	C	Escalation Summary
Safe	CDiff Healthcare Associated Cases	NBT	Feb-25	8	5	7	F	C	Escalation Summary
		UHBW	Feb-25	5	9	5	?	C	Escalation Summary
Safe	Falls Per 1,000 Beddays	NBT	Feb-25	7.2	No Target	5.5	N/A	C	Note Performance
		UHBW	Feb-25	4.4	4.8	5.5	?	C	Escalation Summary
Safe	Total Number of Patient Falls Resulting in Harm	NBT	Feb-25	6	No Target	3	N/A	C	Note Performance
		UHBW	Feb-25	4	2	4	F	C	Escalation Summary
Safe	Medication Incidents per 1,000 Bed Days	NBT	Feb-25	5.8	No Target	5.6	N/A	C	Note Performance
		UHBW	Feb-25	8.6	No Target	8.7	N/A	C	Note Performance
Safe	Medication Incidents Causing Moderate or Above Harm	NBT	Feb-25	0	0	2	F	C	Escalation Summary
		UHBW	Feb-25	2	0	6	F-	C	Escalation Summary

Assurance						Variation			
P*	P	?	F	F-	No icon	H	L	C	H	L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation		Common Cause (natural) Variation	Concerning Variation	

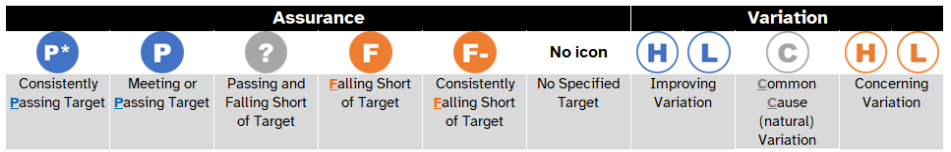
North Bristol NHS Trust

Quality, Safety & Effectiveness

Scorecard

University Hospitals Bristol and Weston NHS Foundation Trust

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Safe	Adult Inpatients who Received a VTE Risk Assessment	NBT	Jan-25	91.6%	95.0%	92.5%	F-	L	Escalation Summary
		UHBW	Feb-25	74.3%	95.0%	76.1%	F-	L	Escalation Summary
Effective	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	NBT	Sep-24	95.5	100.0	95.6	P*	L	Note Performance
		UHBW	Oct-24	89.5	100.0	89.8	P*	L	Note Performance
Effective	Fracture Neck of Femur Patients Treated Within 36 Hours	NBT	Jan-25	68.6%	No Target	83.1%	N/A	C	Note Performance
		UHBW	Feb-25	56.9%	90.0%	46.2%	F-	C	Escalation Summary
Effective	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	NBT	Jan-25	87.1%	No Target	94.9%	N/A	C	Note Performance
		UHBW	Feb-25	90.8%	90.0%	96.2%	?	H	Note Performance
Effective	Fracture Neck of Femur Patients Achieving Best Practice Tariff	NBT	Jan-25	58.6%	No Target	71.2%	N/A	C	Note Performance
		UHBW	Feb-25	46.2%	No Target	46.2%	N/A	C	Note Performance
Safe	Staffing Fill Rate	NBT	Feb-25	97.0%	80% - 120%	98.5%	P	C	Note Performance
		UHBW	Feb-25	107.3%	100.0%	108.4%	P	H	Note Performance



North Bristol NHS Trust

Quality, Safety & Effectiveness

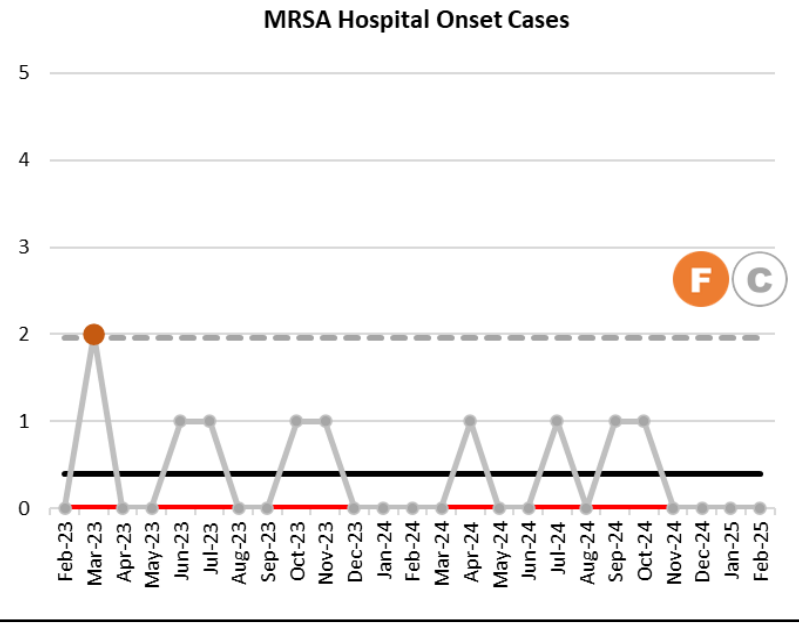
Infection Control

University Hospitals Bristol and Weston NHS Foundation Trust

MRSA Hospital Onset Cases

Latest Month
Feb-25
Target
0
Latest Month's Position
0
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration

Trust Level Risk
No Trust Level Risk



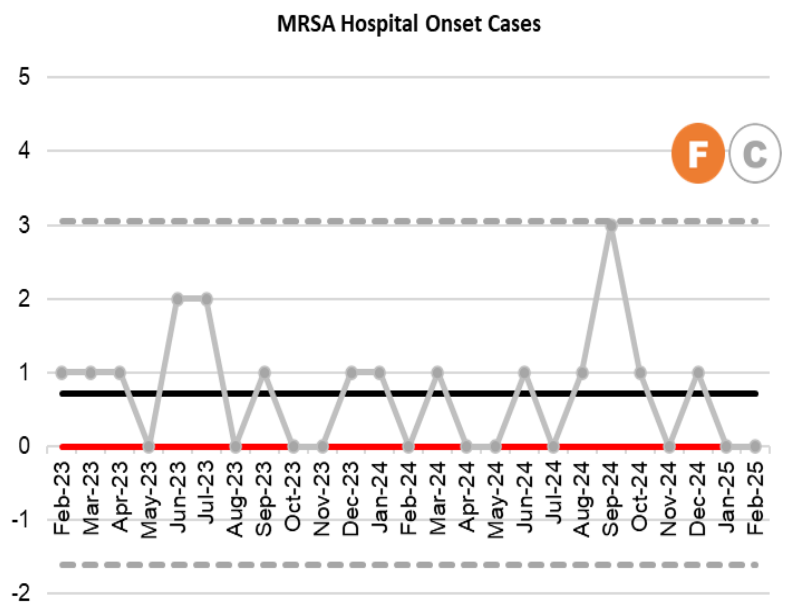
Summary

What does the data tell us?
In February 2025, the Trust had zero MRSA HCAI cases for the last four consecutive months.

Actions being taken to improve
Targeted education around risk assessments, MRSA screening, onward management and decolonisation. Whilst continuing our education around devise management linked to MSSA reduction.

Impact on forecast
Year to date of four cases is over our prediction / trajectory of 0 and equal to our previous yearly position.

MRSA Hospital Onset Cases



Latest Month
Feb-25
Target
0
Latest Month's Position
0
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration.

Corporate Risk
Risk 6013 - Risk that the Trust exceeds its NHSE/I limit for Methicillin Resistant Staphylococcus aureus bacteraemia's

Summary

What does the data tell us?
There have been no additional MRSA cases for February year to date figures are still at seven cases.

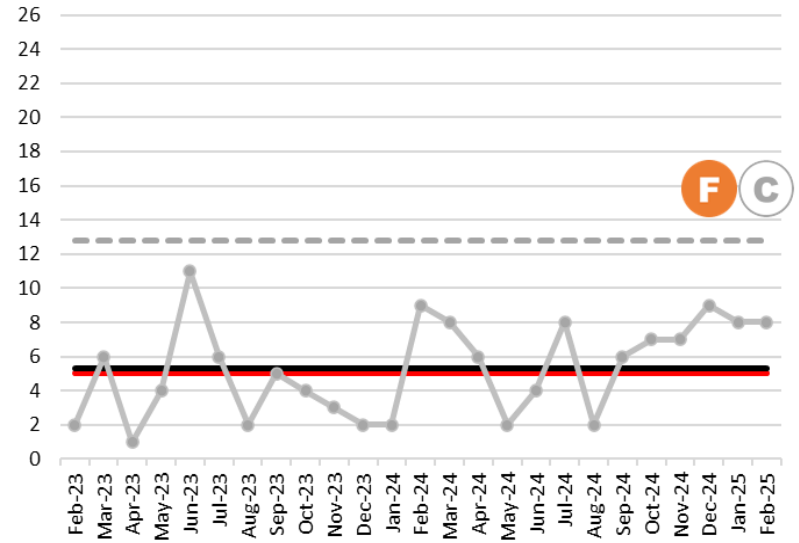
What does the data tell us
The MRSA decolonisation of patient's pathway has been updated and is now in place. The way skin cleansing is delivered, prior to the insertion of peripheral IV lines, has changed and this is rolling out across the Trust to help reduce MRSA risk.

Quality, Safety & Effectiveness

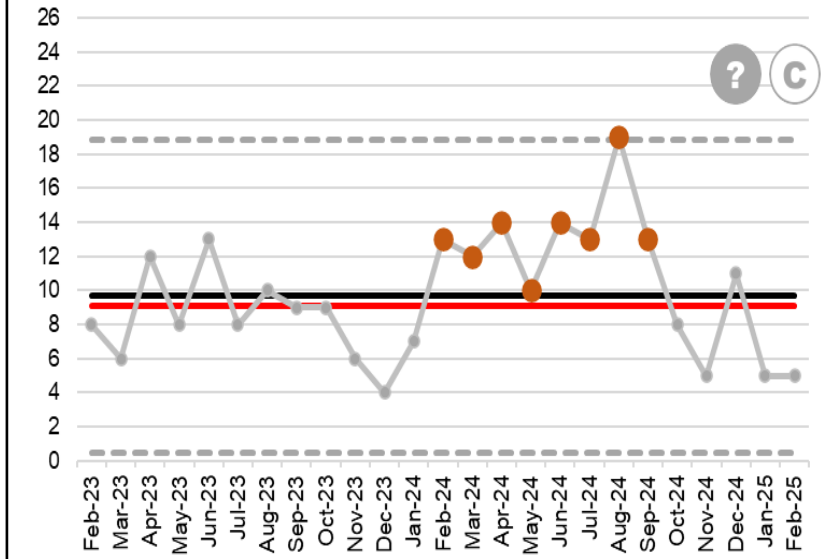
Infection Control

C.difficile Healthcare Associated Cases

Latest Month
Feb-25
Target
5
Latest Month's Position
8
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration
Trust Level Risk
No Trust Level Risk



C.Difficile Healthcare Associated Cases



Latest Month
Feb-25
Target
9.08
Latest Month's Position
5
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.
Corporate Risk
Risk 3216 - Risk that the Trust will breach the NHSE Limits for cases of clostridiodes difficile (12)

Summary

What does the data tell us?
C. difficile – Cases have exceeded set trajectory, C.difficile ward round to commence to reduce incidence of cases.
IPC to continue to provide focused education, especially targeted in areas of repeat infection.

Actions being taken to improve
C. difficile targeted plans include adopting weekly C. difficile ward rounds to review microbiologically treated cases, educate, advise and intervene including escalation to microbiology for escalated symptoms and antibiotic management.

Other projects
Wider education for unexplainable diarrhoea / vomiting and associated testing continues as the backdrop of our Norovirus / C. difficile case / outbreak management. Twice daily cleaning for C. difficile and enhanced cleaning for both organisms continue with collaboration from facilities.

Alcohol free gel – Implementation of Spectrum X alcohol free gel for point of care use being rolled out Trustwide to assist with C. difficile and Norovirus transmission.

Summary

What does the data tell us?
February had five more cases of Clostridium Difficile. The breakdown was four Hospital Onset Hospital Associated (HOHA) cases and one Community Onset Hospital Associated (COHA) case. This take the year-to-date total to 117 cases with a breakdown of 82 HOHA and 35 COHA cases.

Actions being taken to improve:
The quality improvement actions focused on C.Difficile reduction previously reported to the Board continue.

Quality, Safety & Effectiveness

Falls

Inpatient Falls Per 1000 Bed days

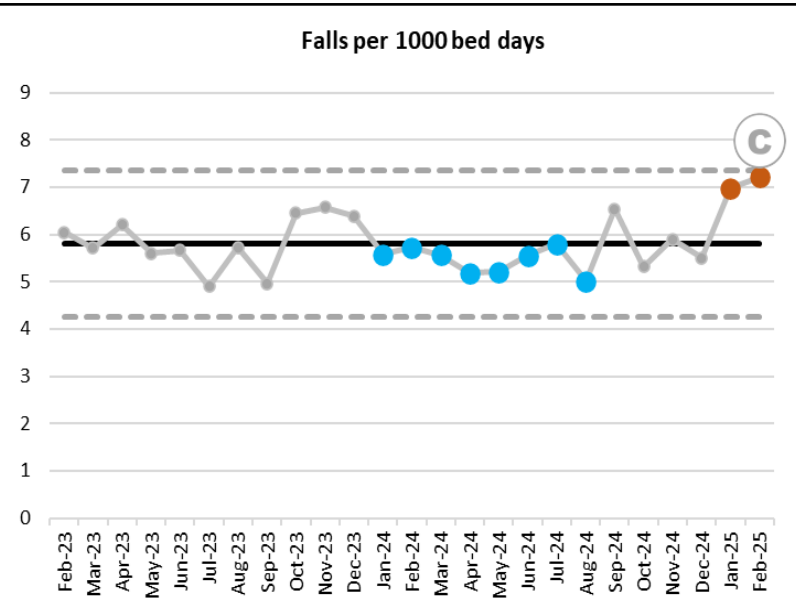
Latest Month
Feb-25

Target
No Target

Latest Month's Position
7

Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit where down is improvement

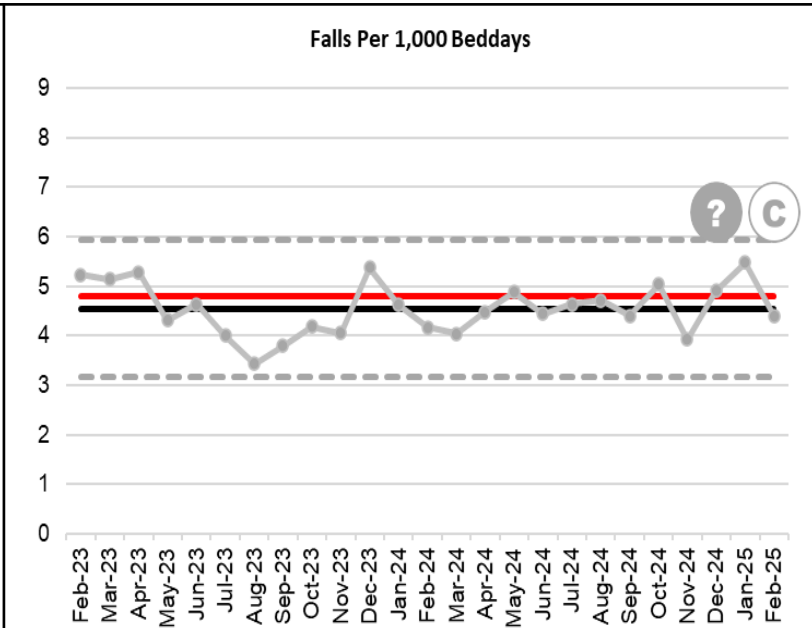
Trust Level Risk
No Trust Level Risk



Summary

No narrative required as per business rules.

Inpatient Falls Per 1,000 Bed days



Latest Month
Feb-25

Target
4.8

Latest Month's Position
4.4

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Corporate Risk
Risk 1598 - Patients suffer harm or injury from preventable falls (12)

Summary

What does the data tell us:
During February 2025: there were 142 falls (100 at Bristol sites and 42 at Weston) giving a rate of 4.4 per 1,000 bed days, below the trust target of 4.8 per 1000 bed days. The number of falls in February 2025 (142) is fewer than January 2025 (195) . There were four falls with moderate or severe physical and/or psychological harm in February 2025, the same as the previous month. Risk of falls continues to remain on the divisions' risk registers as well as the Trust risk register. Actions to reduce falls, all of which have potential to cause harm, is provided below.

Actions being taken to improve:
In February 2025, the divisions of Specialised Services and Diagnostics and Therapies shared their analyses of falls incidents at the Dementia Delirium and Falls (DDF) Steering Group and identified themes relating to falls; staffing issues for patients requiring enhanced care observations, nighttime toileting, incorrect footwear and brakes not being applied to equipment. Teams are focussing on completion of dynamic risk assessments, ensuring availability of appropriate aids and equipment, patient education around call bells, SWARM huddle compliance and reviewing the outlier cover SOP.

Falls Summary Continues on Next Slide

Quality, Safety & Effectiveness

Falls

Falls Resulting in Harm

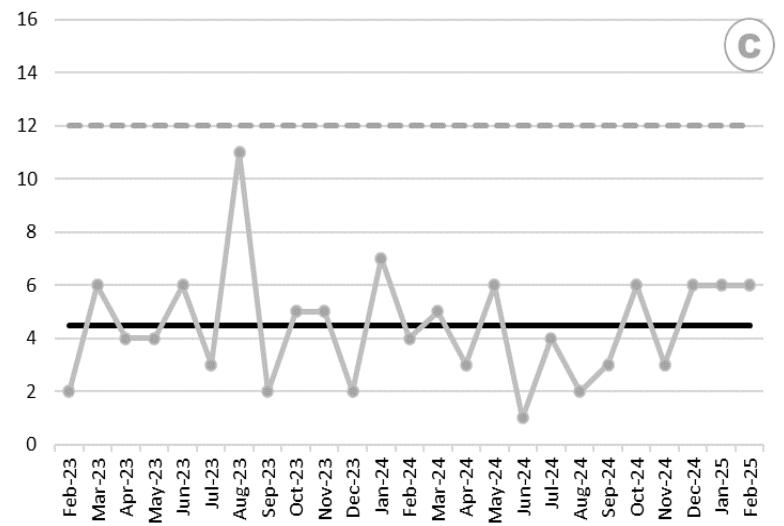
Latest Month
Feb-25

Target
No Target

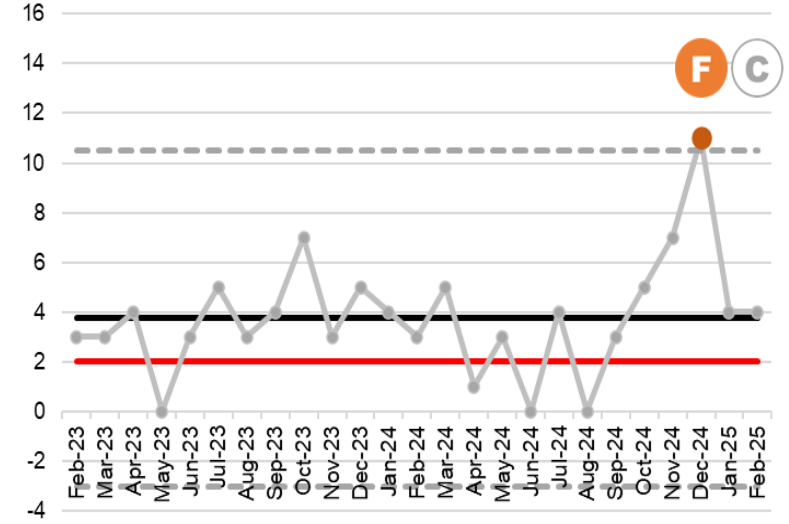
Latest Month's Position
6

Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit where down is improvement

Trust Level Risk
No Trust Level Risk



Total Number of Inpatient Patient Falls Resulting in Harm



Latest Month
Feb-25

Target
2

Latest Month's Position
4

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration.

Corporate Risk
Risk 1598 - Patients suffer harm or injury from preventable falls (12)

Summary

No narrative required as per business rules.

Summary

Falls Summary Continued

Audit: We are participating in the National Audit of Inpatient Falls, the audit is expanding to include hip fractures, head injury, spinal injury or any fracture from an inpatient fall. This may provide new national and local insights for improvement.

Quality Improvement: Improving completion and use of the Multi Factorial Risk Assessment (MFRA) document. Following an update of the MFRA document and education to staff a re-audit is currently being carried out until 31st March 2025.The Multi Factorial Risk Assessment document has been reviewed and updated to embed Personalisation, Prediction, Prevention and Participation in falls prevention and management across the Trust.

Training -The DDF Steering Group provides an education component, bitesize education sessions are delivered to the group on relevant topics. In February the education session focused on nature-based activities and the benefit these provides to patients. The DDF team continue to deliver education sessions and simulation-based training for staff across the Trust.

Impact on forecast

We continue to monitor total falls, falls per 1000 bed days and falls with harm and continue to work on reducing the risk of patient falls balancing this with risks related to reduced mobility, deconditioning and psychological impact of prolonged hospital stays.

North Bristol NHS Trust

Quality, Safety & Effectiveness

Medication Incidents

University Hospitals Bristol and Weston NHS Foundation Trust

Medication Incidents Causing Moderate or Above Harm

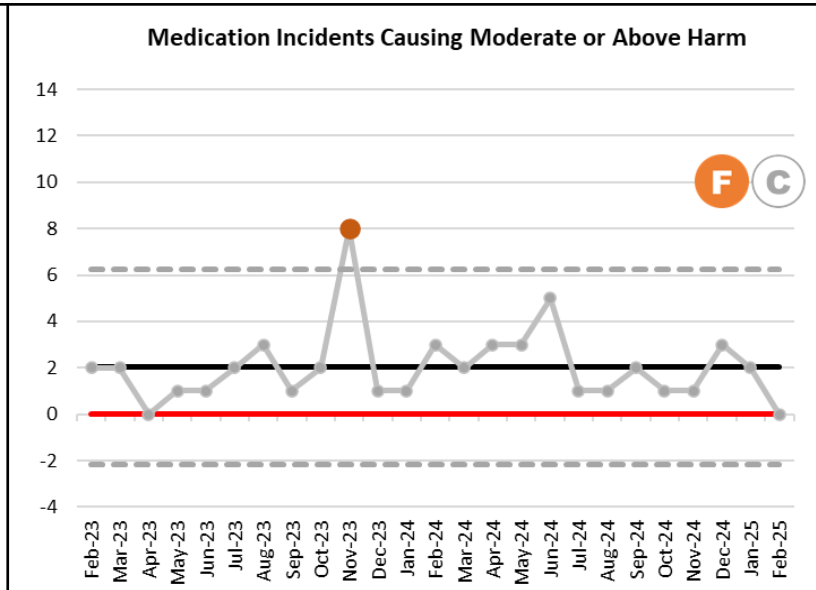
Latest Month
Feb-25

Target
0

Latest Month's Position
0

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration

Trust Level Risk
Risk 1800 – Allergy status may not be identified resulting in medication being incorrectly prescribed or administered. (20)



Summary

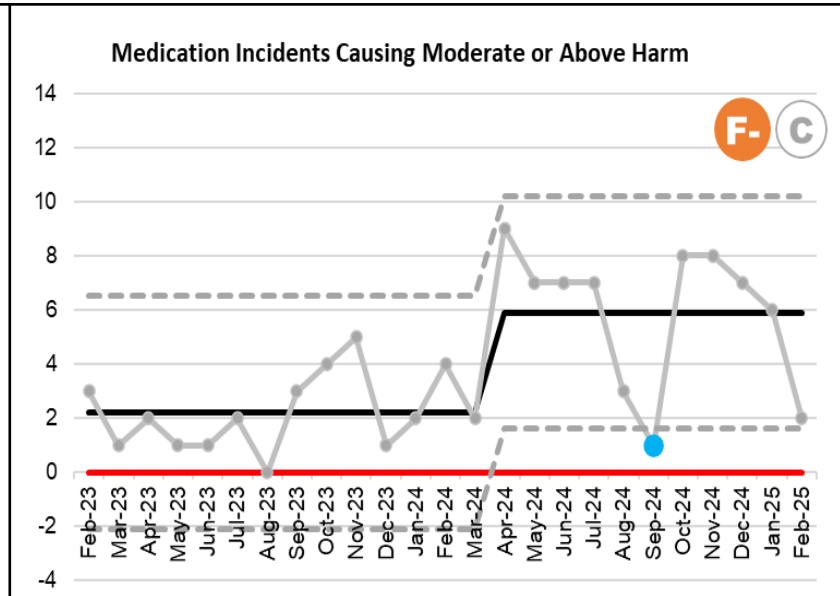
What does the data tell us?
During February 2025 NBT had a rate of 5.6 medication incidents per 1000 bed days which is below the 6 – month average of 5.8 for this measure. The level of medication incidents causing moderate or severe harm or death was 0% this month with no incidents falling into this category.

Actions being taken to improve
The work of the 'Medicines Safety Forum' continues – this is a multidisciplinary group whose aim is to focus on gaining a better understanding of medicines safety challenges and subsequently supporting staff to address these. This group meets monthly, with a high level of engagement from all Divisions and staff groups. Groups initial workstreams are as follows:

- Formation of a 'Drug Administration' sub-group to discuss the processes around this task and consider improvement initiatives.
- Reviewing the competence assessment process for nursing staff ensuring it is practical, fit for purpose and consistently applied.
- Review of the role of other staff groups e.g registered nursing associates and non-registered staff regarding medicines.

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.

Medication Incidents Causing Moderate or Above Harm



Latest Month
Feb-25

Target
0

Latest Month's Position
2

Performance / Assurance
Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration.

Corporate Risk
No Corporate Risk

Summary

What does the data tell us?
The number of medication incidents reported as being associated with moderate or severe harm or death.

This month's data is based on the reporter's initial assessment of harm.

The harm levels since April 2024 are based on the new harm descriptors for physical and psychological harm in the Learning From Patient Safety Events system (LFPSE). The dataset pre-LFPSE roll out is based on previous harm descriptors in place in the Trust.

The data indicates a good reporting culture with a low number of harm incidents compared to number of incidents

Actions being taken to improve
Gaps in harm recording have been identified at UHBW. Work is underway to redesign the Datix form to improve reporting to prevent this field being uncompleted. We are also working to improve data validation post PSIRF. This will support improved LFPSE harm reporting and understanding harm levels.
This report has been developed collaboratively by the UHBW and NBT medicines safety teams. This takes advantage of the new joint Hospital Group Medication Safety Officer role.

Quality, Safety & Effectiveness

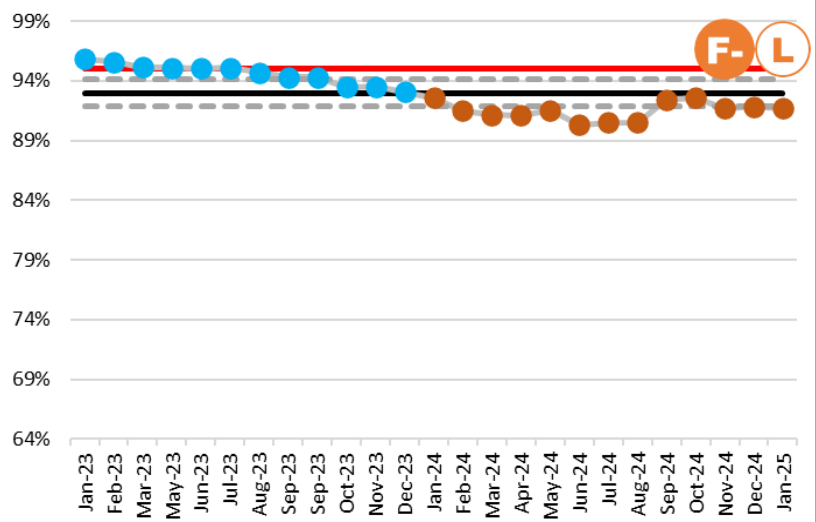
VTE Risk Assessment

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

VTE Risk Assessment Completion

Latest Month
Jan-25
Target
95.0%
Latest Month's Position
91.7%
Performance / Assurance
Special Cause Concerning Variation Low, where down is deterioration and target is greater than upper limit
Trust Level Risk
No Trust Level Risk



Summary

What does the data tell us?
VTE risk assessment completion is static for the past three months.

What is being done to improve?
In June 2022 there was a noticeable dip in VTE RA compliance, and action was taken to improve the situation.
An audit of patient notes revealed that VTE forms were not consistently completed.
All clinicians were reminded of the importance of completing VTE RA for all patients, with regular audit and feedback to the teams – this resulted in an overall improvement in VTE RA compliance.

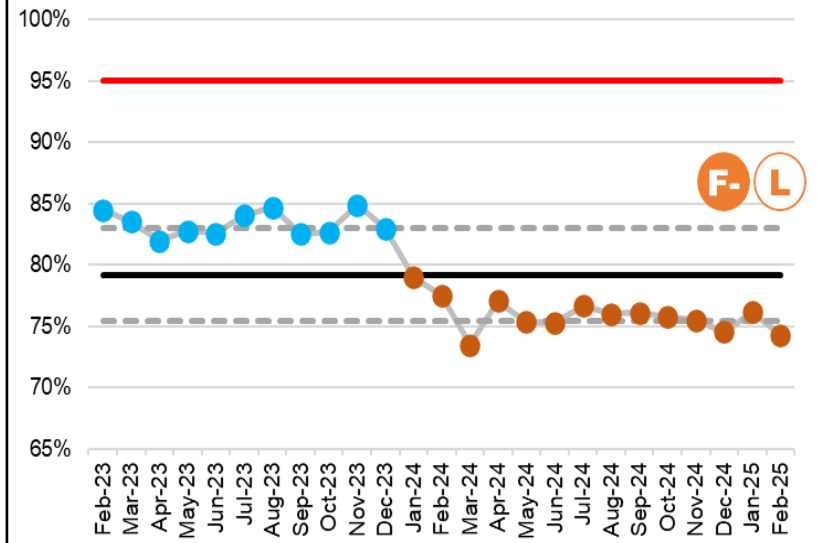
In February 2023, a pilot of a VTE digital assessment took place; this was successful and thus rolled out across the Trust in July 2023. Reasons for the drop in compliance are linked to the hybrid clerking process, with 'main clerking' on paper and VTE RA digital, and we are working towards improving compliance with regular audit, teaching and reminders

Impact on forecast
In September 2025, completion of the VTE RA will become a 'forcing' measure, when the digital prescribing module is initiated, and it is projected that this will improve compliance.

In the meantime, the VTE team are constantly reviewing the requirement for a VTE RA for individual patients, identifying cohorts of patients who do NOT require a VTE RA, and ensuring that the data collection is accurate.

Adult Inpatients Who Received A VTE Risk Assessment

Latest Month
Feb-25
Target
95%
Latest Month's Position
74.3%
Performance / Assurance
Special Cause Concerning Variation Low, where down is deterioration and target is greater than upper limit.
Corporate Risk
No Corporate Risk



Summary

What does the data tell us?
VTE risk assessment compliance remains fairly static at around 75%. (note that the target has been amended from 90 to 95% to bring us in line with national targets.

Actions being taken to improve
CareFlow Medicines Management is due to launch in May 2025, initially in Weston and then across UHBW. This includes a mandated VTE risk assessment completion for all areas which are not acute admissions, or where VTE assessment is completed on a different system- for example Phillips in ITU and Badgernet in maternity. We anticipate that this should significantly increase compliance with the risk assessment.

Monthly audits are undertaken to look at prescribing of VTE prophylaxis. These evidence that our current prescribing where a risk assessment is available is compliant with this risk assessment 95-100% of the time and where there is no evidence of a risk assessment 90% of patient still have VTE prophylaxis prescribed. Again, auditing of this will become easier once CMM is online.

Healthcare Associated VTE events are reviewed monthly, data suggests our numbers are within the expected range and no significant themes have been identified on review of the last 12 months data. All confirmed HAVTE are reported on the Datix system to ensure they are captured. In the next 12 months the VTE team will work to look in detail at this alongside the relevant GIRFT report to ensure learning.

North Bristol NHS Trust

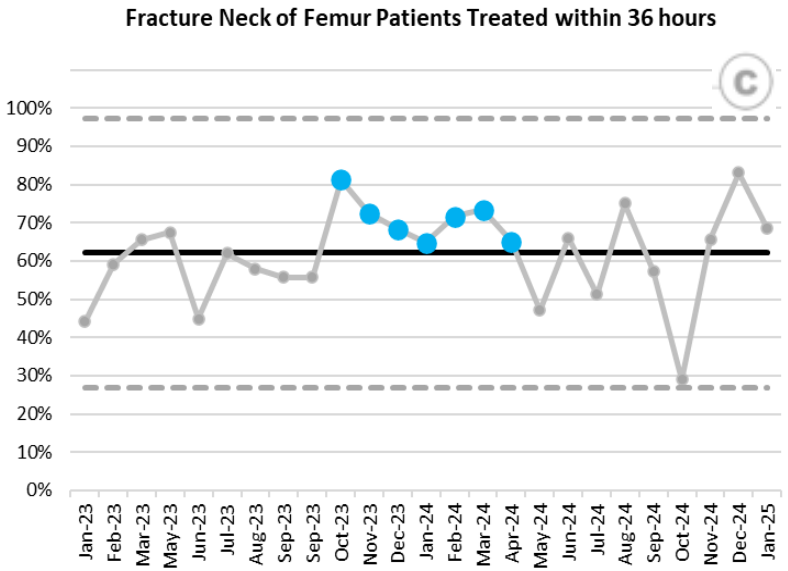
Quality, Safety & Effectiveness

Neck of Femur

University Hospitals Bristol and Weston NHS Foundation Trust

Fracture Neck of Femur Patients Treated Within 36 Hours

Latest Month
Jan-25
Target
No Target
Latest Month's Position
68.6%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration
Trust Level Risk
No Trust Level Risk

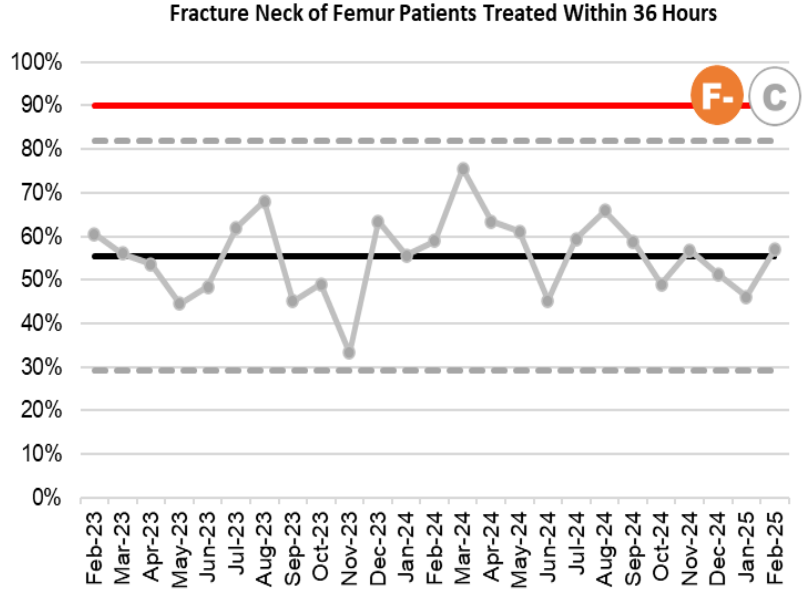


Summary

No narrative required as per business rules.

Fracture Neck of Femur Patients Treated Within 36 Hours

Latest Month
Feb-25
Target
90.0%
Latest Month's Position
56.9%
Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit and down is deterioration.
Corporate Risk
No Corporate Risk



Summary

What does the data tell us?
In the BRI, 21 patients were eligible for Best Practice Tariff (BPT) of which 10 received care that met all elements (48%). The breakdown of data for patients who were treated at Weston is awaited.

Actions being taken to improve
The Orthopaedic Trauma service continue to experience difficulties in achieving the national average percentage of patients with a femoral fragility fractures getting to theatre within 36hrs from admission/diagnosis. At present, to mitigate for this, we are proactively identifying patients who would be appropriate for transfer to the Weston General Hospital site to utilise their theatre capacity. This will largely be patients from their catchment area, but also patients from our catchment area who would otherwise be subjected to unacceptable delays. We have improved our processes for transferring patients and are now working much more efficiently across sites.

In future , the significant reduction in ambulatory trauma being operated on at the BRI (moved to Southmead) will allow us to utilise an am trauma list each day for, largely, inpatient trauma. The majority of inpatient trauma care is for femoral fragility fractures. Being able to operate on am lists will also reduce our breach time. Additionally, we will maintain full day weekend trauma lists which will allow us to 'mop up' any outstanding inpatient trauma from the week.

Caring

Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Caring	Friends and Family Test Score - Inpatient	NBT	Feb-25	92.0%	No Target	91.9%	N/A	C	Note Performance
		UHBW	Feb-25	94.2%	No Target	96.3%	N/A	C	Note Performance
Caring	Friends and Family Test Score - Outpatient	NBT	Feb-25	95.1%	No Target	95.1%	N/A	C	Note Performance
		UHBW	Feb-25	94.2%	No Target	94.4%	N/A	C	Note Performance
Caring	Friends and Family Test Score - ED	NBT	Feb-25	70.3%	No Target	69.6%	N/A	C	Note Performance
		UHBW	Feb-25	87.3%	85.0%	86.5%	?	C	Escalation Summary
Caring	Friends and Family Test Score - Maternity	NBT	Feb-25	94.4%	No Target	90.7%	N/A	C	Note Performance
		UHBW	Feb-25	96.5%	No Target	96.6%	N/A	L	Escalation Summary
Caring	Patient Complaints - Formal	NBT	Feb-25	62	No Target	56	N/A	C	Note Performance
		UHBW	Jan-25	39	No Target	27	N/A	L	Note Performance
Caring	Formal Complaints Responded To Within Trust Timeframe	NBT	Feb-25	77.8%	90.0%	80.0%	F	C	Escalation Summary
		UHBW	Jan-25	58.3%	90.0%	53.6%	F	C	Escalation Summary

Assurance						Variation		
P*	P	?	F	F-	No icon	H L	C	H L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation	Common Cause (natural) Variation	Concerning Variation

North Bristol NHS Trust

Caring

Friends and Family Test

University Hospitals Bristol and Weston NHS Foundation Trust

Friends and Family Test Score - ED

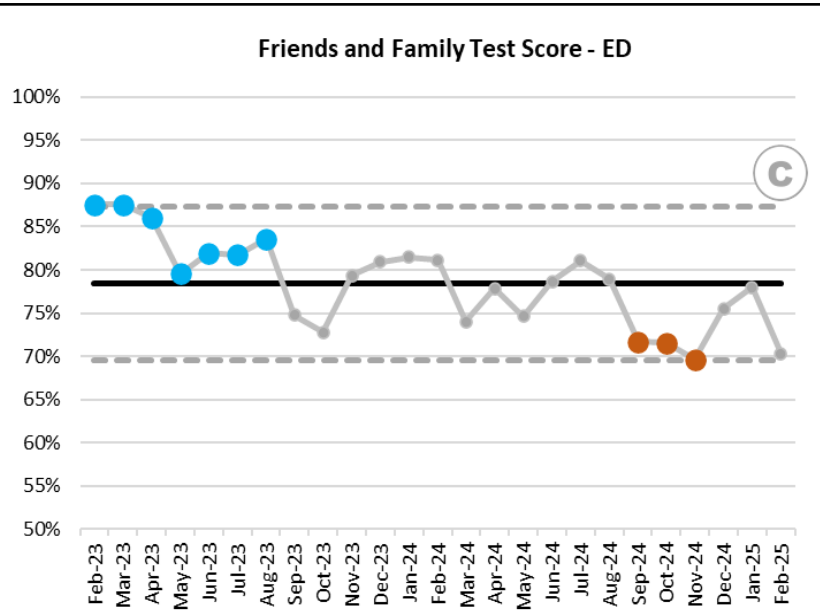
Latest Month
Feb-25

Target
No Target

Latest Month's Position
70.3%

Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration

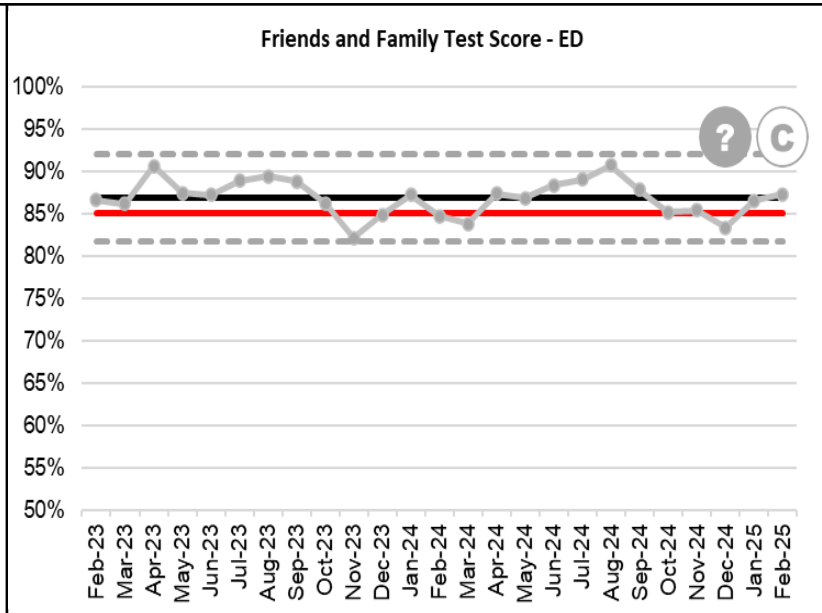
Trust Level Risk
No Trust Level Risk



Summary

No narrative required as per business rules.

Friends and Family Test Score - ED



Latest Month
Feb-25

Target
85%

Latest Month's Position
87.3%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Corporate Risk
No Corporate Risk

Summary

What does the data tell us?:
The overall FFT score for UHBW's Emergency Departments was 87.8% in February 2025, above the target of 85% and well above the latest published (January 2025) national average FFT score for Emergency Departments (80%).
At a department level, results for February 2025, were as follows:
•Bristol Royal Infirmary ED 81.6%
•Bristol Royal Hospital for Children ED 87.8%
•Bristol Eye Hospital ED 93.7%
•Weston General Hospital ED 88.2%

Results of the recently published 2024 Urgent and Emergency Care Survey show that UHBW ranks 13th out of 120 Trusts nationally (Top 10%) for overall experience. At a department level, BRI ED ranks 10th place out of 175 ED sites nationally (top 10%) and WGH ED ranks 35th place (top 20%).

Actions being taken to improve:
Friends and Family Test (FFT) data for UHBW's Emergency Departments is imported into the Patient Feedback Hub on a weekly basis and management teams log in regularly to view FFT scores and comments, taking action as appropriate.

North Bristol NHS Trust

Caring

Friends and Family Test

University Hospitals Bristol and Weston NHS Foundation Trust

Friends and Family Test Score – Maternity

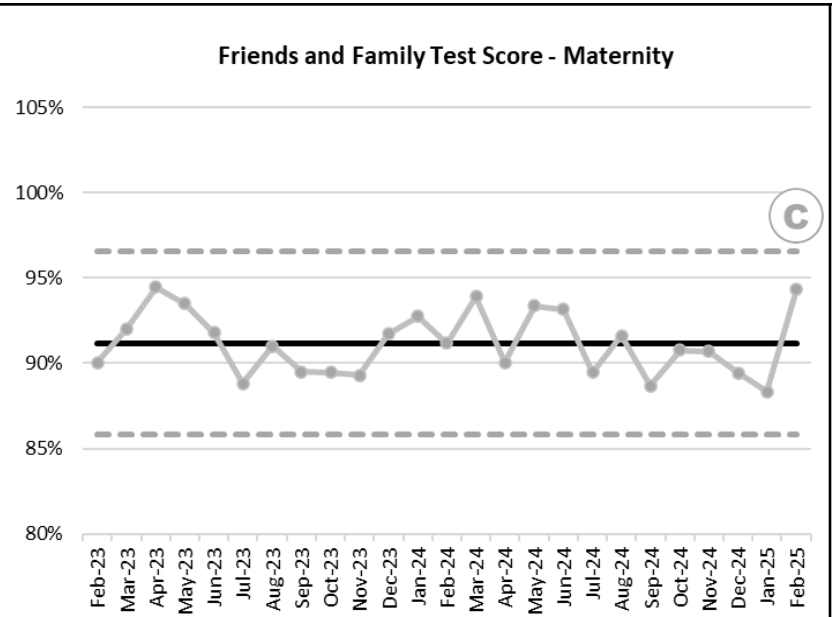
Latest Month
Feb-25

Target
No Target

Latest Month's Position
94.4%

Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration

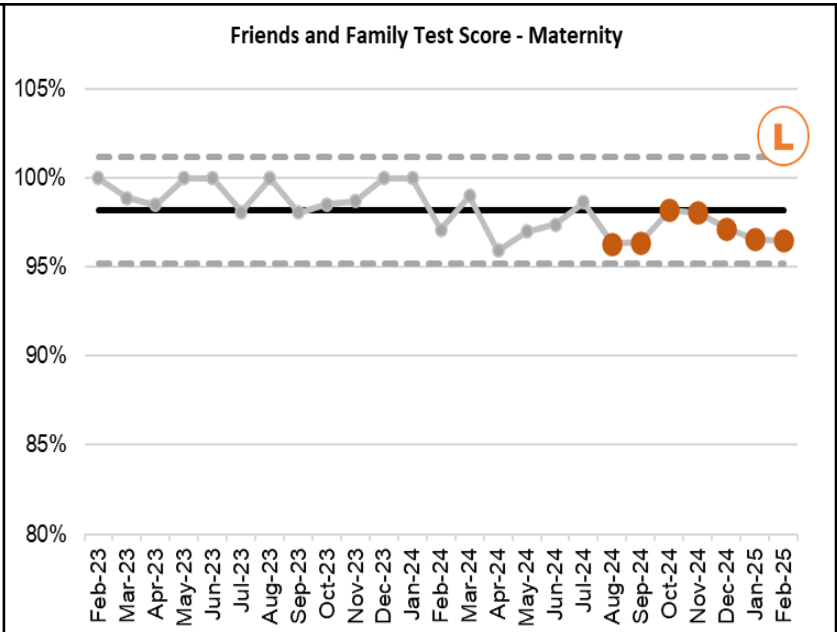
Trust Level Risk
No Trust Level Risk



Summary

No narrative required as per business rules.

Friends and Family Test Score – Maternity



Latest Month
Feb-25

Target
No Target

Latest Month's Position
96.5%

Performance / Assurance
Special Cause Concerning Variation Low, where down is deterioration.

Corporate Risk
No Corporate Risk

Summary

What does the data tell us?:
The overall FFT score for UHBW's maternity service was 96.5% in February 2025 which is above the latest published (January 2025) national average FFT score for Maternity (91%). Whilst the Maternity FFT has no target, it is displaying special cause variation with seven consecutive months below the mean. Broken down by maternity setting, results for February 2025, were as follows:

- Antenatal Community 100%
- Labour Ward 95.1%
- Postnatal Ward 94.9%
- Postnatal Community 100%

Actions being taken to improve:

- Review of other sources of maternity feedback data for potential insights into the decline in FFT scores.
- The Women's Experience Group has produced an improvement plan based on the findings of the National Maternity Survey 2024.
- Maternity services are working with the Maternity and Neonatal Voices Partnership (NVP) to engage with women and get further feedback.

Impact on forecast: Maternity services will monitor the impact of the implementation of its improvement plan in response to the National Maternity Survey 2024.

North Bristol NHS Trust

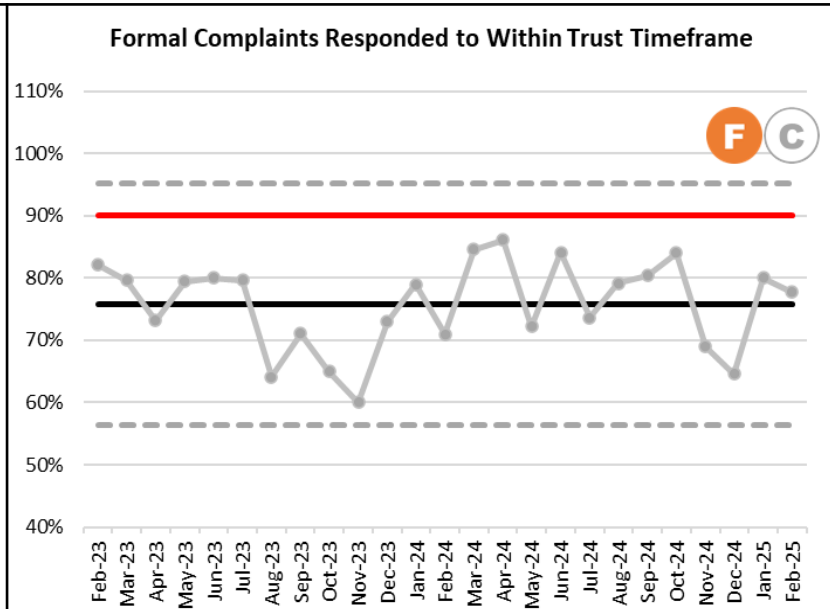
Caring

Complaints

University Hospitals Bristol and Weston NHS Foundation Trust

Formal Complaints Responded To Within Trust Timeframe

Latest Month
Feb-25
Target
90.0%
Latest Month's Position
77.8%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration
Trust Level Risk
No Trust Level Risk



Summary

What does the data tell us?
In February 2025:

- The compliance rate marginally decreased from 80% in January to 78%.
- Out of 45 complaints due, 35 were closed within the agreed timescale, 6 were closed outside the agreed timescale, and 4 remained open at the time of reporting.

A breakdown by clinical division is shown here:

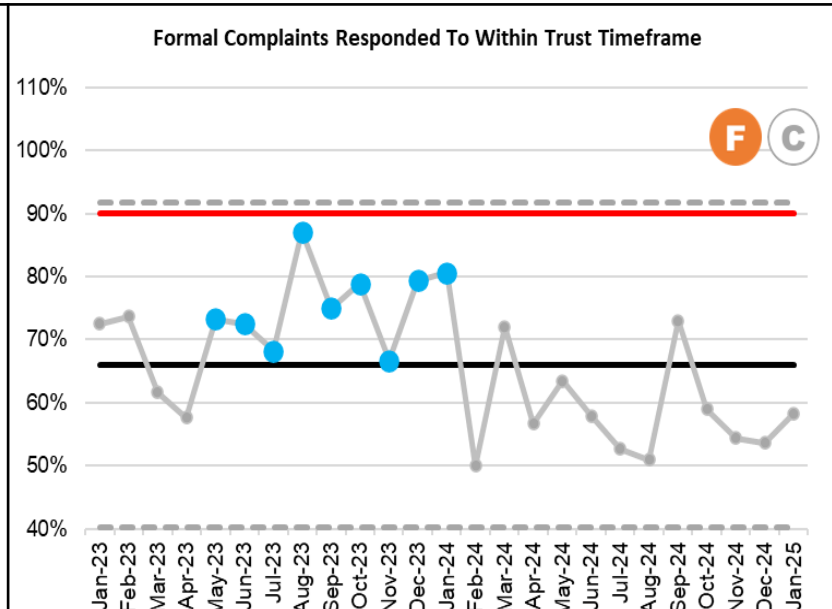
Division	Response Rate %	Target %
ASCR	71%	90%
CCS	100%	90%
Medicine	63%	90%
NMSK	89%	90%
WaCH	88%	90%

Actions being taken to improve

The Complaints and PALS Manager meets weekly with divisional Patient Experience teams to discuss cases due and those overdue. This provides an opportunity to discuss complexities and agree resolution.

Formal Complaints Responded To Within Trust Timeframe

Latest Month
Jan-25
Target
90.0%
Latest Month's Position
58.3%
Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration.
Corporate Risk
Risk 2680 - Complainants experience a delay in receiving a call back (12)



Summary

What does the data tell us?
Responses for 22 Formal Complaints, 89 Informal Complaints and 41 PALS Concerns were sent out to complainants. 86.5% of informal complaints (77 of 89) were responded to by the agreed deadline (target 90%), an improvement on the 79% reported for December. 54.5% of formal complaints (12 of 22) were responded to by the agreed deadline (target 90%), a similar percentage to the 53.6% reported for December.
97.6% of PALS concerns (40 of 41) were responded to by the agree deadline (target 90%), which compares favourably with the 81.3% reported for December.
Actions being taken to improve:
The PALS and Complaints teams at UHBW and NBT are working closely together to review and align practices where this is possible and desirable. From 1st April, UHBW will be changing its complaints taxonomy to match that of NBT, meaning that formal complaints will become simply 'complaints', whilst the category of informal complaints will disappear; the expectation is that the majority of cases which would currently be investigated as informal complaints will be taken forward as PALS concerns, with a timeframe of 10 working days, as per current informal complaints.
Impact on Forecast:
From 1st April there will be an increase in PALS concerns, because cases previously investigated as informal complaints will now become PALS concerns.

Our People

Scorecard

CQC Domain	Metric	Trust	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action
Our People	Workforce Turnover Rate	NBT	Feb-25	11.6%	11.9%	11.7%	P	L	Note Performance
		UHBW	Feb-25	10.8%	12.0%	11.1%	P*	C	Note Performance
Our People	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	NBT	Feb-25	5.6%	No Target	5.2%	N/A	L	Note Performance
		UHBW	Feb-25	3.3%	5.0%	3.1%	P*	C	Note Performance
Our People	Percentage Agency Usage	NBT	Feb-25	1.0%	3.2%	1.2%	P	L	Note Performance
		UHBW	Feb-25	0.6%	1.0%	0.7%	P*	L	Note Performance
Our People	Sickness Rate	NBT	Feb-25	4.6%	4.4%	4.6%	F-	L	Escalation Summary
		UHBW	Feb-25	4.4%	4.9%	4.7%	P*	C	Note Performance
Our People	Essential Training Compliance	NBT	Feb-25	92.4%	85.0%	92.5%	P*	H	Note Performance
		UHBW	Feb-25	90.4%	90.0%	90.6%	P	H	Note Performance

Assurance						Variation		
P*	P	?	F	F-	No icon	H L	C	H L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation	Common Cause (natural) Variation	Concerning Variation

North Bristol NHS Trust

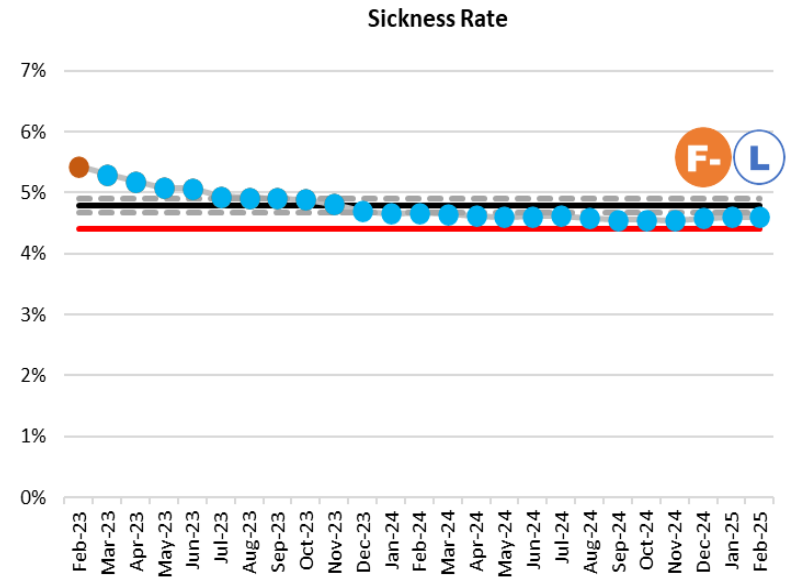
People

Sickness Absence

University Hospitals Bristol and Weston NHS Foundation Trust

Sickness Rate

Latest Month	Target	Latest Month's Position	Performance / Assurance	Trust Level Risk
Feb-25	4.4%	4.6%	Special Cause Improving Variation Low, where down is improvement but target is less than lower limit	No Trust Level Risk

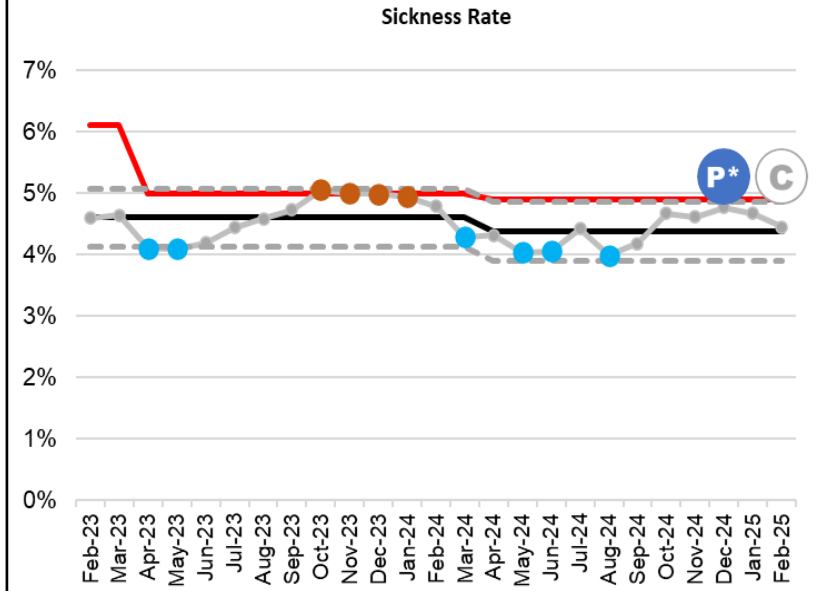


Summary

What does the data tell us?
The Trust rolling 12-month sickness absence rate has shown statistically significant improvement but have plateaued at 4.6% against a target for 2024/25 of 4.4%.

Actions being taken to improve
Staff Experience Team delivering wellbeing drop ins taking staff experience offer to teams, these can be booked via LINK 312 staff members have attended the sessions. Staff Health and Wellbeing draft plan approved at Executive Management Team - plan being shared with key stakeholders or feedback ahead of launch in April 2025. April Stress Awareness month campaign planned with Lunch & Learn webinars, regular communications and resources.

Sickness Rate



Latest Month	Target	Latest Month's Position	Performance / Assurance	Corporate Risk
Feb-25	4.9%	4.4%	Common Cause (natural/expected) variation, where target is greater than upper limit where down is improvement.	No Corporate Risk

Summary

No narrative required as per business rules.

Finance

Position Statement

NBT - Statement of comprehensive income at 28 February 2025

This month the Trust has delivered a financial position £1.5m surplus above plan. The financial position for February 2025 shows the Trust has delivered a £1.8m deficit against a £0.8m planned deficit which results in a £1.0m adverse variance year to date.

Contract income is £22.9m better than plan. This is driven by additional pass-through income of £11.0m, and settlement of prior year contracts has delivered a £4.6m benefit.

Other income is £46.4m better than plan. The is due to new funding adjustments and pass through items, £39.8m favourable. The remaining £6.6m favourable variance is driven by prior period invoicing and additional activity, £3.3m favourable, and medical education funding, £2.3m favourable.

Pay expenditure is £20.5m adverse to plan. New funding adjustments, offset in income, have caused a £18.3m adverse variance. Undelivered CIP is £7.8m adverse and there are overspends on medical and nursing pay, £1.7m adverse. This is offset by AfC vacancies, £9.4m favourable.

Non-pay expenditure is £49.9m adverse to plan. Of which £32.5m relates to pass through items. This remaining adverse position is driven primarily by increased medical and surgical consumable spend to deliver activity, £6.4m adverse, and in tariff drugs, £2.4m adverse, which is supporting increased elective and non-elective activity. £6.9m is driven by items such as IT, Bristol Ambulance costs and UKHSA Activity.

	Month 11			Year to date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Contract Income	75.6	82.6	7.0	795.3	818.2	22.9
Income	1.1	9.3	8.2	49.0	95.5	46.4
Pay	(47.6)	(52.4)	(4.9)	(530.1)	(550.6)	(20.5)
Non-pay	(28.3)	(37.2)	(8.9)	(315.0)	(364.9)	(49.9)
Surplus/(Deficit)	**0.8**	**2.3**	**1.5**	**(0.8)**	**(1.8)**	**(1.0)**

UHBW - February 2025

2024/25 YTD Income & Expenditure Position

Net I&E deficit of £2,483k against a breakeven plan, an improvement of £1,926k from last month.

Total operating income is £39,673k ahead of plan due to higher than planned income from activities (£31,643k) and other operating income (£8,030k). The higher than planned position is primarily due to additional income received from ICB Commissioners and NHS England South-West Specialised Commissioning.

Total operating expenditure is £47,342k adverse to plan due to higher than planned non-pay costs of £25,109k and higher than planned pay expenditure of £22,004k. Higher than planned operating expenditure is due to higher than planned staff in post, the impact of non-pay inflation, higher than planned pass-through costs and the YTD shortfall in savings delivery.

Key Financial Issues

Recurrent savings delivery below plan – YTD CIP delivery is £29,310k, behind plan by £8,382k or 22%.

Recurrent savings YTD are £17,391k, an improvement of £1,894k in the month.
Delivery of elective activity below plan – elective activity must be delivered in line with plan. The cumulative YTD value of elective activity is £2,765k behind plan, an improvement of £348k in February.

Failure to deliver the financial plan – failure to deliver the planned savings and failure to earn the planned level of ERF would constitute a breach of the statutory duty to break-even and will result in regulatory intervention. A forecast outturn assessment has been completed and as a system, and with further mitigations, the break-even plan remains achievable.

Strategic Risks

The scale of the Trust's recurrent deficit and CDEL constraint presents a significant risk to the Trust's strategic ambitions. Further work is required to develop the mitigating strategies, whilst acknowledging the Systems strategic capital prioritisation process will have a major influence and bearing on how we take forward strategic capital, including, for example, the Joint Clinical Strategy. This risk is assessed as high.

Finance

Position Statement

NBT - Statement of Financial Position at 28 February 2025

Capital spend is £36.4m year-to-date (excluding leases). This is driven by spend on the Elective Centre, and is below the forecasted spend for Month 11.

Cash is £56.9m at 28 February 2025, a £5.7m decrease compared with Month 12. The decrease is driven by the I&E deficit and capital. Cash is expected to remain relatively stable in M12, resulting in a cash position of approximately £52.3m.

Non-Current Liabilities have decreased by £1.7m in Month 11 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 £69m increase in the Income and Expenditure Reserve for the year.

	23/24 Month 12 £m	24/25 Month 10 £m	24/25 Month 11 £m	In-Month Change £m	YTD Change £m
Non-Current Assets	**538.4**	**546.0**	**552.4**	**6.4**	**14.0**
Current Assets					
Inventories	11.7	11.7	11.8	0.2	0.1
Receivables	49.4	62.0	53.7	(8.2)	4.3
Cash and Cash Equivalents	62.7	32.0	56.9	25.0	(5.7)
Total Current Assets	**123.8**	**105.6**	**122.5**	**16.9**	**(1.3)**
Current Liabilities (< 1 Year)					
Trade and Other Payables	(99.9)	(78.0)	(93.6)	(15.7)	(6.3)
Deferred Income	(14.4)	(19.0)	(17.7)	1.3	3.3
Financial Current Liabilities	(23.6)	(23.6)	(23.6)	0.0	(0.0)
Total Current Liabilities	**(138.0)**	**(120.6)**	**(134.9)**	**(14.3)**	**(3.1)**
Non-Current Liabilities (> 1 Year)					
Trade Payables and Deferred Income	(6.2)	(6.5)	(6.5)	(0.0)	0.4
Financial Non-Current Liabilties	(571.8)	(581.7)	(580.0)	1.7	8.2
Total Non-Current Liabilities	**(578.0)**	**(588.2)**	**(586.5)**	**1.6**	**8.6**
Total Net Assets	**(53.7)**	**(57.2)**	**(46.5)**	**10.6**	**7.2**
Capital and Reserves					
Public Dividend Capital	485.2	507.3	516.9	9.5	31.7
Income and Expenditure Reserve	(541.8)	(610.8)	(610.8)	0.0	(69.0)
Income and Expenditure Account - Current Year	(69.0)	(25.6)	(24.5)	1.1	44.5
Revaluation Reserve	71.9	71.9	71.9	0.0	0.0
Total Capital and Reserves	**(53.7)**	**(57.2)**	**(46.5)**	**10.6**	**7.2**

UHBW - Year to Date Financial Position

In February, the Trust delivered a £1,926k surplus against the plan of break-even. The cumulative YTD position at the end of the month is a net deficit of £2,483k (£4,409k net deficit last month) against a breakeven plan. The Trust is £2,483k adverse to plan. The cumulative YTD net deficit is 0.2% of total operating income.

Significant operating expenditure variances in the year-to-date position include: the shortfall on savings delivery; premium pay pressures and over-establishment mainly relating to nursing and medical staff; higher than planned pass-through costs (matched by additional patient care income) and the impact of unfunded non-pay inflation.

YTD pay expenditure is c3% higher than plan. Medical staffing costs in the Women's & Children's Division and nursing costs continue to cause significant overspends across Surgery, Specialised and Women's & Children's Division with continuing over-establishment and high nursing pay costs in total across substantive, bank and agency staff.

Agency and bank expenditure decreased in February. Agency expenditure in month is £714k, compared with £897k in January. Bank expenditure in month is £4,702k, compared with £5,158k in January and £4,069k in December.

Total operating income is higher than plan by £39,673k. The shortfall in ERF of £2,765k is offset by higher than planned pass-through payments, additional commissioner funding and additional other operating income.

	Month 11			YTD		
	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's
Income from Patient Care Activities	90,902	97,154	6,252	1,025,102	1,056,745	31,643
Other Operating Income	10,137	12,095	1,958	111,508	119,538	8,030
Total Operating Income	**101,039**	**109,249**	**8,210**	**1,136,610**	**1,176,283**	**39,673**
Employee Expenses	(62,113)	(64,525)	(2,412)	(686,159)	(708,163)	(22,004)
Other Operating Expenses	(34,120)	(39,961)	(5,841)	(398,450)	(423,559)	(25,109)
Depreciation (owned & leased)	(3,717)	(3,941)	(224)	(39,993)	(40,221)	(228)
Total Operating Expenditure	**(99,950)**	**(108,427)**	**(8,477)**	**(1,124,602)**	**(1,171,944)**	**(47,342)**
PDC	(1,210)	(1,131)	79	(13,310)	(12,442)	868
Interest Payable	(247)	(204)	43	(2,717)	(2,440)	277
Interest Receivable	292	445	153	3,212	5,162	1,950
Net Surplus/(Deficit) inc technicals	**(76)**	**(67)**	**9**	**(807)**	**(5,380)**	**(4,573)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	76	1,993	1,917	807	2,897	2,090
Net Surplus/(Deficit) exc technicals	**0**	**1,926**	**1,926**	**0**	**(2,483)**	**(2,483)**

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Assurance and Variation Icons – Detailed Description

VARIATION ICON	ASSURANCE ICON	P*	P	?	F	F-	*No icon*
		Consistently Passing target (target outside control limits)	Passing target	Passing and Falling short of target subject to random variation	Falling short of target	Consistently Falling short of target (target outside control limits)	No Target
H	Special Cause Improving Variation High, where up is improvement	Special Cause Improving Variation High, where up is improvement and target is less than lower limit.	Special Cause Improving Variation High, where up is improvement and last six data points are greater than or equal to target.	Special Cause Improving Variation High (where up is improvement) and last six data points are hitting and missing target, subject to random variation.	Special Cause Improving Variation High, where up is improvement but last six data points are less than target.	Special Cause Improving Variation High, where up is improvement but target is greater than upper limit.	Special Cause Improving Variation High, where up is improvement and there is no target.
L	Special Cause Improving Variation Low, where down is improvement	Special Cause Improving Variation Low , where down is improvement and target is greater than upper limit.	Special Cause Improving Variation Low, where down is improvement and last six data points are less than target.	Special Cause Improving Variation Low (where down is improvement) and last six data points are both hitting and missing target, subject to random variation.	Special Cause Improving Variation Low, where down is improvement but last six data points are greater than or equal to target.	Special Cause Improving Variation Low, where down is improvement but target is less than lower limit.	Special Cause Improving Variation Low, where down is improvement and there is no target.
C	Common Cause (natural/expected) variation	Common Cause (natural/expected) variation, where target is less than lower limit where up is improvement, or greater than upper limit where down is improvement.	Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is improvement, or less than target where down is improvement.	Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.	Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration, or less than target where down is deterioration.	Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration or greater than upper limit down is deterioration.	Common Cause (natural/expected) variation with no target.
H	Special Cause Concerning Variation High, where up is deterioration	Special Cause Concerning Variation High, where up is deterioration but target is greater than upper limit.	Special Cause Concerning Variation High, where up is deterioration, but last six data points are less than target.	Special Cause Concerning Variation High, where up is deterioration and last six data points are both hitting and missing target, subject to random variation.	Special Cause Concerning Variation High, where up is deterioration and last six data points are greater than or equal to target.	Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit.	Special Cause Concerning Variation High, where up is deterioration and there is no target.
L	Special Cause Concerning Variation Low, where down is deterioration	Special Cause Concerning Variation Low, where down is deterioration but target is less than lower limit.	Special Cause Concerning Variation Low, where down is deterioration but last six data points are greater than or equal to target.	Special Cause Concerning Variation Low, where down is deterioration and last six data points are both hitting and missing target, subject to random variation.	Special Cause Concerning Variation Low, where down is deterioration and last six data points are less than target.	Special Cause Concerning Variation Low, where down is deterioration and target is greater than upper limit.	Special Cause Concerning Variation Low, where down is deterioration and there is no target.

KEY
Note Performance
Constitutional Standards and Key Metrics = Escalation Summary

North Bristol NHS Trust

Perinatal Quality Surveillance Matrix (PQSM) Dashboard data

Month of Publication March 2025

Data up to January 2025

Activity	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date	Trend	SPC		Comment
																Variation	Assurance	
Number of women who gave birth (>=24 weeks or <24 weeks live)	461	440	447	425	459	449	444	444	463	481	397	454	448	447				
Number of women who gave birth (>=22 weeks)	463	442	448	426	459	448	444	444	463	482	397	455	447	448				
Number of babies born (>=24 weeks or <24 weeks live)	466	446	449	429	463	456	451	453	472	486	401	460	454	453				
Number of livebirths 22+0 to 26+6 weeks	0	3	1	3	4	3	5	4	0	2	4	2	0	2				
Number of live births 24+0 to 36+6 weeks	36	36	24	27	33	34	36	40	28	37	28	41	33	33				
Number of livebirths <24 weeks	0	1	1	1	0	1	3	2	0	1	3	1	1	1				
Induction of labour rate %	31.7%	31.4%	34.5%	32.7%	29.8%	30.1%	25.0%	28.8%	33.0%	31.0%	28.2%	30.4%	29.7%	30.5%				
Unassisted birth rate %	45.6%	43.2%	43.6%	43.1%	45.3%	46.1%	45.5%	45.5%	46.7%	42.2%	45.8%	43.8%	44.9%	44.7%				
Assisted birth rate %	9.1%	8.9%	11.2%	10.8%	8.5%	9.6%	8.6%	7.9%	8.0%	9.4%	8.3%	10.8%	9.6%	9.3%				
Caesarean section rate (overall) %	44.9%	47.5%	44.7%	45.9%	46.2%	43.0%	45.0%	46.4%	45.4%	48.4%	45.6%	44.9%	44.6%	45.6%				
Elective caesarean section rate %	20.6%	21.6%	19.9%	18.8%	17.2%	18.3%	20.5%	23.2%	19.7%	23.1%	21.4%	20.3%	21.4%	20.5%				
Emergency caesarean section rate %	24.3%	25.9%	24.8%	27.1%	29.0%	24.7%	24.5%	23.3%	25.7%	25.4%	24.2%	24.7%	23.2%	25.1%				

Safe - Maternity Workforce	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date	Trend	SPC		Comment
																Variation	Assurance	
One to one care in labour (as a percentage)* excludes BBAs	99%	100%	99.7%	100%	100%	100%	100%	100%	100.0%	100%	100%	100%	100%	99.9%		H	?	
Compliance with supernumerary status for labour ward coordinator	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%%	99.9%		H	?	
Number of times maternity unit attempted to divert or on divert	0	1	0	0	0	1	1	1	0	1	1	1	1	0.6			?	
Number of obstetric consultant non-attendance to 'must attend' clinical situations	0	0	0	0	0	0	0	0	0	0	0	0	0	0			?	
Consultant Led MDT ward rounds on CDS day	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.8%		H	?	
Consultant Led MDT ward rounds on CDS evening/night	93.0%	96.0%	81%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96.7%		H	?	
Percentage of 'staff meets acuity' - CDS	69%	51%	67%	70%	71%	44%	62%	61%	62%	52%	67%	51%	55%	60.2%			F	
Percentage of 'up to 3 MWs short' - CDS										44%	29%	45%	41%					
Percentage of '3 or more MW's short' - CDS										4%	4%	5%	3%					
Confidence factor in Birthrate+ (data recording on CDS)	83.3%	89.7%	81.2%	85.0%	80.7%	81.7%	76.9%	78.5%	83.9%	75.8%	81.1%	80.0%	87.1%	81.9%			P	

Safe - Maternity Workforce	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date	Trend	SPC Variation	SPC Assurance	Comment
Band 5/6/7 Midwifery Vacancy Rate (inclusive of maternity leave) WTEs	5.59%	8.04%	6.17%	3.06%	2.68%	1.43%	-1.25%	-2.19%	-1.17%	-1.23%	-1.45%	-1.12%	-2.14%	1.3%		L	?	
Obstetric Consultant Vacancy Rate (inclusive of maternity leave) WTEs									4.76%	4.76%	4.76%	4.76%	0.00%					Calculated using current obs PAs in job plans (154.26, excluding external PAs) / current + FMU post (162) currently being recruited. WTE is shared O&G. Vacances in Gynae with small impact on Obstetric activity
Obstetric Resident Doctor Vacancy Rate (inclusive of maternity leave) WTEs									0%	0%	0%	2%	2%					Locum shifts worked to cover sickness & pregnancy-related on-call changes, not vacancy.
Midwifery Shift Fill Rate (%) - acute services* day					60.1%	55.3%	52.7%	60.4%	51.4%	89.7%	90.3%	92.6%	93.7%	71.8%			?	
Midwifery Shift Fill Rate (%) - acute services* night					46.9%	55.8%	50.0%	52.8%	61.0%	98.2%	99.0%	100.7%	103.0%	74.1%		H	F	
Obstetric Shift Fill Rate - acute services* day									100%	100%	100%	100.0%	100.0%					On-call shifts only.
Obstetric Shift Fill Rate - acute services* night									100%	100%	100%	100.0%	100.0%					No consultant acting down required in Feb 25

Safe - Neonatal Workforce	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date	Trend	SPC Variation	SPC Assurance	Comment
Number of NICU consultant non-attendance to 'must attend' clinical situations	0	0	0	0	0	0	0	0	0	0	0	0	0	0			?	
Band 5/6/7 Neonatal Nursing Vacancy Rate (inclusive of maternity leave) WTEs				18.00%	10.81%	4.58%	6.69%	9.62%	2.77%	3.23%	2.59%	7.70%	9.98%	7.60%			?	
Neonatal Nurse Qualified in Speciality establishment rate	35%	52%	54%	59%	59%	59%	55%	55%	43%	56%	56%	55%	52%	53%			F	
Neonatal Consultant Vacancy Rate (inclusive of maternity leave) WTEs									0%	0%	0%	0%	0%					Ongoing long-term sickness.
Neonatal Resident Doctor Vacancy Rate (inclusive of maternity leave) WTEs									0%	0%	0%	0%	7.60%					Includes ANNP & PA from as part of the tier 1 rota. 26 WTE for tier 1 & tier 2 rota. 1 WTE Maternity leave from Jan 25, 1 WTE appointment from tier 2 rota to specialist post on consultant rota, new starters in Feb 25 & March 25 with rotation.
Neonatal Nursing Fill Rate (%) - acute services* using BAPM acuity tool									100.0%	96.7%	98.2%	100.0%	98.3%					
Neonatal Nursing QIS Fill Rate (%) - acute services using BAPM acuity tool									54.2%	49.2%	63.6%	78.0%	73.3%					
Neonatal (Medical) Shift Fill Rate (%) - acute services* day using BAPM acuity tool									100%	100%	100%	100%%	100.0%					No unsafe shifts – some consultant acting down.
Neonatal (Medical) Shift Fill Rate (%) - acute services* Night using BAPM acuity tool									100%	100%	100%	100%%	100.0%					No unsafe shifts – some consultant acting down.

Training	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date	Trend	SPC		Comment
																Variation	Assurance	
Training compliance fetal wellbeing day - Obstetric Consultants	89%	89%	89%	94%	72%	94%	94%	88%	55%	57%	90%	79%	90%	83%				
Training compliance fetal wellbeing day - Other Obstetric Doctors	70%	71%	72%	72%	69%	57%	57%	37%	74%	79%	86%	76%	76%	69%				
Training compliance fetal wellbeing day - Midwives (ALL)	86%	91%	82%	87%	77%	84%	86%	85%	81%	85%	95%	90%	87%	86%				
Training compliance in maternity emergencies and multi-professional training - Obstetric Consultants	95%	95%	89%	94%	89%	89%	89%	94%	60%	60%	100%	95%	90%	88%				
Training compliance in maternity emergencies and multi-professional training - Other Obstetric Doctors	97%	69%	73%	75%	63%	51%	51%	66%	66%	73%	88%	76%	68%	70%				
Training compliance in maternity emergencies and multi-professional training (includes NBLS) - Midwives (ALL)	80%	89%	73%	79%	82%	78%	80%	83%	69%	72%	94%	94%	89%	82%				
Training compliance in maternity emergencies and multi-professional training - Anaesthetic Consultants	75%	72%	62%	59%	66%	79%	65%	70%	78%	81%	93%	90%	90%	75%				
Training compliance in maternity emergencies and multi-professional training - Other Anaesthetic Doctors	100%	74%	73%	60%	64%	40%	79%	77%	62%	74%	100%	91%	95%	76%				
Training compliance in maternity emergencies and multi-professional training - Maternity care assistants - ALL	71%	95%	90%	80%	76%	75%	77%	77%	63%	69%	94%	93%	90%	81%				
Training compliance annual local NBLS - NICU Consultants								50%	74%	92%	92%	94%	94%	80%				
Training compliance annual local NBLS - NICU Resident doctors (who attend any births)								100%	100%	100%	100%	94%	94%	99%				
Training compliance annual local NBLS NICU ANNPs (ALL)								80%	82%	100%	100%	82%	91%	89%				
Training compliance annual local NBLS NICU Nurses (Band 5 and above)								97%	92%	96%	96%	88%	98%	94%				
Training compliance annual local NBLS MSWs, HCAs and nursery nurses (dependant on their roles within the service - for local policy to determine)								80%	81%	91%	91%	88%	90%	86%				

Safe - Delivery Metrics	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date average	Trend	SPC		Comment
																Variation	Assurance	
Number of shoulder dystocias recorded (vaginal births)	11	5	9	7	8	9	8	9	8	8	9	9	10	8				
% of women with a high degree (3rd and 4th) tear recorded	2.8%	3.9%	3.6%	4.3%	5.3%	7.1%	5.7%	3.8%	3.6%	6.5%	7.4%	3.2%	5.6%	4.8%				
Number of women with a retained placenta following birth requiring MROP	6	9	4	8	12	8	11	6	12	13	3	9	9	8				
Number of babies with an Apgar Score <7 at 5 mins (all gestations)	3	6	11	6	6	11	17	5	10	9	8	7	5	8				

Infant Feeding & Skin to Skin	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date average	Trend	SPC		Comment
																Variation	Assurance	
% of babies where breastfeeding initiated within 48 hours	84.0%	78.9%	82.3%	78.3%	80.9%	81.5%	77.6%	78.0%	84.5%	80.0%	82.5%	79.1%	76.3%	80.3%				
% of babies breastfeeding on Day 10	76.6%	74.0%	76.6%	76.4%	75.0%	72.3%	72.4%	72.8%	74.5%	76.7%	81.2%	73.5%	73.1%	75.0%				
% of babies breastfeeding at transfer to community	74.1%	67.8%	65.6%	70.9%	82.0%	69.5%	67.6%	65.9%	68.2%	69.5%	71.2%	66.9%	66.9%	69.7%				
% of babies where skin to skin recorded within 1st hour of birth	84.0%	83.8%	81.8%	82.8%	91.0%	83.7%	80.2%	81.4%	83.4%	81.1%	85.0%	81.2%	82.4%	83.2%				

Perinatal Morbidity and Mortality inborn	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date average	Trend	SPC		Comment
																Variation	Assurance	
Total number of perinatal deaths (excluding late fetal losses)	2	1	3	1	2	4	1	4	4	0	3	4	6	2				
Number of late fetal losses 16+0 to 23+6 weeks excl TOP	1	4	0	1	0	0	5	0	3	2	4	1	2	2				
Number of stillbirths (>=24 weeks excl TOP)	1	0	1	0	1	2	0	2	2	0	1	1	5	1				
Stillbirths per 1000 live births	2.15	0.00	2.23	0.00	2.16	4.41	0.00	4.42	4.24	0.00	2.49	2.17	11.01	2.71				
Number of neonatal deaths : 0-6 Days	1	0	1	1	1	2	1	0	1	0	1	1	0	1				
Number of neonatal deaths : 7-28 Days	0	1	1	0	0	0	0	2	1	0	0	2	1	1				
Neonatal Deaths before 28 days per 1000 live births (ALL)	2.15	2.24	4.45	2.33	2.16	4.39	2.22	4.42	4.28	0.00	2.49	6.5	2.2	3				
* NND before 28 days per 1000 live births (Inborn babies only)	2.15	0.00	2.23	2.33	2.16	4.39	2.22	4.42	4.28	0.00	2.49	6.5	2.2	3				
PMRT grading C or D themes in report	1	2	1	0	1	3	2	1	4	0	0	2	3	1				
Suspected brain injuries in term (37+0) inborn neonates (no structural abnormalities) (MNSI referral)	0	0	0	1	0	0	0	0	0	0	1	1	3	0				

Maternal Morbidity and Mortality	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date average	Trend	SPC		Comment
																Variation	Assurance	
Number of maternal deaths (MBRRACE)	0	0	0	0	1	1	1	1	0	0	0	0	0	0				
Direct causes	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
Indirect causes	0	0	0	0	1	1	1	1	0	0	0	0	0	0				
Number of women who received enhanced care on CDS (HDU)	22	33	26	29	37	46	41	37	29	36	40	37	32	34				
Number of women who received level 3 care (ICU)	0	0	0	2	1	3	2	0	0	3	3	1	1	1				

Insight	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date average	Trend	SPC		Comment
																Variation	Assurance	
Number of datix incident reported	100	130	144	95	117	104	125	124	107	110	79	95	99	111				
Number of datix incidents graded as moderate or above (total) (Physical Harm)	0	2	0	2	0	4	2	3	1	4	0	1	0	1				
Datix incident moderate harm (not PSII, excludes MNSI)	0	2	0	2	0	4	1	2	1	1	0	0	0	1				
Datix incident PSII (excludes MNSI)	0	0	0	0	0	0	0	0	0	0	0	1	0	0				
New MNSI referrals accepted	0	0	0	1	0	1	0	2	0	1	0	1	1	1				
Outlier reports (eg. MNSI/NHSR/CQC) or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
Trust Level Risks (number shared with LMNS)* score 12 or >	7	4	3	4	3	3	4	3	3	3	2	3	3	3				

NICU Data	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date average	Trend	SPC		Comment
																Variation	Assurance	
Neonatal Admission to NICU	52	57	51	42	45	42	38	45	48	50	33	55	50	47				
of which Inborn Babies booked with NBT	37	43	32	32	31	35	26	32	29	32	20	37	34	32				
of which Inborn Babies -booked elsewhere	1	3	2	6	6	0	4	5	2	2	4	2	0	3				
of which readmission	4	4	6	0	2	3	5	3	11	8	2	5	3	4				
of which ex-utero admission	8	7	11	4	3	4	3	3	3	8	6	9	7	6				
of which source of admission cannot be derived	1	0	0	0	3	0	0	2	3	0	1	2	3	1				
Neonatal Admission to Transitional Care	42	35	24	31	29	28	37	38	29	32	26	28	40	32				
Admission rate at term	4.2%	6.4%	5.2%	5.0%	4.2%	4.8%	2.9%	5.1%	3.6%	4.2%	2.7%	4.1%	6.0%	4.5%				
NICU babies transferred to another unit for higher/specialist care	5	9	6	4	5	4	6	4	6	0	2	4	8	4.6				
NICU babies transferred to another unit due to a lack of available resources	0	0	0	0	0	0	4	6	1	1	0	3	0	1.3				
NICU babies transferred to another unit due to insufficient staffing	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
Attempted baby abduction	0	0	0	0	0	0	0	0	0	0	0	0	0	0				

Involvement	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Year to date average	Trend	SPC		Comment
																Variation	Assurance	
Friends and family Test score (response rate % who rated 'very good' or 'good') NICU	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	97%				
Friends and family Test score (response rate % who rated 'very good' or 'good') maternity	92%	91%	93%	90%	93%	92%	89%	91%	89%	92%	91%	90%	87%	91%				
Service User feedback: Number of Compliments (formal)	67	26	110	106	61	96	93	36	37	24	13	14	29	57				
Service User feedback: Number of Complaints (formal)	5	4	3	1	1	6	3	4	9	3	4	0	11	4				
Staff feedback from frontline champions and walk-abouts (number of themes)	4	5	0	0	10	0	0	8	0	7	0	0	0	3				

Telephone Triage											Nov-24	Dec-24	Jan-25	Year to date	Trend	SPC		Comment
																Variation	Assurance	
Attendance to triage											820	850	822	83067%				
BSOTS KPI Initial assessment within 15 minutes											70%	63%	69%	67%				
NICE KPI Initial assessment within 30 minutes											91%	88%	91%	90%				
Calls answered by triage (Day 0730-2000)											907	916	902	912				
Calls answered by triage (Night 2000-0700)											293	334	291	314				
Phone calls abandoned on triage (Day 0730-2000)											134	176	146	152				
Phone calls abandoned on triage (Night 2000-0700)											27	34	22	28				
Calls answered by other clinical areas (CDS and Mendip - Day + Night)											688	729	726	714				
Phone calls abandoned in other clinical areas (CDS and Mendip - Day + Night)											23	20	18	20				

University Hospitals Bristol and Weston
NHS Foundation Trust

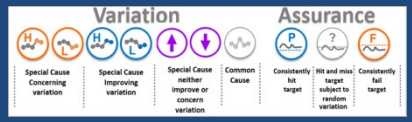
Perinatal Quality Surveillance (PQSM)

February 2025

UHBW Maternity

Inspected and rated Good
Care Quality Commission

Maternity Workforce & Acuity



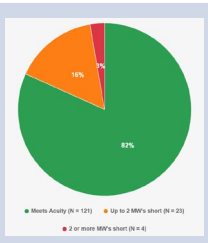
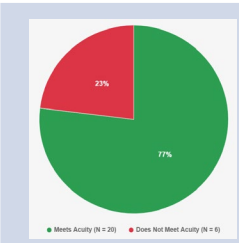
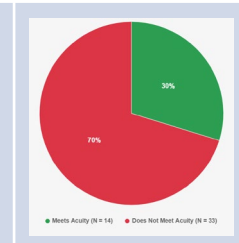
Safe – Maternity Workforce	Target	Local Threshold G	A	R	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Year to date average	Trend	SPC Variation	SPC Assurance	Comment	Countermeasure / Action
One to one care in labour (as a percentage)* excludes BBAs	SBLV3 100%	100%		≤99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					
Compliance with supernumerary status for labour ward coordinator	SBLV3 100%	100%		≤99%	100%	100%	100%	100%	100%	100%	100.0%					
Number of times maternity unit attempted to divert or on divert	Local	0		≥2	3	0	0	0	0	0	0.3					
Number of obstetric consultant non-attendance to 'must attend' clinical situations	Local	0		≥2	0	0	0	0	0	0	0					
Consultant Led MDT ward rounds on CDS day	SBLV3 100%	100%		≤90%	100%	100%	100%	100%	100%	100%	100.0%					
Consultant Led MDT ward rounds on CDS evening/night	SBLV3 100%	100%		≤90%	100%	100%	100%	100%	100%	100%	100.0%					
Percentage of 'staff meets acuity' - CDS	Birthrate + 100%	≥90%		≤85%	69%	73%	85%	87%	85%	82%	80.5%				Recommended lower target (suggested by Birthrate +) is 85%	
Confidence factor in Birthrate+ (data recording on CDS)	Birthrate + 60%	≥55%		≤45%	61.1%	79.0%	90.0%	88.2%	87.6%	88.1%	69.6%				Local target adjusted from 70% to 85% from January 2025 to reflect this	
Percentage of 'staff meets acuity' - Ward 73	Birthrate + 100%	≥90%		≤85%	64%	29%	79%	86%	52%	77%					Birthrate+ Accuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC	
Confidence factor in Birthrate+ (data recording on Ward 73)	Birthrate + 60%	≥55%		≤45%	9.2%	13.7%	23.3%	17.7%	20.2%	23.2%					Birthrate+ Accuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC	Action required to improve compliance with completing Birthrate + data submission
Percentage of 'staff meets acuity' - Ward 76	Birthrate + 100%	≥90%		≤85%	0%	36%	58%	56%	31%	30%					Birthrate+ Accuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC	
Confidence factor in Birthrate+ (data recording on Ward 76)	Birthrate + 60%	≥55%		≤45%	4.2%	17.7%	31.7%	20.2%	25.8%	42.0%					Birthrate+ Accuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC	Action required to improve compliance with completing Birthrate + data submission

Birthrate Plus®

Capture of intrapartum (CDS) data is required 6 times during a 24-hour period (00:30, 04:00, 08:00, 12:00, 16:00 & 20:00), there is an hour's window for entering data: 30 mins before and 30 mins after the scheduled time.

Capture of ward data is required 4 times during a 24-hour period (02:00, 08:00, 14:00 and 20:00) ,there is a window for data entry 30 minutes before the scheduled entry time and 60 minutes afterwards.

Data entered outside of the time window may still be recorded by will not contribute to the overall compliance calculation.

Central Delivery Suite (CDS)	Antenatal & Postnatal Inpatients (Ward 73)	Transitional Care (Ward 76)
		

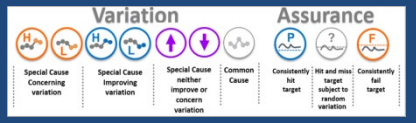
Is the standard of care being delivered?

- **No episodes where the supernumerary status of the CDS coordinator was not maintained**

What are the top contributing factors to over/under achievement?

- **Low compliance with completing Birthrate+ consistently on Ward 73 and Ward 76 impacts the reliability of this data**

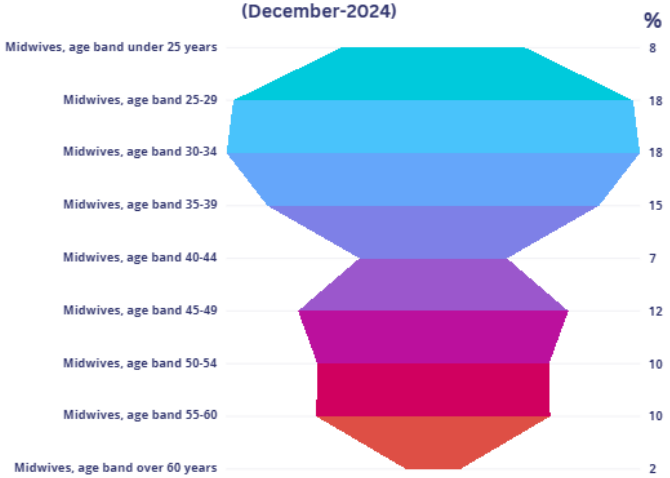
Maternity Workforce & Acuity



Safe – Maternity Workforce	Target	Local Threshold G	A	R	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Year to date average	Trend	SPC Variation	SPC Assurance	Comment	Countermeasure / Action
Band 5/6/7 Midwifery Vacancy Rate (inclusive of maternity leave) WTEs	197.78 WTE 100%	≤5		≥10	6.48	2.95	3.16	1.16	0.16	0.16	5.39				Current vacancy rate of 0.16 wte, with 10.96 wte in onboarding process	
Obstetric Consultant Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3	0.9	0.9	0.9	0.9	0.9	1.0					Short-term vacancacy due to maternity leave, anticipated vacancy will be filled by locum position in March 25	
Obstetric Registrar Vacancy Rate (inclusive of maternity leave)WTEs		≤1		≥3	2.4	2.4	2.4	2.4	2.4	-1.0						
Obstetric SHO Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3	-1.0	-1.0	-1.0	-1.0	-1.0	0						
Midwifery Shift Fill Rate (%) – acute services* day		≥97.5%		≤95%	95.1%	92.3%	102.1%	99.5%	101.1%	87.6%						
Midwifery Shift Fill Rate (%) – acute services* night		≥97.5%		≤95%	87.4%	88.7%	98.8%	92.5%	95.1%	95.0%						
Obstetric Shift Fill Rate – acute services* day		≥97.5%		≤95%	98.2%	99.1%	96.7%	99.6%	98.3%	98.1%						
Obstetric Shift Fill Rate – acute services* night		≥97.5%		≤95%	98.9%	98.9%	100.0%	98.9%	100.0%	100.0%						
Anaesthetic (Obstetric) Shift Fill Rate (%) – acute services* day		≥97.5%		≤95%	100%	100%	98.2%	96.9%	100.0%	100.0%						
Anaesthetic (Obstetric) Shift Fill Rate (%) – acute services* night		≥97.5%		≤95%	100%	100%	100%	100%	99%	95.2%						

UHBW Midwives in post: demographics

Data Source: NHS Model Health System (December-2024)



Midwifery Staff currently in the on-boarding process:

Band 7 – 0.0 wte **Band 6 – 0.0 wte** **Band 5 – 10.96 wte**

UHBW Midwives in post: Ethnicity

Data Source: NHS Model Health System (December-2024)

Demographic profile of staff in post: Ethnicity	Provider value	Peer average	National value	National value method	Chart
Midwives: Asian/Asian British	2.0%	1.8%	2.4%	Provider median	
Midwives, Black/African/Caribbean/Black British	4.4%	3.3%	5.7%	Provider median	
Midwives: Mixed/Multiple ethnic groups	2.7%	1.7%	2.0%	Provider median	
Midwives: Not stated	1.8%	1.7%	1.8%	Provider median	
Midwives: Other	0.3%	0.6%	0.9%	Provider median	
Midwives: White	88.8%	92.1%	89.2%	Provider median	

February 2025

Midwifery Maternity Rate:

8.4 wte

NICE Midwifery Red Flags

NICE Red Flags, as identified within: Safe midwifery staffing for maternity settings, NG14 published 27/02/2015

NICE Red Flags (as identified within 'Safe midwifery staffing for maternity settings, NG14, published 27/02/2015)

	Data Source	Reliability of Data	Rationalle for current reliability assessment	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Delayed or cancelled time-critical activity	Datix/ BadgerNet/ Birthrate +	Variable	Cat 1 and Cat 2 CS delays captured in BadgerNet. All other delayed or cancelled time-critical activities rely of Datix submission by clinical staff	17	18	12	15	23	18
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	Datix/ Birthrate +	Variable	Relies on Datix submission by clinical staff	0	0	0	0	3	0
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	Datix/ Birthrate +	Variable	Relies on Datix submission by clinical staff	7	4	2	2	2	6
Delay of more than 30 minutes in providing pain relief	Datix/ Birthrate +	Variable	Relies on Datix submission by clinical staff	0	0	0	0	1	0
Delay of 30 minutes or more between presentation and triage	BadgerNet/ Birthrate +	Good	Data extracted from BadgerNet	19.47% (111 attendances)	6.56% (40 attendances)	5.29% (32 attendances)	5.06% (29 attendances)	9.66% (64 attendances)	9.57% (5 attendances)
Full clinical examination not carried out when presenting in labour	BadgerNet/ Birthrate +	Good	Data extracted from BadgerNet	27.7% 103 assessments not completed / partially completed	15.9% 65 assessments not completed / partially completed	17.59% 57 assessments not completed / partially completed	16.6% 56 assessments not completed / partially completed	22.8% 85 assessments not completed / partially completed	19.8% 66 assessments not completed / partially completed
Delay of 2 hours or more between admission for induction and beginning of process	BadgerNet/ Birthrate +	Good	Data extracted from BadgerNet	78.8% 104 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 401 minutes	75.2% 109 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 352.5 minutes	74.4% 99 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 201 minutes	73.1% 106 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 274 minutes	80.15% 105 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 352 minutes	68.6% 94 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle Median time = 230 minutes
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	Datix/ BadgerNet/ Birthrate +	Variable	SEPIS trigger data extracted directly from BadgerNet. Recognition of abnormal urine output relies of Datix submission by clinical staff	6	4	5	5	8	2
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	Datix/ BadgerNet/ Birthrate +	Good	Data extracted from BadgerNet	0	0	0	0	0	0

Neonatal Workforce & Acuity

Safe – Neonatal Workforce	Target	Local Threshold G	A	R	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Year to date average	Trend	SPC Variation	SPC Assurance	Comment	Countermeasure / Action
Number of NICU consultant non-attendance to 'must attend' clinical situations	Local	0		≥2	0	0	0	0	0	0	0.08					
Band 5/6/7 Neonatal Nursing Vacancy Rate (inclusive of maternity leave) WTEs		≤5		≥10	-2.54	-7.54	-11.61	-2.91	-0.3	-2.91						
Neonatal Nurse Qualified in Speciality establishment rate	BAPM 70%	≥70%		≤60%	62.0%	62.0%	66.0%	61.0%	60.0%	61.0%	56.75%					A3 Project relating to QIS Staffing to be undertaken by NICU Matron and Deputy Director of Midwifery and Nursing
Neonatal Consultant Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3	0	0	0	0	0	0					* 1.0wte consultant on LTS, locum recruited for 6 months (due to be in position by end of March 25	
Neonatal Registrar Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3	-0.7	-0.7	-0.7	-0.7	-0.7	0					Will be 0.7 at end of March for 6 months due to filling locum consultant role	
Neonatal SHO Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3	0.9	0.9	0.9	0.9	0.9	0						
Neonatal Nursing Fill Rate (%) – acute services* day using BAPM acuity tool		≥97.5%		≤95%	98.4%	116.3%	100.6%	97.2%	100.8%	113.4%						
Neonatal Nursing Fill Rate (%) – acute services* night using BAPM acuity tool		≥97.5%		≤95%	104.6%	102.5%	106.3%	103.4%	105.0%	112.1%						
Neonatal Nursing QIS Fill Rate (%) – acute services* day using BAPM acuity tool		≥70%		≤60%	62.4%	77.3%	65.0%	58.3%	61.5%	72.1%						A3 Project relating to QIS Staffing to be undertaken by NICU Matron and Deputy Director of Midwifery and Nursing
Neonatal Nursing QIS Fill Rate (%) – acute services* night using BAPM acuity tool		≥70%		≤60%	62.4%	63.2%	66.6%	64.7%	60.1%	73.1%						
Neonatal (Medical) Shift Fill Rate (%) – acute services* day		≥97.5%		≤95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						
Neonatal (Medical) Shift Fill Rate (%) – acute services* Night		≥97.5%		≤95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						

SONAR Workforce

No delayed / postponed dispatches or other operational impact resulted from gaps in the Middle Tier Rota – related to the resilience we have in the system

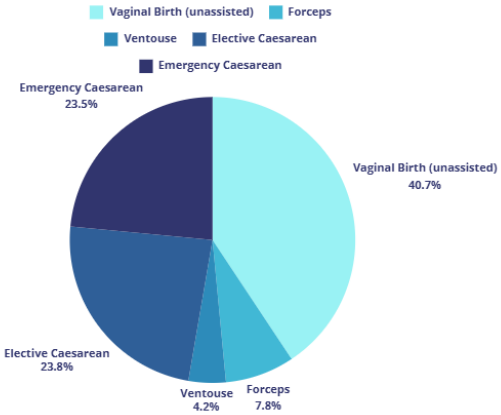
	Staffing (Funded)	Vacancy Rate	February Uncovered Shifts
Nursing Tier	12.0	0.41 WTE	Data Pending
Middle Tier	12.0	0.49 WTE	Data Pending
Consultant	24 hr cover		Data Pending

Maternity Metrics: February

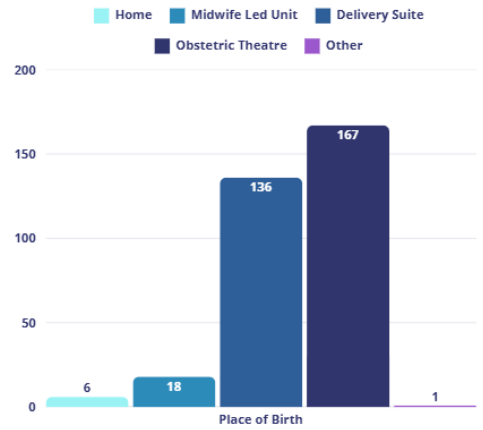
Percentage of Women booked with a Continuity Team (%)

Mode of Birth

332 Registerable Babies born during February 2025



Location of Birth



Induction of Labour Rate

41.2%

VBAC

16.4%

Shoulder Dystocia's (% of vaginal births)

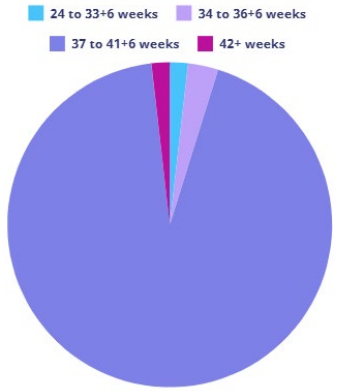
1.1%

% of women commencing vaginal birth sustaining a 3rd/4th degree tear

3.9%

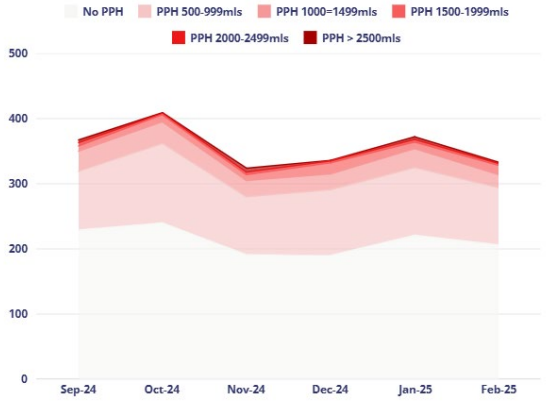
Gestation at Delivery

332 Registerable Babies born during February 2025

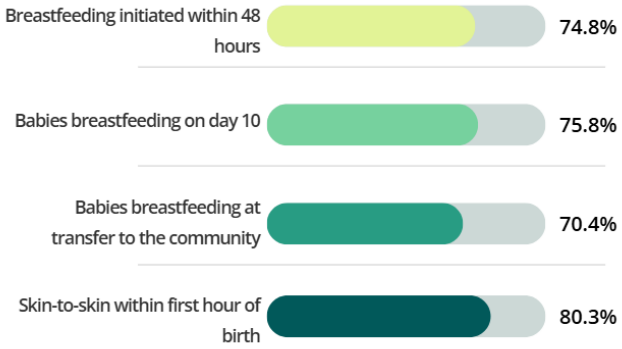


Postpartum Haemorrhage (PPH)

(Count of women)



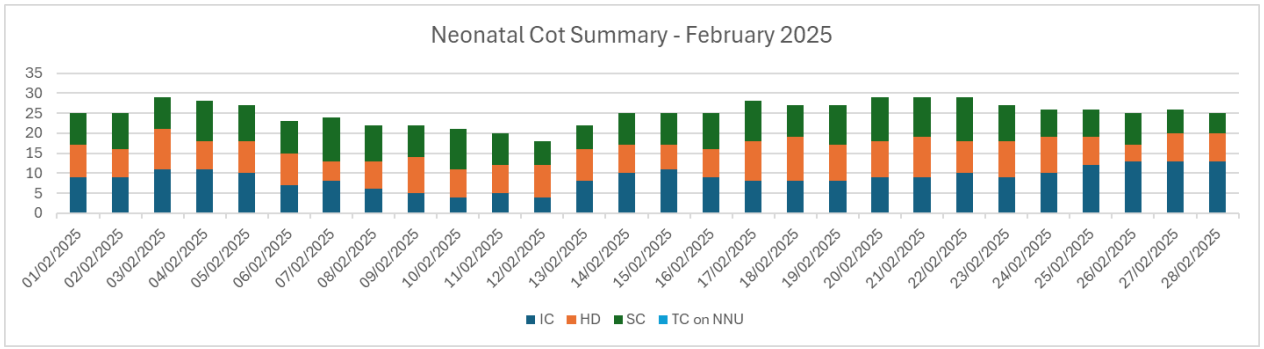
Infant Feeding & skin to skin (%)



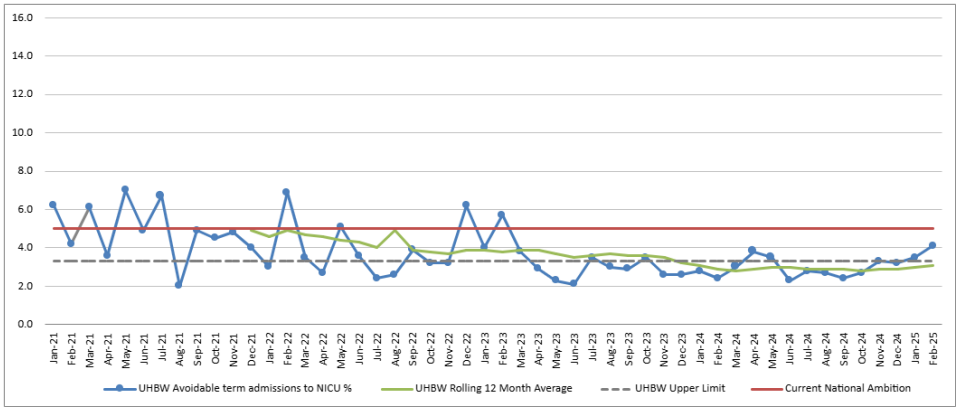
Neonatal Metrics: February

Neonatal Commissioned Cot Summary

Intensive Care (IC) Cots	= 15
High Dependency (HD) Cots	= 8
Special Care (SC) Cots	= 8
Transitional Care (TC) Cots	= 16

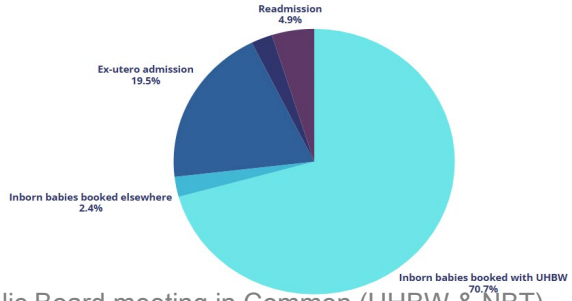


Avoidable Term Admission Rate in NICU (ATAIN)

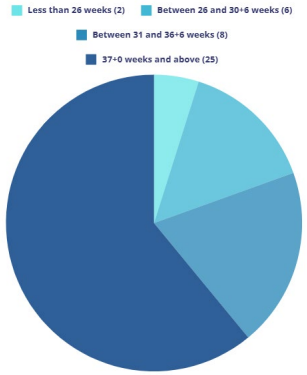


NICU Admission by Source

41 Babies Admitted to NICU in February 2025

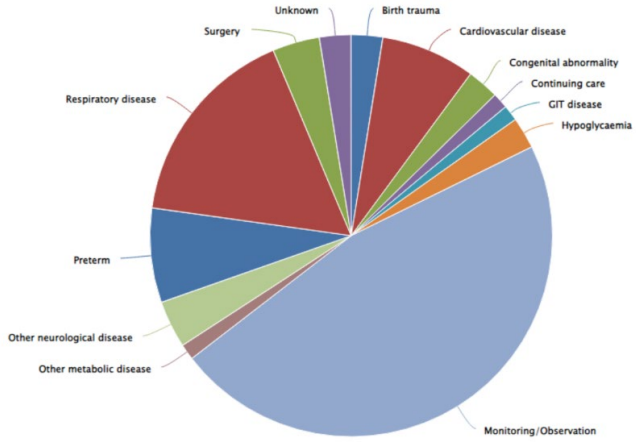


NICU Admission by Gestation



NNU* Principal reason for first admission

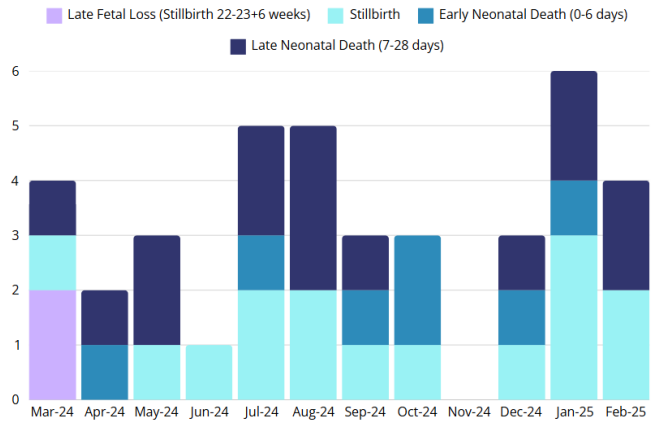
***NNU includes babies requiring neonatal care admitted to either NICU, Transitional Care or the Postnatal Ward**



Perinatal Mortality & Morbidity

UHBH Perinatal Mortality

Stillbirths and Neonatal Deaths

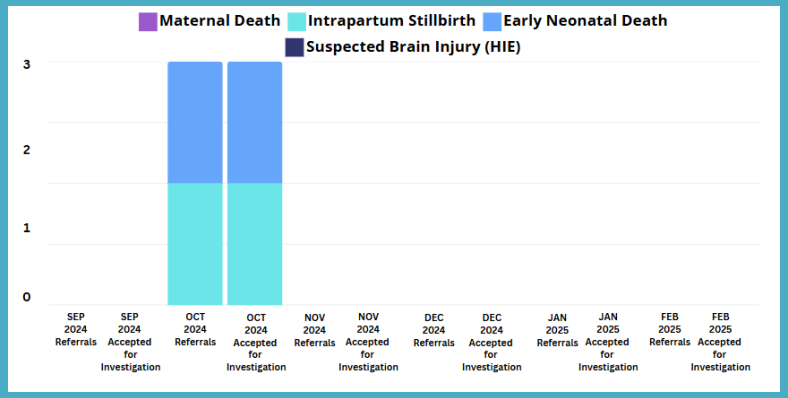


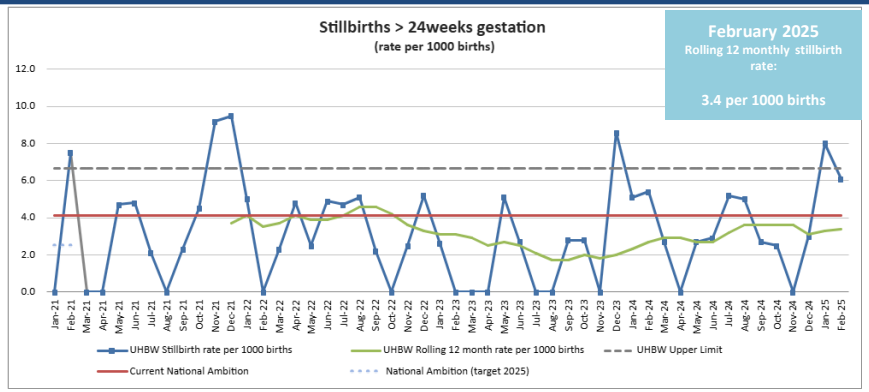
Maternity and Newborn Safety Investigations (MNSI)

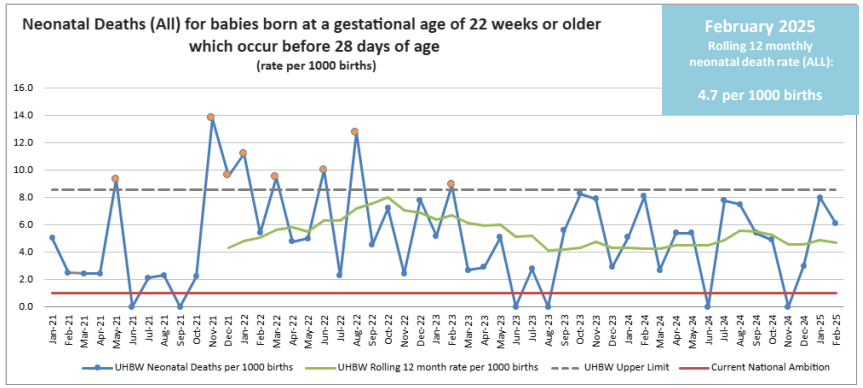
The Maternity and Newborn Safety Investigations (MNSI) programme investigates certain cases of:

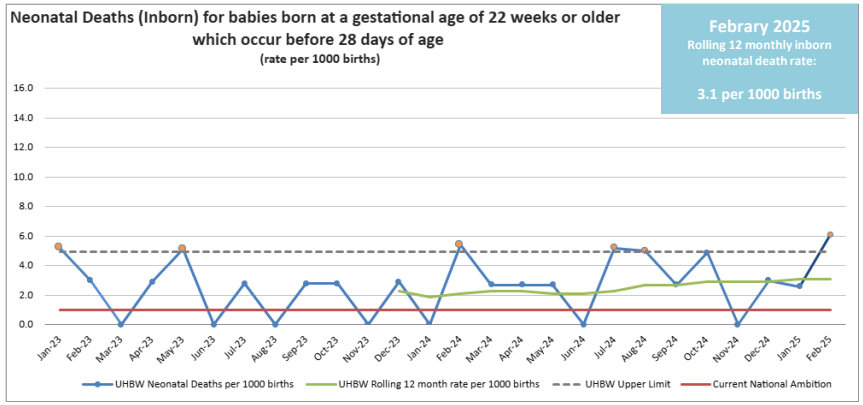
- Early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour in England
- maternal deaths in England

MNSI Referrals & Investigations by Criteria

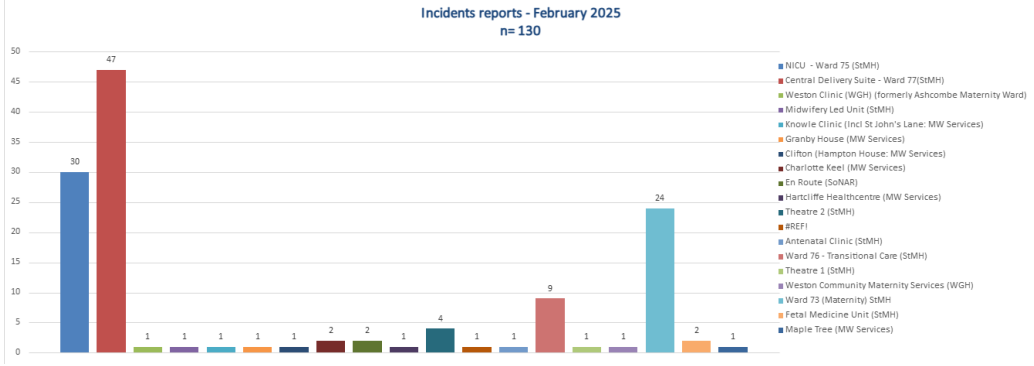


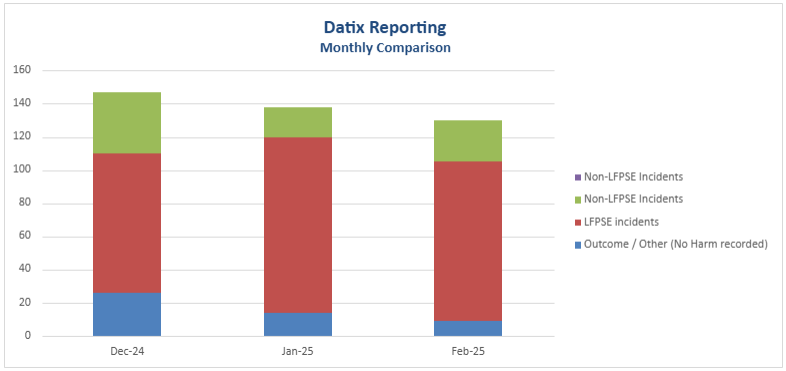






Incident Reporting & Reviews





CQC Action Required:
The service must ensure incidents are reviewed in a timely manner.
Regulation 17 (2) (b)

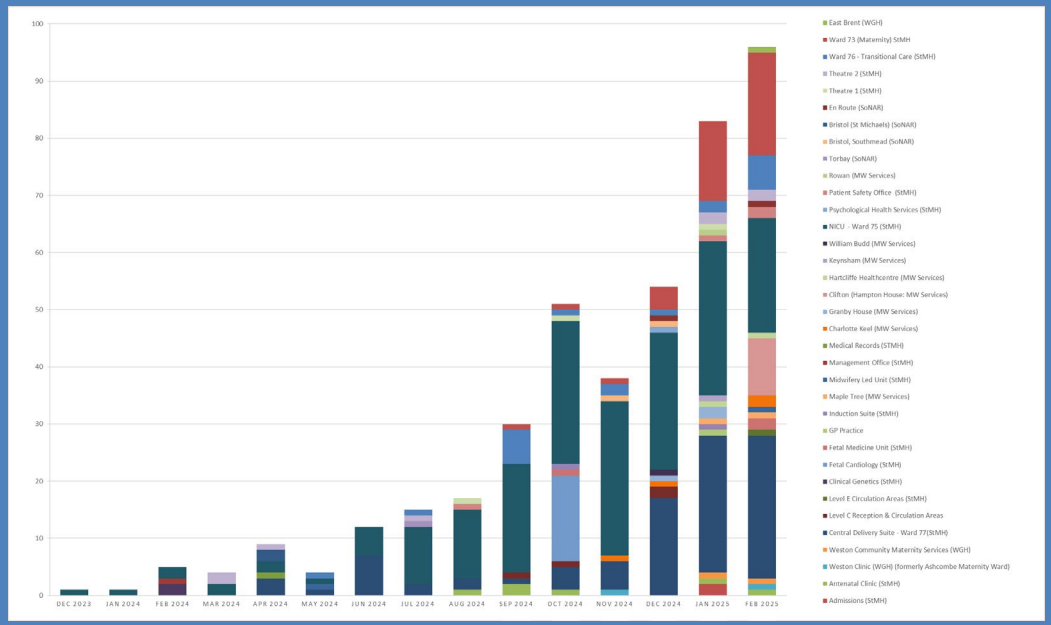
Steady progress, although slower than desirable being made.

The QPS team continues to offer support to Datix / Incident handlers to ensure timely review and closing of incidents.

Current Hotspots:

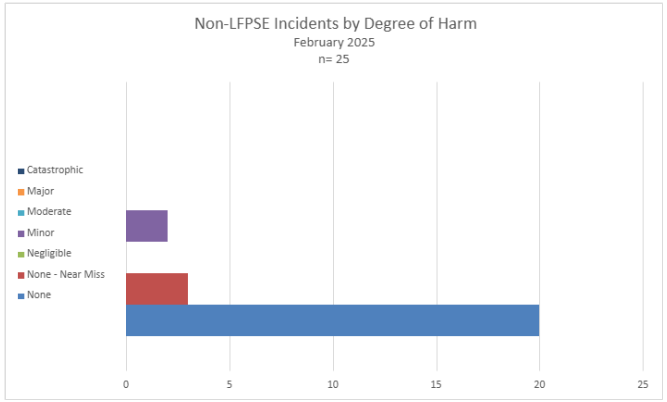
- **NICU**
- **Central Delivery Suite**

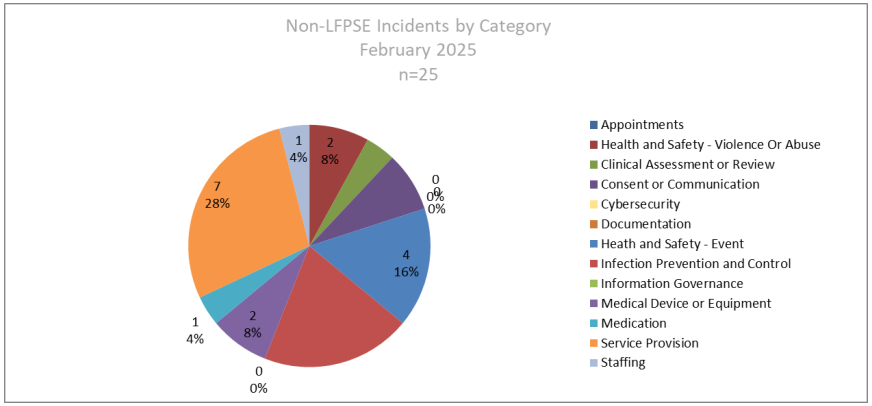
Acuity within these area's continues to impact timely review and closure of Datix / incidents.



Incident Reporting & Reviews

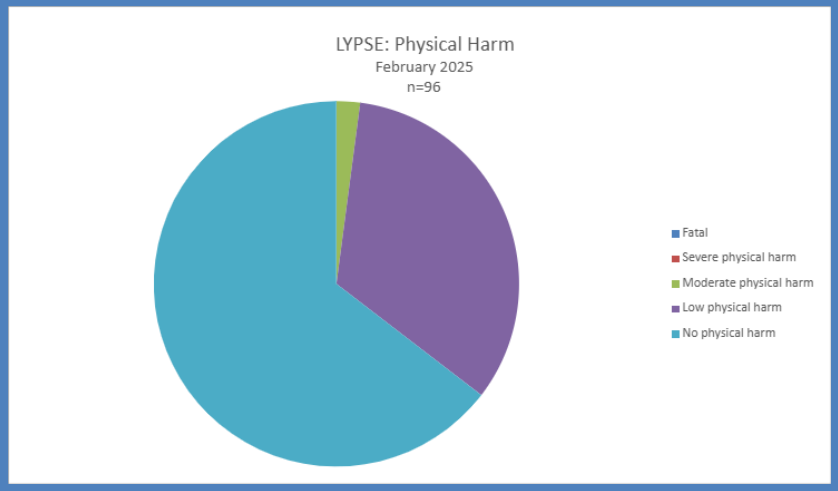
A total of 130 Datix were reported in February 2025, these consisted of 25 non-LFPSE incidents, 96 LFPSE incidents and 9 'other' events

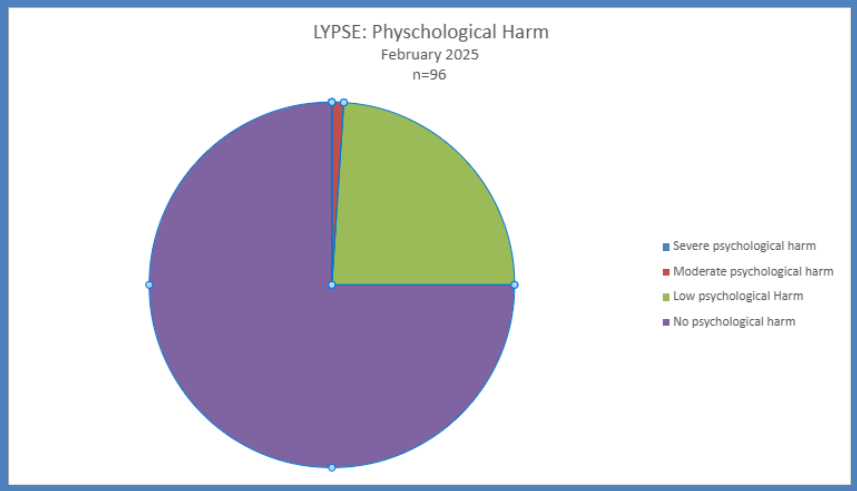




Learning from Patient Safety Events (LFPSE)

96 incidents met the LFPSE criteria in February
Each incident is categorised by Physical and Psychological harm. The breakdown of these is as follows:





Incident Reporting & Reviews

New Cases Reported in February 2025

Datix	Date of Incident	Harm	Incident	Outcome / Learning / Actions	MNSI Reference (If applicable)
283367	03/02/2025	Moderate physical harm Moderate psychological harm	Hysterectomy At Or Following Caesarean Section	**Meets criteria for PSIRF Learing Response:** Verbal DOC completed, written DOC completed **For review in M&M forum**	N/A
284077	26/02/2025	Moderate physical harm No psychological harm	Treatment Recognised Complication	**Initial incident review to be completed to confirm level of harm** Long line extravastion into pleural cavity	N/A

Incident Reporting & Reviews

Ongoing MNSI Investigations / PSIIs

Datix	Date of Incident	Harm	Incident	Outcome / Learning / Actions	MNSI Reference (If applicable)
254196	25/04/2024	Severe physical harm Moderate psychological harm	Emergency Caesarean for fetal wellbeing Post-operative Illius with conservative manangement Subseqent bowel perforation / ICU admission	**Meets criteria for PSIRF Learing Response:** Verbal DOC completed, written DOC completed in conjuction with Surgical Services Joint RIR Meeting held with Surgical Services Accepted for **Trust PSII** (investigation due to commence July 2024) Referral for psychological services completed Initial patient debrief meeting held 15/07/2024	N/A
No Datix Submitted	26/05/2024		(HEMS) admission to PICU (BCH) following postnatal collapse at home of a baby born at Gloucester MRI - Evidence of Hypoxic Ischaemic Enchelopathy (HIE)	Ongoing MNSI Investigation (Gloucester Referral) **UPDATE Requested from MNSI**	MI-037464
265400	22/08/2024	No physical harm Moderate psychological harm	Intrapartum Stillbirth	MNSI Investigation Draft report received and circulated for factual accuracy review **Awaiting updated draft report**	MI-038042
269518	03/10/2024	No physical harm Moderate psychological harm	Intrapartum Stillbirth	Ongoing MNSI Investigation Delay in draft report - due to change of MNSI investigation team - anticipated early April 2025	MI-038599
270410	11/10/2024	Outcome	Early Neonatal Death (Day 6 Collapse at home)	MNSI Investigation Draft report received and circulated for factual accuracy review **Awaiting updated draft report**	MI-038674
279844	16/01/2025	Never Event	Retained Vaginal Swab following instrumental delivery	**Meets criteria for PSIRF Learing Response:** Verbal DOC completed, written DOC completed Accepted for **Trust PSII** (Referral for psychological services completed, Investigation commenced	N/A

Maternity Safety Support Programme:

N/A

Coroner's regulation 28:

N/A

Service Insights: Patient & Staff Engagement

Patient Safety Walk Round

February 2025

Departments: Ward 76 (Transitional Care)
Ward 73 (Antenatal/Postnatal/IOL)

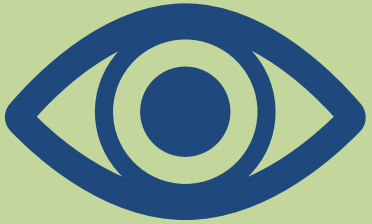
Date: Wednesday 26th February 2025

All staff spoken to felt that they could raise concerns if they had any

Discussion with long standing ward member of staff very positive feedback regarding ward leadership and changes that they have brought on the ward, support for complex safeguarding cases and plans for safeguarding supervision. Teamwork and happy team felt very positive place to work.

Staff shared feeling really valued by completion of Greatix.

Timely Completion of Birthrate Plus acuity tool for both Wards was discussed



- Keys for the medicine cupboards were found unsecured on the cupboard in the treatment rooms of both wards
- A drug key bunch was found unattended on the trolley in the treatment room of ward 76
- An unlocked medication drawer was observed, posing a potential risk of unauthorised access and compromising medication security in ward 76 .

Compliance with National Directives: Maternity (and Perinatal) Incentive Scheme – Year 6

MIS Safety Actions	Compliance with MIS Actions Year 5	Progress with MIS Actions Year 6
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?		
Can you demonstrate an effective system of clinical workforce planning to the required standard?		
Can you demonstrate an effective system of midwifery workforce planning to the required standard?		
Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version 3?		
Listen to women, parents and families using maternity and neonatal services and coproduce services with users.		
Can you evidence the required elements of local training plans and 'in-house', one day multi professional training?		
Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?		
Have you reported 100% of qualifying cases to MNSI and to NHS Resolutions Early Notification (EN) Scheme?		

The Maternity Incentive Scheme (MIS) was developed in 2017. The scheme is designed to support safer maternity and perinatal care by driving compliance with ten 'safety actions'. The safety actions are updated annually by a collaborative advisory group, consisting of representatives from NHS Resolution, NHS England, The Royal College of Obstetricians and Gynaecologists (RCOG, the Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), the Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity Newborn Safety Investigation Programme (MNSI).

MIS Year 6

Compliance Achieved

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

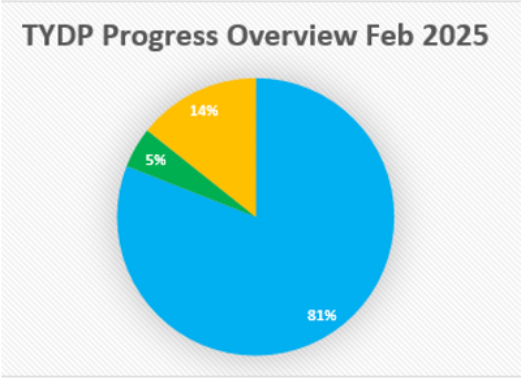
Compliance with National Directives: Three Year Delivery Plan

Entering the third and final year. Progress reviewed jointly with NBT and the LMNS on 17th February. Majority of deliverables/objectives are now BAU or are ready to commence.

The areas of focus for the final year are those deliverables which have not commenced. These are joint, system wide projects:

- **Theme 1**: Joint project with LMNS and UHBW to achieve all personalised care objectives across LMNS and Trust responsibilities in BNSSG
- **Theme 1**: Collect and disaggregate local data and feedback by population groups. LMNS working on dashboard, LMNS to update on plan once dashboard is launched and how the availability of the system dashboard will support this objective
- **Theme 2**: Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce. Both Trusts to review workforce data by ethnicity (breakdown of banding and ethnicity) and work with LMNS to.
- **Theme 3**: Consider culture, ethnicity and language when responding to incidents (NHSE 2021). Recording ethnicity of incident data requires improvement. Scoping Joint plan.
- **Theme 4**: Implement version 3 of the Saving Babies' Lives Care Bundle and adopt the national MEWS and NEWTT-2 tools. Awaiting v3.2 of SBL to implement and implementation plan for NEWTT-2 and MEWS needed (system wide)

Joint system level progress review scheduled for September 2025



Compliance with National Directives: Ockenden

The Maternity Incentive Scheme (MIS) was developed in 2017. The scheme is designed to support safer maternity and perinatal care by driving compliance with ten 'safety actions'. The safety actions are updated annually by a collaborative advisory group, consisting of representatives from NHS Resolution, NHS England, e (MNSI).

IEA	Number of Assurance Questions	N/A for UHBW or National Actions	Red	Amber	Green	Blue	Completed and evidenced	% of Compliance
1. Workforce Planning and Sustainability	11	1	0	0	0	0	10	100
2. Safe Staffing	10	2	0	0	0	1	7	88
3. Escalation and Accountability	5	0	0	0	0	0	5	100
4. Clinical Governance and Leadership	7	1	0	0	0	0	6	100
5. Incident Investigations and Complaints	7	0	0	0	0	2	5	71
6. Learning from Maternal Deaths	3	2	0	0	0	0	1	100
7. Multidisciplinary Training	9	0	0	0	0	0	9	100
8. Complex Antenatal Care	5	0	0	0	1	0	4	80
9. Pre-term Birth	4	1	0	0	0	0	3	100
10. Labour and Birth	6	0	0	1	0	0	5	83
11. Obstetric Anaesthesia	5	2	0	0	0	0	3	100
12. Postnatal Care	4	0	0	0	0	0	4	100
13. Bereavement Care	4	0	0	1	0	0	3	75
14. Neonatal Care	8	3	0	1	0	0	4	80
15. Supporting Families	3	0	0	1	0	0	2	67
TOTAL	91	12	0	4	1	3	71	90

N/A for UHBW or National Action
Immediate remedial action required to progress
Action required for successful delivery of this activity
Activity on target
Completed activity (evidence sign off required)
Completed activity (evidence signed off)

Next Steps for Progression:

- IEA10 – Installation of centralised CTG monitoring
- IEA13 – Creation of new ' Bereavement Champion' role to support 7 day bereavement support
- IEA14 – Neonatal Staffing action plan review scheduled
- IEA15 – Improving accessibility to psychological services to ensure equitability for all patients/families