Inspected and rated
Outstanding
Care Quality Commission

NHS
University Hospitals Bristol
NHS Foundation Trust

University Hospitals Bristol NHS Foundation Trust

Annual Report and Accounts 2017/18

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

University Hospitals Bristol NHS Foundation Trust
Annual Report and Accounts 2017/18

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Contents

1. Chairman's Statement

Welcome to the Annual Report and Accounts, including the Quality Report, for University Hospitals Bristol NHS Foundation Trust for the year from 1 April 2017 to 31 March 2018.

It is a pleasure to have joined the Trust this year and to have had the opportunity to work with so many people who are dedicated to improving the health of the people we serve through exceptional care, teaching and research.

I am aware that the NHS is facing mounting pressures, but I firmly believe that our positive and professional response and pride in the services we provide will continue to meet these challenges.

One of our central pillars as we move forward has to be working towards the concept of one public service and this means that continuing to build our relationships nationally, regionally and locally with other health and social care providers has to be a priority.

We are a large Trust, but we cannot continue to successfully deliver effective services in isolation and, as a major specialist centre providing tertiary services for over seven million people across South West England and South Wales, we have a responsibility to help build networks of care across the region and work together to find long-term solutions.

Robert Woolley, our Chief Executive, continues to jointly lead the local Sustainability and Transformation Partnership (now named Healthier Together), along with Julia Ross the Chief Executive of the Clinical Commissioning Group (CCG) for Bristol, North Somerset and South Gloucestershire (BNSSG). This partnership brings together key partners in the region and is developing plans to meet the health needs of our local population.

During 2017/18 we also strengthened our partnership with Weston Area Health NHS Trust (WAHT). In May we announced that we had signed a formal partnership and agreed to increase the level of joint working between the two Trusts in the interests of patients and staff. In January 2018 we went further, announcing our intention to pursue an organisational merger with WAHT. This was supported by our Council of Governors and by the Board of WAHT. The potential merger builds on our formal partnership enabling greater joint working between the organisations and more seamless care to patients. We are now conducting a comprehensive appraisal process to assess the clinical and financial benefits of a merger within the context of the 'Healthy Weston' programme.

The outcome of the 'Healthy Weston' programme being run by the CCG should provide vital information about the health services that will need to be commissioned in our region in the future and we look forward to participating in this work in the coming months.

As an NHS Foundation Trust, we greatly benefit from the insight and experience of our Governors. The majority of Governors are elected to represent their constituencies and they bring a range of challenge and rigour to the Board. This has been an important element of the improvement that we have experienced in recent years and is valuable to the success of the organisation.

As we move forward into 2018/19 we are refreshing our strategy for the next five to ten years so that the 'Outstanding' grading we were awarded by the Care Quality Commission is sustained. This achievement was built on the care, pride and professionalism of our staff that go the extra mile day in and day out and this needs to be a key element of our strategy for the future.

In the spirit of 'recognising success', one of our shared Trust values, I want to end by thanking everyone who has, and will continue, to provide outstanding care to our communities.

Thank you.

Jeff Farrar QPM, OStJ
Chairman
24 May 2018

2. Chief Executive's Foreword

Staff at University Hospitals Bristol NHS Foundation Trust (UH Bristol) have risen to the challenges that the NHS, our hospitals and our services faced in 2017/18 with unparalleled commitment and caring. The Care Quality Commission (CQC) commended our staff for their dedication to patients when they rated the Trust as Outstanding in March last year.

The NHS as a whole faced increasing financial pressure and growing demand for services, particularly during the winter months. In Bristol, we faced these challenges, too.

We planned extensively for the colder months but our hospitals came under sustained pressure. Despite this, we maintained the quality of our care during these difficult months and even improved access to some services. For example, we achieved the 62 day GP cancer waiting time standard during the third quarter of the year and we achieved the six week diagnostic waiting standard in February. However, the unrelenting demand meant that the experience of some patients was not as good as it should have been and the long period of extensive pressure also took its toll on our staff.

A lot has been written about the financial challenge facing the NHS but we know that there is a correlation between delivering the best quality of care and managing finances well. Keeping control of the money enables us to continue investing for the benefit of both patients and staff. I am delighted that, here at UH Bristol, we delivered a financial surplus for the 15th year in a row, while maintaining our focus on staff well-being and the quality of our care. This excellent result is thanks to the hard work of all staff across the Trust.

At UH Bristol, we are united by our aim to deliver the best care we can to our patients. We act on the feedback we receive from patients and their representatives, undertake research that will bring improvements in future practice and work hard to improve services for the benefit of patients and their families. Our drive to deliver best care is central to our improvement programme, Transforming Care. To further guide our work, we have a quality strategy and we set quality objectives each year.

During 2017/18, the Care Quality Commission published the results of the 2016 national survey of adult inpatients, which ranked us as the top equal acute trust in the country for patient experience. We know that we have more work to do, particularly as services come under increasing pressure, but this hugely positive feedback from our patients chimes with the CQC's own observations from their last inspection about the humanity and compassion of our staff.

We were extremely proud that a significant patient safety initiative, developed and implemented by the staff in the adult Emergency Department (ED) in the Bristol Royal Infirmary was recognised as best practice, to be rolled out to other hospitals across England. The ED patient safety checklist, which also won a Health Service Journal award and a British Medical Journal award, reduces incidents caused by failure to recognise patient deterioration or respond to delays in delivering care. The checklist can be completed by any member of clinical staff and encompasses all the elements of basic care and early triggers for specific care pathways.

One of our strategic priorities as a Trust is to deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation. I would like to offer particular congratulations to Professor Ramanan, consultant paediatric rheumatologist, and colleagues in the Sycamore trial, whose findings were published in the New England Journal of Medicine. This clinical trial, funded by charity Arthritis Research UK and the National Institute for Health Research, discovered a new way to prevent children with arthritis and eye disease from losing their sight. The research team found that a drug called Adalimumab, in combination with Methotrexate, was an effective therapy in children and adolescents with Juvenile Idiopathic Arthritis and associated uveitis. An early analysis of the data was so convincing that the trial was stopped early and the drug therapy has already been approved for use.

As well as encouraging our staff to take part in research, we want to foster innovation and actively help staff to identify ideas for improvement. In the last year, we established a Quality Improvement Academy inside the Trust to give them the tools to bring their good ideas to life and we were overwhelmed by the positive response.

In 2017/18, we also saw how the technological boost we received when we were designated one of 16 Global Digital Exemplars in England was helping us to improve the quality and safety of the care we deliver. For example, we are implementing an electronic nursing observation system that includes an automated escalation system for deteriorating patients. In time, the early warning scores calculated in Vitalpac will feed through to our new WardView electronic boards, which are replacing the old magnetic whiteboards on wards. Another example of a digital system improving care is a new electronic prescribing tool, called EPMA, that will reduce avoidable harm from medicines. When implemented, it will enable prescribing information to be easily included in in clinical documents and viewed alongside patient observations and the results of tests and investigations.

At UH Bristol, we believe wholeheartedly that our staff are central to the care that we provide to patients and their families. We want to improve the experience of staff at work and support them to do their roles to the best of their ability and to stay well and healthy.

It was therefore encouraging to see from the latest NHS Staff Survey that the measure of how engaged our staff feel at work continues to increase and that we consistently rate higher than other acute trusts on the percentage of staff who agree their Trust is a great place to work and to receive treatment. While there is more work to do, this is very encouraging.

This year, we also took steps to improve the quality of leadership across the Trust – something that was highlighted in previous staff surveys. We defined explicit 'leadership behaviours', based on our Trust values of Respecting Everyone, Embracing Change, Recognising Success and Working Together, which will – once embedded through training – give more consistency in how staff are led and managed.

At Board level, we bade a sad farewell to Dr John Savage, our Chairman, who stood down after 13 years in the role. I publicly thank him on behalf of all of us in the Trust for his wise and principled leadership, which has been a significant factor in our success. We also said goodbye to Non-executive Director, Lisa Gardner, Chair of the Finance Committee and to our Medical Director, Dr Sean O'Kelly, who was appointed to the role of Medical Director for Professional Leadership at NHS Improvement.

At the same time, it was my pleasure to welcome our new Chairman, Jeff Farrar, who recently retired from a highly successful career in the police, three new Non-executive Directors on the board – Professor Steven West, Madhu Bhabuta and Martin Sykes – and a new Director of People, Matthew Joint, who brings a wealth of organisational development experience to the Trust gained in large and complex business environments.

As we move into what will undoubtedly be another challenging year for the NHS, I want to acknowledge the contribution of our staff, patient and family supporters, volunteers, governors, NHS partners, hospital charities and everyone else who helped us through the last year. My commitment to all of you is that we will continue to do the right things to deliver best care to patients by supporting and empowering our staff.

With best wishes

Robert Woolley
Chief Executive
24 May 2018

3. Performance Report

3.1 Overview

2017/18 was a very challenging year for the Trust and despite the backdrop of continual operational and financial pressures, the Trust has continued to deliver high quality care to our patients.

During the year there were significant pressures on the Emergency Department and this coupled with issues in the timely discharge for patients meant that the Trust was unable to consistently achieve the national access standards, including waiting times for diagnostics, in A&E, for referral to treatment and those relating to cancer.

There were improvements against the access targets in year including achievement of the diagnostics target in February 2018 and the delivery of the cancer 62 day GP standard in quarter three (October to December 2017) for the first time since 2012.

Although the majority of the care delivered was of high quality the Trust reported seven Never Events. These have all been investigated and the learning identified to mitigate the risk of reoccurrence.

Finally the tireless and fantastic contribution of our staff to continue delivering high quality services during this very challenging year needs to be recognised. The latest annual staff survey, which was undertaken in 2017, shows that staff engagement has risen to its highest level and the Trust is now in the top 25 per cent for its peer group in this key measure.

3.1.1 Principal activities of the Trust

University Hospitals Bristol NHS Foundation Trust (UH Bristol) is a Public Benefit Corporation authorised by NHS Improvement, the Independent Regulator of NHS Foundation Trusts on 1 June 2008. The Trust provides services in the three principal domains of clinical service provision, teaching and learning, and research and innovation. The most significant of these with respect to income and workforce is the clinical service portfolio consisting of general and specialised services.

We have over 9,000 staff who deliver over 100 different clinical services across nine different sites. With services from the neonatal intensive care unit to care of the elderly, we provide care to the people of Bristol and the South West from the very beginning of life to its later stages. We are one of the country's largest acute NHS Trusts with an annual income of over half a billion pounds.

For general provision, services are provided to the population of central and south Bristol and the north of North Somerset, a population of about 350,000 patients. A comprehensive range of services, including all typical diagnostic, medical and surgical specialties provided through outpatient, day care and inpatient models. These are largely delivered from the Trust's own city centre campus with the exception of a small number of services delivered in community settings such as South Bristol Community Hospital.

Specialist services are delivered to a wider population throughout the South West and beyond, serving populations typically between one and five million people. The main components of this portfolio are children's services, cardiac services and cancer services as well as a number of smaller, but highly specialised services, some of which are nationally commissioned.

As a University Teaching Trust, we also place great importance on teaching and research. The Trust has strong links with both of the city's universities and teaches students from medicine, nursing and other professions allied to health. Research is a core aspect of our activity and has an increasingly important role in the Trust's business with a significant grant secured in partnership with University of Bristol from NIHR in 2016/17 for a Biomedical Research Centre. The Trust is a full member of Bristol Health Partners, and of the West of England Academic Health Science Network, and also hosts the recently established Collaboration for Leadership in Applied Health Research for the West of England.

Whilst we do not believe that diversity in the Boardroom is adequately represented solely by a consideration of gender, we are required to provide a breakdown of the numbers of female and male directors in this report. The gender make-up of the seven Executive

Directors, is five male and two female. Of the nine Non-executive Directors, three are female and six are male.

3.1.2 Our mission, vision and values

Our mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. Our vision is for Bristol and our hospitals, to be among the best and safest places in the country to receive care. Our strategic intent is to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services.

We want to be characterised by:

- High quality individual care, delivered with compassion
- A safe, friendly and modern environment
- Employing the best and helping all our staff fulfil their potential
- Pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
- Our commitment to partnership and the provision of leadership to the networks we are part of, for the benefit of the region and the people we serve.

In addition to a common mission and vision, we share our Trust **values**:

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Developed with staff from all our hospitals, these shared values set out the ethos and principles that underpin how we work.

3.1.3 Our Strategic Priorities

Our key strategic priorities are derived from our vision, and can be summarised as:

- We will consistently deliver high quality individual care, with compassion
- We will provide leadership to the networks we are part of, for the benefit of the region and people we serve
- We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation
- We will ensure a safe, friendly and modern environment
- We will strive to employ the best workforce and help all our staff fulfil their individual potential for our patients and our staff
- We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal
- We will ensure we are soundly governed and are compliant with the requirements of our regulators.

We are committed to address the aspects of care that matter most to our patients, and during 2017/18 we have continued to ensure our strategy remains dynamic to the changing needs of our patients and significant changes within both the national and local planning environment.

We have built on work started in 2016/17 to prioritise and stratify our clinical strategy and in 2017/18, we have focussed on progressing the development of these core areas of clinical strategy, along with key enabling strategies, such as our digital agenda. Our plans have been developed to align with the priorities and processes of the local Healthier Together Sustainability and Transformation Partnership, which has provided us with the opportunity to progress our strategic priorities at pace and to work together with our partners to resolve some of the system-wide challenges we face. The decision made at the Board in January 2018 to pursue an organisational merger via acquisition with Weston Area Health Trust, represents significant progress in this approach and we will develop plans for the partnership and service specific alignment during 2018/19.

In 2017/18 we have also begun a programme of work to renew our current Trust Strategy ‘Rising to the Challenge our 2020 Vision’. We

have achieved a great deal of progress in delivering our strategic priorities outlined above since the publication of our current strategy in 2014, including moving from a Care Quality Commission assessment of 'requires improvement' to 'outstanding' during 2017, opening the new BRI ward block and developing and expanding our specialist and research services. We now plan to build on these successes and look ahead to how we will manage the opportunities and challenges that we face internally and externally over the next five years to ensure we remain an outstanding organisation, committed to the delivery of high quality healthcare across a broad portfolio of services.

Our new strategic review, 'Embracing Change, Proud to Care – Our 2025 Vision' was launched in March 2018, involving significant staff, public and external stakeholder engagement and we plan to publish our new Trust strategy in early 2019. We have embarked on this process to renew and recommit to our overall organisational strategy, with the objective of setting the strategic direction for the Trust, with a clear position on what we want to achieve and how we will do this to ensure our organisational vision remains fit for purpose.

3.1.4 Transforming Care

Our focus is unrelentingly on delivering best care and ensuring our patients' need are at the heart of all that we do. In order to lead and run a successful organisation, we also need to ensure that patient flow through our hospitals is efficient, that we deliver best value, that we build the capability of our staff members, and that we play a leading, partnership role in health and care delivery. Getting these things right enables us to improve the quality of our service and do the right thing for patients.

At UH Bristol everything we do fits into the six pillars of our Transforming Care programme – Delivering best care, Improving patient flow, Delivering best value, Renewing our hospitals, Building capability, and Leading in partnership.

- Pillar 1: Delivering best care

Delivering best care, ensuring that our patients receive excellent quality treatment at the appropriate time and setting, and are appropriately discharged from hospital, is one of our key objectives. Wherever we work in the Trust and whatever our role, we are all united in a common endeavour to deliver the best care we can to patients.

During 2017/18 we launched a programme to develop a Customer Care mind set in our staff. We have learned from other sectors and developed a set of customer care principles which define what we mean by great service. We have introduced these into staff induction and training to grow focus on this important area.

Our Quality Improvement (QI) programme has developed strongly over the year. We have launched the QI Hub where staff can share ideas for improvement and seek help from QI coaches and experts. In July we held our first QI Forum, a poster competition for QI projects which attracted over 70 entries demonstrating the breadth of quality improvement taking place across our hospitals and improving care for patients.

Our outpatients transformation programme has focussed on the development of high standards of care in clinics by undertaking audits and improvement against agreed standards for care delivery. We have taken steps to address many areas such as communications with patients in clinic areas and have introduced innovation with the adoption of paperless referrals from GPs and paperless triage of these referrals by our clinical staff.

- Pillar 2: Improving patient flow

The flow of patients through our hospitals is integral to ensuring that they receive excellent care. Patient flow has been the focus of sustained work in all areas of our hospitals and this continued in 2017/18 with good progress made on the work we began in the previous year.

During this year our performance against key access targets has improved. Underpinning this has been work across all areas of patient flow. As well as the efforts made to improve flow through our emergency department, all of our ward

areas have participated in work to improve patient flow by establishing good daily routines around ward rounds and board rounds to ensure plans for discharge start early. We have made progress in the use of Estimated Dates of Discharge (EDD) in planning patient discharge, and have made great progress in how we use our discharge lounge. As a result far more patients now are using our discharge lounge than one year ago, and the number of discharged patients leaving before midday has steadily increased, meaning greater availability of beds for patients waiting to be admitted to a ward and patients getting home at a better time for them and their families.

Patient flow has also been supported by the use of real time information from our IT systems. During 2017/18 we have rolled out electronic ward white boards to most of our inpatient wards. This gives greater visibility of the information stored and ensures greater accuracy of information for all who use it. Alongside this a paperless reporting project has ensured this data is used in more of our daily patient flow meetings so that we can make these meetings more efficient and make better decisions more quickly.

- Pillar 3: Delivering best value

Good financial management and strong governance provide the foundation for the delivery of high quality health services. Our ability to make efficiency savings and work to secure value for money for more than a decade has enabled us to invest in our hospital infrastructure and training our staff that puts us in a good position to continue improving the care we provide into the future.

I am pleased to report that the Trust maintained a healthy financial position for the financial year ended 31 March 2017. We achieved an income and expenditure surplus of £19.903m before technical items, efficiency savings of £12.121m, a year end cash position of £71.092m and we have a strong balance sheet resulting in a Continuity of Services risk rating of 1.

- Pillar 4: Renewing our hospitals

For over a decade we have been pursuing a strategy to renew our hospitals, providing a physical environment that matches the quality of care we provide and one that enables us to implement new care pathways and more efficient ways of working. During 2017/18 we took advantage of our status as a Global Digital Exemplar to introduce new IT systems more rapidly than would otherwise be possible. By the end of the year we had introduced into some of our wards a new electronic observations system, meaning that information from routine patient observations is entered and stored electronically rather than on paper, making it much easier to access and use this information, and to share or escalate observations which may be of concern.

We have started to introduce electronic prescribing and medicines administration into our wards, which will bring both patient safety and productivity improvement benefits as it is rolled out. We have introduced a Clinical Utilisation Review tool which gives daily information on every patient to ensure we are caring for them in the right setting and flags up patients whose care is delayed or could be moved to a more appropriate location and we are introducing tools to improve communications – within and between teams within our hospitals, and with teams outside of our trust to promote sharing of data and better planning of onward care.

- Pillar 5: Building capability

Our staff are our greatest asset and it is essential that we attract and nurture a strong workforce, support their development, create a culture of motivation and recognise them for their good work and retain their expertise within our services. During 2017/18 we have introduced a new staff appraisal process, supported by a new electronic system to improve both the quality and completion of staff appraisals. Alongside this we rolled out a Leadership Behaviours programme, setting out the expected behaviours of leaders across

our trust, in response to feedback from staff that quality of leadership is a key factor in staff engagement.

We have continued with our Admin Transformation programme, which seeks to ensure that we recruit, train and develop our crucial admin workforce as effectively as possible. We have completed the renewal of training pathways for admin staff, ensuring a better quality of off the job training before staff take up a patient facing role.

During 2017/18 we launched our Quality Improvement (QI) Academy. Through our 'Bronze' programme the Academy provide training in basic QI methods and tools to any member of staff who wishes to learn about them. Alongside this our 'Silver' programme provides support to staff members undertaking a QI project. During the year nearly 200 members of staff completed the Bronze course and our first cohort of seven projects completed the Silver programme. The feedback from participants has been excellent throughout and we will continue to develop these programmes in 2018/19.

- Pillar 6: Leading in partnership

The NHS does not work in isolation and it is essential that we lead in partnership – commensurate with our role as a major teaching, research and tertiary provider – to design and operate the most effective health system for greater Bristol. As the pressure on our hospital services has grown, it has become more essential for all health and social care partners to work in partnership to find solutions.

As part of the NHS's response to the Five Year Forward View, local areas have begun to develop bold plans to meet the challenges set out in the forward view. Throughout 2017/18 UH Bristol has continued to take a lead role in the collaborative work for Bristol, North Somerset and South Gloucestershire (BNSSG) through our local Sustainability and Transformation Partnership (STP), 'Healthier Together', and we are continuing to actively work with our partners to influence the transformation in health and social care that is required for the long term and which is a condition of our continuing success.

UH Bristol is currently not engaged in any formal consultation process with the Local Authorities or Health Overview and Scrutiny Committees (HOSCs) to support any major changes in services for our patients. There have, however, been a number of developments to services over the past 12 months including UH Bristol partnering with Taunton and Somerset NHS Foundation Trust to provide a Clinical Genetics service for Somerset. The Trust has also formalised an agreement for delivery of the Somerset Dermatology services with Taunton and continues to engage actively in conversations with other local providers, through the STP, to continue to develop our services in BNSSG to improve services for patients in the local population.

During the year, we have continued to actively support our partnership arrangements with Weston Area NHS Health Trust (WAHT), supporting a number of joint clinical and managerial posts to help stabilise the delivery of acute services in Weston for the North Somerset population. This arrangement builds on long-standing, positive working relationships which give local people access to a range of services delivered or supported by Bristol and Weston clinicians. UH Bristol and WAHT also announced in 2017/18 the intention to work together towards continuing to strengthen the partnership between the two organisation through 2018/19 and into future years including a decision made at the Board in January 2018 to pursue an organisational merger via acquisition with WAHT.

A key aspect of this partnership has been UH Bristol providing support to the BNSSG CCG-led Healthy Weston programme. This programme of work is designing the shape and function of future of clinical services on the Weston hospital campus and considering options for how hospital services and care will be provided for North Somerset patients going forward.

3.1.5 Key risks to delivering our objectives

The Board Assurance Framework was reviewed during 2017/18 and this has a clear alignment with the corporate risk register. The Board monitors the Framework quarterly, including delivery of the Trust's Strategic Priorities, the controls and assurances in place and the actions being taken to minimise risk.

A summary of the top risks to our operational or strategic plans in 2017/18 are outlined below:

- Achievement of national performance targets, including accident and emergency waiting times (four hour wait), cancer waiting time standards, and Referral to Treatment (RTT) targets
- Increases in demand and acuity of patients being admitted via Accident and Emergency; the impact on patient flow and access to treatment
- The financial consequences arising from the loss of Sustainability and Transformation funding
- The significant challenges to deliver the financial plan without compromising on the quality of clinical services
- The financial consequences of using agencies who are non-compliant with national pricing caps
- The impact on the quality of care received by patients suffering from mental health disorders from spending prolonged time in the Emergency Department
- Challenges in relation to meeting new clauses within National Hospital Contract.

3.1.6 Going concern disclosure

As part of its reporting requirements the Trust has to provide a statement on whether the accounts were prepared on a going concern basis. After making enquiries, the directors have a reasonable expectation that UH Bristol has adequate resources to continue in operational existence for the foreseeable future. The Trust has a long term financial plan spanning the next five years. In particular it has set a surplus budget for 2018/19 of £20.6m (including technical items), it is planning to receive income of £690.2m, has agreed contracts to the value of £581.6m with Commissioners and is forecasting cash balances of £80.0m at the end of March 2019. Therefore the Trust continues to adopt the going concern basis in preparing the accounts.

3.2 Performance Analysis

The 2017/18 year has been challenging. Control totals introduced by NHS Improvement last year as a response to the significant underlying deficit in the NHS provider sector continued. In recognition of a Trust accepting its control total it is able to earn additional Sustainability and Transformation funding, and have the risk of core performance fines removed.

The Trust submitted its Operational Plan on 30 March 2017 to achieve a surplus of £12.957m (before technical items), assuming receipt of £13.313m Sustainability and Transformation funding, which represents a £0.356m deficit excluding Sustainability and Transformation funding.

Sustainability and Transformation funding is earned by the Trust during the year if it delivers its control total and agreed A&E performance. 70 per cent is linked to financial performance and 30 per cent to A&E performance. Additional incentive Sustainability and Transformation funding is allocated once the provider sector's final year end performance is known.

Despite the challenge, the Trust delivered a surplus of £19.903m (excluding technical items), which is a major achievement considering the unprecedented financial and operational pressures both locally and nationally. This included £18.960m of Sustainability and Transformation funding. Excluding the Sustainability and Transformation funding the surplus was £0.943m compared to the planned deficit of £0.356m. This was a good financial performance and was the 15th year in a row that the Trust delivered a surplus or breakeven position (excluding technical items).

The Trust achieved its financial plan throughout the year and therefore earned all of the £9.319m core Sustainability and Transformation funding available. The A&E performance was not achieved at quarter one (84.8 per cent against target of 90 per cent), was achieved at quarters two and three (90.9 per cent and 92.8 per cent respectively) and was not achieved at quarter four (78.9 per cent against a target of 95 per cent). Sustainability and Transformation performance funding of £2.297m was earned out of the £3.994m available.

In recognition of the Trust's financial performance, NHS Improvement allocated the Trust further incentive Sustainability and Transformation funding of £7.344m. This increased the Trust surplus from £12.559m to £19.903m, excluding technical items.

The 2017/18 plan required savings of £11.520m to be made to bridge the gap between the amount of money needed to run its services and the income it could expect to receive. The Trust has an established process for generating savings. There are transactional work streams to deliver savings at a transactional level such as improving purchasing, controlling agency spend and use of technology, as well as productivity projects such as improving theatre efficiency, reducing length of stay and improving out-patients. The Trust delivered savings of £12.121m.

The Trust's statement of financial position remained strong with net current assets of £56.359m and a year-end cash and cash equivalent balance of £71.092m.

The Trust invested £25.402m on capital, improving the Trust's estate, purchasing medical equipment and investing in information technology.

The Trust's financial performance is also measured using a set of rating metrics established by NHS Improvement. The Use of Resources Rating (URR) ranges from one, the lowest risk, to four, the highest risk. The rating is designed to reflect the degree of financial concern NHS Improvement has about a provider and the level of regulatory intervention required. At the end of March 2018, the Trust had a risk rating of one.

More detailed financial information is provided within the Finance Review (Section 3.3).

3.2.1 Referral to Treatment (RTT)

The national compliance standard remained at 92 per cent of patients waiting less than 18 weeks from referral to treatment. During the year 2017/18 the compliance standard of 92 per cent was not delivered in any single month. The volume of patients waiting over 18 weeks for treatment grew in a number of

specialities leading up to the noncompliance of the national standard. This relates to a growth in outpatient referrals and the impact of winter pressure on elective cancellations.

The management of unanticipated growth and the change in RTT compliance for 2018/19 is monitored weekly, through the RTT, Diagnostic and Cancer performance meeting. Guidance from our regulators requires steady state to be delivered month on month and the Trust has agreed, that we will deliver a performance percentage month on month of no less than 87 per cent, whilst striving to deliver an aggregate performance across all Divisions of 92 per cent.

3.2.2 Accident & Emergency four hour maximum wait

The Trust failed to meet the national 95 per cent standard for the number of patients discharged, admitted or transferred within four hours of arrival in our emergency departments, in any month in 2017/18. For the three emergency departments:

- Bristol Children's Hospital (BCH) achieved the 95 per cent standard in six months, and achieved 94.9 per cent for the year
- Bristol Eye Hospital (BEH) achieved the 95 per cent standard in five months, and achieved 96.6 per cent for the year
- Bristol Royal Infirmary (BRI) did not achieve the 95 per cent standard in any month, and achieved 79.6 per cent for the year.

For the financial year there was a Sustainability and Transformation Fund (STF) improvement trajectory in place which aimed to get to 95 per cent by March 2018. For quarters two and three, the target trajectory was 90 per cent at Trust level. The Trust achieved 90.9 per cent in quarter two and so achieved the funds for that quarter. For quarter three, the Trust achieved 88.6 per cent; however in agreement with NHS England and NHS Improvement, each Acute Trust was allocated a share of activity from Walk In Centres and Minor Injury Units in their region. For the Trust this was the Bristol, North Somerset and South Gloucestershire (BNSSG) region. The result of this apportionment was carried out and published by NHS England as 'Acute Trust Footprint' data. This data was used to assess whether a Trust achieved the STF target for quarter three. The Trust's performance after apportionment was 92.8 per cent. So, for the purposes of assessing achievement at national level, the Trust achieved the STF target of 90 per cent for quarter three. The Trust delivered 81.5 per cent in quarter four; with apportionment, this rose to 86.1 per cent so was not enough to achieve for quarter four.

Overall, A&E attendance levels were up 2.7 per cent in 2017/18 compared to 2016/17 (3.5 per cent increase at BRI and 2.4 per cent increase at BCH. However, the proportion of patients admitted to an inpatient bed as a result of their emergency department attendance remained the same at 25.5 per cent (34 per cent at BRI and 24 per cent at BCH). Proportion of patients arriving by ambulance remained steady at 26.5 per cent (39 per cent at BRI and 19 per cent at BCH).

There was a significant increase in emergency admissions to inpatient beds coming via direct GP referrals, as opposed to through the emergency departments. This figure rose from 3890 in 2016/17 to 5672 in 2018/19, which is a 45 per cent increase. This was driven by changes in the use of the Acute Medical Unit (A300). One four bed bay was converted to initially four, and then six trolleys to support expected patients being assessed and where possible discharged home in the same day, resulting in a rise in short stay (<24 hours) admissions. Following the overnight closure of the Emergency Department at Weston General Hospital, additional ambulance activity was received in the overnight period. An average of six attendances and three admissions were seen in adult services.

The number of Delayed Transfers of Care (DToC) patients remained the same in 2017/18 compared with 2016/17. Each year averaged 32-33 DToC patients at each month-end. Total bed days lost to DToC patients fell from 12399 to 11572. However bed days lost to patients from Bristol Unitary Authority rose slightly from 9520 to 9675.

This year there was continued focus on ensuring as many patients as possible were

managed in the correct specialty ward. The number of bed days spent outlying rose from 8854 to 9098. However, outlier bed days showed an almost two-fold increase in January – March 2018 due to winter pressures. Looking at quarters one to three only, the reduction this year compared to last year would be around 15 per cent. Ward A518 was added to the Trust's inpatient bed base in Medicine to offset the withdrawal of the virtual ward model and the impact of the overnight closure at Weston General Hospital; however this meant there was no additional inpatient capacity to open to support winter pressures. Broadly in line with expectations we relied heavily on extreme escalation particularly the Medical Rehabilitation Unit and Queen's Day Unit.

3.2.3 Cancer

The 62 day standard for starting treatment after a GP referral for suspected cancer was subject to a refreshed action plan to improve performance from July 2017, following a challenging start to the year. This was due primarily to cancellations of surgery, which remains a challenge for the Trust, along with other factors which were part of the winter pressures on the organisation. The Trust case mix for this standard remains very challenging compared to the average provider. This is acknowledged by commissioners.

A revised trajectory and targeted action plan were put in place and delivered good results. The trajectory was achieved in every month up to and including December and in quarter three the national 85 per cent standard was achieved for the first time since 2012. This was a significant achievement by the organisation, particularly in a quarter where nationally only 82.9 per cent was achieved.

Quarter four saw a rise in cancellations, along with other factors including high levels of patient choice post-Christmas, which in February prompted a high proportion of late referrals from other providers. These factors caused a dip below the recovery trajectory and the national standard. The organisation is now focussing on improving and sustaining performance at or above the 85 per cent standard, through actions including close working with other hospitals to improve shared pathways, and measures to reduce cancellations of surgery.

The Trust performed well against the 31 day subsequent treatment standards for radiotherapy and chemotherapy, and the two week wait first appointment standard. These were achieved in every quarter of the year. The 31 day first definitive treatment standard was achieved in quarters two and three, but fell below the 96 per cent threshold in the first and last quarters of the year. Surgical cancellations were the main reason for this performance. Likewise, the 31 day subsequent surgery standard was non-compliant in quarters one and four for the same reason.

The 62 day standard for treatment following referral from a screening programme was compliant in quarter two only. This standard has extremely low numbers and most breaches are unavoidable – commonly due to patient choice to delay diagnostics.

Overall, whilst significant challenges are still present for achievement of the cancer standards, during 2017/18 the Trust has made positive steps to improving performance against these targets and has strong plans to build on this during 2018/19.

3.2.4 Diagnostic waiting times

This covers the top 15 high volume diagnostic tests. The standard is that, at each month-end, 99 per cent of patients waiting for one of these tests should've been waiting under six weeks. Month-end performance varied from 97.6 per cent to 99.2 per cent across 2017/18 and the average month-end performance was 98.3 per cent

The test areas that achieved each month were Audiology, Echocardiography, DEXA Scans, Peripheral Neurophysiology, Colonoscopy, Flexi Sigmoidoscopy and Cystoscopy.

Sleep Studies experienced higher demand that expected and this test area averaged 83 per cent for the year. Demand management plans are being developed with commissioners and additional capacity is being developed through use of GP with Special Interest, additional consultant capacity and in-house waiting list initiatives. Computed Tomography (CT) averaged 96 per cent, with increase in Cardiac demand

(24 per cent average growth in last three years), long-term sickness in the department and general radiographer staff vacancies resulting in under performance against the standard. Magnetic Resonance Imaging (MRI) averaged 98.7 per cent with loss of capacity and increased acuity in paediatric General Anaesthetic cases contributing to under-performance and also high demand for Cardiac MRI tests. Non-obstetric Ultrasound achieved for the year on average, but saw a drop in performance from quarter four due to loss of capacity due to winter pressures and radiology vacancies.

3.2.5 Overseas Visitors (patients who are not ordinarily resident in the UK)

The Trust is committed to fulfilling its obligations under the Overseas Visitors NHS Hospital Charging Regulations 2015, updated 2017. During 2017, divisional posts were centralised into a corporate team to provide a seven day a week eligibility checking service across the Trust. The team, which works in a non-discriminatory way, are responsible for establishing an individual's right to free NHS hospital treatment, for the raising of invoices and from October 2017, for advising clinicians on their obligations to provide treatment under the regulations. In 2017/18, 9500 patients were investigated by the team with 10 per cent determined as charge liable.

3.2.6 Important events since the end of the financial year

A fire in the Bristol Haematology and Oncology Centre on 10 May 2018 resulted in the need to evacuate 53 patients and staff. No one was harmed during the evacuation and work is under way at the time of submission to ensure that services can be safely and quickly returned to normal. An investigation into the fire has been established and the investigation report, particularly key outcomes and learning points, will be reported to the Board in due course.

Table 1: Performance against national standards

National standard	Target	2015/16	2016/17	2017/18	Notes regarding 2017/18
A&E maximum wait of 4 hours	95%	90.4%	85.0%	86.5%	Target not met in each quarter
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	99.0%	97.6%	97.9%	Target met in each quarter
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	52.8%	52.6%	52.2%	Target met in each quarter
A&E Unplanned re-attendance within 7 days	<5%	3.0%	2.6%	2.8%	Target met in each quarter
A&E Left without being seen	<5%	2.4%	2.2%	1.9%	Target met in each quarter
Cancer - 2 Week wait (urgent GP referral) *	93%	95.9%	94.8%	94.5%	Target met in each quarter
Cancer - 31 Day Diagnosis To Treatment (First treatment) *	96%	97.5%	96.7%	95.8%	Target met in quarter 2 and 3
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery) *	94%	96.8%	94.4%	92.8%	Target met in quarter 2 and 3
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy) *	98%	98.9%	98.7%	98.6%	Target met in each quarter
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy) *	94%	97.1%	96.6%	96.3%	Target met in each quarter
Cancer - 62 Day Referral To Treatment (Urgent GP Referral) *	85%	80.6%	79.3%	81.2%	Target met in quarter 3
Cancer - 62 Day Referral To Treatment (Screenings) *	90%	68.6%	69.4%	78.1%	Target met in quarter 2
Cancer - 62 Day Referral To Treatment (Upgrades) *	85%		87.9%	84.9%	Target met in quarter 1 and 4
18-week Referral to treatment time (RTT) incomplete pathways	92%	91.3%	91.7%	89.6%	Target not met in each quarter
Number of Last Minute Cancelled Operations	<0.8%	1.03%	0.98%	1.19%	Target not met in each quarter
Last Minute Cancelled Operations Re-admitted within 28 days	95%	88.7%	90.8%	94.2%	Target met in quarter 2
6-week diagnostic wait	99%	98.97%	97.79%	98.29%	Target not met in each quarter
Primary PCI - 90 Minutes Door To Balloon Time	90%	93.3%	91.7%	93.3%	Target met in each quarter

*Cancer data does not include March 2018 data, so quarter 4 is incomplete

3.3 Finance Review

3.3.1 Financial analysis

The Trust's financial performance including its Operational Plan, savings programme, Use of Resource Ratings, cash flow and statement of financial position is reported on a monthly basis to the Trust's Finance Committee. The Finance Committee is responsible for detailed scrutiny of the financial performance and provides reports to the Board and Audit Committee on key issues.

The Trust reported a surplus before technical items of £19.903m. This included Sustainability and Transformation funding of £18.960m of which core and performance Sustainability and Transformation funding was £11.616m and incentive funding was £7.344m. The Operational Plan was to deliver a surplus of £12.957m, excluding technical items, with core and performance Sustainability and Transformation funding of £13.313m, i.e. a deficit of £0.356m excluding Sustainability and Transformation funding. This was exceeded with a surplus of £0.943m. The performance against the Operational Plan is shown below:

Table 2: Performance against operational plan

	Operational Plan 2017/18 £m	Actual 2017/18 £m	Variance favourable/(adverse) 2017/18 £m
Clinical income	557.405	570.203	12.798
Non clinical income - excluding S&T funding	86.998	93.775	6.777
Total operating income (excluding S&T funding)	644.403	663.978	19.575
Employee expenses	(378.582)	(384.969)	(6.387)
Non pay expenses	(231.311)	(244.482)	(13.171)
Total operating expenses	(609.893)	(629.451)	(19.558)
Depreciation	(22.764)	(22.218)	0.546
Interest receivable	0.100	0.189	0.089
Interest payable	(2.955)	(2.954)	0.001
Public dividend capital dividend	(9.247)	(8.601)	0.646
Total financing costs	(34.866)	(33.584)	1.282
Net surplus/(deficit) before technical items excluding S&T funding	**(0.356)**	**0.943**	**1.299**
Sustainability and Transformation Funding:			
- Core	9.319	9.319	-
- Performance	3.994	2.297	(1.697)
- Incentive	-	7.344	7.344
Net surplus/(deficit) before technical items including S&T funding	**12.957**	**19.903**	**6.946**
Depreciation on donated assets	(1.561)	(1.570)	(0.009)
Donations re assets	-	1.204	1.204
Net impairments	(1.314)	(1.032)	0.282
Total technical items	(2.875)	(1.398)	1.477
Net surplus after technical items	**10.082**	**18.505**	**8.423**

There are a number of items classified as technical which are excluded when considering the Trust's financial performance. Technical items include depreciation on donated assets, donated income in respect of property, plant and equipment, impairments and reversal of impairments. Excluding Sustainability and Transformation funding the Trust achieved a surplus of £0.943m against a deficit plan of £0.356m.

3.3.2 Sustainability and Transformation funding

Sustainability and Transformation funding (STF) has three elements; core, performance and incentive.

Core Sustainability and Transformation funding income of £9.319m is dependent on the Trust delivering its control total. This was achieved given that the surplus was £0.943m compared with the planned deficit of £0.356m.

Performance funding is dependent on delivering A&E performance standards. Performance funding was not achieved at quarter one (84.8 per cent against target of 90 per cent), was achieved at quarters two and three (90.9 per cent and 92.8 per cent respectively) and was not achieved at quarter four (78.9 per cent against a target of 95 per cent). The STF performance funding loss of £1.697m reflects this.

Incentive Sustainability and Transformation funding was allocated by NHS Improvement following the Trust's submission of its key data return on 17 April 2018. The Trust received £7.344m as follows:

	£m
Incentive STF (finance)	1.299
Incentive STF (bonus)	1.764
Incentive STF (general distribution)	4.281
	7.344

Incentive Sustainability and Transformation funding (finance) rewards providers that have delivered a financial position which is better than their control total. Payment is £1 for every £1 delivered above the 2017/18 control total. Therefore the Trust received £1.299m.

Incentive Sustainability and Transformation funding (bonus) is paid from a capped national pot to those providers that delivered their control total, weighted to reward providers that exceeded their control total and committed to improvement earlier in the financial year. The Trust received £1.764m.

Incentive Sustainability and Transformation funding (general distribution) uses the balance of unearned Sustainability and Transformation funding to pay all providers that signed up to a control total in 2017/18. The value of payment is on a sliding scale based on distance from control total weighted by initial Sustainability and Transformation funding allocations. The Trust received £4.281m.

3.3.3 Savings

In delivering the surplus of £19.903m, excluding technical items, the Trust achieved £12.121m of savings against its plan of £11.520m. Specific work streams were established focussing on transactional efficiencies such as obtaining best value through purchasing, controlling spend and use of technology as well as productivity projects focussing on improving theatre utilisation and efficiency, reducing length of stay, improving patient flow and improving outpatient utilisation and efficiency.

Table 3: Savings achieved

	£m	£m	£m
Allied Healthcare Professionals productivity	0.100	0.100	-
Capital charges	1.000	1.000	-
Diagnostic testing	0.213	0.114	(0.099)
Estates and Facilities	0.628	0.596	(0.032)
Healthcare Scientists productivity	0.221	0.216	(0.005)
Income, fines and external	1.399	1.557	0.158
Medical pay	0.395	0.457	0.062
Medicines	0.771	1.006	0.235
Nursing pay	0.447	0.343	(0.104)
Other/corporate	0.168	0.168	-
Productivity	0.961	0.665	(0.296)
Non pay	4.439	5.291	0.852
HR Pay and productivity	0.182	0.131	(0.051)
Trust Services	0.501	0.474	(0.027)
Blood	0.003	0.003	-
Unidentified	0.092	-	(0.092)
Total savings	**11.520**	**12.121**	**0.601**

3.3.4 Statement of financial position

The Trust had a strong statement of financial position (balance sheet) throughout the year with net current assets at 31 March 2018 of £56.359m. This included year-end cash and cash equivalents of £71.092m. This represents an increase in cash over the year of £5.651m. The table below shows the use of cash during the year.

Table 4: Use of cash 2017/18

	£m
Net cash flow from operating activities	39.963
Capital expenditure	(25.734)
Other net cash flows from investing activities	1.414
Public Dividend Capital received	7.428
Capital loan repayments to the Department of Health and Social Care	(5.834)
Interest payments to the Department of Health and Social Care in respect of capital loans	(2.741)
Public Dividend Capital dividend payment	(8.249)
Finance lease payments	(0.596)
Increase in cash balance 2017/18	5.651

3.3.5 Capital

The Trust's planned capital expenditure for 2017/18 was £52.735m. This included ambitious strategic investment plans that the Trust subsequently recognised would be delivered in future years. Capital funding is allocated to individual schemes in five areas which are monitored during the year. The Trust's capital programme is managed through the Trust's Capital Programme Steering Group. In 2017/18 the Trust spent £25.402m on capital schemes with net underspends on completed schemes totalling £0.017m and slippage on current schemes accounting for £27.325m. The table below provides a summary of the Trust's capital income and expenditure for 2017/18.

Table 5: Funding and expenditure on capital schemes

	Operational Plan 2017/18 £m	Actual 2017/18 £m	Variance 2017/18 £m
Source of Funding:			
Public Dividend Capital	7.428	7.428	-
Donations - cash	1.018	0.720	(0.298)
Donations - direct	0.168	0.168	-
Depreciation	22.236	22.219	(0.017)
Cash balances	21.885	(5.133)	(27.018)
Total funding	52.735	25.402	(27.333)
Expenditure:			
Strategic schemes	(19.908)	(2.010)	17.898
Medical equipment	(13.465)	(8.040)	5.425
Information technology	(11.446)	(8.217)	3.229
Estates replacement	(2.591)	(2.660)	(0.069)
Operational capital	(10.859)	(4.475)	6.384
Planned slippage	5.534	-	(5.534)
Total expenditure	(52.735)	(25.402)	27.333

3.3.6 Counter-fraud and corruption

The Board of Directors takes the prevention and reduction of fraud very seriously and has policies in place to minimise the risk of fraud and corruption and procedures for reporting suspected wrongdoing.

The Trust works closely with the Local Counter Fraud Specialist (LCFS) to implement the NHS Protect national strategy on countering fraud and to ensure the Trust is working with the LCFS in fully complying with NHS Protect and commissioner requirements.

Work is carried out across the four key areas of Counter Fraud activity:

- Strategic governance
- Inform and involve
- Prevent and deter
- Hold to account.

All staff receive fraud awareness training as part of the Trust Induction Programme.

Further guidance, which includes details of the Counter Fraud strategy and policy, is also available on the Trust's intranet, along with contact details for the LCFS and the NHS.

3.3.7 Protect fraud and corruption reporting line.

Fraud prevention messages are regularly raised via the Trust's communication systems which include posters in workplaces and the dissemination of Counter Fraud newsletters.

3.3.8 Anti-Bribery Statement

The Bribery Act 2010 came into force on 1 July 2011. The aim of the Act is to tackle bribery and corruption in both the private and public sector.

The Act defines the following key offences with regards to bribery:

- Active bribery (offering, promising or giving a bribe)
- Passive bribery (requesting, agreeing to receive or accepting a bribe)
- Bribery of a foreign public official.

The Act also sets out a corporate offence of failing to prevent bribery by an organisation not having adequate preventative procedures in place.

UH Bristol does not tolerate any form of bribery whether by its staff, contractors or suppliers. Bribery can have a detrimental effect on the Trust and can undermine the public's perception of the Trust.

The Board is committed to applying and enforcing effective anti-bribery measures to prevent, examine and eradicate fraud, bribery and corruption. The Board will seek to apply the strongest penalties to anyone involved in bribery activities; staff and suppliers alike.

To reduce both the Trust's and its staff's exposure to Bribery there are clear policies in place:

- Staff Conduct Policy
- Countering Fraud and Bribery Policy
- Freedom to Speak Up Policy.

A register of interest for directors, staff and governors is held to demonstrate the open and transparent way we conduct our work within the Trust.

Concerns or suspicions regarding bribery, corruption or fraud may be reported by contacting the Local Counter Fraud Specialist.

Robert Woolley
Chief Executive
24 May 2018

4. Sustainability report

4.1 Overview

As an NHS organisation we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability involves spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and longer term, even in the context of the rising costs of natural resources. Demonstrating that we consider the social and environmental impact of what we do ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

We understand that health is very much influenced by the environment and we are working to reduce our environmental impact, in particular our carbon footprint, and in turn reduce our contribution to climate change. Reducing these impacts also enables us to address one of our key challenges, which is to maintain and develop the quality of our services, whilst managing with fewer resources.

UH Bristol has a sustainable development management plan 'Big Green Scheme Strategy – Care without Costing the Earth: Our vision of sustainable healthcare 2015-2020'. Areas for action include the development of sustainable models of care, energy, water, travel, procurement and waste. Having a Board approved strategy is essential to ensure that we fulfil our commitment to conducting all aspects of our activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to approve such a plan.

It is our duty to contribute towards the ambition set in the 2014 Sustainable Development Strategy (SDS), in line with the legally binding 2008 Climate Change Act, of reducing the carbon footprint of the NHS, public health and social care system by 34 per cent (from a 1990 baseline). This is equivalent to a 28 per cent reduction from a 2013 baseline by 2020. It is our aim to achieve this target by reducing our carbon emissions by 28 per cent by 2020 using 2013/14 as the baseline year.

4.2 Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Table 6: Sustainability Policy Table

Area	Is sustainability considered?
Travel	Yes
Business Cases and annual business plans	Environmental impact is assessed
Procurement (environmental)	We are working with Bristol and Weston Purchasing Consortium to develop a Sustainable Procurement Strategy to address the environmental and social impacts of procurement
Procurement (social impact)	
Suppliers' impact	

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan. The Board approved our Sustainable Development Management Plan in the last 12 months so our plans for a sustainable future are well known within the organisation and clearly laid out.

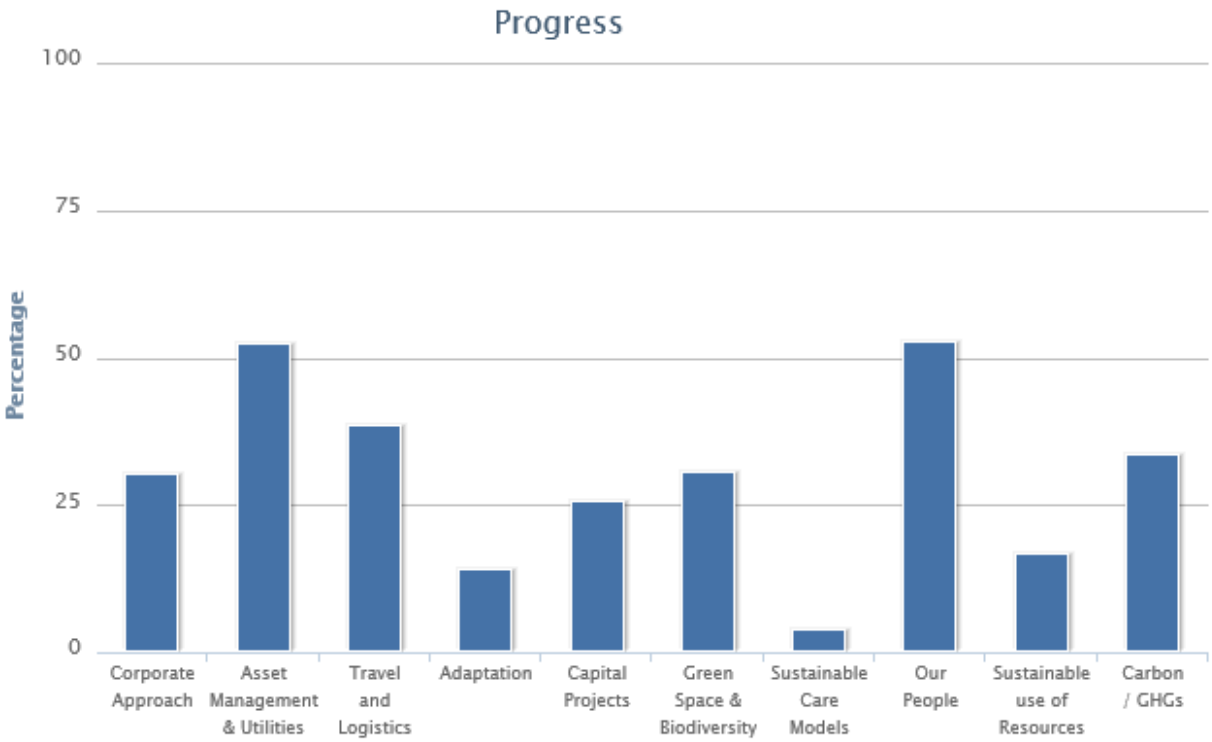
We measure our impact as an organisation on corporate social responsibility through the use of the Sustainable Development Assessment Tool (SDAT). Our most recent application of the Sustainable Development Assessment Tool was in March 2018, scoring 30 per cent (see table 7). Plans to improve this are included in the Sustainable Development Management Plan.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples in recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods and droughts, which are expected to increase as a result of climate change. Our Board approved plans address the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events. Through our

business continuity planning we have begun to identify the risks we need to consider and the associated adaptations.

To ensure that our services continue to meet the needs of our local population during such events we are also developing adaptation plans with health organisations across our region.

Table 7: SDAT Assessment Score 30 per cent



Our organisation is starting to contribute to these Sustainable Development Goals at a local level:

We are working in partnership with volunteers from the University of Bristol and Avon Wildlife Trust to develop and improve existing spaces for patients, staff and to benefit wildlife.

4.3 Performance

Since the 2013/14 baseline year, significant service and organisational restructuring has taken place. In order to provide some organisational context, the table below may help explain how both the organisation and its performance on sustainability has changed over time.

Table 8: Performance on sustainability

Context info	2014/15	2015/16	2016/17	2017/18
Floor Space (m^2)	205,924	206,310	195,044	195,044
No. of Staff	7,544	8,249	8,496	8,677

We have supported the Climate Change Act targets as follows:

4.3.1 Energy

UH Bristol has spent £4,148,595 on energy in 2017/18, which is a 7.8 per cent increase on energy spend from 2016/17. We have reduced our carbon emissions from energy use year on year.

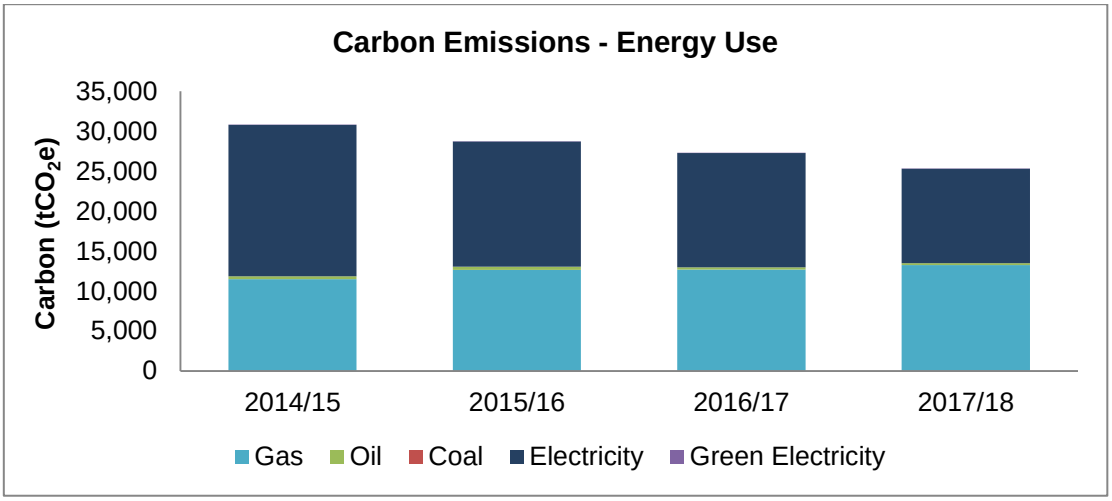


Table 9: Energy use and spend

Resource		2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	54,742,120	60,496,985	60,701,598	62,552,655
	tCO_2e	11,485	12,661	12,686	13,262
Oil	Use (kWh)	1,126,981	1,198,427	868,669	727,117
	tCO_2e	361	383	275	238
Coal	Use (kWh)	0	0	0	0
	tCO_2e	0	0	0	0
Electricity	Use (kWh)	30,616,820	27,233,690	27,665,724	26,547,528
	tCO_2e	18,962	15,657	14,298	11,833
Green Electricity	Use (kWh)	43,766	52,520	55,804	42,964
	tCO_2e	27	30	29	19
Total Energy CO_2e (Carbon dioxide equivalent)		30,835	28,731	27,288	25,352
Total Energy Spend		£4,698,461	£4,289,488	£3,847,783	£4,148,595

Our carbon emissions from energy consumption have reduced by 1822 tonnes (7 per cent) in the past year.

Since changes to the Climate Change Levy regarding renewable energy have been applied, our electricity no longer comes from renewable sources due to increased cost implications.

We have continued to implement energy saving projects through improving controls, lighting, insulation, heating and cooling.

4.3.2 Travel

We can improve local air quality and improve the health of our community by promoting active travel – to our staff and to the patients and public that use our services.

Every action counts; we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise, caused by cars as well as other forms of transport, all cause health problems for our local population, patients, staff and visitors.

Table 10: Average travel levels

Category	Mode	2014/15	2015/16	2016/17	2017/18
Patient and visitor travel	miles	28,017,099	28,992,086	30,005,436	30,856,225
	tCO_2e	10,294.30	10,484.57	10,844.28	10,994.84
Business travel and fleet	miles			762,008	136,688
	tCO_2e			275.40	48.71
Staff commute	miles	7,246,899	7,924,134	8,164,656	8,335,279
	tCO_2e	2,662.72	2,865.65	2,950.79	2,970.07
Owned electric and PHEV mileage	miles				15,048
	tCO_2e				1.71

We do not currently capture detailed in year travel data so these figures are based on patient and staff numbers with average travel levels applied. Our annual staff travel survey shows that over a quarter of staff travel to work actively (walking or cycling). We have introduced electrical vans for facilities use. The Early Supported Discharge (ESD) team at South Bristol Community Hospital have trialled two electric bicycles to make home visits to stroke patients recently discharged from hospital. This has been such a success that they have secured three more. Now all the team are using the e-bikes. This means they are putting fewer cars on the road for short local journeys and the journey times are proving to be the same or less than by car.

4.3.3 Waste

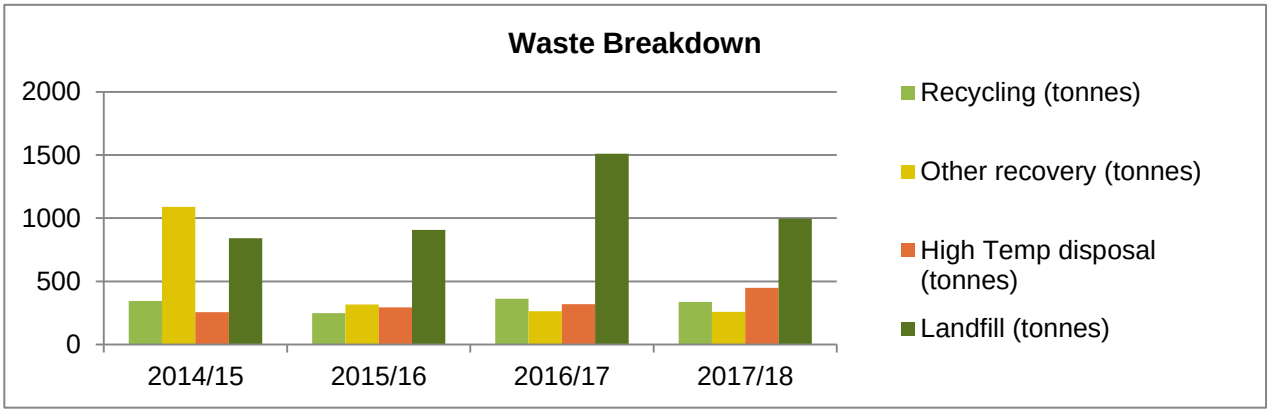
Overall waste has decreased despite higher levels of activity. We have managed to improve the level of recycled or reused waste from 15 per cent to 17 per cent.

We have conducted waste audits to support areas in improving their waste management. We continue to roll out Dry Mixed Recycling to further areas across the site. We have trialled the removal of general waste bins showing this has improved levels of recycling.

The re-use of goods and community equipment in the NHS has several key co-benefits, reducing cost to the NHS, it also reduces emissions from procuring and delivery of new goods and can provide social value when items are reused in the community. We are increasing reuse through supplying the Children's Scrapstore and partnering with local organisations (Collecteco).

Table 11: Waste management

Waste		2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	344.45	249.00	363.00	336.68
	tCO_2e	7.23	4.98	7.62	7.33
Other recovery	(tonnes)	1091.00	317.00	264.00	258.00
	tCO_2e	22.91	6.34	5.54	5.61
High Temp disposal	(tonnes)	256.40	294.00	320.00	448.00
	tCO_2e	56.41	64.39	70.40	98.56
Landfill	(tonnes)	842.17	907.00	1512.00	996.41
	tCO_2e	205.84	221.69	468.72	343.25
Total Waste (tonnes)		2534.02	1767.00	2459.00	2039.09
% Recycled		14%	14%	15%	17%
Total Waste tCO_2e		292.39	297.39	552.29	454.75



The movement to a paperless NHS can be supported by staff reducing the use of paper at all levels, this reduces the environmental impact of paper, reduces the cost of paper to the NHS and can help improve data security. The Trust is implementing IT programmes developing paperless working, for example patient observation charts will be paperless across most of the Trust by June 2018.

Table 12: Use of paper

Paper		2017/18
Volume used	Tonnes	126
Carbon emissions	tCO_2e	120

4.3.4 Water

Despite increased activity, we have reduced our consumption of water in 2017/18. We have repaired steam and condensate leaks in pipes across the precinct significantly reducing the demand for water at our boiler house.

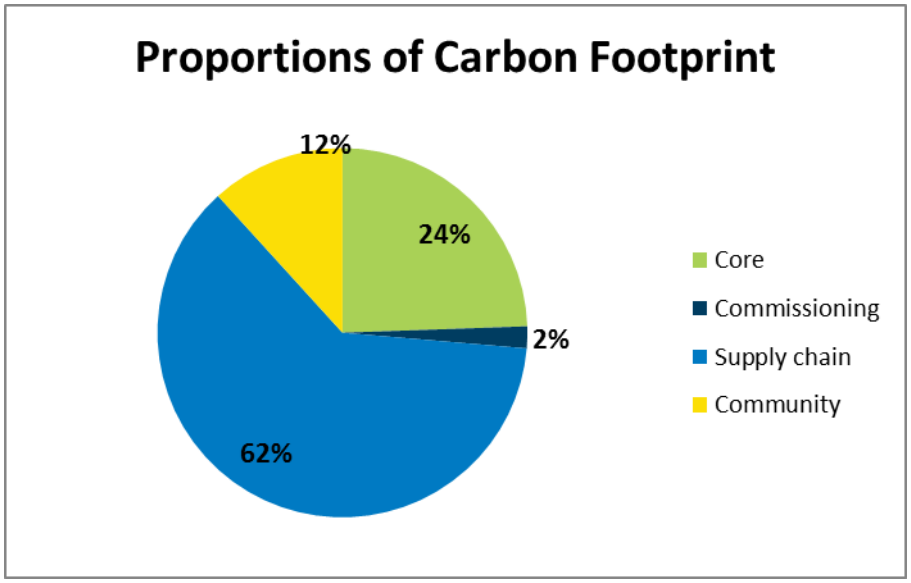
Table 13: Consumption of water

Water		2014/15	2015/16	2016/17	2017/18
Mains	m^3	233,323	234,553	250,457	233,033
	tCO_2e	213	214	228	227
Water & Sewage Spend		£375,289	£412,357	£485,126	£461,650

4.4 Modelled carbon footprint

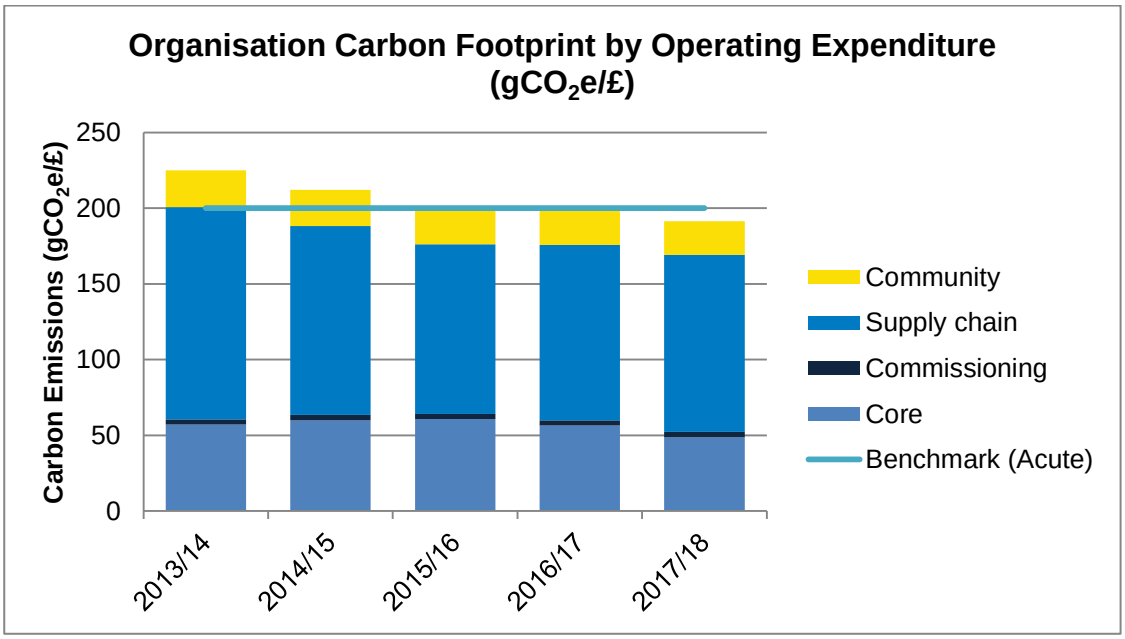
The information provided in the previous sections of this report use the Estates Return Information Collection as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit. More information can be accessed: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx

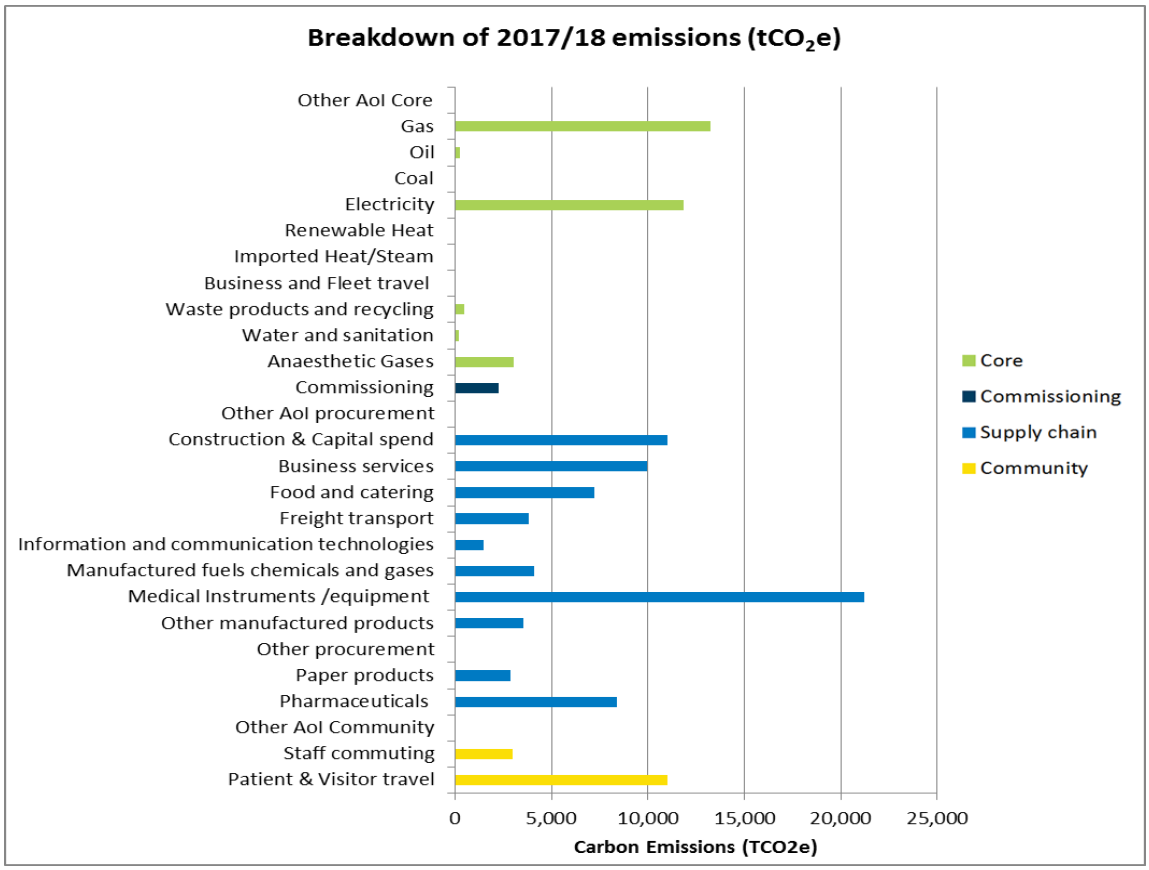
This model indicates an estimated total carbon footprint of 115,470 tonnes of CO_2e for the Trust. Our carbon intensity is 185 grams of CO2e emissions per pound of operating expenditure (gCO2e/£). Average emissions for acute services nationally is 200 grams per pound of operating expenditure.



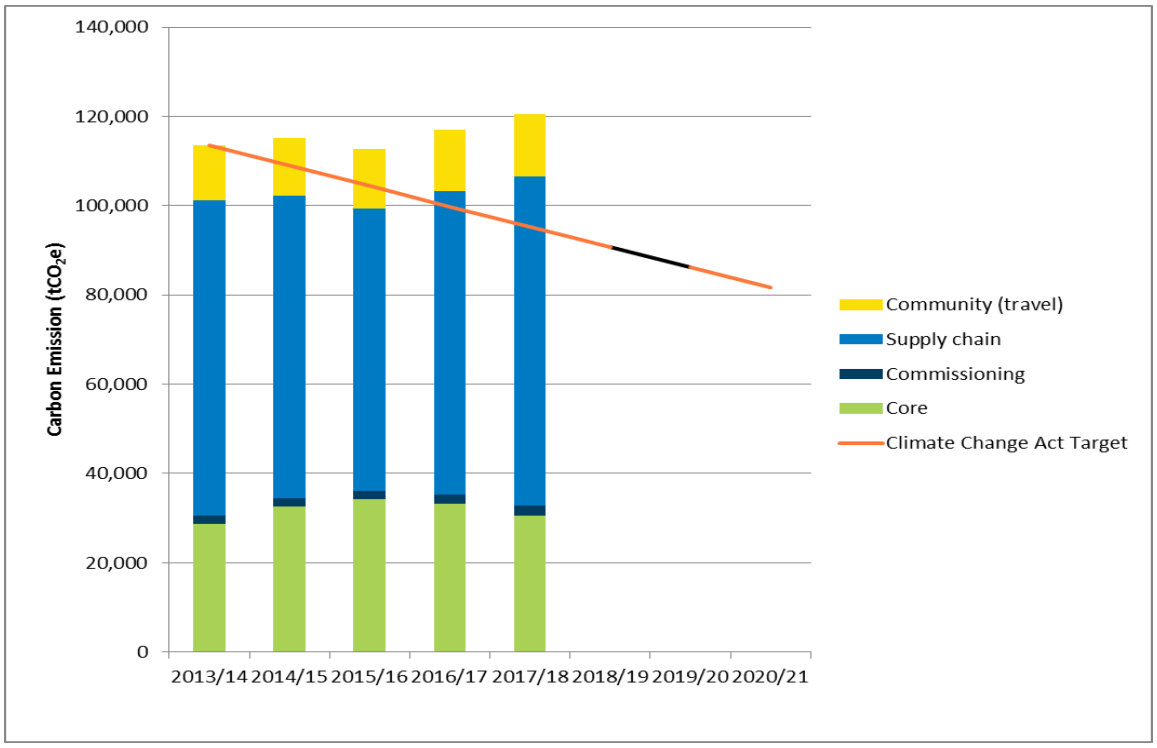
Category	% CO_2e
Core	24%
Supply Chain	62%
Commissioning	2%
Community (travel)	12%

Our performance is now below the benchmark for acute trusts nationally. This is principally driven by higher procurement emissions due to the level of investment that the Trust has made in recent years. The investment in infrastructure has improved the efficiency of our buildings and reduced our emissions in the longer term.





We are monitoring our Sustainable Development Action Plan to ensure we are contributing to Climate Change Act targets.



5. Accountability Report

5.1 Director's Report

The Board of Directors is responsible for exercising all of the powers of the Trust; however, it has the option to delegate these powers to senior management and other committees. The Board sets the strategic direction within the context of NHS priorities, allocates resources, monitors performance against organisational objectives, ensures that clinical services are safe, of a high quality, patient-focused and effective, ensures high standards of clinical and corporate governance and, along with the Council of Governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

The Board is accountable to stakeholders for the achievement of sustainable performance and the creation of stakeholder value through development and delivery of the Trust's long term vision, mission and strategy. The Board ensures that adequate systems and processes are maintained to deliver the Trust's annual plan, deliver safe, high quality healthcare, measure and monitor the Trust's effectiveness and efficiency as well as seeking continuous improvement and innovation. The Board delegates some of its powers to a committee of Directors or to an Executive Director and these matters are set out in the trust's scheme of delegation. Decision making for the operational running of the Trust is delegated to the executive management team.

There are specific responsibilities reserved by the entire Board, which includes approval of the Trust's long term objectives and financial strategy; annual operating and capital budgets; changes to the Trust's senior management structure; the Board's overall 'risk appetite'; the Trust's financial results and any significant changes to accounting practices or policies; changes to the Trust's capital and estate structure; and conducting an annual review of the effectiveness of internal control arrangements.

The Board of Directors has formally assessed the independence of the Non-executive Directors and considers all of its current Non-executive Directors to be independent in that notwithstanding their known relationships with other organisations, there are no circumstances that are likely to affect their judgement that cannot be addressed through the provisions of the Foundation Trust Code of Governance as evidenced through their declarations of interest, annual individual appraisal process and the ongoing scrutiny and monitoring by the Trust Secretary.

5.1.1 Directors' interests

Members of the Board of Directors are required to disclose details of company directorships or other material interests in companies held which may conflict with their role and management responsibilities at the Trust. The directors declare any interests before each Board and committee meeting which may conflict with the business of the trust and excuse themselves from any discussion where such conflict may arise. The Trust is satisfied with the independence of the Board for the entire year.

The Trust Secretary maintains a register of interests, which is available to members of the public by contacting the Trust Secretary, University Hospitals Bristol NHS Foundation Trust, Trust Headquarters, Marlborough Street, Bristol. BS1 3NU. Email: Trust.Secretariat@UHBristol.nhs.uk

5.1.2 Political donations

The Trust has made no political donations of its own.

5.1.3 Internal audit

The Audit Committee had ensured that there was an effective internal function established by management that met mandatory Government Internal Audit Standards and provided appropriate independent assurance. The Trust receives its internal audit service from Audit South West Internal Audit, Counter Fraud and Consultancy Service.

Table 14: Board of Directors – terms of office

Board Member
Jeff Farrar, Chairman
Appointment 1 December 2017
End of first tem 30 November 2020
John Savage, Chairman
Appointment 1 June 2008
End of first term 31 May 2011
End of second term 31 May 2014
End of third term 31 May 2017
Appointment extended for a further six months to 30 November 2017
David Armstrong, Non-executive Director
Appointment 28 November 2013
End of first term 27 November 2016
28 November 2016 re-appointed for a second term of three years
Madhu Bhabuta, Non-executive Director (Designate)
Appointment 3 July 2017
End of first term 2 July 2020
Julian Dennis, Non-executive Director
Appointment 1 June 2014
End of first term 31 May 2017
1 June 2017 re-appointed for a second term of three years
Lisa Gardner, Non-executive Director
Appointment 1 June 2008
End of first term 31 May 2011
End of second term 31 May 2014
End of third term 31 May 2017
Appointment extended for a further six months to 30 November 2017
John Moore, Non-executive Director
Appointment 1 January 2011
End of first term 31 December 2014
End of second term 31 December 2017
1 January 2018 re-appointed for a third term of three years
Anthony (Guy) Orpen, Non-executive Director
Appointment 2 May 2012
End of first term 1 May 2015
End of second term 1 May 2018
2 May 2018 re-appointed for a third term of three years
Alison Ryan, Non-executive Director

Appointment 28 November 2013 End of first term 27 November 2016 End of second term 27 November 2019 (to include 12-month sabbatical from August 2017-August 2018)
Martin Sykes Appointment 4 September 2017 End of first term 31 August 2020
Steven West Appointment 3 July 2017 End of first term 2 July 2020
Emma Woollett, Vice Chair/ Senior Independent Director Appointment 1 June 2008 End of first term 31 May 2011 End of second term 31 May 2014 End of third term 31 May 2017 Appointment extended for a further six months to November 2017 Appointment extended for a further six months to May 2018
Jill Youds, Non-executive Director Appointment 1 November 2014 End of first term 31 October 2017 Re-appointed for a second term of three years
Robert Woolley, Chief Executive Appointed 8 September 2010
Paula Clarke, Director of Strategy and Transformation Appointed 4 April 2016
Paul Mapson, Director of Finance and Information Appointed 1 June 2008
Carolyn Mills, Chief Nurse Appointed 6 January 2014
Alex Nestor, Acting Director of Workforce and Organisational Development Appointed 11 July 2016 until 31 October 2017
Sean O'Kelly, Medical Director Appointed 18 April 2011 until 19 September 2017
Mark Smith, Deputy Chief Executive and Chief Operating Officer Appointed 13 February 2017
Matthew Joint, Director of People Appointed 1 November 2017
Mark Callaway, Interim Medical Director Appointed 20 September 2017

Biographies of the members of the Board are provided at **Appendix A**.

5.1.4 Statement on compliance with cost allocation and charging guidance

The Trust has complied with the cost allocation and charging requirements set out in guidance issued by HM Treasury.

5.1.5 Income disclosures

The Trust can confirm that income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

The Trust provides a variety of goods and services to patients, visitors, staff and external organisations. Such goods and services include: catering, car parking, pharmacy products, IT Services, and medical equipment maintenance. The income generated covers the cost of the services and where appropriate makes a contribution towards funding patient care. The Trust does not levy fees and charges where the full cost exceeds £1 million or the service is otherwise material to the accounts.

5.1.6 Quality governance

The Trust is committed to and expects to provide excellent health services that meet the needs of our patients and their families and provides the highest quality standards. The Trust's annual quality delivery plans and quality strategy (2016-2020) set out the actions we will take to ensure that this is achieved.

The Trust's quality improvement programme led by the Chief Nurse, Medical Director and Chief Operating Officer continues to show us what is possible when we have a relentless focus on quality improvement. In our last strategy, we recognised that access to services is integral to patient experience and that great patient experience happens when staff feel valued, supported and motivated. In our revised strategy, we have now made this wider view of quality integral to our definition.

Our quality strategy and quality improvement work is therefore structured around four core quality themes:

- Ensuring timely access to services
- Delivering safe and reliable care
- Improving patient and staff experience
- Improving outcomes and reducing mortality.

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services. The Trust's Quality Impact Assessment process involves a structured risk assessment, using our standardised risk assessment framework, which includes assessment against the risk domains of safety, quality and workforce. The Medical Director and Chief Nurse are responsible for assuring themselves and the Board that Cost Improvement Programmes will not have an adverse impact on quality. The Trust's overall processes for monitoring quality and triangulating information provide a framework within which to monitor the impact of schemes.

The Trust has a robust Quality Governance reporting structure in place through an established Quality and Outcomes Committee, Our internal business planning and associated monitoring processes underpin the triangulation of our quality, workforce and finance objectives. Our Operating Plans are developed through the five clinical and Trust Services corporate divisions with monthly and quarterly Divisional Reviews conducted with the Executive team. The Trust's Clinical Quality Group monitors compliance with Care Quality Commission Fundamental Standards on an ongoing basis and our Quality and Outcomes Committee monitors performance against a range of performance standards.

5.1.7 Statement as to Disclosure to Auditors

The Board of Directors confirms that each individual who was a Director at the time that this report was approved has certified that: So far as the Director is aware, there is no relevant audit information of which the NHS foundation trust's Auditor is unaware, and; the Director has taken all

the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's Auditor is aware of that information.

5.1.8 Prompt Payments Code

The Trust aims to pay its bills promptly and is a signatory to the Prompt Payments Code (PCC) which stipulates that its members should pay 95 per cent of invoices within 60 days and aim to move towards 30 days as a norm. The Trust's performance against the 60 day target is set out in the table below.

Table 15: Performance against Prompt Payments Code

	Year ended 31 March 2018	Year ended 31 March 2017
Total invoices paid in the year	173,258	167,704
Total invoices paid within 60 days	164,464	158,250
Percentage of invoices paid within 60 days	95%	94%

The Trust ensures all invoices are properly authorised before being paid. The complexity of services provided by other organisations requires detailed checking by clinical staff, both in terms of activity and services provided. Clinical staff responsible for the authorisation of invoices will prioritise clinical care during periods of resource pressure.

The better payment practice code standard relates to payment of invoices within 30 days. The Trust's performance against this standard is shown in the table below.

Table 16: Performance against Better Payment Practice Code

	Year ended 31 March 2018			Year ended 31 March 2017		
	NHS contracts	Other invoices	Total	NHS contracts	Other invoices	Total
No. invoices paid within 30 days	2,933	134,204	137,137	2,812	116,328	119,140
No. invoices paid	4,692	168,566	173,258	4,662	163,027	167,689
Proportion paid within 30 days – number	62.5%	79.6%	79.2%	60.3%	71.4%	71.0%
Value of invoices paid within 30 days	£54.18m	£168.60m	£222.78m	£55.99m	£154.23m	£210.23m
Value of invoices paid	£78.21m	£206.19m	£284.40m	£68.17m	£202.13m	£270.31m
Proportion paid within 30 days – value	69.3%	81.8%	78.3%	82.1%	76.3%	77.8%

The Directors are responsible for preparing the annual report and accounts and consider that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy

5.1.9 Council of Governors

NHS Foundation Trusts are 'public benefit corporations' and are required by the National Health Service Act 2006 to have a Council of Governors (the Council), the general duties of which are to:

- Hold the Non-executive Directors individually and collectively to account for the performance of the board of directors
- Represent the interests of the members of the corporation as a whole and the interests of the public.

The Council is responsible for regularly feeding back information about the Trust's vision, strategy and performance to their constituencies and the stakeholder organisations that either elected or appointed them. The Council discharges a further set of statutory duties which include appointing, re-appointing and removing the Chairman and Non-executive Directors, and approving the appointment and removal of the Trust's External Auditor.

The Council and Board of Directors communicate principally through the Chairman who is the formal conduit between the two corporate entities. Clear communication between the Board and the Council is further supported by governors regularly attending meetings of the Board, and Executive and Non-executive Directors regularly attending meetings of the Council.

Communications and consultations between the Council and the Board include the Trust's annual Quality Report; strategic proposals; clinical and service priorities; proposals for new capital developments; engagement of the Trust's membership; performance monitoring; and reviews of the quality of the Trust's services.

The Board of Directors present the Annual Accounts, Annual Report and Auditor's Report to the Council at the Annual Members' Meeting.

The Council has developed a good working relationship with the Chairman and Directors, and through the forums of governors' focus groups (dealing with matters of constitution; strategy and planning; and quality and performance monitoring), development seminars and informal meetings, governors are provided with information and resources to enable them to engage in a challenging and constructive dialogue with the Board of Directors.

Meetings of the Council are scheduled to follow the Board meetings held in public, and good attendance by governors at both has meant governors are kept up to date on current matters of importance and have the opportunity to follow up on queries in more detail with all members of the Board.

There were five Council meetings in the year, including the Annual Members' Meeting, which in addition to being attended by governors and the Board of Directors, were also open to members and the general public.

Governors are required to disclose details of any material interests which may conflict with their role as governors at each Council meeting. A register of interests is available to members of the public by contacting the Trust Secretary at the address given in Appendix B of this report.

All governor and membership meetings and activities formally report into the Council meetings, with many of these updates led by governors. There is also a standing agenda item of an update from the Chief Executive, providing an opportunity to brief governors on the significant issues facing the Trust, provide updates on developments and report on performance. The structure of the agenda for the meeting of the Council allows time for governors' questions and discussion. This is valued by governors and Board members alike, and has helped to provide greater interaction between the two groups.

At the Council meeting in April 2017, governors approved the appointment of the lead governor as a joint role between Malcolm Watson and Sharmily Yogananth, subject to Sharmily's re-election as a staff governor. As Sharmily Yogananth was not re-elected in June 2017, Malcolm Watson continued in the role as sole lead governor.

In April 2017 the Council of Governors approved the appointment of PwC as the Trust's External Auditors for a three-year period.

In July 2017 the Council approved changes to the Trust Constitution, brought forward by the governor Constitution Focus Group and ratified by the Board of Directors in July 2017.

In January 2018 the Council received a Strategic Outline Case for UH Bristol and Weston Area Health NHS Trust to further develop their partnership working and pursue an organisational merger through acquisition. Governors supported the Board in its decision to proceed subject to certain financial conditions being met.

During the year the governors' Nominations and Appointments Committee recommended a number of actions for approval to the Council of Governors, the details of which are outlined below.

Further comment on the interaction of the Council and the Board of Directors is provided in the Annual Governance Statement included in section 5.7 of this report.

Table 17: Membership and attendance at Council of Governors meetings 2017/18
The figure in brackets denotes the number of meetings an individual could be expected to attend by virtue of their membership of the Council. A figure of zero in brackets (0) indicates that the individual was not a member or that their attendance was not mandatory. 'C' denotes the Chair of the meeting. Sickness or other reasons for absence are not recorded.

Number of Council of Governors meetings: 1 April 2017-31 March 2018	**5**
Chairman: John Savage (until 30/11/17)	**C4(4)**
Chairman: Jeff Farrar (1/12/17 – 31/3/18)	**C1(1)**
Governors Public –South Gloucestershire	
Pauline Beddoes	2(5)
Malcolm Watson	4(5)
Public – North Somerset	
Graham Briscoe	1(2)
Clive Hamilton	2(2)
Penny Parsons	2(3)
John Rose	3(3)
Public Bristol	
Bob Bennett	2(2)
Mo Schiller	2(2)
Sue Silvey	2(2)
Carole Dacombe	4(5)
Tom Frewin	3(5)
Maureen Phillips	2(3)
Jenny James	2(3)
Mary Whittington	3(3)
Public (Rest of England and Wales)	
Hussein Amiri	1(5)
Jonathan Seymour-Williams	4(5)
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	
Edmund Brooks	0(2)
Angelo Micciche	2(2)
Ray Phipps	5(5)
Anne Skinner	2(2)
Rashid Joomun	3(5)
Kathy Baxter	4(5)
Derek Wholey	1(2)
Tony Tanner	2(3)
John Sibley	2(3)
Carers of patients 16 years and over	
Sue Milestone	2(5)
Garry Williams	3(5)
Carers of patients under 16 years	
Lorna Watson	1(2)
John Chablo	3(3)
Graham Papworth	2(3)
Staff Non-clinical Healthcare Professional	
Karen Stevens	1(2)
Sharmily Yogananth	1(2)
Jane Westhead	3(3)
Neil Morris	3(3)
Staff Other Clinical Healthcare Professional	
Andy Coles-Driver	3(5)
Staff Medical and Dental	
Ian Davies	0(2)
Bala Thyagarajan	0(2)
Staff Nursing and Midwifery	
Florene Jordan	5(5)
Maria Wahab	0(2)
Jo Roberts	1(3)
Appointed Governors	
Marc Griffiths	0(2)
Sally Moyle	1(3)
Tim Peters	1(2)
Astrid Linthorst	3(3)
Jeanette Jones	2(2)
Sophie Jenkins	2(3)
Marty McAuley	2(3)
Carole Johnson	1(5)
Beatrice Lander	1(2)
Olivia Garrett	0(2)
Siobhan Coles	0(2)
Sujan Canagarajah	0(2)
Non-executive Directors	
Emma Woollett	2(0)
Lisa Gardner	0(0)
John Moore	2(0)

Anthony (Guy) Orpen	1(0)
Alison Ryan	3(0)
David Armstrong	4(0)
Julian Dennis	3(0)
Jill Youds	3(0)
Martin Sykes	2(0)
Madhu Bhabuta	2(0)
Steven West	1(0)
Executive Directors	
Robert Woolley	5(0)
Mark Smith	3(0)
Sean O'Kelly	2(0)
Mark Callaway	1(0)
Paul Mapson	2(0)
Alex Nestor	3(0)
Matthew Joint	2(0)
Carolyn Mills	4(0)
Paula Clarke	4(0)

5.1.10 Governors' Nominations and Appointments Committee

The Governors' Nominations and Appointments Committee is a formal Committee of the Council established in accordance with the NHS Act 2006, the UH Bristol Trust Constitution, and the Foundation Trust Code of Governance for the purpose of carrying out the duties of governors with respect to the appointment, re-appointment, removal, remuneration and other terms of service of the Chairman and Non-executive Directors. There are 12 governor members.

As a result of the 2017 governor elections, eight vacancies arose on this committee on 31 May: these were filled by governors in line with the terms of reference and approved by the Council of Governors on 28 July 2017.

The Committee met on five occasions during the course of the year. One of its main areas of focus in 2017 was the appointment of a new Chairman and Non-executive Directors. External recruitment consultants Odgers Berndtson were engaged as the search consultants for the positions. The Committee was involved from the start of the process in September 2016 through to interviews in April/May 2017 for the Non-executive Directors and July 2017 for the Chair. The Committee recommended the appointment of Martin Sykes as Non-executive Director and Steven West and Madhu Bhabuta as Non-executive Directors (Designate) and their recommendation was agreed by the full Council of Governors on 26 May 2017. The Council of Governors subsequently approved the appointment of Steven West (Non-executive Director Designate) as a Non-executive Director for the period 1 September 2017 to 31 May 2018 (as cover for Alison Ryan's sabbatical), and for the period from 1 June 2018 (as replacement for Emma Woollett) until 31 June 2020. The Committee further recommended the appointment of Jeff Farrar as Trust Chairman which was approved at the Council of Governors meeting on 28 July 2017.

During the year, the Committee also supported the re-appointment of John Moore and Guy Orpen for third and final three-year terms of office, subject to annual review and annual re-appointment in line with the Foundation Trust Code of Governance. In July, the Committee supported the appointment of Jill Youds as Senior Independent Director from September 2017. In March 2018 the Committee supported the appointment of Jill Youds as Vice-Chair (taking over from Emma Woollett as she reached the end of her term of office), with Julian Dennis taking on the role of Senior Independent Director from 1 June 2018.

The Committee's work also included reviewing activity records and annual performance appraisals for each of the Non-executive Directors. In September 2017 the Committee reviewed the current remuneration of Non-executive Directors and recommended an uplift of £1,000 per annum because there had been no increase in Non-executive Director remuneration at UH Bristol for some years, and it had fallen behind in relation to comparable Trusts. The Committee conducted a self-review and review of its terms of reference in October 2017.

5.1.11 Performance and development of the Council of Governors

There is continued focus on supporting the Council to have closer links and increased contact with the Board members, and to improve the content and structure of meetings held for governors. For example,

Non-executive Directors attend the governor focus groups and meetings of the Chairman's and Non-executive Directors' Counsel. These interactions allow for open discussion and relationship building at regular intervals throughout the year.

The quarterly Governor Development Seminars form an important part of the programme of development for governors. The programme for the seminars provides governors with core training, skills development and updates from across the Trust to enable governors to perform their statutory duties effectively.

5.1.12 Governor elections

Governor elections are held every two years out of three. 2017 was an election year and there were 14 seats up for election over seven constituencies. Nominations ran from 7 March to 4 April 2017, with a ballot vote from 28 April to 24 May 2017. New governors took up office on 1 June 2017.

One governor was elected unopposed as their constituency was uncontested:

- Staff – Medical and Dental (one to elect) – **Bala Thyagarajan**

Thirteen governors were elected following a ballot:

- Public-Bristol (three to elect): **Maureen Phillips, Jenny James** and **Mary Whittington**
- Public North Somerset (two to elect): **Penny Parsons** and **John Rose**
- Patient-Carer of Patients under 16 years (two to elect): **John Chablo** and **Graham Papworth**
- Patient-Local (three to elect): **Tony Tanner**, **John Sibley** and **Derek Wholey**
- Staff-Nursing and Midwifery (one to elect): **Jo Roberts**
- Staff-Non-clinical Healthcare Professionals (two to elect): **Neil Morris** and **Jane Westhead**

The following appointments were made to our Appointed Governor roles:

- **Sujan Canagarajah and Siobhan Coles** joined the Council as the appointed governors from the Trust's Youth Involvement Group, for a one year term of office from October 2017
- **Sophie Jenkins** was appointed to the Council representing the UH Bristol Joint Union Committee from June 2017.
- **Cllr Carole Johnson** was reappointed for another three-year term of office from 1 June 2017 as Appointed Governor from Bristol City Council.
- **Astrid Linthorst** took up office as the Appointed Governor from the University of Bristol from June 2017
- **Marty McAuley** was appointed to the Council from South Western Ambulance Service NHS Foundation Trust from 1 June 2017
- **Sally Moyle** was appointed to the Council from the University of the West of England from 1 June 2017.

On 31 October 2017, Bala Thyagarajan left the Trust and it was decided to run an election to fill this vacancy in Spring 2018.

On 21 January, Derek Wholey resigned from his role as patient governor. Consideration of this vacancy will be included in a review of the patient governor constituencies planned for 2017/18

Table 18: Governors by constituency – 1 April 2017 to 31 March 2018

Constituency	Name	Tenure	Elected or Appointed
Public Governors			
Public South Gloucestershire	Pauline Beddoes	June 2010 to May 2019	Elected
Public South Gloucestershire	Malcolm Watson	June 2016 to May 2019i	Elected
Public North Somerset	Clive Hamilton	June 2011 to May 2017	Elected
Public North Somerset	Graham Briscoe	June 2014 to May 2017	Elected
Public North Somerset	Penny Parsons	June 2017 to May 2020	Elected
Public North Somerset	John Rose	June 2017 to May 2020	Elected
Public Bristol	Mo Schiller	June 2008 to May 2017	Elected
Public Bristol	Sue Silvey	June 2011 to May 2017	Elected
Public Bristol	Bob Bennett	June 2014 to May 2017	Elected
Public Bristol	Carole Dacombe	June 2016 to May 2019	Elected
Public Bristol	Tom Frewin	June 2016 to May 2019	Elected
Public Bristol	Maureen Phillips	June 2017 to May 2020	Elected
Public Bristol	Jenny James	June 2017 to May 2020	Elected
Public Bristol	Mary Whittington	June 2017 to May 2020	Elected
Public – Rest of England and Wales	Hussein Amiri	June 2016 to May 2019	Elected
Public – Rest of England and Wales	Jonathan Seymour-Williams	June 2016 to May 2019	Elected
Patient Governors			
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	Angelo Micciche	October 2013 to May 2017	Elected
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	Anne Skinner	June 2008 to May 2017	Elected
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	Edmund Brooks	June 2014 to May 2017	Elected
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	Ray Phipps	Mar 2015 to May 2019	Elected
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	Rashid Joomun	June 2016 to May 2019	Elected

Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	Kathy Baxter	June 2016 to May 2019	Elected
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	Derek Wholey	June 2017 to Jan 2018	Elected
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	Tony Tanner	June 2017 to May 2020 June 2013 to May 2016	Elected
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	John Sibley	June 2017 to May 2020	Elected
Carers of patents 16 years and over	Sue Milestone	June 2013 to May 2019	Elected
Carers of patients 16 years and over	Garry Williams	June 2016 to May 2019 June 2010 to May 2013	Elected
Carers of patients under 16 years	John Chablo	June 2017 to May 2020	Elected
Carers of patients under 16 years	Graham Papworth	June 2017 to May 2020	Elected
Staff Governors			
Medical and Dental	Ian Davies	June 2013 to May 2017	Elected
Medical and Dental	Bala Thyagarajan	June to October 2017	Elected
Nursing and Midwifery	Florene Jordan	June 2010 to May 2019	Elected
Nursing and Midwifery	Maria Wahab	June 2016 to May 2017	Elected
Nursing and Midwifery	Jo Roberts	June 2017 to May 2019	Elected
Non-clinical Healthcare Professional	Karen Stevens	June 2014 to May 2017	Elected
Non-clinical Healthcare Professional	Sharmily Yogananth	June 2016 to May 2017	Elected
Non-clinical Healthcare Professional	Jane Westhead	June 2017 to May 2020	Elected
Non-clinical Healthcare Professional	Neil Morris	June 2017 to May 2020	Elected
Other Clinical Healthcare Professional	Andy Coles-Driver	June 2016 to May 2019	Elected
Appointed Governors			
University of Bristol	Tim Peters	March 2011 to May 2017	Appointed
University of Bristol	Astrid Linthorst	June 2017 to May 2020	Appointed
University of the West of England	Marc Griffiths	October 2013 to May 2017	Appointed
University of the West of England	Sally Moyle	June 2017 to May 2020	Appointed
Bristol City Council	Carole Johnson	June 2016 to June 2017 June 2017 to May 2020	Appointed

South Western Ambulance Service NHS FT	Marty McAuley	June 2017 to May 2020	Appointed
Joint Union Committee	Jeanette Jones	June 2008 to May 2017	Appointed
Joint Union Committee	Sophie Jenkins	June 2017 to May 2020	Appointed
Youth Involvement Group	Beatrice Lander	September 2016 to August 2017	Appointed
Youth Involvement Group	Olivia Garrett	September 2016 to August 2017	Appointed
Youth Involvement Group	Siobhan Coles	October 2017 to August 2018	Appointed
Youth Involvement Group	Sujan Canagarajah	October 2017 to August 2018	Appointed
Voluntary/Community Groups	*Post removed July 2017*		*Appointed*

5.1.13 Foundation Trust membership

The Trust maintains a broadly representative membership of people from eligible constituencies in keeping with the NHS Foundation Trust governance model of local accountability through members and governors. The Trust has three membership constituencies as follows:

- A public constituency comprising Bristol; North Somerset; South Gloucestershire; and Rest of England and Wales
- A patient constituency comprising local patients; carers of patients 16 years and over; and carers of patients under 16 years
- A staff constituency comprising medical and dental; nursing and midwifery; other clinical healthcare professionals; and non-clinical healthcare professionals.

Eligibility for public membership is open to members of the public who are not eligible to become a member of the Trust's staff constituency, are not members of any other constituency and are seven years of age and above. The patient constituency is open to all those who have attended one of the Trust's hospitals as a patient, or as the carer of a patient, and who are neither eligible to become a member of the staff constituency nor are less than seven years of age. Staff are automatically registered as members on appointment and may opt out if they wish. Information on opting out of the scheme is included in induction packs and on the intranet.

Membership numbers have declined in 2017/18 as a result of a continued proactive approach through the year in seeking updated contact information from public and patient members for whom the membership office only holds a postal address. At 31 March 2018 public and patient membership totalled 8,947 and staff membership 10,365. The combined membership at 31 March 2018 stands at 19,312.

Table 19: Members of the Foundation Trust

Public constituency	**2017/18**
At year start (April 1)	5,520
New members	85
Members leaving	290
At year end (March 31)	5,315
Patient constituency	**2017/18**
At year start (April 1)	3,879
New members	27
Members leaving	274
At year end (March 31)	3,632
Staff constituency	2017/18
At year start (April 1)	10,524
New members	1,741
Members leaving	1,900
At year end (March 31)	10,365

5.1.14 Membership strategy

During the year the membership office continued to progress the quarterly priorities as agreed with governors in 2016/17. From May to August 2017 the membership office focussed on filling the 14 governor vacancies, liaising with stakeholder organisations to fill appointed governor vacancies, and the induction of new governors. From September to January the focus was on reviewing membership engagement methods and practices (including plans for encouraging applications from sections of the community currently under-represented within membership – broadly identified as the under 40s, residents of South Gloucestershire, the Chinese community and white non-British communities), and setting priorities for 2018/19.

Recruitment methods and engagement activities were discussed with governors in early 2018, and governors agreed on and pledged their support to a defined and measurable set of activities. These activities include a monthly 'meet and greet' stall within the hospitals, and increasing the number of health information talks for members to 10 a year, with governors taking an active role in introducing the events as well as attending to hear from and talk to members. Governors provide a monthly update to members on their role and activities via the member e-newsletter, which also contains a summary of UH Bristol and local health news alongside offers for members to participate in events or surveys. Governors also have contact with members through the public edition of the Trust's Voices magazine (issued twice a year to members).

In 2018/19 recruitment and engagement activities will be reviewed and assessed, alongside preparations for the next round of elections due to take place in May 2019.

Further information about membership along with details of how members can contact their governors is available on the Trust website: www.uhbristol.nhs.uk/membership and at Appendix B.

Table 20: Analysis of current membership

Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	157*	187,308
17-21	254	64,223
22+	4,714	701,995
Ethnicity:		
White	4,501	806,242
Mixed	72	21,138
Asian or Asian British	188	32,531
Black or Black British	131	28,584
Other	2	5,072
Socio-economic groupings:		
AB	1,536	72,696
C1	1,569	91,716
C2	1,057	56,721
DE	1,137	63,324
Gender analysis		
Male	2,263	473,907
Female	2,939	479,619
Patient constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	158	N/A
17-21	177	N/A
22+	3,268	N/A
Staff constituency	**Number of members**	
	10,365	

This analysis excludes public members with no date of birth (219), public members with no stated ethnicity (421) and no stated gender (113). *Members of UH Bristol must be at least seven years of age

5.2 An Overview of Quality

The Trust's objectives, values, quality and efficiency strategies provide a clear message to all staff that high quality services and excellent patient experience are the first priority for the Trust.

The Trust's quality strategy has remained focussed on responding to national requirements and delivering our commitment to address aspects of care that matter most to our patients. Which they describe as: keeping them safe; minimising waiting for treatment; being treated as individuals; being involved in decisions about their care; being cared for in a clean and calm environment; receiving appetising and nutritional food and achieving the best clinical outcomes possible for them. The safety of our patients, the quality of their experience of care, and the success of their clinical outcomes are at the heart of everything we want to achieve as a provider of healthcare services. The Trust has continued to make progress in the last 12 months to improve the quality of care that we provide to patients and address any known quality concerns.

We have much to be proud of. The Trust's quality improvement programme has shown us what is possible when we have a relentless focus on quality improvement. Healthcare does not stand still. We need to continuously find new and better ways of enhancing value, whilst enabling a better patient experience and improved outcomes. Never has there been a greater need to ensure we get the best value from all that we do.

5.2.1 Our Patient Safety Improvement Programme 2015-2018

We reported last year on the development of our 'Sign up to Safety' programme, building on our previous involvement in the Safer Care South West programme and the partnership work with colleagues in the West of England Patient Safety Collaborative to identify and develop opportunities for system wide safety improvements and to share and learn from each other. In line with the national Sign up to Safety initiative, the overall aim of our programme is to reduce mortality and harm to patients.

5.2.2 Stakeholder relations

UH Bristol is currently not engaged in any formal consultation process with the Local Authorities or Health Overview and Scrutiny Committees (HOSCs) to support any major changes in services for our patients. There have, however, been a number of developments to services over the past 12 months including UH Bristol partnering with Taunton to provide a Clinical Genetics service for Somerset. The Trust has also formalise and substantiated running the Somerset Dermatology services with Taunton and continues to engage actively in conversations with other local providers, through the STP to continue to develop our services in BNSSG to improve services for patients in the local population.

UH Bristol has continued to actively support our partnership arrangements with Weston Area Health NHS Trust (WAHT), supporting a number of joint clinical and managerial posts to help stabilise the delivery of acute services in Weston for the North Somerset population. This arrangement builds on long-standing, positive working relationships which give local people access to a range of services delivered or supported by Bristol and Weston clinicians. UH Bristol and WAHT also announced in 2017/18 the intention to work together towards continuing to strengthen the partnership between the two organisation through 2018/19 and into future years. A key aspect of this has been UH Bristol providing acute leadership and support to the BNSSG CCG programme Healthy Weston. This programme of work is designing the shape and function of future of clinical services on the Weston hospital campus and how hospital services and care will be provided for North Somerset patients going forward.

Further information is contained within the Quality Report in Appendix C.

5.2.3 Research and Innovation

Research remains an essential part of delivering excellent evidence-based care and the services we deliver as part of the Trust's tripartite mission to provide exceptional healthcare, research and teaching every day. During 2017/18 nearly 7000 of our patients gave their time to take part in the research that we lead and host at UH Bristol.

We have just completed the first year of our National Institute for Health Research (NIHR) Biomedical Research Centre, which draws on the expertise of clinicians and academics to translate novel ideas into health benefits. Our five year award allows us to invest in the BRC's five programmes of research in cardiovascular disease and nutrition, diet and lifestyle, surgical innovation, reproductive and perinatal health and mental health, exploiting our local partnerships' strengths in population studies, laboratory science and patient-based research to benefit our patients and the local population.

The total value of our NIHR grant income (>£7m/year) continues to increase year on year, comprising the NIHR BRC, NIHR CLAHRC West, 19 NIHR project or programme grants and four NIHR Fellowships.

New grants awarded in 2017/18 include:

- an NIHR-HTA funded trial comparing gabapentin and placebo alongside other pain regimens in surgical patients – this is a £1.1 million grant led by Professor Chris Rogers and Dr Ben Gibbison
- Dr Charlotte Bradbury was been awarded £350,000 by NIHR to trial first line treatment pathways in immune thrombocytopaenia
- Professor Julian Hamilton-Shield's NIHR-i4i award to evaluate and validate a novel way of measuring breath ammonia started recruitment of patients to test the device. This is a collaboration with an industrial partner to investigate ways of managing rare metabolic diseases and was awarded over £700,000.

We have worked with researchers to submit 12 grant applications for NIHR funding, and whilst not all will be successful, this is a measure of the Trust's engagement with research.

After successful completion of recruitment and/or other deliverables, three UH Bristol grants have closed or nearing the end:

- Reducing arthritis fatigue: clinical teams using cognitive-behavioural approaches (RAFT) led by Professor Sarah Hewlett, was awarded through an NIHR commissioning brief that asked us to test whether a simplified psychological intervention that could be delivered widely in the NHS reduces rheumatoid arthritis fatigue and is an efficient use of NHS resources. Professor Hewlett and her team are now working on a training package 'RAFT' before roll out in the NHS
- Can skin grafting success rates in burn patients be improved by using a low friction environment – a feasibility study? (SILKIE), led by Dr Amber Young. The aims of this NIHR research for patient benefit feasibility study are in part to determine whether patients can be recruited and the study be run in an NHS setting. Once all data have been analysed the team will decide whether the study warrants a full scale randomised clinical trial
- Transmission – Radiotherapy Active Pixel System (TRAPS): Towards a Clinical Prototype for Real-Time 2D Verification of Intensity Modulated Radiotherapy. This NIHR-Invention for Innovation grant was led by Diane Crawford at UHBristol, building on work done in collaboration with University of Bristol School of Physics. The grant achieved its outcomes, and the team are now in discussion with potential commercial partners about taking forward the technology.

We have maintained good relationships with partner NHS Trusts within the NIHR Clinical Research Network: West of England (CRN:WoE), and working closely together we have all focussed on our performance in

delivering portfolio research. This has improved significantly during 2017/18, demonstrating our commitment to generating evidence to support changes in patient care.

Examples of our successes include: Recruiting over 1200 patients into a study in the Bristol Eye Hospital in which we aimed to improve decision making and calibrating health utilities for Cataract Surgery; recruiting the first patient in the UK to a number of trials in the Children's Hospital; recruiting the first patient globally to a commercial phase I trial in adults with steroid resistant Acute Graft versus Host Disease in the Bristol Haematology and Oncology Centre.

Our commercial income levels, generated through collaborative and contract commercial trials, have remained healthy, at almost £2 million in 2017/18. Commercial research allows us flexibility to increase staffing in our non-commercial areas, as well as making novel treatments available to our patients.

Over the last year we have seen an increase in the number of early phase trials and trials involving Advanced Therapy Medicinal Products (ATIMPs), which can offer cutting edge treatments for our patients. We have been developing our portfolio of commercial trials in new areas, including identifying a pipeline of research in haematology, and opening adult vaccine studies, both growing areas for us.

As we move into 2018/19 we expect to prioritise partnership working through our large NIHR infrastructures and with our clinical network partners, and to maintain our focus on delivering the research we are funded to do, effectively and expertly.

5.3 Remuneration Report

This is the Report of the Remuneration, Nominations and Appointments Committee of the Board of Directors, for the financial year of 1 April 2017 – 31 April 2018.

5.3.1 Annual Statement on Remuneration

The purpose of the Remuneration Committee is to decide the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors, and to review the suitability of structures of remuneration for senior management. In 2017/18, the Committee was chaired by the Vice-Chair and Senior Independent Director and was attended by all Non-executive Directors (from 2018-19, the Committee will be chaired by the Chairman of the Board). The Committee is attended by the Chief Executive and Director of People in an advisory capacity when appropriate, and is supported by the Trust Secretary to ensure it undertakes its duties in accordance with applicable regulation, policy and guidance.

The committee met on six occasions in the reporting period to consider the annual review of Executive Director's performance, objectives for 2017/18, and current remuneration levels and appointments for the Medical Director. The Committee reviewed and approved the Trust's Fit and Proper Persons Policy.

5.3.2 Major decisions and substantial changes

The Committee carried out an annual review of Executive remuneration, with reference to national benchmarking data for Executive Director Remuneration. The Committee introduced a succession planning framework in order to establish a clear succession plan for Executive roles and agreed a timetable of training to support the induction of new Committee members and to ensure the continuous development of existing members of the Committee. In September 2017 Matthew Joint took up the role of Director of People.

In reviewing the suitability of pay and conditions of employment for Very Senior Managers, the Committee takes account of the principles and provisions of the Foundation Trust Code of Governance, national policy in respect of VSM pay, national pay awards, comparable employers, national economic factors and the remuneration of other members of the Trust's staff.

5.3.3 Senior Manager's Remuneration Policy

The overarching policy statement is as follows: 'Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with the skills and experience required to lead the NHS Foundation Trust successfully, but an NHS Foundation Trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.' For the purposes of the annual report, the definition of 'VSM' is the Executive Directors of the Board.

The remuneration policy has been reviewed and is in line with the principles contained in the letter from the Secretary of State in respect of VSM Pay dated 2 June 2015, October 2016 and guidance issued in February 2017 and March 2018 from NHSI/NHSE. In this context, there are currently four VSMs employed at the Trust with an annual salary greater than the salary of the Prime Minister.

The Trust has, in setting these salaries, taken into account market conditions in the public sector as a whole and the NHS in particular. The Trust is satisfied that having regard to these factors that remuneration to these very senior managers is reasonable and compares favourably with the rest of the public sector.

Accounting policies for pensions and other retirement benefits (which apply to all employees) are contained in Note 1 of the Annual Accounts.

The following tables show the remuneration for the senior managers of the Trust for 2017/18 and 2016/17. There were no taxable benefits, annual performance related bonuses or exit packages paid to any director in either year. This information has been subject to audit.

Table 21: Remuneration for the senior managers of the Trust 2017/18

Directors remuneration for 2017/18 (£'000)	Salary	Pension Related Benefits	Total
	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Chair:			
John Savage until 30 November 2017	30-34	n/a	30-34
Jeff Farrar from 1 December 2017	15-19	n/a	15-19
Executive Directors			
Robert Woolley, Chief Executive	190-194	0	190-194
Mark Smith, Chief Operating Officer	155-159	30-32.4	185-189
Paula Clarke, Director of Strategy and Transformation	130-134	27.5-29.9	160-164
Paul Mapson, Director of Finance and Information	145-149	0	145-149
Carolyn Mills, Chief Nurse	135-139	37.5-39.9	175-179
Alex Nestor, Acting Director of Workforce until 31 October 2017	60-64	5-7.4	70-74
Matthew Joint, Director of People from 1 November 2017	60-64	0-2.4	60-64
Sean O'Kelly, Medical Director until 19 September 2017	90-94	0	90-94
Mark Callaway, Medical Director from 20 September 2017	100-104	25-27.4	130-134
Non-executive Directors			
David Armstrong	10-14	n/a	10-14
Julian Dennis	15-19	n/a	15-19
Lisa Gardner until 30 November 2017	10-14	n/a	10-14
John Moore	15-19	n/a	15-19
Guy Orpen	10-14	n/a	10-14
Alison Ryan until 31 July 2017	5-9	n/a	5-9
Emma Woollett	15-19	n/a	15-19
Jill Youds	10-14	n/a	10-14
Steven West from 3 July 2017	5-9	n/a	5-9
Martin Sykes from 4 September 2017	5-9	n/a	5-9
Madhu Bhabuta from 3 July 2017	5-9	n/a	5-9

Table 22: Remuneration for the senior managers of the Trust 2016/17

Directors remuneration for 2016/17 (£'000)	Salary	Pension Related Benefits	Total
	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Chair			
John Savage	50 - 54	n/a	50 - 54
Executive Directors			
Robert Woolley, Chief Executive	190-194	127.5-129.9	320-324
Owen Ainsley, Chief Operating Officer from 13 June 2016 until 12 February 2017	70-74	42.5-44.9	115-119
Paula Clarke, Director of Strategy and Transformation from 1 April 2016	130-134	27.5-29.9	155-159
Sue Donaldson, Director of Workforce and Organisational Development until 12 March 2017	115-119	-	115-119
Deborah Lee, Chief Operating Officer and Deputy Chief Executive until 12 June 2016	30-34	12.5-14.9	45-49
Paul Mapson, Director of Finance and Information	155-159	50.0-52.4	205-209
Carolyn Mills, Chief Nurse	130-134	107.5-109.9	240-244
Alex Nestor, Acting Director of Workforce and Organisational Development from 11 July 2016	65-69	55.0-57.4	120-124
Sean O'Kelly, Medical Director	195-199	40.0-42.4	235-239
Mark Smith, Chief Operating Officer from 13 February 2017	20-24	5.0-7.4	25-29
Non-executive Directors			
David Armstrong	10-14	n/a	10-14
Julian Dennis	10-14	n/a	10-14
Lisa Gardner	15-19	n/a	15-19
John Moore	15-19	n/a	15-19
Guy Orpen	10-14	n/a	10-14
Alison Ryan	15-19	n/a	15-19
Emma Woollett	20-24	n/a	20-24
Jill Youds	10-14	n/a	10-14

There were no payments made for loss of office in either 2017/18 or 2016/17.

There were no payments to past senior managers in either 2017/18 or 2016/17.

The following tables show the pension benefits for the senior managers of the Trust for 2017/18 and 2016/17. As Non-executive Directors do not receive pensionable remuneration, there are no entries in respect of any pensions. This information has been subject to audit.

Table 23: Pension benefits for the year ended 31 March 2018

Name	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at age 60 related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Real Increase in Cash Equivalent Transfer Value	Employer funded con-tribution to growth in CETV
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Robert Woolley	-	-	60-64	185-189	1,420	1,377	12	6
Paula Clarke	0-2.4	-	0-4	-	55	26	28	14
Paul Mapson	-	-	-	-	-	-	-	-
Carolyn Mills	2.5-4.9	7.5-9.9	50-54	150-154	981	859	102	51
Alex Nestor	0-2.4	-	30-34	75-79	523	481	18	9
Sean O'Kelly	0-2.4	0-2.4	65-69	200-204	1,500	1,424	20	10
Mark Smith	0-2.4	2.5-4.9	35-39	105-109	761	677	68	34
Mark Callaway	2.5-4.9	2.5-4.9	60-64	160-164	1,156	1,031	54	27
Matthew Joint	0-2.4	-	0-2.4	-	16	-	16	8

This table includes details for the directors who held office at any time in 2017/18.

Real increases and employer's contributions are shown for the time in post where this has been less than the whole year.

As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Table 24: Pension benefits for the year ending 31 March 2017

Name	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2017	Lump sum at age 60 related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2016	Real Increase in Cash Equivalent Transfer Value	Employer funded con-tribution to growth in CETV
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Robert Woolley	5.0-7.4	17.5-19.9	60-64	185-189	1,377	1,159	191	95
Owen Ainsley	0-2.4	2.5-4.9	10-14	30-34	204	164	24	12
Paula Clarke	0-2.4	-	0-4	-	26	-	26	13
Sue Donaldson	0-2.4	0-2.4	15-19	50-54	362	330	24	12
Deborah Lee	0-2.4	0-2.4	30-34	100-104	664	553	20	10
Paul Mapson	0-2.4	2.5-4.9	70-74	215-219	n/a	n/a	n/a	n/a
Carolyn Mills	2.5-4.9	12.5-14.9	45-49	140-144	859	762	80	39
Alex Nestor	2.5-4.9	2.5-4.9	30-34	75-79	481	423	35	17
Sean O'Kelly	0-2.4	2.5-4.9	65-69	190-199	1,424	1,289	105	52
Mark Smith	0-2.4	0-2.4	30-34	100-104	677	583	10	5

This table includes details for the directors who held office at any time in 2016/17.

Real increases and employer's contributions are shown for the time in post where this has been less than the whole year.

As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

Table 25: Future Policy Table

Element of pay (component)	How component supports short and long term objective/goal of the Trust	Operation of the component	Description of the framework to assess pay and performance
Basic Salary	Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a consist approach to leadership.	Individual pay is set for each Executive Director on appointment; this is by reviewing salaries of equivalent posts within the NHS. (Please note that this does not include additional payments over and above the role such as clinical duties and Clinical Excellence award. Total remuneration can be found in the remuneration tables in the Annual Report on Remuneration).	Pay is reviewed annually by the Remuneration and Nomination Committee in respect of national NHS benchmarking. In addition any Agenda for Change cost of living pay award, when agreed nationally, is considered for payment to the Executive Directors. Performance is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of the financial year.
Pension	Provides a solid basis for recruitment and retention of top leaders in the sector.	Contributions within the relevant NHS pension scheme.	Contribution rates are set by the NHS pension scheme.

Note 1: Where an individual Executive Director is paid more than £142,500, the Trust has taken steps to assure that remuneration is set at a competitive rate in relation to other similar NHS Trusts and that this rate enables the trust to attract, motivate and retain executive directors with the necessary abilities to manage and develop the Trust's activities fully for the benefits of patients.

Note 2: The components above apply generally to all Executive Directors in the table and there are no particular arrangements that are specific to an individual director.

Note 3: The Remuneration, Nominations and Appointments Committee adopts the principle of the Agenda for Change framework when considering Executive Directors pay. However, unlike Agenda for Change, there is no automatic salary progression within the salary scale.

5.3.4 Fair pay multiple

The Trust is required to disclose the relationship between the remuneration of the highest-paid director and the median remuneration of the organisation's workforce. The mid-point of the banded remuneration of the Trust's highest paid director in 2017/18 was £197,500 (2016/17, £197,500). This was 6.6 times (2016/17, 6.8 times) the median remuneration of the workforce, which was £29,839 (2016/17, £29,179). In 2017/18, no (2016/17, nil) employees received total remuneration in excess of the highest paid director. Remuneration ranged from £15,408 to £198,454, (2016/17, £15,251 to £195,501).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. This information has been subject to audit.

5.3.5 Remuneration of Non-executive Directors

The remuneration of the Chairman and Non-executive Directors is determined by the Governors' Nominations and Appointments Committee. The Committee is a formal Committee of the Council of Governors established in accordance with the NHS Act 2006, the UH Bristol Constitution, and the Monitor Foundation Trust Code of Governance and has responsibility to review the appointment, re-appointment removal, remuneration and other terms of service of the Chairman and Non-executive Directors.

Members of the Committee are appointed by the Council of Governors as set out in paragraph 9 of Annex 6 of the Trust's Constitution (Standing Orders of the Council of Governors). The membership includes eight elected public, patient or carer governors, two appointed governors, and two elected staff governors.

The Committee is chaired by the Chairman of the Trust in line with the Foundation Trust Code of Governance, and in his absence, or when the Committee is to consider matters in relation to the appraisal, appointment, re-appointment, suspension or removal of the Chairman, the Senior Independent Director.

The purpose of the Committee with regard to remuneration is to consider and make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Chairman and other Non-executive Directors, and on a regular basis, monitor the performance of the Chairman and other Non-executive Directors. In September 2017 the Committee reviewed the current remuneration of Non-Executive Directors and recommended an uplift of £1,000 per annum because there had been no increase in Non-Executive Director remuneration at UH Bristol for some years, and it had fallen behind in relation to comparable Trusts.

5.3.6 Assessment of performance

All Executive and Non-executive Directors are subject to individual performance review. This involves the setting and agreeing of objectives for a 12 month period running from 1 April to 31 March each year. During the year, regular reviews take place to discuss progress, and there is an end-of-year review to assess achievements and performance.

Executive Directors are assessed by the Chief Executive. The Chairman undertakes the performance review of the Chief Executive and Non-executive Directors. The Chairman is appraised by the Senior Independent Director and rigorous review of this process is undertaken by the Governors' Nominations and Appointments Committee chaired for this purpose by the Senior Independent Director and advised by the Trust Secretary. No element of the Executive and Non-executive Directors' remuneration was performance-related in this accounting period.

5.3.7 Expenses

Members of the Council of Governors and the Board of Directors are entitled to expenses at rates determined by the Trust. Further details relating to the expenses for members of the Council of Governors and the Board of Directors may be obtained on request to the Trust Secretary.

Table 26: Expenses paid to Governors and Directors

Year	*Directors*			*Governors*		
	No. in office	*No. reimbursed*	*Amount (£)*	*No. in office*	*No. reimbursed*	*Amount (£)*
2017/18	*22*	*14*	*33,744*	*51*	*16*	*3,293*
2016/17	*19*	*14*	*13,347*	*48*	*13*	*4,367*

5.3.8 Duration of contracts

All Executive Directors have standard substantive contracts of employment with a six-month notice provision in respect of termination. This does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the Executive Director.

5.3.9 Early termination liability

Depending on the circumstances of the early termination, the Trust would, if the termination were due to redundancy, apply the terms under Section 16 of the Agenda for Change Terms and Conditions of Service; there are no established special provisions. All other Trust employees (other than Non-executive Directors) are subject to national terms and conditions of employment and pay.

Robert Woolley
Chief Executive
24 May 2018

5.4 Staff Report

We recognise our workforce is our most valuable asset and have developed a clear Workforce and Organisational Development Strategy. Our aim is to be an employer of choice attracting, supporting and developing a workforce that is skilled, dedicated, compassionate, and engaged, so that it can continue to deliver exceptional care, teaching and research every day.

5.4.1 Analysis of staff costs

The following table analyses the Trust's staff costs, following the format required by the Trust Accounts Consolidation and distinguishes between staff with a permanent employment contract with the Trust (which excludes non-executive directors) and other staff such as bank staff, agency staff and inward secondments from other organisations where the Trust is paying the whole or the majority of their costs but the individual does not have a permanent contract of employment. This information has been subject to audit.

Table 27: Analysis of staff costs

	2017/18			2016/17		
	Total	Permanent	Other	Total	Permanent	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	313,385	288,778	24,607	298,684	277,484	21,200
Social security costs	28,595	27,501	1,094	26,859	25,999	860
Pension costs	36,851	35,809	1,042	34,631	33,770	861
Apprenticeship levy	1,505	1,505	-	-	-	-
Termination benefits	80	80	-	99	99	-
Agency/contract staff	8,863	-	8,863	11,229	-	11,229
Total Gross Staff Costs	389,279	353,673	35,606	371,502	337,352	34,150
Income in respect of salary recharges netted off expenditure	(2,730)	(2,730)	-	(2,406)	(2,406)	-
Employee expenses capitalised	(1,580)	(871)	(709)	(979)	(592)	(387)
Net employee expenses	384,969	350,072	34,897	368,117	334,354	33,763

5.4.2 Analysis of average whole time equivalent staff numbers

An analysis of the average whole time equivalent staff numbers employed by the Trust for 2017/18 and 2016/17 is shown in the table below. The information uses the categories required by the Trust Accounts Consolidation and distinguishes between staff with a permanent employment contract with the Trust and other staff such as bank staff, agency staff and inward secondments from other organisations where the Trust is paying the whole or the majority of their costs. This information has been subject to audit.

Table 28: Average staff numbers (whole time equivalents)

Staff category	2017/18			2016/17		
	Total	Permanent	Other	Total	Permanent	Other
Medical and dental	1,185	1,107	78	1,166	1,066	100
Administration and estates	1,842	1,659	183	1,721	1,588	133
Healthcare assistant and other support	831	767	64	855	801	54
Nursing, midwifery & health visitors	3,366	2,992	374	3,322	2,976	346
Scientific, therapeutic and technical	1,221	1,185	36	1,170	1,135	35
Healthcare science staff	146	145	1	142	142	-
Total staff	8,591	7,855	736	8,376	7,708	668

5.4.3 Education, Learning and Development

We are committed to high quality Education, Learning and Development to support the teaching of all staff groups including undergraduates, postgraduates, clinical and non-clinical to aid their lifelong learning and continued development.

Our vision is to 'enable our staff to deliver exceptional patient care through our excellence in education and our culture of continuous learning and development.'

As one of the UK's leading teaching hospital trusts, closely linked to academic institutions locally, nationally and worldwide, we have an extremely successful history of developing clinical skills and careers. The Trust supports a range of undergraduate and postgraduate education placements such as medical, dental, nursing and healthcare scientists, and positively encourages postgraduate study and research for nursing, Allied Health Care Professionals, Health Care Scientists, medical and dental staff. This includes active continuous professional development that include; a variety of courses, apprenticeships and programmes provided by Higher Education Institutions, together with locally run programmes such as the preceptorship programme; simulation training courses, workshops, conferences, seminars and e-Learning to keep professionals up to date with the latest clinical developments and patient safety matters.

We have been focussing on the development and implementation of a robust apprenticeship offer for both new and existing staff, aligned to the regional transformation priorities for clinical and non-clinical roles and progression pathways. The Trust is placing particular emphasis upon recruiting apprentices as new staff going into a job role. This will result in the Trust providing a wide range of training and learning opportunities for all staff, whilst also improving recruitment offer and means to retain our staff into the future. The Trust is also developing a variety of continuous professional development opportunities to encourage internal succession for staff across all disciplines.

Induction and essential training programmes remain the foundation for new starters joining the organisation with increasing efforts made to focus upon the core skills framework, which is aligned to an electronic pass-porting system across the South West of England.

We have continued to build on the excellent working partnerships with Health Education England in the Southwest including the Severn Deanery, and our local colleges and Higher Education Institutions in particular the Universities of Bristol and the West of England, and we are committed to continue working constructively with them. We continue to work closely with North Bristol NHS Trust

and other NHS organisations within the transformation education forum.

Our involvement with the Sustainability, Transformation and Partnership groups (STPs), has placed a major focus on workforce redesign to prepare staff to work across different care settings to meet patient needs and to upskill staff to support initiatives such as Making Every Contact Count, new roles, new ways of working to support improved staff flexibility and the embracing of research and innovation.

5.4.4 Equality and Diversity

The Trust provides services to the socially and ethnically diverse population of Bristol, as well as to service users from our neighbouring counties, and specialist services for the wider South West.

Each of our patients and members of staff is a unique individual with different needs and aspirations. The Trust aims to recognise and celebrate these differences by providing an environment which is inclusive for patients, carers, visitors and staff.

The Trust is fully committed to adherence to the Equality Act 2010, and undertaking action under the Public Sector Equality Duties (PSED) as defined within the Act.

These commitments are set out in the Trust's Equality, Diversity and Human Rights Policy, and underpinned by the Trust's Equality and Diversity Strategic Objectives for 2016-2019:

- To improve access to services for our local communities
- To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust
- To work towards a more inclusive and supportive working environment for all of our staff.

The Director of People is the nominated Executive lead for equality and diversity on the Board of Directors, with day to day responsibility for workforce equality and diversity issues carried out by members of the Organisational Development team.

The Equality and Diversity Group is chaired by the Head of Organisational Development, and is the Trust's key group in relation to delivering the equality and diversity objectives and ensuring that the Trust is compliant with legislative and regulatory requirements relating to equality and diversity.

The Public Sector Equality Duty is a requirement under the Equality Act 2010 and applies to public bodies and others carrying out public functions. It requires these organisations to publish information to show their compliance with the Equality Duty. The information must show that the organisation has had due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between people who share a protected characteristic and people who do not
- foster good relations between people who share a protected characteristic and people who do not share it.

The range of equalities information published by the Trust on its public website includes an annual Equality and Diversity Report, demographic information in relation to its workforce and service users, and measures to improve equality.

The Workforce Race Equality Standard (WRES) requires NHS organisations to show progress against nine measures of workforce equality, including a specific indicator of the level of black and minority ethnic representation at Board level. The Trust has now published three reports on the Standard, and progress is monitored by the Board.

5.4.5 The NHS Equality Delivery System (EDS2)

The EDS2 is a toolkit which aims to help organisation improve the services they provide for their local communities and provide better working environments for all groups. The Trust is continuing with the extensive piece of work required to grade its performance against these goals and outcomes (and to have the self-assessment commented on by internal and external stakeholders).

Findings from the National Staff Survey and Care Quality Commission scheduled inspections are helpful in contributing to the evidence to support delivery of the WRES and EDS2. Both the WRES and EDS2 are included in the 2018/2019 Standard NHS Contract, which also requires NHS Trusts and Foundation Trusts to publish Workforce Disability Equality Standard (WDES) information for the first time in August 2019.

5.4.6 Gender Pay Gap Reporting

The gender pay gap is a measure of the difference between the average earnings of men and women. Public sector organisations are required to publish and report specific figures about their gender pay gap to show the pay gap between their male and female employees each year. The Trust's Gender Pay Gap report is available on its website and has been reported on the Government's Gender Pay Gap reporting portal as required.

5.4.7 Training and the Equality Act

Equality, Diversity and Human Rights is one of the subjects included in the UK NHS Core Skills Framework. Basic information is included in the Trust Living the Values training, delivered as part of Trust Induction and as bespoke sessions. All staff are expected to complete Equality, Diversity & Human Rights training as part of their three-yearly Essential Training update. This can be achieved through on-line or face-to-face training. The session provides basic information as well as more detail about the Equality Act, the Public Sector Equality Duty, and how the Trust fulfils its obligations.

5.4.8 Equality and diversity in the workplace

Delivery of the Trust's Equality and Diversity objectives relating to gaining employment with and progressing within the Trust, and providing an inclusive and supportive working environment for all of our staff is key to improving staff experience in the workplace.

The experiences of staff from different demographic groups are indicated by the responses to the National Staff Survey and the Workforce Race Equality Standard. This information is provided in the Trust's Equality and Diversity Annual Report and the WRES Report, available on the Trust's website and updated in July of each year.

The Trust's recruitment procedures and Policy reflect the requirement to advance equality of opportunity, and include a commitment to interview all applicants with a disability who meet the minimum criteria for a job vacancy.

The Trust has been accredited as a Disability Confident Employer, and is a Mindful Employer signatory – an initiative which provides employers with access to information, support and training relating to staff who experience mental ill health.

The Trust's Supporting Attendance Policy includes guidance on the Trust's duty to provide reasonable workplace adjustments to support the continuing employment of staff who have become disabled.

The Trust has three Staff Forums which meet regularly where staff can share experiences, ideas and support:

- Black, Asian and Minority Ethnic Workers Forum
- Living and Working with Disability, Illness or Impairment Forum
- Lesbian, Gay, Bisexual and Transgender Forum.

All three groups are represented on the Trust's Equality and Diversity Group and are integral to its work.

5.4.9 Analysis of staff diversity profile

The Trust's annual statutory monitoring of workforce and patient data reflects information as at 31 March 2018. Some of the key workforce data is given in the tables below. This data applies to staff with a permanent employment contract with the Trust.

Table 29: Staff with permanent contract	**March 2018**	
Gender – All staff with a permanent employment contract	**Total**	**%**
Male	2,124	22.66%
Female	7,251	77.34%
TOTAL	9,375	100.00%

Table 30: Directors by gender	**March 2018**	
Gender – Directors (Executive and non-Executive)	**Total**	**%**
Male	11	73.33%
Female	4	26.67%
TOTAL	15	100.00%

Table 31: Senior Managers by gender	**March 2018**	
Gender – Other Senior Managers *	**Total**	**%**
Male	6	37.50%
Female	10	62.50%
TOTAL	16	100.00%

For the purposes of the Staff section of the report, Senior Managers are defined as Divisional Directors, Clinical Chairs and Heads of Nursing for the Trust's Divisions

Table 32: Ethnicity

	March 2018	
Ethnicity	**Total**	**%**
A - White - British	6,902	73.62%
B - White - Irish	117	1.25%
C - White - Any other White background	790	8.43%
D - Mixed - White & Black Caribbean	41	0.44%
E - Mixed - White & Black African	19	0.20%
F - Mixed - White & Asian	37	0.39%
G - Mixed - Any other mixed background	58	0.62%

	March 2018	
Ethnicity	**Total**	**%**
H - Asian or Asian British - Indian	347	3.70%
J - Asian or Asian British - Pakistani	31	0.33%
K - Asian or Asian British - Bangladeshi	7	0.07%
L - Asian or Asian British - Any other Asian background	129	1.38%
M - Black or Black British - Caribbean	160	1.71%
N - Black or Black British - African	244	2.60%
P - Black or Black British - Any other Black background	86	0.92%
R - Chinese	44	0.47%
S - Any Other Ethnic Group	194	2.07%
Z - Not Stated	169	1.80%
TOTAL	9,375	100.00%

Table 33 : Disability	**March 2018**	
Disability	**Total**	**%**
No	8,721	93.02%
Not Declared	401	4.28%
Yes	253	2.70%
Total	9,375	100.00%

Table 34: Age profile	**March 2018**	
Age profile	**Total**	**%**
16 – 20	95	1.01%
21 – 25	814	8.68%
26 – 30	1,476	15.74%
31 – 35	1,360	14.51%
36 – 40	1,237	13.19%
41 - 45	1,034	11.03%
46 – 50	988	10.54%
51 – 55	1,071	11.42%
56 – 60	797	8.50%

Age profile	March 2018	
61 – 65	400	4.27%
66 – 70	77	0.82%
71 - 75	24	0.26%
76-80	2	0.02%
Total	9,375	100.00%

Table 35: Religious belief	March 2018	
Religious belief	**Total**	**%**
Atheism	1,332	14.21%
Buddhism	51	0.54%
Christianity	3,611	38.52%
Hinduism	94	1.00%
Islam	187	1.99%
Jainism	3	0.03%
Judaism	9	0.10%
Sikhism	20	0.21%
Other	615	6.56%
I do not wish to disclose my religion/belief	3,385	36.11%
Undefined	68	0.73%
Total	9,375	100.00%

Table 36: Sexual orientation	March 2018	
Sexual orientation	**Total**	**%**
Bisexual	52	0.55%
Gay	74	0.79%
Heterosexual	6,508	69.42%
Lesbian	42	0.45%
I do not wish to disclose my sexual orientation	2,631	28.06%
Undefined	68	0.73%
TOTAL	9,375	100.00%

5.4.10 Occupational Health and Safety and Wellbeing

The Trust hosts Avon Partnership NHS Occupational Health Service (APOHS) which provides an integrated occupational health service with the objective of making a positive impact on sickness absence through both healthy working environments and healthy management styles. The service works proactively, through consensus and evidence based practice, to enable staff to achieve and maintain their full employment potential within a safe working environment, thus enhancing the quality of their working lives. These services include: new employee surveillance; immunisations; Health at Work Advice and referrals; ill health referrals; and health and wellbeing support.

During the year APOHS has provided additional capacity to support staff with emotional issues, which has dramatically reduced waiting times for counselling. In addition the self-help tools on the APOHS website have increased and provided emotional resilience building workshops which have supported many groups of staff to avoid problems.

APOHS has also continued the moved to providing on-line support to staff and managers via its web portal, reducing the time to clear new staff for work. Also, reducing the time it takes for a manager to receive advice following a referral.

5.4.11 A safe and healthy working environment

The overall strategy for health and safety in the Trust complies with the Health and Safety Executive guidance document number HSG65: Managing for Health and Safety and the NHS Staff Council, Workplace health and safety standards, which are implemented in full as the healthcare models for safety management systems. These models include the domains of health, safety, welfare and wellbeing and are based upon continuous improvement.

Health and safety risk assessments, safe systems of work, practices and processes are managed at ward and department level to ensure that all key risks to compliance with legislation have been identified and addressed. This includes physical and psychological hazards as well as the broader environmental risk assessments.

Health and safety is integral to the Trust's Risk Management Strategy, from which the five-year Health and Safety Action Plan 2013 – 2018 was developed. Progress against this is subject to annual review via an independent auditor – The British Safety Council. This is monitored at Trust Health and Safety/Fire Safety Committee with summary reports to the Risk Management Group. This year the Trust retained a five star (excellent) rating out of a possible five stars for a third consecutive year.

In addition there is the annually reviewed risk management training matrix which identifies requirements beyond the essential health and safety training in place for all staff. For example, health and safety for executives /senior managers and mandatory departmental risk assessors.

The annually reviewed risk management training prospectus includes all risk management training programmes. This is monitored by the Trust Health and Safety/ Fire Safety Committee for compliance each quarter.

Expertise within the Manual Handling Team has enabled the trust to access the most up to date knowledge and skills to reduce the risk of musculoskeletal disorders to the workforce and deliver efficient service improvement.

The Trust has part achieved the NHS England Commissioning for Quality and Innovation (CQUIN) 2017/18 for Staff Health and Wellbeing. This concerns frontline worker uptake of the seasonal flu vaccination programme and improvement of responses to three identified wellbeing questions set out in the annual NHS Staff Survey. Formal assessment of our provision towards a healthy food and drink CQUIN is to be announced later this year.

The Trust continues to deliver established and successful initiatives, as well as new opportunities that facilitate and improve the wellbeing of the workforce which, in turn, delivers excellent quality care to our service users.

The Workplace Wellbeing agenda has become an integral part of the Trusts support system and networks for colleagues, complementing its Health and Safety and Occupational Health Services.

We have developed a three-year Workplace Wellbeing Strategy which retains a strategic focus on psychological health and prevention of musculoskeletal disorders.

5.4.12 Sickness absence

The table below shows average sickness for 2017/18.

Table 37: Average sickness for 2017/18

Figures converted by DHSC to Best Estimates of Required Data Items		Statistics published by NHS Digital from ESR Data Warehouse		
Average FTE 2017	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
8002	72,987	9.1	2,920,863	118,400

5.4.13 Expenditure on consultancy

Consultancy is defined as the provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the business as usual environment. For 2017/18 the Trust's expenditure on consultancy was £0.373m (2016/17: £0.615m).

5.4.14 Off payroll payments

Individuals can only be paid via invoice provided the Trust's 'engaging workers off payroll' procedure has been followed. All engagements falling within the scope of IR35 require invoices to be paid via the payroll system and are therefore subject to PAYE. The procedure ensures that the appropriate employment checks have been made, an agreement detailing the terms of engagement has been issued and all HMRC and other statutory regulations have been met.

The Trust makes use of highly paid 'off payroll' arrangements only in exceptional circumstances. For instance, where there is a requirement for short term specialist project management experience which cannot be filled within the existing workforce because of capacity or in-house knowledge and experience. Where an executive director post becomes vacant, the Trust Board looks to put in place an 'acting-up' arrangement, but may select an interim manager to provide cover pending recruitment.

The following tables provide information for 2017/18 regarding off-payroll engagements entered into at a cost of more than £245 per day that last for longer than six months, and any off-payroll engagements of board members and/or senior officials with significant financial responsibility.

Table 38: All off-payroll engagements as of 31 March 2017, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2018	-
Of which…	
Number that have existed for less than one year at time of reporting	-
Number that have existed for between one and two years at time of reporting	-
Number that have existed for between two and three years at time of reporting	-
Number that have existed for between three and four years at time of reporting	-
Number that have existed for four or more years at time of reporting	-

Table 39: All new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that have reached six months in duration, between 1 April 2017 and 31 March 2018.	1
Of which…	
Number assessed as within the scope of IR35	-
Number assessed as not within the scope of IR35	1
Number engaged directly (via PSC contracted to the Trust) and are on the Trust's payroll	-
Number of engagements reassessed for consistency/assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	-

Table 40: Any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	-
Number of individuals that have been deemed 'board members, and/or, senior officials with significant financial responsibility' during the financial year. The figure includes both off-payroll and on-payroll engagements	37

5.4.15 Exit packages

The table below shows the number and cost of staff exit packages (termination benefits) in 2017/18. Termination benefits are payable to an employee when the Trust terminates their employment before their normal retirement date, or when an employee accepts voluntary redundancy in exchange for these benefits. Comparative figures for 2016/17 are shown in brackets. This information has been subject to audit.

Table 41: Exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	- (-)	8 (-)	8 (-)
£10,000 - £25,000	1 (-)	2 (-)	3 (-)
£25,001 - £50,000	- (1)	- (-)	- (1)
£50,000 - £75,000	- (1)	- (-)	- (1)
Over £75,000	- (-)	- (-)	- (-)
Total number of exit packages by type	**1 (2)**	**10 (-)**	**11 (2)**
Total cost (£'000)	20 (99)	60 (-)	80 (99)

An analysis of the non-compulsory departures agreed, which has been subject to audit, is as follows:

Table 42: Analysis of non-compulsory departures

	2017/18		2016/17	
	No.	£'000	No.	£'000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignation contractual costs (MARS)	-	-	-	-
Contractual payments in lieu of notice	7	47	-	-
Non-contractual payments requiring HMT approval	3	13	-	-
Total	10	60	**-**	**-**

For a statement of the Accounting Officer's responsibilities, see section 5.6

5.4.16 Engaging with staff

The Trust is transforming the care it delivers, building health care services which are driven by quality and excellence. This requires a set of common Trust values and leadership behaviours which are transparent across the Trust. The Trust values act as a vital guide to what is important and how we are expected to behave towards patients, relatives, carers, visitors and each other.

The values and leadership behaviours are embedded at recruitment and induction stages and within all subsequent leadership and management development programmes.

The design of the leadership and management development programmes builds on the foundation of the values and leadership behaviours to ensure our leadership agenda supports leaders to use the platform to influence real cultural change within their areas for the benefit of their teams and the patients.

The Trust values the role and contribution both Trade Unions and Professional Associations make in supporting and representing the Trust's workforce; and their active participation in partnership working across the Trust. Regular consultation with staff takes place through both informal and formal groups, including the Partnership Forum, Policy Group and the Local Negotiating Committee (for medical and dental staff). Staff and management representatives consult on change programmes, terms and conditions of employment, policy development, pay assurance and strategic issues, thereby ensuring that workforce issues are proactively addressed. The Trust also has a cohort of staff governors who work closely with Board of Directors on behalf of their staff constituents to ensure that the Board remains focussed on staff issues on the frontline.

5.4.17 NHS staff survey

The Trust takes part in the Annual National Staff Survey and subsequently develops action plans to improve staff experience. The response rate to the National Staff Survey was 43 per cent.

The 2017 staff survey overall engagement score has improved consecutively for the fourth year. The results indicate that staff continue to feel more engaged and this is demonstrated by their ability to feel that they are able to contribute to improvements at work. On the whole staff feel the Trust is a great place to work and receive treatment, and communication continues to improve between senior management and staff. The majority of staff in the Trust feel they have the opportunity to progress and that they are able to continue to develop their skills through our training opportunities, and this is delivered through the continued improvement in quality of appraisal.

However, staff have identified that we still have areas that require improvement if we are to achieve our ambition of being one of the best teaching hospitals to work for.

The Trust's top five ranking scores (the five key findings where UH Bristol compared most favourably with other acute Trusts in England), and the Trust's bottom five ranking scores (the five key findings where UH Bristol compared least favourably with other acute Trusts in England) are shown in the following table:

Table 43: Top five ranking scores

	2017		2016		
Top five ranking scores	Trust	National Average for Acute Trusts	Trust	National Average for Acute Trusts	Trust Improvement/ Deterioration since 2016
% of staff reporting errors near misses or incidents witnessed in the last month *(the higher the score the better)*	92%	90%	92%	90%	Remains the same year on year
Staff recommendation of the organisation as a place to work or receive treatment *(the higher the score the better)*	3.95	3.75	3.90	3.76	Increase (improvement) of 0.05
% of staff believing the Organisation provides equal opportunities for career progression or promotion *(the higher the score the better)*	88%	85%	89%	87%	Decrease of 1%
Fairness and effectiveness of procedures for reporting errors near misses and incidents *(the higher the score the better)*	3.78	3.73	3.75	3.72	Increase (improvement) of 0.03
% of staff able to contribute towards improvement at work *(the higher the score the better)*	71%	70%	71%	70%	Remains the same year on year

Table 44: Bottom five scores

	2017		2016		
Bottom five ranking scores	Trust	National Average for Acute Trusts	Trust	National Average for Acute Trusts	Trust Improvement/ Deterioration since 2016
Quality of non-mandatory training learning or development (the higher the score the better)	3.99	4.05	4.03	4.05	Decrease of 0.04
% of staff appraised in the last 12 months (the higher the score the better)	79%	86%	85%	87%	Decrease of 6%
Staff motivation at work (the higher the score the better)	3.87	3.92	3.88	3.94	Decrease of 0.01
% of staff satisfied with the opportunities for flexible working patterns (the higher the score the better)	49%	51%	49%	51%	No overall change
% of staff witnessing potentially harmful errors, near misses or incidents in the last month (the lower the score the better)	32%	31%	32%	31%	No overall change

5.4.18 Key areas for improvement

The Trust recognises that it needs to continuously engage and listen to its workforce and seeks to respond to all suggested areas for improvement. We continue to look at ways of improving staff motivation through our extensive improving staff experience programme and in particular build on the work we have done on communication between managers and their teams. This work has been directed both corporately by the Senior Leadership Team and locally by divisional management teams.

During 2017 we implemented the Leadership Behaviours across the organisation which sets out leadership expectations supporting the organisational values; we also implemented a recognition framework to ensure equity of staff experience across the organisation and at a local level. The introduction of robust improving staff Experience plans focussed at Divisional level has supported our agenda for developing local and meaningful engagement interventions to influence positive cultural change.

Our priorities for 2018 will include embedding and development of the next phase of new E-Appraisal process to include 360 degree feedback and the leadership behaviours, a review of our leadership programmes and, in particular, the delivery of a bespoke programme for our top 100 leaders in the organisation. In terms of recognition we will launch a long service badge at our 70th NHS Birthday celebrations which will complement our recognition framework commitment.

5.4.19 Staff consultations

The Trust is committed to innovation and continuous improvement in order to deliver responsive and accessible services which deliver excellent patient care. As part of the continuous improvement journey the Trust embraces technological innovation, new ways of working and system and pathway redesign and development.

The Trust undertakes many change projects throughout the year, including skill mix/role redesign and internal transfers of service. Some of the bigger examples of change management consultations are as follows:

- A review and reconfiguration of catering services across the Trust in order to deliver a more efficient and effective service to patients
- Standardisation of a number of administrative job descriptions across the Trust, with benefits including greater clarity for staff and patients, and saving time in recruitment processes
- Divisional Management team restructures to provide better managerial coverage and improved divisional governance
- Continuing implementation of the electronic document management system as part of an ongoing digitisation programme
- Managing change projects positively, supportively and through partnership working is seen as fundamental to the sustained delivery of responsive services, engaged and motivated staff and excellent patient care
- Implementation of the Junior Doctors Contract (2016) which necessitated a complete review of all junior medical rotas and terms and conditions. A project group managed implementation which ensured there was collaboration with Divisional colleagues, junior doctors and the BMA enabling a successful implementation. The project group continues to monitor the impact of the contract and develop strategies to support safe staffing whilst protecting the quality of education and raising the morale of doctors in training.

5.4.20 Staff policies and actions applied during the financial year

This year the Trust undertook a major review of the Supporting Attendance Policy, in order to better reflect our aims of positively supporting staff health and wellbeing. In May 2017 the Trust introduced a Probationary Policy to ensure that all new members of staff get the level of support that is right for them when joining the Trust. All our policies are regularly reviewed to ensure that they

meet with best practice standards and legislation, and with our corporate objectives.

5.4.21 Tackling Harassment and Bullying

The Board is committed to ensuring a more inclusive and supportive working environment for all of our staff. This includes providing an environment free from harassment, bullying, discrimination or abuse from colleagues or service users.

All members of staff have the right to be treated with consideration, dignity and respect, and have a responsibility to set a positive example by treating others with respect and to act in a way which is in line with the Trust's Values.

The Trust's Dignity at Work Policy emphasises the positive behaviours expected of all of its staff. It provides a framework which seeks to ensure that all complaints are addressed in a fair and consistent way, encouraging informal resolution where possible, and ensuring protection against victimisation and discrimination.

The Trust has a confidential harassment and bullying advisory service which is available to all members of staff. Advisors have been trained to support staff and are available to listen to issues, talk through problems, and explain the options available to any member of staff who believes they have been subjected to or witnessed harassment or bullying in the workplace, or have been accused of harassment and/or bullying.

Medical trainees also have access to a mentor who can give advice and offer support on any issues, including harassment and bullying, which may have an adverse effect on their experience at work.

5.4.22 Trade Union facility time reporting

The Trade Union (Facility Time Publication Requirements) Regulations 2017 put into effect the provision in the Trade Union Act 2016 whereby certain public sector employers will be expected to report annually on use of facility time provided to trade union officials. The first deadline for publication is 31 July 2018.

As a public sector employer with more than 49 employees, UH Bristol is subject to these regulations.

Facility time covers duties carried out for the trade union or as a union learning representative, e.g. accompanying an employee to disciplinary or grievance hearing. It will also cover training received and duties carried out under the Health and Safety at Work Act 1974. The regulations require the following information to be published:

- the number of employees who were relevant union officials during the relevant period, and the number of full time equivalent employees
- the percentage of time spent on facility time for each relevant union official
- the percentage of pay bill spent on facility time
- the number of hours spent by relevant union officials on paid trade union activities as a percentage of total paid facility time hours.

Table 45: Relevant union officials

Number of employees who were relevant union officials during 2017/18	Full-time equivalent employee number
49	8120

Table 46: Percentage of time spent on facility time

Percentage of time	No of employees
0%	-
1-50%	45
51%-99%	-
100%	4

Table 47: Percentage of pay bill spent on facility time

The total cost of facility time	£137,942
The total pay bill	£385,196,000
The percentage of the total pay bill spent on facility time	0.036%

Table 48: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours	100%

5.4.23 Freedom to Speak Up

The Trust has fully implemented the national requirements as recommended by Sir Robert Francis in his Freedom to Speak Up review. The Trust has appointed the Trust Secretary as the Freedom to Speak Up Guardian, and has approved a Freedom to Speak Up Policy which provides a framework of support for members of staff who wish to raise concerns. The Guardian is supported by a number of Freedom to Speak Up Advocates who operate across the Trust and are accessible to all staff. The Trust is compliant with the requirements as set out by the National Freedom to Speak Up Guardian and ensure that all training and quarterly returns are achieved.

An annual report on issues and learning from the Freedom to Speak Up process is presented to the Board by the Guardian. In summary for 2017/18 there were 13 referrals to the Freedom to Speak Up Guardian, all of which were investigated and responses provided to the individual's raising the concerns. Where possible learning to ensure issues were not repeated were identified and shared. The issues raised related to a range of concerns which included attitude and behaviour of staff, staffing issues, and application of Trust policy.

Further actions are planned during 2018/19 to ensure that a positive speaking up culture is maintained and developed. The Trust has worked with its charity, Above and Beyond, to produce and circulate publicity materials to promote the Freedom to Speak Up Guardian and Advocate roles and the key messages about Speaking Up. There is enhanced information in the Trust induction for all staff, and the Trust is planning to increase the number of Advocates who are locally accessible to staff. The Guardian is also ensuring that he is visible across the Trust by attending key meetings and talking to staff groups to promote the messages.

5.5 NHS Foundation Trust Code of Governance

As a public benefit corporation UH Bristol is required either to 'comply' with the practices set out in the NHS Foundation Trust Code of Governance or to 'explain' what suitable alternative arrangements it has in place for the governance of the Trust. UH Bristol has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The Board considers that it was fully compliant with the provisions of the Code in 2017/18, with the exception of paragraph A.5.12. Governors of UH Bristol are not provided with copies of the minutes of private Board meetings due to the confidential nature of business, however, are provided with a summary of discussion of business at Board meetings held in public and meetings of the Council of Governors, where appropriate. Compliance with the Mandatory Disclosures is available from the Trust Secretary.

The Board is committed to the highest standards of good corporate governance and follows an approach that complies with this Code through the arrangements that it puts in place for our governance structures, policies and processes and how it will keep them under review. These arrangements are set out in documents that include:

- The Constitution of the Trust
- Standing orders
- Standing financial instructions
- Schemes of delegation and decisions reserved to the Board
- Terms of reference for the board of directors, the Council of Governors and their committees
- Role descriptions
- Codes of conduct for staff, directors and governors
- Annual declarations of interest
- Annual Governance Statement.

All of the Non-executive Directors are considered to be independent in character and in judgement. The Executive Directors are appointed on a substantive basis and all Directors undertake an annual appraisal process to ensure that the board remains focussed on the patient and delivering safe, high quality, patient centred care. Additional assurance of independence and commitment for those Non-executive Directors serving longer than six years is achieved via a rigorous annual appraisal and review process in line with the recommendations outlined in the Code. A report of the Governors' Nomination and Appointments Committee is detailed further in this report. The composition of the Board over the year is set out in table 14.

The Board is accountable to stakeholders for the achievement of sustainable performance and the creation of stakeholder value through development and delivery of the Trust's long term vision, mission and strategy. The Board ensures that adequate systems and processes are maintained to deliver the Trust's annual plan, deliver safe, high quality healthcare, measure and monitor the Trust's effectiveness and efficiency as well as seeking continuous improvement and innovation. The Board delegates some of its powers to a committee of Directors or to an Executive Director and these matters are set out in the trust's scheme of delegation. Decision making for the operational running of the Trust is delegated to the executive management team.

There are specific responsibilities reserved by the entire Board, which includes approval of the Trust's long term objectives and financial strategy; annual operating and capital budgets; changes to the Trust's senior management structure; the Board's overall 'risk appetite'; the Trust's financial results and any significant changes to accounting practices or policies; changes to the Trust's capital and estate structure; and conducting an annual review of the effectiveness of internal control arrangements.

5.5.1 Board Performance

Boards of NHS Foundation Trusts have faced significant challenges, financial and operational, in 2017/18. Good governance is essential if we are to continue providing safe, sustainable and high quality care for patients.

The Board has been through a period of change in 2017/18 with the appointment of a

new Chairman, Jeff Farrar, and two new Non-executive Directors (Designate) as part of our succession planning for NEDs. These individuals received a thorough induction into the organisation and will receive ongoing training as part of the wider Board development programme.

The Board monitors performance of the organisation against the NHS Improvement Single Oversight Framework with the focus on four key areas of performance: A&E four hours, 62-day GP cancer, Referral to Treatment (RTT) times and six week diagnostic waits. The Board does this, plus review of quality and workforce information, via review of the Quality & Performance Report.

The Board has undertaken a significant amount of work over the past year to improve its approach to governance. This involved strengthening the reporting into the Board and Committees, taking action on sub-standard performance and driving continuous improvement, ensuring delivery of best-practice, and identifying and managing risks to quality of care.

The Trust has approved a policy for Fit and Proper Persons and as part of this policy, retrospective checks have been completed for all Directors. Appropriate checks are cross-referenced with the Disqualified Directors Register on the Companies House website on an annual basis. It can be confirmed that as at the date of this report, none of the above mentioned Directors appeared on the Disqualified Directors' Register.

5.5.2 Performance of the Board and Board Committees

The Board of Directors undertakes regular assessments of its performance to establish whether it has adequately and effectively discharged its role, functions and duties during the preceding period.

Throughout the year, the Board adhered to a comprehensive cycle of reporting, to ensure that it focused on the key strategic issues and to ensure that it met good practice principles. In addition the Board met outside of the formal meetings in seminar format to undertake development activities including helping to shape decisions prior to formal decision making, understanding changes in local, regional and national context and to undertake joint learning around new or complex topics.

The findings of Internal Audit combined with the Head of Internal Audit Opinion set out in the Annual Governance Statement support the Board's conclusions as to the efficacy of their performance.

In addition the Board expects each of its Committees to undertake a review of their performance and report this to the Board alongside any proposed changes to the Terms of Reference. These reviews were undertake during the year.

5.5.3 Qualification, appointment and removal of Non-executive Directors

Non-executive Directors and the Chair of the Trust are appointed by the Governors at a general meeting of the Council of Governors. The recruitment, selection and interviewing of candidates is overseen by the Governors' Nominations and Appointments Committee which also makes recommendation to the Council of Governors for the appointment of successful candidates. The Foundation Trust Constitution requires that Non-executive Directors are members of the public or patient constituencies. Removal of the Chair or any other Non-executive Director is subject to the approval of three-quarters of the members of the Council of Governors.

5.5.4 Committees of the Board of Directors

The Board has established the two statutory committees required by the NHS Act 2006 and the Foundation Trust Constitution. The Directors Remuneration, Nominations and Appointments Committee and the Audit Committee each discharge the duties set out in the Foundation Trust Constitution and their Terms of Reference as set out below.

The Board has chosen to deploy two additional designated committees to augment its monitoring, scrutiny, and oversight functions, particularly with respect to quality and outcomes and financial management. These are the Quality and Outcomes Committee and the Finance Committee. The role, functions and summary activities of the Board's committees are described below.

Table 49: Board and Sub-Committee Attendance 2017/18

The Board of Directors discharged its duties during 2017/18 in ten private and public meetings, and through the work of its committees. The table below shows the membership and attendance of Directors at meetings of the Board of Directors and Board committees. A figure of zero (0) indicates that the individual was not a member and 'C' denotes the Chair of the Board or committee.

	Board of Directors	Remuneration & Nomination Committee	Audit Committee	Quality & Outcomes Committee	Finance Committee
No. of meetings	10	6	5	12	11
Chairman					
Jeff Farrar	3 (C3)	2	1	4	4
John Savage	7 (C7)	2	(0)	5	6
Chief Executive					
Robert Woolley	10	5	5	(0)	10
Non-executive Directors					
David Armstrong	8	3	2	7	7
Madhu Bhabuta	6	(0)	(0)	2	(0)
Julian Dennis	9	5	5	12 (C12)	9
Lisa Gardner	6	1	2	(0)	6 (C6)
John Moore	6	2	5 (C5)	(0)	(0)
Anthony (Guy) Orpen	5	0	(0)	(0)	(0)
Alison Ryan	4	1	3	4	(0)
Martin Sykes	6	3	2	2	7 (C5)
Steven West	4	1	(0)	2	(0)
Emma Woollett	7	5 (C5)	3	4	4
Jill Youds	8	5 (C1)	2	9	7
Executive Directors					
Mark Callaway	7	(0)	(0)	6	(0)
Paula Clarke	7	(0)	(0)	(0)	(0)
Matthew Joint	6	4	1	6	3
Paul Mapson	9	(0)	5	(0)	10
Carolyn Mills	10	(0)	(0)	11	(0)
Alex Nestor	4	2	(0)	5	2

Sean O'Kelly	3	(0)	1	3	(0)
Mark Smith	10	(0)	(0)	12	11

5.5.5 Remuneration and Nomination and Appointments Committees

The purpose of the Directors' Nominations and Appointments Committee is to conduct the formal appointment to, and removal from office, of Executive Directors of the Trust, other than the Chief Executive (who is appointed or removed by the Non-executive Directors subject to approval by the Council of Governors). The committee also gives consideration to succession planning for Executive Directors, taking into account the challenges and opportunities facing the Trust, and the skills and expertise that will be needed on the Board of Directors in the future.

The Committee is chaired by the Vice-Chair and Senior Independent Director and is attended by all Non-executive Directors. The Committee is attended by the Chief Executive and Director of People in an advisory capacity when appropriate, and is supported by the Trust Secretary to ensure it undertakes its duties in accordance with applicable regulation, policy and guidance.

The committee met on six occasions in the reporting period to consider the annual review of Executive Director's performance, objectives for 2017/18, current remuneration levels, appointment of the Medical Director, and the review of the Fit and Proper Persons Policy

The Remuneration Committee carried out an annual review of Executive Director remuneration which took into account national guidance and market benchmarking analysis as well as size of portfolios and performance and considered whether any adjustments need to be made to the current remuneration arrangements.

The Committee also took an opportunity to review the Executive Director portfolios supported by a comprehensive assessment of individual performance review of individual members of the Executive team. The Chairman provided a review of the performance of the Chief Executive as part of this process.

The Committee has begun to discuss the overlap of responsibilities and duties of both the Remuneration Committee and Directors' Nomination and Appointments Committee with regard to Board succession and the need for close alignment in the future.

5.5.6 Audit Committee

The primary purpose of the Audit Committee is to provide oversight and scrutiny of the Trust's governance, risk management, internal financial control and all other control processes, including those related to quality and performance. These controls underpin the Trust's Assurance Framework so as to ensure its overall adequacy, robustness and effectiveness. This addresses risks and controls that affect all aspects of the Trust's day to day activity and reporting.

Additional oversight and scrutiny, in particular relating to quality and patient care performance is also provided through the Quality and Outcomes Committee and Finance Committee and information is triangulated from all three forums to ensure appropriate oversight and assurance can be provided to the Board in line with the Committee's delegated authority. The day to day performance management of the Trust's activity, risks and controls is however the responsibility of the Trust's Executive.

The Audit Committee is comprised of not less than four Non-executive Directors and is chaired by a Non-executive Director who is considered to have recent and relevant financial experience. The committee met on five occasions during the year with the Chief Executive, Chief Operating Officer/Deputy Chief Executive, other Trust Officers and the Internal and External Auditors in attendance. The Chair of the committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

The Committee reviews the effectiveness of systems of governance, risk management

and internal control across the whole of the Trust's activities, and is responsible for providing the Board with assurance on how these activities are implemented, the adequacy of Audit plans and performance against these and the committee's review of accounting policies and the annual accounts.

Three Non-executive Directors also serve on the Quality and Outcomes Committee or Finance Committee as well as the Audit Committee to allow for triangulation of related intelligence when considering processes and outcomes. Terms of Reference of all Board committees are published in the public domain.

During 2017/18, the Audit Committee reviewed the Annual Report and Accounts including the Annual Governance Statement together with the Head of Internal Audit statement and External Audit opinion.

The Trust reappointed Price Waterhouse Coopers (PwC) as External Auditors in April 2017. In order to ensure that the independence and objectivity of the External Auditor is not compromised, the Trust has in place a policy that requires the Committee to approve the arrangements for all proposals to engage the External Auditors on non-audit work. The External Auditors did not undertake any non-audit work during the period. PwC has also provided a statement of the perceived threats to independence and a description of the safeguards in place.

Both at the date of presenting the audit plan and at the conclusion of their audit, PwC confirmed that in its professional judgement, they are independent accountants with respect to the Trust; within the meaning of UK regulatory and professional requirements and that the objectivity of the audit team is not impaired. Together with the safeguards provided by PwC, the Audit Committee accepts these as reasonable assurances of continued independence and objectivity in the audit services provided by PwC within the meaning of the UK regulatory and professional requirements.

During the year the external audit service was tendered and PwC were reappointed for a three year term. The process to appoint the external auditors involved a small working group of the Governors and the appointment was approved by the Council of Governors on 28 April 2017.

The Trust's Internal Audit and Counter Fraud function is provided by Audit South West through a consortia arrangement. The Audit Committee agreed the Strategic Audit Plan and received regular reports throughout the year to assist in evaluating and continually improving the effectiveness of risk management and internal control processes in the trust.

The committee sought reports and assurances from Directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. Notably, the committee received assurance with regard to risk management and Trust wide systems and processes relating to the procurement service.

Additionally during the year, the Audit Committee continued to review the Clinical Audit function and its increased focus on improved patient outcomes and research.

5.5.7 Audit Committee Chair's opinion and report

In support of the Chief Executive's responsibilities as Accountable Officer for the Trust, the Audit Committee has examined the adequacy of systems of governance, risk management and internal control within the Trust. From information supplied, the Committee has formed the opinion that there is a generally adequate framework of control in place to provide reasonable assurance of the achievement of objectives and management of risk.

Assurances received are sufficiently accurate, reliable and comprehensive to meet the Accountable Officer's needs. Provision of reasonable assurance and governance, risk management and internal control arrangements within the Trust includes aspects of excellence and there is on-going attention to control improvement where these are considered suitable. Further detail on the Trust's systems of internal control is provided in the Annual Governance Statement.

Financial controls are adequate to provide reasonable assurance against material misstatement or loss, and the quality of both

Internal Audit and External Audit over the past year has been satisfactory.

The Committee received assurance that the Internal Audit function remained adequate by reviewing and approving the Internal Audit and Counter Fraud strategy and ensuring that it remained consistent with the audit needs of the Trust and also took into consideration the content of the Board Assurance Framework. The Committee also received the Internal Audit and Counter Fraud Annual Report which provided assurance of the service delivered throughout the year. Both the Internal Audit Team and External Auditors have unrestricted access to the Chair of the Audit committee.

The Committee received regular Internal Audit progress reports which highlighted progress against Internal Audit recommendations from all reports carried out during the period and the Committee received periodic updates from the Chief Executive on areas where slippage against target dates had occurred.

With regard to specific areas of concern and high risk, the Committee has taken an opportunity during the past year to establish stronger controls to ensure that high risks are managed and addressed appropriately throughout the organisation. Regular reports are delivered to the Trust's Senior Leadership Team, chaired by the Chief Executive, to highlight slippage against the milestones for implementation of recommendations from Internal Audit reports. This has strengthened the ability to hold individuals to account and allow the Audit Committee increased sightedness on issues at divisional and operational level.

In summary, the Audit Committee has acknowledged the work of the executive particularly in a year of operational and financial challenge and the Committee has been encouraged by the drive and ambition to provide high quality care. The Committee will continue to support the Trust to ensure that systems of internal control and risk management both support and encourage this ambition through collaborative working with Internal and External Audit colleagues.

5.5.8 Quality and Outcomes Committee

The Quality and Outcomes Committee was established by the Board of Directors to support the Board in discharging its responsibilities for monitoring the quality and performance of the Trust's clinical services and patient experience. This includes the fundamental standards of care (as determined by Care Quality Commission), national targets and indicators and patient reported experience and serious incidents. The Committee is attended by three Non-executive Directors, one of whom is the Chair, and by the Chief Nurse, Medical Director, Chief Operating Officer and Director of People. The Committee is also supported by the Trust Secretary or Deputy Trust Secretary in an advisory role.

The committee reviews the outcomes associated with clinical services and patient experience and the suitability and implementation of performance improvement and risk mitigation plans with particular regard to their potential impact on patient outcomes. The committee is also required, as directed by the Board from time to time, to consider issues relating to performance where the Board requires this additional level of scrutiny.

During the course of the year, the committee met on 12 occasions and considered a set of standard reports as follows:

- The quality and performance report
- The corporate risk register
- The clinical quality group meeting report (including clinical audit)
- Complaints and patient experience reports
- Serious Incident Reports and Never Events.

Ad hoc reports were also requested and received on particular areas of concern to the Committee. During 2017/18, the Chair of the Committee has worked closely with Executive members of the Board to continue to improve significantly the quality of serious incident reporting including never events, and how the Trust can demonstrate Trust wide learning from such incidents. The Quality and Outcomes Committee has received the

process of reviewing the quality and performance reporting and terms of reference to ensure that the Committee remain sighted on the appropriate and relevant information and indicators. This review has led to improved reporting mechanisms and assurance and oversight provided to the Board and increased sightedness on divisional quality governance.

5.5.9 Finance Committee

The Finance Committee has delegated authority from the Board of Directors, subject to any limitations imposed by the Schedule of Matters Reserved to the Board, to review and make such arrangements as it considers appropriate on matters relating to:

- Control and management of the finances of the Trust
- Target level of cash releasing efficiency savings and actions to ensure these are achieved
- Budget setting principles
- Year-end forecasting
- Commissioning
- Capital planning.

The Finance Committee met on 12 occasions in the course of this reporting period. The Chair of the committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

5.5.10 Single Oversight Framework

NHS Improvement's Single Oversight Framework (SOF) has four performance metrics:

- Accident and Emergency (A&E) four hour waiting standard
- 62 day GP cancer standard
- Referral to Treatment (RTT) incomplete pathways standard
- Six week diagnostic waiting times standard.

The national standards are:

- 95 per cent for A&E four hour waits
- 85 per cent for 62 day GP cancer
- 92 per cent for Referral to Treatment (RTT) incomplete pathways
- 99 per cent for six week diagnostic waiting times.

Sustainability and Transformation Funds (STF) targets were agreed for each indicator at the start of the financial year; these were submitted to NHS Improvement as part of their monthly monitoring of acute Trusts

Performance against these four SOF standards is covered in detail in the performance report. A summary of the Trust's performance in 2017/18 against the wider range of national access and other Key Performance Indicators is also included in the performance report.

Table 50: Performance (%) against the agreed trajectories for the four key access standards in 2017/18 during each quarter.

Access Key Performance Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
A&E 4-hours	Actual	82.3	84.2	87.9	90.5	91.3	90.8	90.1	90.3	85.3	82.7	83.2	78.9
	Traj.	82.5	83.5	85	90	90	90	90	90	90	90	92	95
62-day GP cancer	Actual	76.5	77.8	81.7	75.0	85.2	80.2	84.3	88.6	82.9	78.4	81.3	87.3
		78.8			80.1			85.4			82.4		
	Traj.	81	81	81	83.6	83.6	83.6	82.5	82.5	82.5	82.6	82.6	82.6
RTT	Actual	91.1	91.1	91.0	90.2	89.9	89.4	90.0	88.9	88.3	88.1	88.4	87.0
	Traj.	92	92	92	92	92	92	92	92	92	92	92	92
6-week diagnostic	Actual	98.6	98.8	98.6	98.5	97.6	97.7	98.2	98.3	97.6	97.8	99.2	98.5
	Traj.	99	99	99	99	99	99	99	99	99	99	99	99

	National standard met
	STF trajectory met
	Neither STF or national standard met

5.5.11 Risk rating

Financial risk is assessed by NHS Improvement using a Use of Resource Rating (URR). The rating ranges from 1, the lowest risk, to 4, the highest risk. The URR is the average of five metrics:

- Liquidity which measures how long in days the Trust's working capital would cover its operating costs
- Capital Service Cover which measures the degree to which the Trust's generated income covers its financing obligations
- Income and expenditure margin which measures the degree to which the Trust is operating at a surplus/(deficit)
- Net surplus/(deficit) margin variance from plan which measures the variance between the Trust's planned I&E margin and the actual I&E margin in year
- Variance from agency ceiling which measures the variance between the Trust's actual agency expenditure and the maximum ceiling set by NHS Improvement.

For 2017/18, the Trust achieved an overall URR of 1. The table below sets the Trust's performance against the metrics. The rating achieved is a good result and reflects the sound financial position of the organisation.

Table 51: Performance against Use of Resources Rating 2017/18

Metric	Weighting	Metric performance	Metric rating
Liquidity	20%	24.9 days	1
Capital servicing capacity	20%	3.03 times	1
Income and expenditure margin	20%	2.91%	1
Variance in income and expenditure margin	20%	0.94%	1
Variance from agency ceiling	20%	34.3%	1
Overall URR rounded			1

5.5.12 2018/19 Financial Outlook

The Trust submitted a final 2018/19 Operational Plan to NHS Improvement on 30 April 2018. The 2018/19 Operational Plan is year two of the current NHS planning period 2017/19. The Trust's plan is a surplus of £18.480m excluding technical items and is in line with the Control Total advised by NHS Improvement.

The headlines for the 2018/19 Operational Plan are:

- Acceptance of the 2018/19 Control Total advised by NHS Improvement
- Inclusion of Provider Sustainability Funding (PSF) of £15.5m
- Removal of core performance fines
- A planned net income and expenditure surplus of £18.5m before technical items
- A planned net income and expenditure surplus of £20.6m after technical items
- A savings requirement of £25.5m or 5.1% of recurring budgets
- A planned year end cash balance of £80.0m
- Planned capital expenditure of £47.1m
- A Use of Resources Rating (UoRR) of 1, the highest rating.

The 2018/19 plan is challenging but deliverable requiring the following key actions:

- Delivery of planned activity volumes as defined in Divisional Operating Plans and signed Service Level Agreements (SLAs) with Commissioners
- Delivery of National performance access targets, minimising Service Level Agreement (SLA) fines especially Referral to Treatment breaches
- Delivery of the CQUIN targets agreed with Commissioners
- Delivery of the planned savings requirement of £25.7m
- Delivery of the Divisional operating Plans
- Maintenance of strict cost control including the effective management of national and local cost pressures.

Robert Woolley
Chief Executive
24 May 2018

5.6 Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of University Hospitals Bristol NHS Foundation Trust.

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require University Hospitals Bristol NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Bristol NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Robert Woolley
Chief Executive
24 May 2018

5.7 Annual Governance Statement

5.7.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

5.7.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of University Hospitals Bristol NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in University Hospitals Bristol NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

5.7.3 Capacity to handle risk

As Chief Executive, I have overall responsibility for risk management within the Trust, for meeting all statutory requirements and adhering to the guidance issued by NHS Improvement and the Department of Health and Social Care in respect of governance.

The Trust Senior Leadership Team, which I chair, has the remit to ensure the adequacy of structures, processes and responsibilities for identifying and managing key risks facing the organisation, prior to board discussion.

The Board brings together the corporate, financial, workforce, clinical, information and research governance risk agendas. The Board Assurance Framework (BAF) ensures that there is clarity about the risks that may impact on the Trust's ability to deliver its strategic objectives together with any gaps in control or assurance.

Day to day management of risks is undertaken by operational management, who are charged with ensuring risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where problems are identified. There is a process of escalation to executive directors, relevant committees and governance groups for risks where there are difficulties in implementing mitigations.

Staff receive appropriate training to equip themselves to manage risk in a way appropriate to their authority and duties. The Trust has an e-learning package on risk management to complement the existing risk assessment training programme. The purpose being to raise risk management awareness, at Divisional and departmental level, and to ensure staff are aware of their responsibilities in relation to risk management.

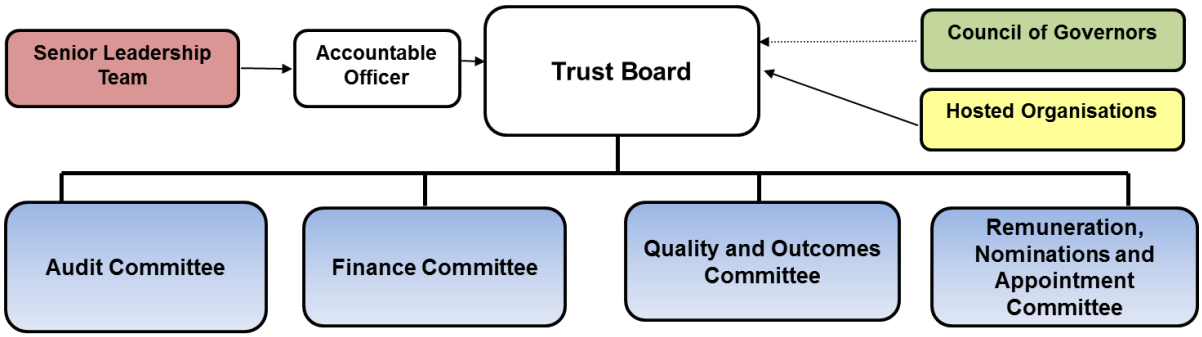
The Board committee structure is detailed earlier in the annual report and summarised below.

The Trust performance report is reviewed by the Finance Committee, the Quality and Outcomes Committee and the Board at each meeting. Where there is sustained adverse performance in any indicator, this is reviewed in detail at the appropriate Board committee.

Indicators relating to the quality of patient care are reviewed at the Quality and Outcomes Committee – patient and staff experience, patient safety and clinical performance.

The process of identification, assessment, analysis and management of risks (including incidents) is the responsibility of all staff across the Trust and particularly of all managers.

Table 52: Board Committee structure



The process for the identification, assessment, reporting, action planning, review and monitoring of risks is detailed in the Trust Risk Management Strategy and continues to be central to the improvements made in this important area during the last year.

Board members receive training in risk management which includes an overview of the risk systems. Staff receive training in identification, analysis, evaluation and reporting of risk. Training at induction covers the wider aspects of governance. The emphasis of our approach is increasingly on the proactive management of risk and ensuring that risk management plans are in place for all key risks.

The Board is responsible for the periodic review of the overall governance arrangements, both clinical and non-clinical, to ensure that they remain effective. The Trust commissioned an externally facilitated review against the Well-Led Framework in 2015 and has implemented the actions as recommended and where appropriate adopted these practices into 'business as usual'. The Trust's internal auditors have reviewed progress each year since the report and have communicated their findings to the Audit Committee. The CQC, in its latest inspection report, gave a rating of Outstanding for the Well-led domain which recognised the strong culture of good governance throughout the organisation.

The Trust has a robust escalation process in place whereby risks are escalated from the 'Floor to the Board' to ensure the whole risk management framework is dynamic. The Senior Leadership Team receive a monthly report from each divisional board and corporate service of any new or existing risks rated 12 or above and also ongoing oversight of the status of these risks.

Emphasis continues to be put into ensuring intelligence from incident investigation, patient safety projects, clinical audits and patient feedback is encompassed into the risk management framework. The Risk Management Group receives quarterly themes of these methods of feedback whereby Members are proactively looking for areas of unquantified risk.

Through ensuring consistent and evidence based risk assessments are managed at the appropriate level risk register, divisions are able to prioritise resources using risk-based information.

5.7.4 The risk and control framework

The risk management policy describes our approach to risk management and outlines the formal structures in place to support this approach. The policy was updated in 2017 to reflect best practice in risk management methodologies. This policy sets out the key responsibilities and accountabilities to ensure that risk is identified, evaluated and controlled. The Board has overall responsibility but it delegates the work to the Senior Leadership Team.

At UH Bristol, risk is considered from the perspective of enterprise-wide risk management, with the approach to managing quality risk, organisational risk and financial risk following the same core principles. The management of these risks is approached systematically to identify, analyse, evaluate and ensure economic control of existing and potential risks

posing a threat to our patients, visitors, staff, and reputation of the organisation.

We recognise it is not possible to eliminate all elements of risk. The use of risk registers is fundamental to the control process.

Each division maintains risk registers containing clinical and non-clinical risks. All unresolved risks affecting multiple departments or the division as a whole are placed on a 'divisional' risk register, whilst individual departments maintain 'departmental' risk registers containing risk to the achievements of each individual department's objectives. The escalation process between these risk registers is monitored on a monthly basis via the divisional management team. Staff review and agree risk scoring and escalation of risks, and where risks scoring 12 or above are confirmed, these are included in the monthly report to the Senior Leadership Team for potential inclusion on the corporate risk register.

Risks are identified through third-party inspections, recommendations, comments and guidelines from external stakeholders and internally through incident forms, complaints, risk assessments, audits (including clinical and internal), information from the Patient Complaints and Support Team, benchmarking and claims and national survey results. External stakeholders include the Care Quality Commission (CQC), NHS Improvement, the Health and Safety Executive (HSE), NHS Resolution (NHSR) (previously the NHS Litigation Authority), the Medicines and Healthcare Products Regulatory Agency and the Information Commissioner's Office.

The divisional management teams ensure that operational staff identify and mitigate risk. Corporate committees provide internal assurance to the Board that the mitigations are effective and the risks are adequately controlled. Risk is monitored and communicated via these committees reporting to the Audit Committee and ultimately the Board. Our clinical audits, internal audit programme and external reviews of the organisation are the sources used to provide assurance that these processes are effective and risk monitoring is fully embedded.

The Audit Committee oversees and monitors the performance of the risk management system, and internal auditors and external auditors (PwC) work closely with this committee. The internal auditors undertake reviews and provide assurances on the systems of control operating within the Trust.

The Trust's Board Assurance Framework (BAF) details the principle risks to the achievement of its strategic plans.

The BAF is reviewed in a number of forums, as well as quarterly by the Board. The Trust's risk appetite is such that high risks require action to be taken and to be reported within 24 hours of identification of the risk.

During 2018/19, we plan to further improve our BAF to ensure that, at Board level, we are focusing on the key strategic risks to delivering our plans and the mitigating actions taken to enhance controls. The Board also reviews and agreed the level of risk we are prepared to accept across the Trust (the Trust's risk appetite) on an annual basis. All risks in our BAF are reviewed by one of the Board Assurance committees.

A summary of the top risks to our operational or strategic plans in 2017/18 are outlined below:

- Achievement of national performance targets, including accident and emergency (four hour wait), cancer waiting time standards, and Referral to Treatment (RTT) target
- Increases in demand and acuity of patients being admitted to Accident and Emergency; the impact on patient flow and access to treatment
- The financial consequences arising from the loss of Sustainability and Transformation funding
- The significant challenges to deliver the financial plan without

compromising on the quality of clinical services

- The financial consequences of using agencies who are non-compliant with national pricing caps
- The impact to the quality of care received patients suffering from mental health disorders from spending prolonged time in the ED
- Challenges in relation to meeting new clauses within National Hospital Contract.

Responsibility for the controls pertaining to each principal risk is assigned to an executive director with oversight by a designated Board committee. As at the year end, the BAF tracked seven principal risks and 22 related corporate risks which could potentially impact one of the Trust's governing objectives.

The categorisation of these risks is summarised below:

Corporate risk categorisation	**Number of risks**
Workforce Risks	5
Quality	4
Compliance/Statutory	4
Financial Risks	4
Patient Safety	3
Health and Safety	1
Reputational	1
Total	**22**

The results of internal audit reviews are reported to the Audit Committee which takes a close interest in ensuring system weaknesses are addressed. Procedures are in place to monitor the implementation of control improvements and to undertake follow-up reviews if systems are deemed less than adequate. Internal audit recommendations are robustly tracked via reports to the Audit Committee. The counter fraud programme is also monitored by the Audit Committee.

5.7.5 Quality governance arrangements

The Trust is committed to and expects to provide excellent health services that meet the needs of our patients and their families and provides the highest quality standards.

The Board and Senior Leadership Team of UH Bristol have a critical role in leading a culture which promotes the delivery of high quality services. This requires both vision and action to ensure all efforts are focussed on creating an environment for change and continuous improvement.

The Trust's annual quality delivery plans and quality strategy (2016-2020) set out the actions we will take to ensure that this is achieved.

We do have much to be proud of. The Trust's quality improvement and transformation programmes, led by the Chief Nurse, Medical Director, and Deputy Chief Executive and Chief Operating Officer, continues to show us what is possible when we have a relentless focus on quality improvement. Our quality strategy and quality improvement work is structured around four core quality themes:

- Ensuring timely access to services
- Delivering safe and reliable care
- Improving patient and staff experience
- Improving outcomes and reducing mortality.

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services. The Trust's Quality Impact Assessment process involves a structured risk assessment, using our standardised risk assessment framework, which includes assessment against the risk domains of safety, quality and workforce. The Medical Director and Chief Nurse are responsible for assuring themselves and the Board that Cost Improvement Programmes will not have an adverse impact on quality. The Trust's overall processes for monitoring quality and triangulating information provide a

framework within which to monitor the impact of schemes.

The Trust has a robust Quality Governance reporting structure in place through an established Quality and Outcomes Committee. Our internal business planning and associated monitoring processes underpin the triangulation of our quality, workforce and finance objectives. Our Operating Plans are developed through the five clinical and Trust Services corporate divisions with monthly and quarterly Divisional Reviews conducted with the Executive team. The Trust's Clinical Quality Group monitors compliance with Care Quality Commission Fundamental Standards on an ongoing basis and our Quality and Outcomes Committee monitors performance against a range of performance standards.

Our governors engage with the quality agenda via their Strategy Focus Group and Quality Focus Group. Each quarter, the Board and its sub-committees receive the Board Assurance Framework and the Trust's Risk Register which report high level progress against each of the Trust's corporate objectives (including quality objectives) and any associated risks to their achievement. Additionally, the Board's Audit Committee works with the Trust's Clinical Audit and Effectiveness team to consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission and is currently rated as 'Outstanding'. The Trust did not receive a core services inspection from the Care Quality Commission in 2017/18.

There are no material inconsistencies between the Annual Governance Statement, the annual and board statements required by NHS Improvement, the corporate governance statement and reports arising from Care Quality Commission planned and responsive reviews of the Trust. The Directors' approach to quality governance is explained in more detail in the Quality Report.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5.7.6 Review of economy, efficiency and effectiveness of the use of resources

The Trust has a range of processes to ensure that resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff and the presentation of monthly finance and performance reports to the Finance and Quality and Outcomes Committees, Executive Committee and to the Board. More information about this is in the financial review section of this report.

Our external auditors are required as part of their annual audit to satisfy themselves the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the Trust has not.

5.7.7 Information governance

Information governance (IG) provides the framework for handling information in a secure and confidential manner; covering the collecting, storing and sharing information, it will provide assurance that personal and sensitive information is managed legally, securely, efficiently and effectively in order to deliver the best possible care and service.

The Trust has an Information Risk Management Group chaired by the Medical Director, who is the Senior Information Risk Owner (SIRO), which is the principal body overseeing IG compliance and the management of information risks. This group has a reporting line into the Senior Leadership Team. It also oversees submission of the Trust's information governance toolkit.

The Trust's control and assurance processes for information governance include:

- the key structures in place, principally the Information Asset Owners and Information Asset Administrators who maintain the Trusts systems containing all patient and staff personal data
- a trained Caldicott Guardian, a trained senior information risk owner (SIRO) and a trained data protection officer
- a risk management and incident reporting process
- staff training
- information governance risk register
- the Information Governance Toolkit, against which the Trust achieved a satisfactory score of 67 per cent for 2017/18
- internal audit review of the evidence provided to comply with the criterion of the information governance toolkit.

During 2017/18 progress has continued to be made to raise staff awareness about information governance issues. This has included:

- Staff information including posters, guidance and articles have been published in the Trust-wide, weekly 'Newsbeat' email, which make staff aware of incidents that have occurred and remind staff of their responsibilities
- The Trust Medical Records Manager and Information Governance Officer undertake monthly spot checks around the hospital; the Trust has a positive culture in relation to incident reporting; the lessons learned from all incidents are shared to educate staff
- The Information Management and Technology Board, in conjunction with the Information Risk Management Group, identify, assess and monitor data, cyber, and infrastructure threats to the organisation. Where the risk is controlled by the Information Management and Technology Board, the Information Risk Management Group are provided with regular assurance and evidence to support the criteria of the Information Governance Toolkit
- An implementation group, chaired by the Trust Secretary, has been tasked with oversight of the preparations required to ensure the Trust is compliant with the incoming European Data Protection Regulation (GDPR) and the subsequent Data Protection Bill, that will repeal the Data Protection Act 1998.

Two cases recorded in the Information Governance Incident Reporting Tool were reported to the Information Commissioner's Office in 2017/18. The details are provided in the following table.

Table 53: Incidents reported to the Information Commissioner's Office 2017/18

Date of Incident	Date Incident Reported	Incident description	Data loss or Confidentiality	Action by Information Commissioner
January 2017	November 2017	Lost a set of patient notes, leaving the organisation unable to respond to a subject access request.	Lost or Stolen Paperwork	No further action.
December 2017	January 2018	Documents relating to four individuals disclosed in error in response to a subject access request.	Disclosed in Error	No further action.

5.7.8 Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The annual quality report and quality accounts provide a firm foundation for our quality ambitions: looking back to identify progress, celebrate success and understand our challenges; and looking ahead by setting specific annual quality objectives which, if delivered, will make a significant difference to the safety, effectiveness and experience of care that our patients receive.

The structure of our annual quality report and accounts follows prescribed guidance from NHS Improvement and NHS England; the themes we report are agreed with our governors and tested with our commissioners. Our choice of annual quality objectives is shaped through consultation with our staff, members and our Involvement Network (patients and public).

The process of producing the quality report and accounts is overseen by the Chief Nurse and Medical Director, who have a shared board-level leadership responsibility for quality. Drafts of the report and account are reviewed by our Clinical Quality Group, Senior Leadership Team, Audit Committee and Quality and Outcomes Committee prior to approval by the Board. Local stakeholders submit formal statements for inclusion in the quality report and accounts describing their relationship and interaction with the Trust on matters of quality, and offering comment on the Trust's reported quality story and ambitions. Data included in the report and accounts is cross-referenced for accuracy with quality and performance data reported to the board during the previous year; national comparative indicators published in the report and accounts are also guided by local data quality frameworks. Finally, external auditors carry out detailed testing of three indicators included in the report, one of which is selected by our governors.

A Data Quality Framework has been developed by the Trust, which encompasses the data sets that underpin the key access and quality indicators reported in monthly in the Trust Quality and Performance Report and on an annual basis in the Quality Report. The framework addresses the six dimension of data quality (i.e. accuracy, validity, reliability, timeliness, relevance and completeness), and describes the process by which the data is gathered, reported

and scrutinised by the Trust. The Data Quality Report is underpinned by the Data Quality Policy which describes the policy and procedures for supporting data quality across the Trust, including core responsibilities of staff. The Trust's approach to Data Quality is being reviewed and is due to be updated in 2018/19.

5.7.9 Never Events

There have been nine Never Events reported during the year. The Trust has identified that the number of reported Never Events meet the definition of a 'Significant Issue' as described within the Foundation Trust Annual Reporting Manual:

- One retained piece of swab following a dental procedure
- One misplaced naso-gastric tube
- Two wrong lens implants
- One mis-selection of high strength midazolam
- One wrong side dental nerve block
- Two wrong tooth removals
- One retained nylon tape following a cardiac surgery procedure.

We have investigated these cases thoroughly and have learned that a number of these were caused by human error which had occurred in situations where there was a difficulty or change in plan before or during the procedure. In autumn 2017 we proactively invited NHS Improvement to conduct an independent and objective review of our four dental never events. At the time of writing (April 2018) a formal report is awaited but initial informal feedback suggested we should continue to focus on cultural and human factors. More learning points are published in the Quality Account 2017/18.

5.7.10 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the audit committee, finance committee and the quality and outcomes committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of the internal audit work. My review of the effectiveness of the system of internal control is informed by executives and managers within the organisation, who have responsibility for the development and maintenance of the system of internal control and the assurance framework. The BAF itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its objectives have been reviewed.

The assurance framework has been reviewed by the Trust's internal auditors. They have confirmed that a BAF has been established which is designed and operating to meet the requirements of the 2017/18 annual Governance Statement. Their opinion supported that there is an effective system of internal control to manage the principal risks identified by the organisation and stated that no significant issue remained outstanding at the year-end which would impact the opinion.

The Board reviews risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the performance in the key areas of finance, activity, national standards, patient safety and quality and

workforce. This enables the Board of Directors to focus on key issues as they arise and address them.

The Audit Committee oversees the effectiveness of the Trust's overall risk management and internal control arrangement. On behalf of the board, it independently reviews the effectiveness of risk management systems in ensuring all significant risks identified, assesse, recorded and escalated as appropriate. The Audit Committee regularly receives reports on internal control and risk management matters from the internal and external auditors.

None of the internal or external auditors' reports considered by the audit committee during 2017/18 raised significant internal control issues. There is a full programme of clinical audit in place.

The responsibility for compliance with the CQC essential standards is allocated to lead executive directors who are responsible for maintaining evidence of compliance. The trust is addressing all areas of underperformance and non-compliance identified either through external inspections, patient and staff surveys, raised by stakeholders, including patients, staff, governors and others or identified by internal peer review.

5.7.11 Conclusion

The Board is committed to continuous improvement of its governance arrangements to ensure that systems are in place which ensure risks are correctly identified and managed and that serious incidents and incidents of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action, so that the patients, service users, staff and stakeholders of University Hospitals Bristol NHS Foundation Trust can be confident in the quality of the service we deliver and the effective, economic and efficient use of resources.

My review confirms that University Hospitals Bristol NHS Foundation Trust has sound systems of internal control up to the date of approval of the annual report and accounts. However one significant internal control issue has been identified in this report relating to the number of Never Events reported during the year. The Board will keep these under review during 2018/19 to ensure that the organisation learns from and is able to demonstrate improvements to reduce the chance of reoccurrence.

Robert Woolley
Chief Executive
24 May 2018

Appendix A – Biographies of Members of the Board of Directors

Jeff Farrar – Chairman

Jeff Farrar retired from the police service in July 2017 after 35 year service where he reached the rank of Chief Constable in Gwent Police. He has a Masters degree in public administration from Cardiff University, a BSc (Hons) in public administration from Portsmouth University and is currently studying for a Professional Doctorate in social policy at Bath University.

He is a member the Cardiff University Business School International Advisory Board and was the chair of the Welsh Government Effective Services Board. He led on the development of 'public service principles' detailed in the white paper of public service reform and has continued to act as a panel member for senior Welsh Government appointments and awards.

He was formerly the vice chairman of Police Sport UK, chairman of Police Sport (Wales) and chairman of British Police Basketball. He has represented GB Police at Basketball, still competes in the annual GB Basketball Masters events and has completed half and full marathon races. He is a qualified first aider and Officer of St John.

He has planned and commanded some of the most high profile events in the UK including the NATO summit (2014), two FA Cup and Carling finals, The Ryder Cup (2010), Rugby Internationals, International Cricket and World Championship Boxing events. He has led a number of large organisational change programmes which have contributed to over £50 million in revenue savings. He was seconded to National Police Training and Her Majesty's Inspectorate of Constabulary as part of the team that inspected the police service on equality and diversity after the death of Stephen Lawrence.

He was awarded the Queens Police Medal in the 2014 birthday honours list and in 2016 was the winner of Institute of Directors, Director of the Year for the Public Sector in Wales.

Robert Woolley – Chief Executive

Robert has been Chief Executive of University Hospitals Bristol NHS Foundation Trust since 2010, having served on the Board since 2002. In his time as Chief Executive, the Trust has been rated outstanding by the CQC, completed a major redevelopment programme, achieved Biomedical Research Centre status and been named a Global Digital Exemplar, while maintaining a positive financial position throughout. Before moving to Bristol, he spent nine years at Barts and the London NHS Trust in a range of senior planning and operational roles.

Robert is joint executive lead for Healthier Together, the Sustainability and Transformation Partnership for Bristol, North Somerset and South Gloucestershire, as well as a director of the West of England Academic Health Science Network and a member of the Health Education England South of England Education and Training Board. He has an English degree from Oxford University and an MBA with distinction from the University of Bath.

Mark Smith – Chief Operating Officer & Deputy Chief Executive

Mark practiced as a GP until he became the Deputy Medical Director for the North East Strategic Health Authority. Whilst in the role he worked with organisations in the North East to develop commissioning, clinical engagement and the North East Transformation System (NETs) programme which utilised quality improvement methodology to improve patient care. He has worked on several national committees and the High Quality Care for All Strategy whilst on secondment to the Department of Health. He has a wide experience in Heath Informatics including working with the National Programme for IT and developing one on the first national e-referral systems for cancer patients.

Mark has held several Chief Operating Officer roles, including City Hospitals Foundation Trust, Leeds University Teaching Hospital and Brighton and Sussex University Teaching Hospital.

Paul Mapson – Director of Finance and Information

Paul Mapson joined the NHS as a national finance trainee in 1979. He became a fully qualified accountant in 1983 and has undertaken a wide variety of roles within the NHS in the acute sector.

Paul has 11 years of experience at Board level including significant experience in the management of capital projects, specialised commissioning, systems development, information technology and procurement. Prior to joining the Trust in 1991 as Deputy Finance Director, Paul held posts in Somerset, Southmead and Frenchay hospitals. He was appointed Director of Finance in February 2005. Paul serves on the Finance Committee of the Board.

Mark Callaway – Interim Medical Director

Mark has recently been appointed as Interim Medical Director, having previously held the post of Deputy Medical Director with responsibility for Clinical Governance and Quality Improvement.

Management positions he has held at the Trust include Deputy Medical Director for Professional Standards and Commissioning, Clinical Lead for Radiology, Senior Clinical Lead for Emergency Access, and Head of the Division of Medicine. He was also Head of School of Radiology for the Severn Deanery, continues to teach and has an active research portfolio.

He has held roles on committees for NCEPOD, NICE, and the National Cancer Action Team, National Cancer Research Institute, and authored several sets of national guidelines for the Royal College of Radiologists. Dr Callaway maintains a clinical role as an interventional radiologist with a major interest in both gastrointestinal and chest disease and the radiological management of liver disease.

Carolyn Mills – Chief Nurse

Carolyn is an experienced nurse whose career in the NHS spans 30 years. Carolyn has worked in acute, community and academic sectors. She moved into senior nursing leadership roles in 1998. Between 1998 – 2005, Carolyn held two Assistant Director of Nursing positions, at Hillingdon Hospitals NHS Trust and University College London Hospitals NHS Foundation Trust. Previous to joining University Hospitals Bristol NHS Foundation Trust as Chief Nurse in January 2014, Carolyn was Director of Nursing at Northern Devon Healthcare Trust. Carolyn serves on the Quality and Outcomes Committee.

Paula Clarke – Director of Strategy and Transformation

Paula joined the NHS as an NHS General Management trainee in 1991 and over the last 25 years, has held senior manager posts in commissioning, provider and primary care organisations, primarily in the integrated health and social care system in Northern Ireland. Paula has over 8 years' experience at Board level, including one year as the interim Chief Executive of Southern Health and Social Care Trust, providing all health and social care services to c360,000 children and adults and managing an operating income of £550m.

Paula joined UH Bristol in April 2016, and brings to Bristol extensive experience in strategic development, partnership working and service redesign.

Key priorities for Paula are to drive improvement in care through strategic transformation, alongside supporting every member of the organisation to take personal ownership in doing things better every day.

Matthew Joint – Director of People

Matthew joined University Hospitals Bristol NHS Foundation Trust as Director of People in September 2017, having previously held senior corporate roles in Human Resources at Centrica and Amey Plc. Most recently, Matthew held the post of HR Director at Royal Mail Group, where he was responsible more than 40,000 staff. He has extensive experience of implementing major change initiatives in large organisations and has particular expertise in

talent management, leadership and development. Matthew trained as a research psychologist and held a Research Fellowship at Leeds University. He also has an MSc in Civil Engineering.

Emma Woollett – Vice-Chair and Senior Independent Director

Emma was appointed as a Non-executive Director on 1 June 2008, and is Vice-Chair and Senior Independent Director of the Trust. She has worked in both the private and public sectors and has held senior management positions in marketing and business development. She was marketing director for Kwik Save Stores, following its merger with retailer Somerfield plc.

Emma left Somerfield in 2001 to set up a freelance management consultancy practice, providing analytical advice to NHS organisations on capacity planning and waiting list management. Prior to joining Somerfield, Emma spent a number of years as a management consultant for PricewaterhouseCoopers, working worldwide on projects for utility companies looking to develop more commercial approaches within a public sector environment. She started her career in the oil industry and has degrees in physics and international relations from Cambridge University. Emma is Chair of the Remuneration and Nominations Committee, and member of the Finance and Quality and Outcomes Committees.

David Armstrong – Non-executive Director

David was appointed as a Non-executive Director on 28 November 2013. After graduating from Southampton University with First Class Honours in Mathematics and its Applications, David worked in the banking sector before taking up a position as a Systems Engineer with GEC-Marconi in 1983.

During his 30 years in the Aerospace and Defence Sector he worked in a number of Engineering and Project Manager Roles. In 1999 he was appointed as the Alenia Marconi Systems Ltd Business Improvement, ICT and Quality Director and since that time has held board level positions in a number of multi-national Defence Businesses, most recently working for Finmeccanica as UK Vice President of Quality.

He is a Fellow of the Institute of Engineering and Technology and of the Chartered Quality Institute and is a Chartered Engineer and Chartered Quality Professional.

David has also served on a number of policy making committees including Engineering UK's Business and Industry Panel and as a Trustee of the Chartered Quality Institute.

He has recently completed a part-time role as Head of Profession at the Chartered Quality Institute where he was responsible for developing the Profession and raising its profile across academia and the public and private sectors.

Anthony (Guy) Orpen – Non-executive Director

Guy is Deputy Vice-Chancellor at the University of Bristol, a role he has held since 2014. He has previously served as Pro Vice-Chancellor (Research and Enterprise) from 2009-14 in which role he held strategic oversight of the University's research and its engagement with society and industry. He is Chair of the Board of the GW4 research alliance with Bath, Exeter and Cardiff Universities; serves on the Board of Bristol Health Partners (the city's academic health sciences collaboration) and is a non-executive director of the University Hospitals Bristol Foundation Trust. He has chaired the UK National Composites Centre, and served on the Executive Board of the SETsquared Partnership (for enterprise, with the universities of Bath, Bristol, Exeter, Southampton & Surrey).

He has served as Chair of the Board of Trustees of the Cambridge Crystallographic Data Centre and is a member of the Board of the 2015 Company delivers the European Green Capital for Bristol in 2015.He has previously served as Dean of the Faculty of Science (2006-9) and Head of the School of Chemistry (2001-6) and as Professor of Structural Chemistry since 1994.

John Moore – Non-executive Director

John Moore was appointed as a Non-executive Director of University Hospitals Bristol NHS Foundation Trust on 1 January 2011. He is an experienced managing director and Trustee, supporting strategic change throughout organisations. He has multi-sector industrial experience (aerospace, defence, automotive, utilities) together with the public and third sectors.

Following 12 years international corporate life, and having sold a medium sized business, John has taken a Non-executive Director role with University Hospitals Bristol NHS Foundation Trust, and is a Trustee of various charities, including Education Towards a Future.

John is passionate about creating a service and quality culture in the organisations he serves as a board member, whether in an executive or non-executive capacity. A chartered director and chartered engineer, John has a Master's degree in Engineering and a Master of Business Administration from the International Institute for Management Development. He is married with three children and lives near Bristol.

Jill Youds – Non-executive Director

Jill was appointed as Non-executive Director on 1 November 2014, following her role with the Trust as Non-executive Director observer from November 2013.

Jill has a highly successful career in the commercial sector with blue chip organisations such as Virgin Media, where she was an Executive Director, and Lloyds Group. Jill brings her general business leadership experience to the Trust and her specialist interests include People and Workforce and organisation effectiveness. Jill is an experienced Non-executive Director in the public and not-for-profit sectors.

Julian Dennis – Non-executive Director

Julian was appointed as Non-executive Director on 1 June 2014, following his role with the Trust as Non-executive Director observer from 1 November 2013.

A company director and public health scientist, Julian worked for the Public Health Laboratory Service at Porton Down before joining Thames Water. He was appointed a Director of United Kingdom Water Industry Research Limited in 2003 before joining the board of Wessex Water as Director of Environment and Science in 2004. He is also Visiting Professor of Water Science and Engineering at the University of Bath.

Martin Sykes – Non-executive Director

Martin studied chemistry at the University of Newcastle upon Tyne, where he obtained a PhD and spent a number of years working in post-doctoral research. He later qualified as an accountant and joined the NHS in 1995. Martin worked most recently at Frimley Health NHS Foundation Trust as finance director and deputy chief executive. Within the NHS Martin has also held executive responsibility for procurement; information management and technology; information governance; contracting; and strategy.

Steven West – Non-executive Director

Professor West trained as a podiatrist and podiatric surgeon in London, working in the NHS and private/commercial sector from 1982. He entered academia in 1984 as a lecturer, then senior lecturer at The London Foot Hospital and Westminster University. He developed his research interests in the diabetic foot at King's College London and in 1990 was appointed Head of Podiatry at Huddersfield University, and later became Dean of the School of Health and Behavioural Sciences in 1992. In 1995 he joined the University of the West of England (UWE) as Dean of the Faculty of Health and Social Care and Professor of Health and Social Care. In this post he merged three colleges of health into a new faculty, establishing one of the largest faculties of health and social care in the UK.

In 2006 he became Deputy Vice-Chancellor and was appointed Vice-Chancellor in 2008. He is a Fellow of the Society of Chiropodists, the College of Podiatric Medicine, the Royal

Society of Medicine, and Royal Society of Arts. He holds a number of honorary and advisory appointments in his discipline, and healthcare policy and practice nationally and internationally.

In 2013, he became President of Bristol Chamber of Commerce and Chair of the West of England Initiative, forging the link between a business-facing university and the business leadership organisation Business West. He is Chair of the West of England Academic Health Science Network (WEAHSN) that aims to transform health and healthcare by putting innovation at the heart of the NHS. In 2017, Professor West was made a Non-Executive Director for the Higher Education Funding Council for England (HEFCE) and the Office For Students the new Regulatory Body for Higher Education.

Professor West was awarded a Commander of the Order of the British Empire (CBE) in the New Year's Honours list 2017, for services to Higher Education.

Madhu Bhabuta – Non-executive Director (Designate)

Madhu holds an MEng and PhD in Computing and Quantitative Methods from Imperial College, London and an MBA from London Business School, where she specialised in Change and Transformation. She started her career as a research scientist at Imperial College and then moved to industry where she was the lead architect for Orange's 2G and 3G core networks and then as Head of Major Programs.

Madhu then joined Rolls-Royce Plc as to spearhead the formulation of RR's Technology strategy. She was then appointed CIO of the UK Hydrographic Office, leading a team of 200 people and delivering a wide-ranging modernisation and digitisation programme in 2013 and was judged as UK’s top 100 CIOs for the transformation she affected. Madhu was then asked to move to the sponsoring department, the MoD, as the CTO. Most recently, she supported Mitie PLC's Operations and Delivery transformation as their IT Director.

Appendix B – Contact details

The **Trust Secretariat** can be contacted at the following address:

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The **Membership Office** can be contact at the following address:

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Appendix C – Quality Report 2017/18

University Hospitals Bristol
NHS Foundation Trust

Quality Report 2017/18

Contents

Part 1

1.1 Statement on quality from the chief executive

Welcome to this, our tenth annual report describing our quality achievements. Our mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. The Quality Report (also known as the Quality Account) is one of the key ways that the Trust demonstrates to the public and its stakeholders that its services are safe, effective, caring and responsive. The report is an open and honest assessment of the last year, its successes and its challenges.

The Care Quality Commission (CQC) commended our staff for their commitment to our patients when they rated the Trust as Outstanding in March last year and their dedication shone through in 2017/18. At UH Bristol we believe wholeheartedly that our staff are central to the care that we provide to our patients and their families. We want to improve their experience as staff members and support them to do their roles to the best of their ability and to stay well and healthy. It was therefore encouraging to see that the latest NHS Staff Survey results demonstrate that our work is continuing to bear fruit.

During 2017/18, the Care Quality Commission published the results of the 2016 national survey of adult inpatients, which ranked us as the top equal acute trust in the country for patient experience. The equivalent surveys for emergency services and for children's and parents' experiences of care also place University Hospitals Bristol in the top 20% of NHS Trusts. This hugely positive feedback from the people who use our services chimes with the CQC's own observations from their last inspection when they commented on the humanity and compassion of the care they witnessed.

In this report, you will read about the progress we have made towards achieving the goals we set ourselves twelve months ago. These include the successful creation of a Quality Improvement Academy to give our staff the tools they need to put their good ideas into practice, and the introduction of a new mortality review programme so that we take every possible opportunity to learn from deaths in hospital (one of our quality objectives for 2018/19, improving early recognition of when patients are nearing the end of life, relates directly to early findings from this programme).

I am proud that we have delivered these and other improvements in the context of the significant challenges we have faced throughout the year to meet key national access standards and to continue to tackle long-standing pressures around demand, capacity and patient flow. While I am encouraged that we achieved the 62 day GP cancer waiting time standard during the third quarter of the year, and the six week diagnostic waiting standard in February, we have a lot more work to do.

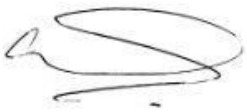
During this year, it has become increasingly apparent to me that we will only continue to make progress as an organisation by working in collaboration with our partners for the greater good of the people we serve. As always, I would like to thank everyone who has contributed to this year's Quality Report, including our staff, governors, commissioners, local councils, and local Healthwatch. To the best of my knowledge, the information contained in this Quality Report is complete and accurate.

Robert Woolley, chief executive

1.2 Introduction from the medical director and chief nurse

We are proud to be leaders in a Trust where staff dedicate themselves to continually improving the quality of care for patients. This Quality Report includes a number of great examples of quality improvement. Even relatively small-scale changes can lead to significant quality benefits for patients. The potential benefit is even greater if quality improvement (QI) techniques are applied consistently across organisations and systems. In this report you will read about the Trust's approach to QI, which supports frontline staff to make improvements, and the shared responsibility for quality which exists between staff and leaders at all levels or our organisation and beyond.

Thank you to all our staff who are constantly doing that little bit extra every day to help patients and their families and who contribute to the Trust's reputation for providing high quality care.



Carolyn Mills
Chief nurse

Dr Mark Callaway
Acting medical director

Part 2

Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

2.1.1 Update on quality objectives for 2017/18

Twelve months ago, we identified eight specific areas of practice where we wanted to see improvements in 2017/18. These were a combination of ambitions we had not fully realised in 2016/17 and new objectives aimed at improving different aspects of patient experience. A progress report is set out below, including a reminder of why we selected each objective and an overall 'RAG' rating of the extent to which we achieved each ambition. Overall, we achieved four objectives and made significant progress in three more.

Objective 1	**To create a new Quality Improvement Academy**
Rationale and past performance	The Trust's Quality Strategy (2016-2020) describes our plans to link up a number of strands of current activity that fall within our shared understanding of quality improvement, creating a learning environment to promote and encourage quality improvement. This includes clinical audit, research and innovation, patient safety and transforming care. All of these existing programmes continue to demonstrate huge value to the organisation, however we recognise that there are opportunities to work together more closely to support innovation and improvement across all areas of the Trust. A key part of this is the development of a new Quality Improvement (QI) Academy.
What did we say we would do?	At UH Bristol, we want to promote and encourage innovation and improvement, so that staff with good ideas can bring them to life for the benefit of patients, staff, the Trust and the wider NHS. Within this ambition, we set out three aims in last year's report: • To support and connect people with our existing quality improvement programmes • To provide support to staff with good ideas outside these programmes • To build capability to support staff to lead improvement independently of these programmes. To create ownership and to build capacity to change, we need to encourage staff with ideas to implement their ideas themselves. To drive and encourage this we are committed to providing staff with support and education to give them the skills to lead improvement themselves. Last year, we said that a key part of this would be the creation of a new QI Academy to provide a broad range of staff with the quality improvement skills and tools they will need. As part of our plan, we said we would establish a quarterly innovation forum to bring together the leaders of QI projects in a structured event to share learning. We also committed to further strengthen our partnership with the West of England Academic Health Science Network.
Measurable target/s for 2017/18	Our target was for 100 members of staff to attend the QI Academy 'Bronze' programme during 2017/18.

How did we get on?	We successfully implemented the 'bronze' and 'silver' level training programmes in our QI Academy. Bronze training provides participants with an introduction to quality improvement methodologies and tools. In addition to regular monthly sessions open to all staff, training has also been delivered to a number of teams and staff groups including the adult emergency department team, dental students, psychologists, foundation doctors and core medical trainees. To date, nearly 200 members of staff have completed the bronze programme with an overall satisfaction rating on feedback of 4.7/5. Our silver programme has also begun, providing staff with hands-on support to develop their QI project ideas. The first students will 'graduate' in April and a second cohort has already started. In July, we held our inaugural QI Forum, giving all staff an opportunity to display their QI work. Over 70 posters were received and displayed and the top three posters received a trophy on the day. The QI Hub has been launched, enabling staff to submit ideas for innovation and improvement projects. Staff who submit ideas to the Hub receive initial advice and direction about how they might best be taken forward. There is now a steady growth in the numbers of submissions month-on-month; in each case, the submission is discussed and a member of the QI Faculty will meet with the team to determine the level of support required. Finally, our QI website continues to grow and houses resources to support staff with QI methodology. In developing our QI Academy and QI approach we engaged with a wide range of stakeholders, including the West of England Academic Health Science Network (WEAHSN), whose advice was invaluable, particularly in pointing us to other trusts in the region who had developed successful QI programmes. We have continued to maintain close contact with the QI team at the WEAHSN to ensure continued alignment of our work with their role in supporting QI across the region. In 2018/19, our goals are for at least 300 staff to attend QI bronze training and to support a minimum of 20 QI projects through the silver programme. By the end of the year, we will also have defined and developed our gold QI offer.
RAG rating	Green – We have successfully implemented QI training programmes and developed a range of other QI resources and initiatives, creating a consistent framework to enable staff to undertake quality improvement activity. The number of staff attending our bronze programme was double our initial target.

Objective 2	**To establish a new mortality review programme**
Rationale and past performance	The purpose of this mortality review programme is to further underpin the established work at UH Bristol around patient safety, assessing standards of care provided to inpatients. Where areas of excellent and good care are established, this can be highlighted and learning fed back. Learning from poorer aspects of care can form the basis of developing quality improvement programmes which will lead to improvement in the provision of inpatient care. This programme replaces the previous inpatient mortality review which

	was established in 2014.
What did we say we would do?	In response to national guidance published in March 2017, and as part of a national pilot, the Trust has redesigned the way it undertakes mortality review. Twelve months ago, we were at a point where we had assembled a multi-disciplinary team to review all inpatient adult deaths. The review process would involve an initial screening assessment, leading to a structured case note review wherever a death has followed an elective procedure or, for example, has involved a patient with learning difficulties or severe mental illness, or where a family has expressed concerns about a patient's care. We said that we would use methodology introduced by the Royal College of Physicians, anticipating that this would highlight aspects of both good and potentially poor care.
Measurable target/s for 2017/18	National guidance sets out measures that needed to be reported to our Trust Board by the third quarter of 2017/18. This included the total number of the Trust's inpatient deaths (including emergency department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of those deaths subjected to review, Trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.
How did we get on?	We introduced the new mortality programme as planned and have screened all 1,315 adult inpatient deaths within UH Bristol. Twenty-two per cent of these cases were subsequently identified as meeting the criteria for a structured review. These reviews indicated that the majority of care provided to these patients had been of an acceptable, or good, standard. We have identified one potentially avoidable death. We have changed the Trust's bereavement leaflet to make families and friends aware that, if they have concerns about the deceased patient's last episode of care, these can be raised with the Trust, and that the process of raising the concerns automatically triggers a structured case note review. This group of patients currently accounts for the largest number of structured case note reviews. We have identified two significant themes for learning: 1. The need to improve early recognition of the dying patient. This has been agreed as a corporate quality objective for 2018/19 (see section 2.12 of this report) 2. The importance of senior clinical staff involvement in the decision to move patients from physiological monitoring to symptomatic control at the end of their lives Since 20 November 2017, we have also been reviewing the care of patients who died within 30 days of discharge from hospital. An initial analysis of these cases has identified 16 patients whose death was unpredicted or unexpected. This group will now further undergo review using structured case note review.
RAG rating	Green – We introduced our new mortality review programme as planned. Early learning from the programme has resulted in one of our quality improvement objectives for 2018/19.

Objective 3	**To develop a consistent customer service mind set in all our interactions with patients and their families**
Rationale and past performance	Customer service is a thread running throughout our Quality Strategy for 2016-20. UH Bristol is a caring organisation: we know from our surveys that the vast majority of patients (97 per cent+) have a positive experience of care in our hospitals, but we also acknowledge that this isn't true of everyone. Aimed squarely at addressing issues which give rise to "the three per cent", this objective marks the first year of an ongoing project aimed at embedding the consistent understanding and application of customer service principles across our organisation.
What did we say we would do?	We said we had identified three levels of intervention to target future improvement activities: - Individual and team behaviours that demonstrate and support a customer service mind set - Establishing a set of customer service principles that can be held up as a mirror to proposed service changes and programmes of work - Initiating specific improvement programmes that directly support excellence in customer service (e.g. telephones, letter, receptions, complaints handling). In the first quarter of the year, we said we would: - hold a workshop targeted at a broad range of hospital staff to explore the concept of customer service within healthcare and to test staff appetite for developing future programmes of work supporting this objective - engage with an external consultant with international experience in leading customer care programmes - achieve sign-up from our Transformation Board for our direction of travel. In the second quarter of the year, we said we would: - continue with staff and patient engagement activities, enabling us to define what customer service means for UH Bristol and to begin to develop our set of customer service principles - identify key customer service "touchpoints" within the organisation - mobilise an executive-led steering group to finalise priorities and objectives and ensure clear ownership for our year one activities - agree at least four work streams supporting excellence in customer service, including measurable improvement targets; we agreed that this would include a telecommunications work stream, carried forward from the previous year's objectives - agree how existing improvement programmes (e.g. outpatients transformation) would support our customer service objective. In the second half the year, we said we would begin to deliver the products and programmes of work described above, some of which we recognised would need to continue into 2018/19 and beyond.
How did we get on?	In 2017/18, following engagement with staff, patients, stakeholders, and an external customer service expert, we identified the following work streams: - Agreeing and embedding customer service principles - Enhancing the Trust's provision of customer service training for staff - Aligning the Trust's key outpatient survey so that it better measures the touch points and customer service principles identified through our staff / patient engagement work during 2017/18

	- Telecommunications improvement project - Developing an internal communications strategy around the programme The development of a set of customer service principles for UH Bristol was a particularly importance step. These principles set out what excellent customer service looks like in a large acute trust, and they now form part of the Trust's induction programme and customer service training. We are also in the process of incorporating the principles into the Trust's volunteers' induction and apprenticeship programmes. Further opportunities for embedding the principles in recruitment, competencies, evaluation and training processes will be pursued in 2018/19. This year, as part of the telecommunications work stream of this quality objective, we carried out an extensive review of complaints, survey and telecoms data and were able to identify ten areas of the Trust that require direct support to ensure effective answering of telephone calls (taken together, these areas account for around 70 per cent of complaints made to the Trust about this issue). The Trust's Transformation Team has begun to work with these teams to identify and address contributing factors, adopting models of good practice evident in high performing areas. Outcome measures for this project have been developed and will continue to be refined as this work continues. Our plans for the second year of this objective are set out in section 2.1.2 of this report.
RAG rating	Green – There have been a range of successful activities and developments in the first year of this programme, including the establishment of a set of customer service principles for the organisation. This has provided a firm foundation to build on in 2018/19.

Objective 4	**To improve staff-reported ratings for engagement and satisfaction**
Rationale and past performance	Our Quality Strategy sets out our ambition that, by 2020, we will be recognised as one of the top 20 NHS trusts to work for. The 2015 and 2016 NHS Staff Survey results had shown incremental improvements in our score for staff engagement (3.69 in 2014, 3.78 in 2015 and 3.83 in 2016). We need to maintain focus in order to realise our 2020 ambition: a staff engagement score of at least 4.00.
What did we say we would do?	Our plans for 2017/18 included: • Implementation of a new E-Appraisal system • Developing a new framework to support line managers to consistently display positive leadership behaviours • Continuing to deliver established and successful health and wellbeing initiatives • Revising our Tackling Bullying and Harassment policy and further developing our tackling bullying advisory service • Developing local improving staff experience plans, in response to the findings of the 2016 NHS Staff Survey.
Measurable target/s for 2017/18	Our target was to achieve year-on-year improvements in the following areas of staff-reported experience: • Staff Friends and Family Test scores (this asks whether staff would recommend the Trust as a place to work and receive treatment)

	• Overall staff engagement (a 'basket' of measures covering staff motivation, involvement and advocacy) • The percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month. We said we would measure improvement via our annual all-staff census (this takes place in the third quarter of the year) and our quarterly Friends and Family Test survey.
How did we get on?	In 2017/18, we: • Implemented the new E-Appraisal system, a revised policy and E-Learning training to support both staff receiving an appraisal and managers who are responsible for undertaking the appraisal. The Trust has experienced significant challenges with the functionality of the E-Appraisal system during its implementation – this continues to be addressed with the supplier and we are committed to ensuring the system improves the appraisal experience for staff going forward. • Launched our Leadership Behaviours in August, led by our Executive Directors. These behaviours are an integral part of our management training and leadership development programmes. • Launched the new dignity at work policy during 'Anti-bullying' week in November. This roadshow week promoted the policy and additional support available to staff across the organisation including our advisory service. • Worked in partnership with divisional teams to mobilise our 'improving staff experience' plans in response to the findings of the 2016 NHS Staff Survey. This has included focus groups, bespoke training, targeted away days, and coaching interventions. • Made progress with our Workplace Wellbeing Strategy and Delivery Plan. The provision of psychological services and initiatives continues to be a strategic priority for supporting colleagues' wellbeing. • Signed the 'Time to Change' employer pledge and made progress with the accompanying action plan. • Achieved our CQUIN target (also see section 2.2.4) for seasonal influenza vaccination uptake – 70 per cent for front-facing staff - and are projecting full achievement of the CQUIN indicator for healthy food and drink. In the 2017 NHS Staff Survey: • Our score for staff engagement improved from 3.83 in 2016 to 3.85 in 2017 and we now rank ahead of the national average for acute trusts (3.79). • Our score for whether staff would recommend the Trust as a place to work or receive treatment has also improved from 3.90 in 2016 to 3.95 in 2017; again better than the national average for acute trusts (3.75). • The percentage of staff *'witnessing potentially harmful errors, near misses or incidents in last month'* was 32 per cent, unchanged from 2016. There was also no change to the proportion of staff *'reporting errors, near misses or incidents witnessed in the preceding month'* which as with the 2016 results; this remained at 92 per cent[1] (better than the national average of 90 per cent). • The percentage of staff reporting *'fairness and effectiveness of procedures for reporting errors, near misses and Incidents'* also remained

[1] Reporting errors is indicative of a positive patient safety culture – a high score is good

	the same as the previous year's findings at 3.78 per cent. This is also better than the national average of 3.73 per cent. • Twenty-four per cent of our staff said that they had experienced harassment and bullying or abuse from other staff[2], compared to a national average of 25 per cent and a Trust score of 23 per cent in 2016. BAME staff experience is unchanged at 28 per cent. • Eighty-eight per cent of our staff said that they believed that the organisation provides equal opportunities for career progression or promotion[3], compared to a national average of 85 per cent and a Trust score of 89 per cent in 2016. The score for BAME staff was 69 per cent in 2017 compared to 77 per cent in 2016 (national average in 2017 was 75 per cent). We will be carrying out a more detailed analysis of the BAME survey data in order to identify any 'hot spot' areas within the Trust to target our efforts to improve the experience of BAME colleagues. In our own all-staff Friends and Family Test (measured in the first quarter of the year): • Sixty-nine per cent of staff said that they would recommend UH Bristol as a place to work compared to 70 per cent in 2016/17. • Eight-nine per cent of staff said that they would recommend UH Bristol as a place to receive treatment, compared to 86 per cent in 2016/17.
RAG rating	Green – We implemented our plan for 2017/18. Our staff engagement rating has improved for the fourth consecutive year and is now ahead of the national average for acute trusts.

Objective 5	**To reduce cancellations of outpatient appointments and to reduce waiting times in clinic**
Rationale and past performance	We recognise the inconvenience and stress caused to patients by altering their planned appointments. From a Trust operational perspective, changing appointments is an inefficient use of our administrative team's resources; there is also evidence to suggest that it contributes to overall Did Not Attend (DNA) performance. In 2016/17, we cancelled 12.8 per cent of consultant-led clinics and 11.6 per cent of all outpatient appointment. This is also the third year we have set the objective of reducing waiting times in clinic.
What did we say we would do?	**Reducing cancelled appointments:** Working with the Trust's Information Management and Technology team, we said we would improve the reporting of reasons for cancellation. We also wanted to extend the notice period for booking of annual leave by consultants from six weeks to eight weeks in order to help reduce the number of clinics being cancelled. Most significantly, we anticipated that improved management of the Trust's electronic referral system would lead to a reduction in the number of patients being cancelled and rebooked because they have been booked into the wrong clinic initially. Planned activity included a full review of the directory of services available to referrers, improved management of capacity and reduction in unavailability of appointment slots – all part of a national CQUIN (also see section 2.2.4).

[2] Indicator KF26 in the NHS staff survey
[3] Indicator KF21 in the NHS staff survey

	Reducing waiting times in clinic: We said we would complete the installation and upgrade of all waiting times boards and 'you said-we did' boards in outpatient departments, and embed the daily management of them into the outpatient standards and monthly quality visits. We also committed to continue to pursue objective measurement of in-clinic waits using the Medway-based tracker that follows patients through their outpatient visit.
Measurable target/s for 2017/18	**Reducing cancelled appointments:** Using CHKS[4] benchmarking information which compares us with a group of 50 other hospitals, we set a target of two per cent improvement in both hospital and patient cancellation rates. **Reducing waiting times in clinic:** We said we would continue to pursue the stretching targets for patient-reported experience that we set ourselves in 2016/17, and complete the implementation of all standardised boards and processes.
How did we get on?	In 2017/18 so far (based on data up to February 2018) we cancelled 12 per cent of consultant led appointments and 10.7 per cent of all outpatient appointments. This represents an improvement on 2016/17, when we cancelled 12.8 per cent of consultant-led clinics and 11.6 per cent of all outpatient appointments. Of the appointments that were cancelled, patients cancelled 13.1 per cent of consultant led appointments and 13.6 per cent of all appointments. This represents a proportional increase compared to 2016/17 when patients cancelled 12.4 per cent of consultant led appointments and 12.9 per cent of all appointments. During 2017/18, the coding of reasons for cancellations has been added as a regular agenda item for the Trust's outpatient steering group. This is enabling a monthly review of which reasons are being used and whether the codes available to staff are providing the insight we need to improve the service. For example, the category of 'hospital cancellation' has been removed as this was felt to be too vague, whilst 'short notice leave' has been added. A decision on the proposal to change clinicians' leave notice period from six to eight weeks is still awaited and the matter has been escalated to the Trust's Workforce and Organisational Development Board. Work is progressing to transfer the booking of all outpatient appointments to the Trust's appointment centre. As this includes the use of partial booking, whereby the patient can choose which appointment they would like at the time of booking, it is hoped this will help reduce the number of patient cancellations in 2018/19. Paper 'switch off' for GP referrals into consultant-led clinics will go live on 4 June 2018. Currently 92 per cent of services are available for patients to book into via the Trust's electronic referral system. Work is ongoing to reach 100 per cent by the end of May 2018, following which the focus will move to all services who receive GP referrals. We hope that giving patients a further opportunity to choose the appointment date and time will reduce patient cancellations. Further work is planned for 2018/19 as part of the productivity work stream within our outpatient transformation programme to reduce hospital and patient cancellation rates. In 2017/18, patient-reported feedback about the timeliness of outpatient

[4] CHKS is a provider of healthcare intelligence and quality improvement services

	appointments was largely unchanged from 2016/17. The same proportion of outpatient attendees told us that their appointment had started on time (that is, within 15 minutes of the appointed time - 72 per cent) and that they had seen a display board with waiting time information on it (47 per cent). However, a larger proportion of outpatient attendees said that they were told how long they would have to wait in-clinic (43 per cent compared to 37 per cent in 2016/17). Audits of outpatient areas found that all clinics had boards present (with the exception of those clinics where it had been previously agreed not to have boards). In most cases, these had been recently updated at the time of the audit, although there were some clinics where the board had only partially been updated. Feedback was given to the sisters and matrons for each area. The use of boards was also checked during Delivering Best Care in Outpatients Week, between 26 February and 2 March 2018. Further work is being piloted with System C (suppliers of the Trust's electronic referral system, Medway) to develop real-time clinic waiting time reports. This will allow the nurses and receptionists to give accurate updates to patients regarding current waiting times in clinics. It is hoped to pilot this and then roll out within 2018/19. Looking ahead to 2018/19, our plan is to improve patient choice by increasing the use of electronic referrals for first appointments and partial booking for follow-ups.
RAG rating	Amber – There were fewer cancelled appointments in 2017/18, however the reduction of around one per cent fell short of our two per cent target. More patients said they had been told how long they would have to wait in clinic, but our other patient-reported measures were unchanged from 2016/17.

Objective 6	**To improve the management of sepsis**
Rationale and past performance	Sepsis is recognised as a major cause of mortality and morbidity in the NHS. We made significant strides in the recognition and rapid treatment of sepsis during 2016/17, but we know there is more to be done.
What did we say we would do?	In 2017/18, we said we would: • Update the Trust's sepsis guidelines following their initial implementation in August 2016 • Implement NICE sepsis guidance • Complete mini-Root Cause Analysis investigations to gain a better understanding of the reasons why inpatients are not appropriately screened for sepsis and/or receiving timely antibiotics. Learning from these will be fed back to the clinical teams. • Undertake training and education in sepsis for all new staff at induction • Provide targeted education to foundation doctors, core trainees and higher specialist trainees in medicine, surgery, emergency medicine and anaesthesia/intensive care • Provide *Face2Face* ward based sepsis education for ward teams • Review SHMI, HSMR and ICNARC data to ensure that sepsis associated mortality continues to be lower than average.
Measurable target/s for 2017/18	Our goal was to achieve locally agreed targets for the national sepsis CQUIN (also see section 2.2.4), the four elements of which are: • Timely identification and treatment of patients with sepsis in emergency

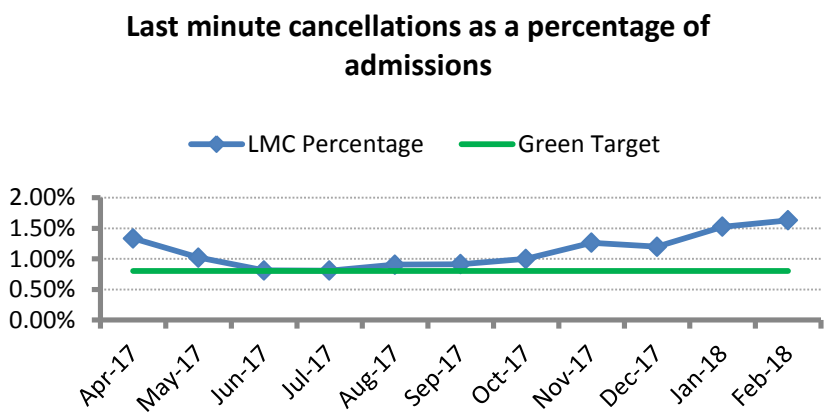
	departments • Timely identification and treatment of patients with sepsis in acute inpatient settings • Timely antibiotic review for patients confirmed as having sepsis (measured for patients who remain in hospital 72 hours after antibiotic treatment commenced) • Reduction in antibiotic consumption per 1,000 admissions
How did we get on?	In 2017/18: • Two patient safety nurses have been in post throughout the year, with an additional half-time post based in the emergency department from August 2017. • The Trust sepsis guidelines have been updated in line with NICE Sepsis guidance to make them easier to use and understand. The guidelines focus on ongoing patient care as well as acute recognition and treatment of sepsis. • Patient safety thermometer data was used to highlight patients in inpatient areas who require screening for sepsis and early treatment if sepsis is identified. Five mini root cause analyses were undertaken where sub-optimal sepsis patient care had occurred (i.e. failure to administer intravenous antibiotics within one hour of recognition). Written feedback has been received positively by ward nursing and medical teams via local morbidity meetings. • Sepsis education has been delivered face-to-face on the wards and in ED. Targeted sepsis education was given at quality and improvement meetings for Thoracic Surgery, Trauma and Orthopaedic teams. Specific sepsis teaching sessions have been held for Foundation doctors, Core trainees in acute medicine, and higher specialist trainees in emergency medicine, anaesthesia and intensive care. • Sepsis education at induction is occurring for all clinical staff with a special focus on August-starting Foundation doctors. • An electronic patient observation system, has been rolled out in Medicine and Surgery, incorporates sepsis screening, which has resulted in a much improved screening rate for inpatient sepsis • Intensive Care national audit data demonstrates that patients with sepsis are being referred and admitted promptly to the Intensive Care Unit (ICU) with mortality rates for sepsis lower than national averages. Intensive Care National Audit and Research Centre (ICNARC) nationally validated data demonstrates that patients with sepsis were admitted to ICU much earlier in 2016/17 (the latest year for which data is currently available) than in previous years. • A maternity sepsis guideline is in place and was audited in 2017/18. • In respect of our CQUIN targets, we fully achieved the part of the CQUIN relating to antibiotic review and partially achieved the other three elements. • The latest hospital mortality data (SHMI – also see section 3.3.1) indicates a falling mortality index of around 80 for all sepsis patients at UH Bristol in 2016/17 compared with an index of 110 in 2014/15 and 90 in 2015/16. This improvement puts UH Bristol's sepsis outcomes in the top 20 per cent of all NHS Trusts. Specifically in relation to children: • A guideline is being developed for febrile infants under the age of three months; this group of patients poses the biggest challenge for early

	appropriate antibiotic therapy as they require full investigation before antibiotics are administered. • A children's sepsis pathway was approved and is being piloted with a focus on education in paediatric outreach teams and on inpatient paediatric wards, including the use of simulation exercises. • Automated screening at triage in the children's emergency department means that the department is now achieving a screening rate of 100 per cent. The delivery of antibiotics within one hour to children with a diagnosis of suspected sepsis continues to be challenging, however antibiotic delivery within two hours has been 100 per cent, with the majority of one hour breaches missing the target by less than 15 minutes. In addition, in those who children who are unstable (and require resuscitation) on initial assessment, antibiotic administration target of 100 per cent is being met. In 2018/19, we will maintain our focus to achieving our targets for sepsis screening and antibiotic administration. In adult services, we will complete the implementation of electronic observations throughout UH Bristol which incorporates mandated sepsis screening for all patients with a highly elevated NEWS score ('NEWS 2' implementation will also take place during this year). In children's services, we will pilot and roll-out the inpatient sepsis screening tool.
RAG rating	Amber – we made significant progress in the effective management of sepsis but only partially achieved our CQUIN goals

Objective 7	**To implement a new, more responsive, system for gathering patient feedback at point of care**
Rationale and past performance	Implementation of the new system was postponed from 2016/17 and carried forward into 2017/18.
What did we say we would do?	During 2017/18, as part of a wider focus on delivering responsive care, we said that we would procure a new in-hospital patient feedback system to run alongside our existing post-discharge surveys. We want more patients and carers to give feedback about quality of care whilst the patients are still in hospital, thereby increasing our opportunities to address any issues or concerns quickly.
Measurable target/s for 2017/18	Our stated target was to achieve a significantly improved score in the 2018 National Inpatient Survey (by virtue of when the survey takes place), in relation to whether patients say that they have been asked about the quality of their care whilst they have been in hospital. In the meantime, we said we would measure progress through our own monthly survey.
How did we get on?	In April 2017, funding was secured to procure the new feedback system and this was followed in May 2017 by approval from the Trust's Information Management and Technology (IM&T) Department Management Group to proceed to tender. Unfortunately, there were significant delays in the procurement process, resulting in the tender not going "live" until February 2018. At the time of writing, a preferred supplier for this system has been identified through the tender process and is pending approval. It is anticipated that the contract will be awarded in May 2018. In conjunction with the procurement process, a professional design agency has been commissioned to develop "marketing" around the new system. This

	will include the development of posters in wards and clinics encouraging patients and visitors to give feedback, signage for the new touchscreen feedback points that will be located around our hospitals, and a re-design of existing feedback materials including comments cards. A key part of our plans was to enable more effective use of service-user feedback, by creating a data "hub" to better utilise this insight within our organisation. We have been able to progress this work stream by utilising the Trust's own "Infoweb" data warehouse, which is available to all staff on the UH Bristol intranet. The production of the Trust's key survey measures is now fully automated to ensure their efficient and accurate use in key management reports. The next stage in this development for 2018/19 will be to produce more effective ward and Divisional-level reporting.
RAG rating	Amber – Progress has been made during 2017/18, and implementation of the new system will take place during the first quarter of 2018/19.

Objective 8	**To reduce the number of last minute cancelled operations**
Rationale and past performance	We understand the impact that the last minute cancellation of operations can have on patients – particularly those who require urgent treatment – and their families, creating uncertainty and adding to worry. This was the fourth consecutive year we have set this objective. In 2016/17, 0.97 per cent of operations were cancelled at the last minute, against a target of no more than 0.92 per cent.
What did we say we would do?	We will conduct a detailed review of 2016/17 data to understand reasons for cancellations and will ensure that our action plan is directed towards areas where the greatest improvement is needed. In particular, we will adopt a new approach around the key themes of staffing, scheduling, capacity (linked to wider issues of bed occupancy and escalation) and improved understanding of the risks and impacts of cancelling operations.
Measurable target/s for 2017/18	We are retaining our existing target to reduce the percentage of operations cancelled at the last minute for non-clinical reasons to no more than 0.92 per cent.
How did we get on?	We are disappointed to report that, in 2017/18, 1.19 per cent of operations were cancelled at the last minute. This represents deterioration on 2017/18 and falls short of both our current annual target (0.92 per cent) and the national target (0.8 per cent). This means that 919 patient operations were cancelled on the planned day of surgery during the year, compared to 734 in 2016/17. Over one third of cancellations in 2017/18 were attributed to a lack of suitable bed (22 per cent due to no ward bed being available, and 17 per cent were due to no High Dependency Unit / Intensive Care Unit bed being available). Twenty three per cent of cancellations were the result of another patient being prioritised, whilst 16 per cent were due to lack of staff. March was a particularly difficult month due to two episodes of severe weather and continued winter demand. At the beginning of 2018/19, we will be taking this analysis a stage further by looking at reasons for cancellations at specialty level, and will use any insight this provides to inform a refreshed improvement plan for the year.

	
RAG rating	Red – Our performance in 2017/18 was worse than in previous years and did not meet our target.

2.1.2 Quality objectives for 2018/19

The Trust is setting eight quality objectives for 2018/19.

Two of these objectives – **developing a customer service mind set**, and **improving staff engagement and satisfaction** – represent a continuation of existing annual quality objectives. The staff engagement objective has been included once again for 2018/19 in response to staff and patient feedback.

We have agreed six new annual quality objectives for 2018/19, four of which address commitments we have previously made in our Quality Strategy for 2016-2020, namely:

- **improving our performance in respect of achieving the NHS 62-day standard for GP referral to treatment;**
- **improving learning from Serious Incidents (including Never Events);**
- **reducing medication incidents involving insulin resulting in moderate or severe harm**; and
- **introducing a programme of mystery shopping**[5].

The mystery shopping programme will be closely linked to our customer service objective.

The first of our remaining two objectives for 2018/19, **improving early recognition of the dying patient**, builds directly on early learning from our mortality review programme. Finally, **maternity services** were rated as the best in country in the 2016 national maternity patient survey, but our position dropped to being in line with national average in the 2017 survey – so our eighth objective is designed to explore what improvements we need to be making in order to return to the top of the pack in the 2019 survey and beyond.

[5] Mystery shopping is a research methodology used to measure the quality of services. The mystery shopper's identity is not known to the service being evaluated.

Objective 1	**To develop a consistent customer service mind set in all our interactions with patients and their families**
Rationale and past performance	Customer service is a thread running throughout our Quality Strategy for 2016-2020. This objective marks the second year of an ongoing project aimed at embedding the consistent understanding and application of customer service principles across our organisation.
What will we do?	During 2018/19, we will build on the developmental work undertaken during the first year of this quality objective, to begin embedding a customer service mind set in key Trust programmes and activities. There are four key areas of focus in 2018/19: **Customer service staff training and development** This work stream will support the training and development of UH Bristol staff in delivering an effective customer service. UH Bristol's principles of excellent customer service, which were developed in collaboration with staff, patients and stakeholders during the first year of this quality objective, will be incorporated into the following training and development activities: • corporate induction • customer service training • volunteer induction • apprenticeship programme • nursing preceptorship programme. In addition, an advanced customer service training module will be developed, based on a successful model developed by Sheffield Teaching Hospitals NHS Foundation Trust. Using the outcomes from the Trust's *Delivering Best Care* week in February 2018, teams will be identified as pilot sites for this advanced training. We will also develop a plan to undertake service level customer service accreditation at UH Bristol, which is an ambition contained in the Trust's Quality Strategy (2016-2020). The accreditation scheme will be a way of testing ourselves against established best practice in customer service and giving recognition to wards and departments in our hospitals that achieve this benchmark. By the end of 2018/19 we will have scoped out and developed the accreditation process for piloting and formal roll-out during 2019/20 onwards. **Telecommunications** This work stream is about ensuring that people who phone the Trust receive an efficient and effective response from our staff. In 2017/18, the Trust's Transformation Team undertook detailed analysis of telecoms, survey and complaints data. This enabled good practice, key barriers and "hot-spots" around the Trust to be identified. In 2018/19, using this insight, the Transformation Team will work with ten UH Bristol departments that require specific support to develop their telephone handling/management practice. During 2018/19, there will also be a Trust-wide focus on communicating good practice and troubleshooting around telephone handling, via UH Bristol's internal communication channels. The Transformation Team will also develop a resource and best practice guidance pack, for teams to use across the Trust.

	Communications We need to get the customer service message across to our staff, clearly and effectively, particularly regarding UH Bristol's Principles of Excellent Customer Service. We also want our stakeholders, including the people who use our services, to see our organisation as one that's increasingly focused on delivering consistently excellent customer service. To this end, our third work stream will be to develop a communications strategy. We will begin by holding a stakeholder workshop in May 2018. **Customer Service in outpatient services** UH Bristol's Principles of Excellent Customer Service support the objectives of the Outpatients Transformation Programme, such as enhancing patient satisfaction by delivering consistently outstanding services provided by responsive, competent and friendly staff. We will review the Trust's Outpatient Service Standards to incorporate the UH Bristol Customer Service Principles. Staff recruitment and competency evaluation processes will also be reviewed to incorporate a customer service element. Finally, to ensure that we are monitoring levels of customer service satisfaction effectively, the Trust's outpatient satisfaction survey will be re-designed around the key customer service "touchpoints".
Measurable target/s for 2018/19	**Project milestones to be delivered:** - Stakeholder workshop - Communications strategy - Incorporation of UH Bristol Customer Service Principles into key training and development programmes - Design and piloting of advanced customer service training - Development of an accreditation scheme for UH Bristol - Review of outpatient standards, recruitment and competency processes **Measurable target to be achieved:** We aim to reduce the number of complaints about telecommunications in the identified top ten departments by 25 per cent by the end of September 2018, and by 50 per cent by the end of March 2019, compared to the same period for 2017/18.
How progress will be monitored	Progress will be monitored via the Trust's Transformation Board.
Board sponsor	Chief nurse
Implementation lead	Director of transformation

Objective 2	**To improve staff-reported ratings for engagement and satisfaction**
Rationale and past performance	Our Quality Strategy sets out our ambition that, by 2020, we will be recognised as one of the top 20 NHS trusts to work for. Successive NHS staff survey results have shown incremental improvements in our score for staff engagement (3.69 in 2014, 3.78 in 2015, 3.83 in 2016, and 3.85 in 2017). We need to maintain focus in order to realise our 2020 ambition: a staff engagement score of at least 4.00.
What will we do?	Our plans for 2018/19 include:

	• A bespoke leadership development programme for our 'Top' 100 leaders which will include a re-launch of our leadership behaviours • A review of our performance management culture with a view to more closely aligning this to an annual cycle where objectives are set and cascaded through the organisation in a more transparent way • Using this year's NHS 70 celebrations to launch our new staff badge as part of our recognition strategy for staff with more than 10 years' service. • Further development of our Dignity at Work programme to focus on decreasing bullying and harassment in the organisation • Wider spread of the use of the 'Happy App' across the organisation We will also prioritise our efforts and interventions to improve our lower ranking scores within the NHS Staff Survey as follows: • We will introduce mandatory "how to be a manager" training for new joiners and staff who are promoted into management roles • We will review the quality of non-mandatory training across the Trust • We will continue to focus on improving staff motivation through the 'Improving staff engagement plans' which are delivered at Divisional level to encourage positive cultural change • We will use 'You said… We did week' in May 2018 to focus on the topic of how we can continue to improve staff communications • We will identify areas within the Trust where staff have expressed dissatisfaction with opportunities for flexible working and explore the potential for local solutions.
Measurable target/s for 2018/19	Our goal is to achieve a staff engagement score of at least 3.90 in the 2018 NHS Staff Survey.
How progress will be monitored	Divisional board meetings, Workforce and Organisational Development Board, Trust Board.
Board sponsor	Director of people
Implementation lead	Divisional directors, supported by corporate organisational development team

Objective 3	**To improve compliance with the 62 day GP referral to first definitive cancer treatment standard**
Rationale and past performance	The 62 day standard for first treatment after GP referral for suspected cancer (hereafter '62 day GP') is a high priority nationally and is seen as a benchmark of good cancer services. The standard has been non-compliant nationally in 2017/18 and the Trust had not achieved quarterly compliance since 2012. The Trust has a very challenging case mix with a high proportion of more complex cancer types that perform poorly at a national level, and a lower proportion of high volume higher performing cancer sites such as breast. The Trust has made significant improvements in performance and achieved the 85 per cent threshold in quarter three of 2017/18. However, following surgical cancellations due to winter pressures and other unavoidable factors (patient choice and late referrals from other providers) performance dropped to around 80 per cent in quarter four (final figure not yet available).

What will we do?	Key actions in our plan to deliver improved performance include: • reducing and minimising the impact of cancellations through critical care capacity review, theatre productivity and effective winter planning; and • working with other providers to reduce late referrals via a virtual waiting list meeting and ongoing thorough waiting list management.
Measurable target/s for 2018/19	Our targets are: • to achieve 85 per cent compliance in six out of 12 months in 2018/19 (we achieved the target for two months in 2017/18, so achievement of this target would represent a significant step forward in performance). • to achieve 85 per cent compliance for non-shared patients (those seen at UH Bristol only) in every quarter during 2018/19.
How progress will be monitored	Performance against the standards is reported monthly, nationally and internally. Informal monitoring reports are produced weekly and distributed internally.
Board sponsor	Chief operating officer
Implementation lead	Deputy chief operating officer

Objective 4	**To introduce a 'mystery shopping' programme within the Trust**
Rationale and past performance	The Trust's Quality Strategy (2016-2020) includes a commitment to introduce mystery shopping as a technique to supplement the variety of ways that we already gather information about patient-reported experience of care in our hospitals, e.g. surveys, interviews and observation techniques. This methodology will also directly support the Trust's work around developing a more consistent customer-service mind set in all our interactions with patients and families (see objective 1, above).
What will we do?	Our initial work stream will focus on training members of the UH Bristol's *Face2Face* volunteer interview team to carry out mystery shopping exercises at key touch points around the Trust, primarily "front of house" services such as receptions, and telephone contacts. In collaboration with the Customer Service Steering Group, a programme of mystery shopping will be developed for the interview team. This will have begun by the end of 2018, with an initial evaluation of the programme taking place at the end of 2018/19. A second work stream will focus on exploring the potential to develop more in-depth mystery shopping, such as patients giving detailed feedback after a planned hospital appointment (our initial focus will be on elective care). This needs to be carefully scoped out with a range of stakeholders, including senior clinical leads and staff-side representatives. If, following these discussions, it is agreed that this approach can be taken forward, the Trust's Patient Experience and Involvement Team will develop and oversee a process for recruiting, training and supporting patients for this role.
Measurable target/s for 2018/19	Completion of the above agreed actions to introduce a mystery shopping programme.
How progress will be monitored	Progress will be monitored by the Trust's Patient Experience Group, which meets on a quarterly basis.
Board sponsor	Chief nurse
Implementation lead	Tony Watkin, patient and public involvement lead

Objective 5	To improve learning from Serious Incidents and Never Events
Rationale	It is a stated aim in our Quality Strategy (2016-2020) that we want to improve learning from serious incidents. We also reported nine Never Events in 2017/18.
What will we do?	In 2018/19: • We will hold multidisciplinary summits for staff to share learning from incident themes and look for organisational improvements. • We will strengthen our action plans resulting from serious incident investigations to focus on fewer, stronger actions by introducing an objective assessment of strength of actions for each incident. • We will audit the quality of our daily safety briefs to ensure lessons arising from incidents are being shared with front-line staff, and make any changes if required. • We will hold "patient safety conversations" (focus groups) with front-line staff to gather and share good practice in response to learning from incidents and to identify blocks that prevent front-line staff from acting to keep people safer. • We will introduce a Trust wide system for learning from excellence. Safety in healthcare has traditionally focused on avoiding harm by learning from errors, however this approach may miss opportunities to learn from excellent practice. Studying excellence in healthcare can create new opportunities for learning and improve staff resilience and morale. • We will develop additional information resources to tell patients and families about how they can help keep themselves/their loved ones safer in hospital.
Measurable outputs for 2018/19	Completion of the above agreed actions to improve learning from serious incidents and never events.
How progress will be monitored	Via quarterly reports to Clinical Quality Group.
Board sponsors	Chief nurse and medical director
Implementation lead	Head of quality (patient safety) Associate medical director for patient safety

Objective 6	To improve early recognition of the dying patient
Rationale and past performance	One of the early major themes to arise from the Trust's systematic review of patient deaths (see sections 2.1.1 and 3.3.2) has been that we are sometimes slow to recognise that a patient is dying. A patient typically has several reviews out-of-hours because of raised National Early Warning Scores (NEWS)[6], however we have identified that junior doctors can be inclined to request an investigation or to try a potentially futile intervention before the patient is eventually recognised as dying and the focus is changed to end of life care. This matters for several reasons: • during the time the patient is dying but not being palliated they may

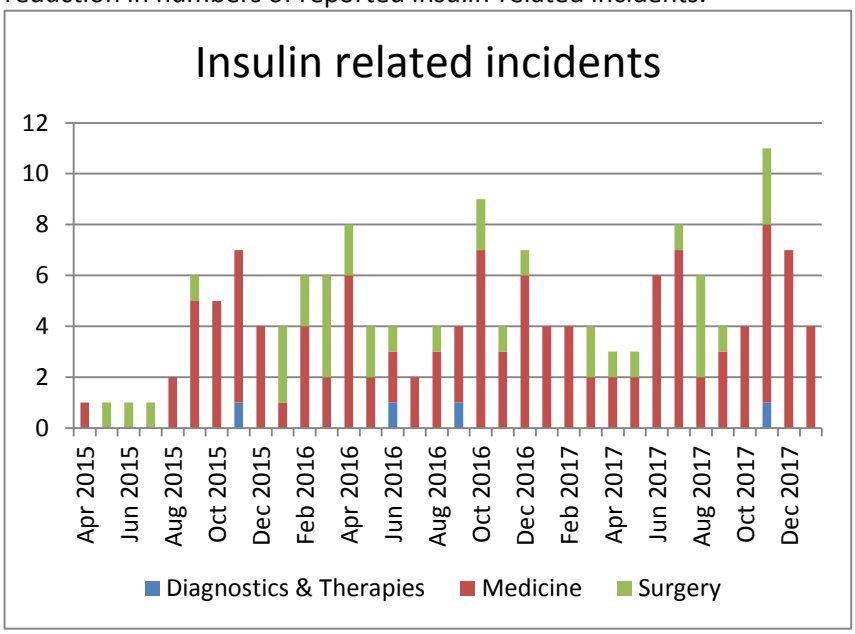
[6] NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

	have pain or breathlessness • late recognition does not allow the patient to make a choice about where they die • patients might be left with 'unfinished business'.
What will we do?	We are going to use a multi-faceted approach to improving the confidence of junior doctors in recognising the dying patient. Initially this will include the use of a pro-forma asking the question "is this patient so unwell they might die on this admission?" for all admissions through the emergency department and acute medical unit. We are also adapting the weekend sticker to ask the question "For patients at ceiling of treatment, when should a move to end of life care be considered?". We also fully expect that further new ideas will emerge during the course of this quality improvement project.
Measurable target/s for 2018/19	Our measure of success will be an increase in the length of time for which the end of life care tool is used for patients, since earlier recognition will mean the end of life tool will be in use for longer. We are planning to collect baseline data in April and then repeat after each intervention is introduced.
How progress will be monitored	Progress will be monitored by the Trust's Mortality Review Group.
Board sponsor	Mark Callaway, acting medical director
Implementation lead	Drs Colette Reid (specialist palliative care), Amanda Beale (gastroenterology) and Rebecca Maxwell (emergency department)

Objective 7	**To improve patients' experiences of maternity services**
Rationale and past performance	Our maternity services were rated as the best in country in the 2016 national maternity patient survey, but our score in the 2017 survey was in line with the national average – so our objective is designed to explore what improvements we need to be making in order to return to the top of the pack in the 2019 survey and beyond.
What will we do?	The provision of hospital and community maternity services at UH Bristol is part of a wider network of maternity care that stretches across Bristol, North Somerset, and South Gloucestershire (the "BNSSG" area). This includes GP practices, commissioning organisations, health visitors, community midwifery / support services, and providers of hospital care. Transformational change needs to occur across these settings to have a significant impact on the whole maternity experience of our service-users. The BNSSG Maternity Transformation Plan , to implement "Better Births", a national 'must do', is an ambitious programme of activity with a particular focus on improving the following aspects of maternity care: • Integrated information technology across and within service providers, to offer women more choice and joined-up care • Review of the initial midwifery "booking" appointment to identify opportunities to free up time for more meaningful conversation and a genuinely personalised care plan • Continuity of carer during the antenatal period, to reduce the number of different midwives women see for their antenatal care • Improved postnatal hospital care, for example through better infant feeding support, staff training, and a review of the bereavement care pathway

	• Improved mental health care during pregnancy or in the first year following birth of the child. In addition, there will be a number of UH Bristol-specific initiatives to support this quality objective during 2018/19: • Following the success of *#conversations* week at the Bristol Royal Hospital for Children, which engaged staff, patients and families in discussions about their experiences of care, the maternity department and LIAISE[7] service will replicate this event at St Michael's Hospital during the first half of 2018/19. • *Patient Experience at Heart* is an approach used previously with great success at St Michael's Hospital, which invites staff at all levels of the service and patients to share their respective experiences. The aim is to identify any barriers to providing a high quality service, which the management team can then address. Further workshops will be held during 2018/19 to draw in staff who have joined the hospital since the programme was last run. • Feedback from our ongoing local survey of women's experiences of maternity care tells us that discharge from hospital is a key area for us to make improvements. We will therefore undertake a specific review of discharge processes in maternity services during 2018/19.
Measurable target/s for 2018/19	The action plan and targets associated with the BNSSG transformation plan are currently in development and will be finalised during the first half of 2018/19. However, these targets will include 20 per cent of all women across BNSSG having continuity of care by a team of midwives. Ultimately, our goal is to return a top quartile performance in the 2019 national maternity survey.
How progress will be monitored	Progress will be monitored through the Postnatal Working Party at St Michael's Hospital, reporting to quality assurance meeting in the Division of Women's and Children's Services.
Board sponsor	Chief nurse
Implementation lead	Head of midwifery

[7] LIAISE is the 'PALS' service (Patient Advice and Liaison Service) for Bristol Royal Hospital for Children

Objective 8	To improve the safe prescribing and use of Insulin
Rationale and past performance	The Trust has put in place several measures in recent years to improve the safety of insulin prescribing and administration but this has not led to a reduction in numbers of reported insulin-related incidents.  Source: Datix system Eighty two per cent of 112 insulin-related incidents reported since April 2015 have been reported as 'no harm'; only 18 percent have resulted in any potential harm. Recent improvement measures have included: • The increased use of Connecting Care to allow diabetes nurse specialists and junior doctors to access GP medication information 24 hours a day for Bristol, North Somerset and South Gloucestershire (BNSSG) patients • The inclusion of specific insulin sections in the adult paper prescription charts • Revisions to the patient self-administration procedure for insulin to allow easier patient assessment by nursing staff • Training of nurses by diabetes nurse specialists • Information to asset prescribers with insulin choice and recognition at admission • Provision of specific guidance for prescribers and nursing staff for high risk products such as 500 unit/ml insulin • Aligning insulin drug naming in pharmacy and electronic prescribing systems to match national recommendations
What will we do?	In 2018/19, we will: • Roll-out Medway electronic prescribing (EPMA) to adult wards (timescale expected to be August-October 2018 for acute medicine and care of the elderly wards) • Review all electronic prescribing systems in the Trust with regard to insulin prescribing to identify any safety gaps and discuss these with system providers • Implement, via Connecting Care, a one click link within Medway (our patient administration system) electronic prescribing, to ensure GP

	information is readily available at the point of admission • Undertake a themed analysis of insulin-related errors • Develop insulin-related safety metrics that can be produced automatically from EPMA and clinical notes • Work with our Emergency Department, Acute Medical Unit (Ward A300) and Older People's Assessment Unit (Ward A400) teams to identify other areas of potential improvement • Collect baseline data of insulin omissions as recorded by pharmacy medicines reconciliation electronic records • Work with West of England Academic Health Science Network patient safety collaborative and BNSSG Clinical Commissioning Group on the quality of insulin prescription-related information at transfers of care.
Measurable target/s for 2018/19	Our goal is that unintentional omission of insulin prescribing on the Acute Medical Unit (Ward A300) and Older People's Assessment Unit (Ward A400) will be 25 per cent lower by the end of 2018/19 when compared with a 2017/18 baseline mean. These wards represent the main admission points for adult patients; medicines reconciliation on admission is a key area of focus to ensure that patients are on the right medication at the start of their time in hospital.
How progress will be monitored	Progress will be monitored by the Diabetes Steering Group.
Board sponsor	Medical director
Implementation lead	Pharmacy manager, clinical services

2.1.2.1 How we selected these objectives

These objectives have been developed, following consideration of:

- the quality priorities of our Trust Board as set out in our quality strategy for 2016-2020;
- views expressed by attendees at our 'Quality Counts' evening in January 2018 (a consultation event aimed at our Involvement Network and Trust members); and
- feedback from an online survey which was open to our staff and any member of the public during March 2018.

2.2 Statements of assurance from the Board

2.2.1 Review of services

During 2017/18, UH Bristol provided relevant health services in 70[8] specialties via five clinical divisions (Medicine; Surgery; Women's and Children's Services; Diagnostics and Therapies; and Specialised Services).

During 2017/18, the Trust Board has reviewed and selected high-level quality indicators covering the domains of patient safety, patient experience and clinical effectiveness as part of monthly performance reporting. Sufficient data was available to provide assurance over the services provided by the Trust. The Trust also receives information relating to the review of quality of services in all specialties via, for example, the Clinical Audit Annual Report. The income generated by UH Bristol services reviewed in 2017/18 therefore, in these terms, represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2017/18.

2.2.2 Participation in clinical audits and national confidential enquiries

For the purpose of the Quality Account, the Department of Health published an annual list of national audits and confidential enquiries, participation in which is seen as a measure of quality of any trust's clinical audit programme. This list is not exhaustive, but rather aims to provide a baseline for trusts in terms of percentage participation and case ascertainment. The detail which follows relates to this list.

During 2017/18, 41 national clinical audits and five national confidential enquiries covered NHS services that University Hospitals Bristol NHS Foundation Trust provides. During that period, University Hospitals Bristol NHS Foundation Trust participated in 93 per cent (38/41) of national clinical audits and 100 per cent (4/4) of the national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2017/18, and whether it did participate, are as follows:

Table 1

Name of audit / Clinical Outcome Review Programme	Participated
Acute	
Case Mix Programme (CMP)	Yes
Fractured Neck of Femur (care in emergency departments)	Yes
Major Trauma Audit	Yes
National Emergency Laparotomy Audit (NELA)	Yes
Pain in Children (care in emergency departments)	Yes
Procedural Sedation in Adults (care in emergency departments)	Yes
Sentinel Stroke National Audit programme (SSNAP)	Yes
Blood and Transplant	
Audit of red cell & platelet transfusion in adult haematology patients	Yes

[8] Based upon information in the Trust's Statement of Purpose (which is in turn based upon the Mandatory Goods and Services Schedule of the Trust's Terms of Authorisation with NHS Improvement)

Management of patients at risk of Transfusion Associated Circulatory Overload	Yes
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes
Cancer	
Bowel cancer (NBOCAP)	Yes
Head & Neck Cancer (HANA)	Yes
Lung cancer (NLCA)	Yes
Oesophago-gastric cancer (NAOGC)	Yes
Heart	
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes
Adult Cardiac Surgery	Yes
Cardiac Rhythm Management (CRM)	Yes
Congenital Heart Disease (CHD)	Yes
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Heart Failure Audit	Yes
Long-term conditions	
Endocrine and Thyroid National Audit	No
Inflammatory Bowel Disease (IBD) programme	No
National Audit of Dementia	Yes
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Yes
National Diabetes Core Audit (Adult)	Yes
National Diabetes Foot Care Audit (NDFA)	Yes
National Diabetes Inpatient Audit	Yes
National Ophthalmology Audit	Yes
National Pregnancy in Diabetes Audit	Yes
Older People	
Fracture Liaison Service Database (FLS)	Yes
National Audit of Inpatient Falls (NAIF)	Yes
National Hip Fracture Database (NHFD)	Yes
National Joint Registry (NJR)	Yes
UK Parkinson's Audit	No
PROMS	
Elective Surgery (National PROMs Programme)	Yes
Women's & Children's Health	
Diabetes (Paediatric) (NPDA)	Yes
National Maternity and Perinatal Audit	Yes
National Neonatal Audit Programme (NNAP)	Yes
Neurosurgical National Audit Programme	Yes
Outcome Review Programmes	
Child Health Clinical Outcome Review Programme	Yes
Learning Disability Mortality Review Programme (LeDeR)	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes

Medical and Surgical Clinical Outcome Review Programme	Yes

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (where known).

Table 2

Name of audit / Clinical Outcome Review Programme	
Acute	
Case Mix Programme (CMP)	100% (1231)
Fractured Neck of Femur (care in emergency departments)	100% (50)
Major Trauma Audit	>100% (408)**
National Emergency Laparotomy Audit (NELA)	139*
Pain in Children (care in emergency departments)	102*
Procedural Sedation in Adults (care in emergency departments)	67*
Sentinel Stroke National Audit programme (SSNAP)	>90% (492)
Blood and Transplant	
Audit of red cell and platelet transfusion in adult haematology patients	>100% (58)**
Management of patients at risk of Transfusion Associated Circulatory Overload	100% (40)
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	15*
Cancer	
Bowel cancer (NBOCAP)	>100% (218)**
Lung cancer (NLCA)	69% (214)
Oesophago-gastric cancer (NAOGC)	238*
Heart	
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	845*
Adult Cardiac Surgery	100% (1309)
Cardiac Rhythm Management (CRM)	100% (1042)
Congenital Heart Disease (CHD)	100% (1189)
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions	100% (2175)
National Cardiac Arrest Audit (NCAA)	69*
National Heart Failure Audit	568*
Long term conditions	
National Audit of Dementia	23*
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	226*
National Diabetes Core Audit (Adult)	510*
National Diabetes Foot Care Audit (NDFA)	49*
National Diabetes Inpatient Audit	74*
National Ophthalmology Audit	100% (4503)
National Pregnancy in Diabetes Audit	30*

Older People	
Fracture Liaison Service Database (FLS)	1530*
National Audit of Inpatient Falls (NAIF)	26*
National Hip Fracture Database (NHFD)	317*
National Joint Registry (NJR)	87% (37)
PROMS	
Elective Surgery (National PROMs Programme)	34*
Women's & Children's Health	
Diabetes (Paediatric) (NPDA)	511*
National Maternity and Perinatal Audit	100% (5467)
National Neonatal Audit Programme (NNAP)	100% (2648)
Neurosurgical National Audit Programme	682*
Paediatric Intensive Care (PICANet)	100% (708)
Outcome Review Programmes	
Child Health Clinical Outcome Review Programme	3*
Learning Disability Mortality Review Programme (LeDeR)	Data not available
Maternal, Newborn and Infant Clinical Outcome Review Programme	60*
Medical and Surgical Clinical Outcome Review Programme	7*

*No case requirement outlined by national audit provider/unable to establish baseline
** Case submission greater than national estimate from Hospital Episode Statistics (HES) data

The reports of 11 national clinical audits were reviewed by the provider in 2017/18. University Hospital Bristol NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

College of Emergency Medicine Audits

- To appoint a 'sepsis champion' and further educate staff in the recognition and management of sepsis through the introduction of posters within the emergency department
- To review and update the departmental asthma guidelines in view of new British Thoracic Society (BTS) guidance
- To conduct a local in-depth audit looking at the process of consultant sign off for different age groups prior to discharge

National Diabetes Foot Care Audit (NDFA)

- To arrange for nurses to administer patient information and consent forms on arrival at clinic and put up posters to remind clinic staff to complete forms
- To compare the Trust's process for recording newly healed but reoccurred ulcers with other trusts for learning purposes
- To review our processes in order to increase the number of patients who are included in this audit
- To establish whether key quality measures used in the audit can be reported on a more frequent basis from our own outpatient data
- To extract results for local trusts from national data so team can compare practice
- To move towards ongoing electronic data collection and review/streamline current clinic pro forma on Medway (the Trust's patient administration system) in light of this.

National Diabetes Audit – Pregnancy in Diabetes

- To complete the national diabetes preconception pilot and liaise with commissioners regarding local provision of services. The Team is registered with National Pregnancy in Diabetes Quality Improvement Collaboration
- For the endocrine antenatal team to continue to deliver teaching and training for primary care staff via annual midwifery teaching courses
- To complete a local audit looking at preterm delivery rates for women with Type 1 and 2 diabetes to try and clarify why the UH Bristol data is higher than national figures

National Audit of Inpatient Falls

- To develop a ward-based checklist to assess the vision of inpatients who are at risk of falls on admission
- To organise and deliver a falls awareness week to increase awareness and training to all staff groups across the Trust
- To devise a business case to support an activities coordinator to work across the Trust
- To identify a patient or carer of someone who has fallen in UH Bristol to become a representative on the Falls Steering Group
- To review and update falls e-learning and intranet information pages
- To conduct a post falls audit locally to determine compliance with the current post falls guideline and implement any actions based on these findings
- To roll out the post falls medical proforma across the Trust and carry out an audit to determine compliance
- To conduct a re-audit of SWARM[9] documentation across the Trust to determine compliance and implement any actions based on these findings.
- To conduct a bed rails and bumpers documentation audit of new risk assessments across the Trust to determine compliance.

National Heart Failure Audit

- To introduce increased outreach services to medicine. This will have the additional benefit of increasing the number of heart failure patients we include in the audit
- To introduce a process of local validation comparing Hospital Episode Statistics (coded) data with data collected by heart failure nurses to increase data capture.

National Maternity and Perinatal Audit

- To introduce midwife-run workshops for couples who have had one previous caesarean section, to help them understand the risks and benefits of vaginal birth after caesarean section (known as VBAC) versus elective caesarean section
- To audit water-births and perineal tears on the Midwifery Led Unit
- To conduct a survey of women's reasons for choice of mode of delivery.

National Emergency Laparotomy Audit (actions completed by October 2016)

- To introduce an Emergency Laparotomy Enhanced Recovery Pathway which will standardise peri-/post-operative care with the aim of safely reducing length of stay
- To educate surgical and anaesthetic trainees regarding the need to better document pre-operative consultant review of high risk patients
- To undertake an audit of CT reporting for NELA patients

Sentinel Stroke National Audit Project

- To increase the role of specialist stroke nurses in facilitation of the pathway
- To undertake further education of clinical staff regarding the importance of the stroke pathway

[9] SWARM is a multidisciplinary tool used to investigate when a patient falls

- To introduce an information stamp which will be used in the notes to make it clear when patients have been discharged from occupational therapy.

National Audit of Dementia

- To improve the assessment of delirium by adding the 4AT assessment to admission clerking proformas
- To increase awareness of the 'This is me' document to help capture the personal needs and information of patients with dementia
- To participate in the dementia wellbeing pre-hospital project (working with primary care) to better understand the personal needs and information of patients before they are admitted
- To introduce a specific continence care plan
- To introduce additional twice yearly dementia/delirium awareness sessions for staff
- To introduce roll specific dementia/delirium e-learning for staff.

The outcome and action summaries of 212 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2017/18; summary outcomes and actions reports are reviewed on a bi-monthly basis by the Trust's Clinical Audit Group. Details of the changes and benefits of these projects will be published in the Trust's Clinical Audit Annual Report for 2017/18[10].

Clinical Outcomes Publication (COP)

Previously the Consultant Outcomes Publication, the Clinical Outcomes Publication (COP) is an NHS England initiative, managed by the Healthcare Quality Improvement Partnership (HQIP) to publish quality measures at the level of individual consultant doctors using National Clinical Audit and administrative data. COP began with ten national clinical audits in 2013, with two further audits/registries added in 2014. Those that published in the inaugural year have continued to build on and develop the number of procedures and quality measures covered including team-based or hospital measures.

The table below shows the clinical specialties/societies that report consultant outcomes and whether the Trust submitted data to the required national audit/registry in 2017/18.

Table 3

Specialty	Clinical audit/registry title	Specialist Association	Submitted
Adult cardiac surgery	National Adult Cardiac Surgery Audit ***Open heart surgery***	Society for Cardiothoracic Surgery	Yes
Bariatric surgery	National Bariatric Surgery Register ***Surgery concerning the causes, prevention and treatment of obesity***	British Obesity & Metabolic Surgery Society	N/A
Colorectal surgery	National Bowel Cancer Audit Programme ***Surgery relating to the last part of the digestive system***	The Association of Coloproctology of Great Britain and Ireland	Yes
Head and neck surgery	National Head and Neck Cancer Audit ***Surgery concerning the treatment of head and neck cancer***	British Association of Head and Neck Oncology	Yes
Interventional cardiology	Adult Coronary Interventions ***Treatment of heart disease with minimally invasive catheter based treatments***	British Cardiovascular Intervention Society	Yes

[10] Available via the Trust's internet site from July 2018

Lung cancer	National Lung Cancer Audit ***Treatment of lung cancer through surgery, radiotherapy, and chemotherapy***	British Thoracic Society and SCTS	Yes
Neurosurgery	National Neurosurgery Audit Programme	Society of British Neurological Surgeons	Yes
Orthopaedic surgery	National Joint Registry ***Joint replacement surgery***	British Orthopaedic Association	Yes
Thyroid and endocrine surgery	BAETS national audit ***Surgery on the endocrine glands to achieve a hormonal or anti-hormonal effect in the body***	British Association of Endocrine and Thyroid Surgeons	No[11]
Upper gastro-intestinal surgery	National Oesophago-Gastric Cancer Audit ***Surgery relating to the stomach and intestine***	Association of Upper-gastrointestinal Surgeons	Yes
Urological surgery	BAUS cancer registry ***Surgery relating to the urinary tracts***	British Association of Urological Surgeons	N/A
Vascular surgery	National Vascular Registry ***Surgery relating to the circulatory system***	Vascular Society of great Britain and Ireland	N/A

All data can be found on the individual association websites and is also published on NHS Choices (MyNHS).

2.2.3 Participation in clinical research

UH Bristol has maintained and expanded its commitment to providing exceptional evidence-based care to patients by offering them the opportunity to take part in research.

The number of patients receiving relevant health services provided or subcontracted by UH Bristol in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 6,925. This compares with 5,521 in 2016/17.

As of 31 March 2018, the Trust had 730 active studies, 46 of which are sponsored by UH Bristol. At the equivalent point 12 months before, the Trust had 684 active studies. Our sponsored research includes trials of investigational medicinal products, investigational devices and surgical interventions.

In a snapshot taken on 31 March 2018, the number of research studies and recruited participants were as follows (March 2017 comparator in brackets):

Table 4

Number of active non-commercial (portfolio) studies	480 (429)
Number of active non-commercial (non-portfolio) studies	112 (121)
Commercial studies registered	138 (142)
Number of recruits in non-portfolio non-commercial trials	1,001 (564)

[11] Unlike the other programmes listed in Table 3, participation in the BAETS national audit is not mandatory. Surgeons are only able to participate if they are members of the British Association of Endocrine and Thyroid Surgeons; the majority of our surgeons are not members.

Number of recruits in portfolio non-commercial trials	5,640 (4,539)
Number of recruits in commercial trials	284 (418)

In the last year, we have further improved the delivery of both commercial and non-commercial trials to time and target which will remain the focus for 2018/19. Examples include:

- In the Bristol Eye Hospital, we have recruited over 1,200 patients into a study seeking to improve decision-making and calibrating health utilities for cataract surgery
- In the Bristol Royal Hospital for Children, we recruited the first patient in the UK to a number of different trials, demonstrating improved efficiencies in trial set up and delivery
- In the Bristol Haematology and Oncology Centre, we recruited the first patient globally to a commercial phase I trial in adults with steroid-resistant Acute Graft versus Host Disease, an achievement which was recognised with a letter to the principal investigator from the chief executive of the National Institute for Health Research Clinical Research Network.

In 2017/18, we achieved an increase in research activity in two medical specialties. We aim to go on and open more research in the sexual health speciality during 2018/19, and to consolidate our activity in stroke, where we increased our recruitment from 48 to 207 patients over the past year.

We have continued to open new commercial studies in a broad range of specialties, and have been exploring several opportunities to develop closer working relationships with individual sponsors. We are involved in an increasing number of early phase commercial trials and those involving Advanced Therapy Investigational Medicinal Products, providing opportunities for our patients to have access to cutting edge treatments. Our performance in delivering commercial trials to time and target continued to improve throughout the year, enhancing our reputation as a reliable site. We have maintained our commercial income to levels seen in the last three years, managing a specialist portfolio of rare diseases research and looking to increase the number of higher recruiting trials alongside this during 2018/19, which will generate further income that can be reinvested in research in the Trust.

UH Bristol currently holds National Institute for Health Research (NIHR) grants bringing in a total research income of over £7 million per year. Our NIHR Biomedical Research Centre, for which we were awarded £20.8m over five years, has just completed its first year. The funding allows us to build on our existing programmes in cardiovascular disease, and nutrition, diet and lifestyle including obesity. Alongside these, our new themes in surgical innovation, reproductive and perinatal health and mental health have been set up and work is under way in these areas. Working in close partnership with the University of Bristol, North Bristol NHS Trust and Avon and Wiltshire Mental Health Partnership NHS Trust, Bristol's novel approach in drawing together population studies, laboratory science and patient-based research will benefit our patients and the local population over the next several years.

After successful completion of recruitment and/or other deliverables, three UH Bristol grants have closed or are nearing the end:

- Reducing arthritis fatigue: clinical teams using cognitive-behavioural approaches (RAFT) led by Professor Sarah Hewlett, was awarded through an NIHR commissioning brief that asked us to test whether a simplified psychological intervention that could be delivered widely in the NHS reduces rheumatoid arthritis fatigue and is an efficient use of NHS resources. Professor Hewlett and her team are now working on a training package "RAFT" to before roll out in the NHS.

- Can skin grafting success rates in burn patients be improved by using a low friction environment? A feasibility study (SILKIE), led by Dr Amber Young. The aims of this NIHR research for patient benefit feasibility study are in part to determine whether patients can be recruited and the study be run in an NHS setting. Once all data have been analysed the team will decide whether the study warrants a full scale clinical trial.
- Transmission - Radiotherapy Active Pixel System (TRAPS): Towards a Clinical Prototype for Real-Time 2D Verification of Intensity Modulated Radiotherapy. This NIHR-Invention for Innovation grant was led by Diane Crawford at UH Bristol, building on work done in collaboration with the University of Bristol School of Physics. The grant achieved its outcomes, and the team is now in discussions with potential commercial partners about taking forward the technology.

We have been awarded three new NIHR project grants in 2017/18, plus an NIHR doctoral fellowship. We continue to work with our staff to develop high quality grants that will help answer important clinical questions and improve patient care. Twice a year we invite applications for small pump priming grants together with Above and Beyond (the official charity for UH Bristol), to encourage newer researchers, and provide preliminary data for the larger NIHR grant applications.

2.2.4 CQUIN framework (Commissioning for Quality and Innovation)

A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between University Hospitals Bristol NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The value of the national CQUIN scheme is set at 2.5 per cent for all commissioned services, other than for prescribed specialised services commissioned by NHS England. As lead provider of Hepatitis C virus (HCV) Operational Delivery Networks, a CQUIN value of 2.8 per cent is offered alongside a further CQUIN value of 2.0 per cent of the applicable contract value of our specialised services. The amount of potential income in 2017/18 for quality improvement and innovation goals was approximately £11.05m based on the sums agreed in the contracts (this compares to £10.74m in 2016/17).

For the first time, CQUINs have been set as a two year scheme, providing greater certainty and stability regarding CQUIN goals. It is intended to deliver clinical quality improvements and drive transformational change. The following 16 CQUIN targets were agreed, with the Trust estimating to achieve 92.6 per cent of the £11.05m total potential income:

- Supporting engagement with Sustainable Transformation Partnerships
- Local financial sustainability - risk reserve
- Improving staff health and wellbeing
- Reducing the impact of serious infections (antimicrobial resistance and sepsis)
- Improving services for people with mental health needs who present to A&E
- Offering advice and guidance
- E-referrals
- Supporting proactive and safe discharge
- Improving HCV (Hepatitis C) treatment pathways through Operational Delivery Networks
- Clinical Utilisation Review
- Hospitals medicines optimisation
- Complex device optimisation
- Nationally standardised dose banding for adult intravenous anticancer therapy

- Haemtrack
- Automated exchange transfusion for sickle cell care
- Dental managed clinical networks

2.2.5 Care Quality Commission registration and reviews

University Hospitals Bristol NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without compliance conditions'. The CQC has not taken enforcement action against the Trust in 2017/18. The Trust was not subject to an inspection of its core services during 2017/18, having been rated as 'Outstanding' following an inspection in November 2016. All actions required by the CQC as a result of the 2016 inspection have been completed.

During 2017/18, representatives from the Trust participated in a CQC workshop to share best practice in meeting the challenge of maintaining quality and safety in Emergency Departments whilst managing increasing service demand. The CQC's findings, published in November 2017, included examples of notable practice at UH Bristol. In February 2018, we also welcomed Ted Baker, the Chief Inspector of Hospitals at the CQC, on a visit to our adult ED.

2.2.6 Data quality

UH Bristol submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES), which are included in the latest published data.

The percentage of records:

- which included the patient's valid NHS number was: 99.5 per cent for admitted patient care; 99.6 per cent for outpatient care; and 97.25 per cent for accident and emergency care.
- which included the patient's valid general practice code was: 99.9 per cent for admitted patient care; 100 per cent for outpatient care and 100 per cent for accident and emergency care.

(Data source: NHS number, Trust statistics. GP Practice: NHS Information Centre, SUS Data Quality Dashboard, April 2017 - December 2017 as at month nine inclusion date)

UH Bristol's information governance assessment report overall score for 2017/18 was 67.0 per cent.

There are no longer any national Payment by Results audits undertaken in England and it has been delegated to each Trust to organise its own clinical coding audit programme.

In May 2017, the accredited auditor for the Trust's clinical coding team undertook an audit of 100 Finished Consultant Episodes (FCEs) across a range of paediatric specialties. The following levels of accuracy were achieved:

- Primary diagnosis accuracy: 96.0 per cent
- Primary procedure accuracy: 91.9 per cent

In July 2017, the clinical coding team also carried out an audit of 100 FCEs in Obstetrics, Gynaecology, Special Care Babies, ENT, Well babies, Midwifery and Gynaecology Oncology.

- Primary diagnosis accuracy: 95.0 per cent
- Primary procedure accuracy: 96.5 per cent

(Due to the sample size and limited nature of the audit, these results should not be extrapolated)

The Trust has taken the following actions to improve data quality:

- The data quality programme involves a regular data quality checking and correction process. This involves the central information system team creating and running daily reports to identify errors and working with the Medway support team and users across the Trust in the correction of those errors (this includes checking with the patient for their most up to date demographic information).
- The Trust has installed self-check-in devices across the Trust in outpatient clinics to assist outpatient reception staff and enable patients to update their own demographic information.

2.3 Mandated quality indicators

In February 2012, the Department of Health and NHS Improvement announced a new set of mandatory quality indicators for all Quality Accounts and Quality Reports. The Trust's performance in 2017/18 (or, in some cases, latest available information which predates 2017/18) is summarised in the table below. The Trust is confident that this data is accurately described in this Quality Report. The Trust maintains a data quality and reporting framework which details what the measures are, where data comes from and who is responsible for it.

Table 5

Mandatory indicator	UH Bristol Most Recent	National average	National best	National worst	UH Bristol Previous
Venous thromboembolism risk assessment	98.4% Apr17-Mar18	95.2%	100%	69.5%	99.1% Apr16-Mar17
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)*	15.6 Apr16-Mar17	12.9	0.0	82.7	15.8 Apr15-Mar16
Rate of patient safety incidents reported per 1,000 bed days	55.97 Apr17-Sep17	42.8	111.69	23.5	56.83 Oct16-Mar17
Percentage of patient safety incidents resulting in severe harm or death	0.28% Apr17-Sep17	0.40%	0.0%	2.0%	0.24% Oct16-Mar17
Responsiveness to inpatients' personal needs	73.4 Apr16-Mar17	68.1	85.2	60.0	71.4 Apr15-Mar16
Percentage of staff who would recommend the provider	83% 2017 survey	70%	86%	47%	81% 2016 survey
Summary Hospital-level Mortality Indicator (SHMI) value and banding	100.0 (Band 2 "As Expected") Oct16-Sep17	100	72.7	124.7	99.4 (Band 2 "As Expected") Oct15-Sep16
Percentage of patient deaths with specialty code of 'palliative medicine' or diagnosis code of 'palliative care'	28.4% Oct16-Sep17	31.6%	59.8%	11.5%	27.6% Oct15-Sep16
Patient Reported Outcome Measures	Comparative groin hernia data for 2016/17 (the most recent complete validated data available) shows that 50% of UH Bristol patients reported an improved EQ-5D score compared to the national average of 51.3%; 65.2% of UH Bristol patients reported an improved EQ-VAS score compared to the national average of 39.2%. An increase in EQ-5D or EQ-VAS scoring indicates that patients felt that their quality of life had improved after surgery. UH Bristol does not carry out any other procedures covered by the national PROMs programme.				
Emergency readmissions within 28 days of discharge: age 0-15	Comparative data for 2011/12*: UH Bristol score 7.8%; England average 10.0%; low 0%; high 47.6%. Comparative data is not currently available for subsequent years from the Health & Social Care Information Centre.				
Emergency readmissions within 28 days of discharge: age 16 or over	Comparative data for 2011/12*: UH Bristol score 11.15%; England average 11.45%; low 0%; high 17.15%. Comparative data is not currently available for subsequent years from the Health & Social Care Information Centre.				

* NHS Digital state "Please note that the planned update of the emergency readmissions to hospital within 28 days of discharge indicators has been delayed whilst we review the methodology", therefore the latest published data is still for financial year 2011/12.

Part 3

Review of services in 2017/18

3.1 Patient safety

The safety of our patients is central to everything we want to achieve as a provider of healthcare. We are committed to continuously improving the safety of our services, and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by successfully implementing proactive patient safety improvement programmes and by working to better understand and improve our safety culture. We will also continue to conduct thorough investigations and analyses when things go wrong, identifying and sharing learning, and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident, and will strive to eliminate avoidable harm as a consequence of care we have provided.

In 2017/18, we have continued to sustain high quality performance in a number of key patient safety indicators as show in Table 6, in particular achieving an improvement in response to deteriorating adult patients, from 92 per cent in 2016/17 to 96 per cent in 2017/18 , and a reduction in the number of falls with harm from 36 in 2016/17 to 25 in 2017/18, despite the incidence of falls per 1,000 bed days increasing slightly from 4.23 in 2016/17 to 4.59 in 2017/18. Disappointingly, there have been nine Never Events in the Trust in 2017/18 despite high levels of WHO[12] checklist compliance in theatres (99.7 per cent). Also disappointingly, the Trust exceeded the threshold for MRSA bacteraemia (five in total). There are ongoing discussions with our commissioners regarding the allocation of some of these cases to the Trust. Additional work has been undertaken to review local policy and practice, as a result of which, the Trust's infection control team has delivered focused micro teaching sessions to staff, amendments have been made to the post-infection review process and the Trust's MRSA screening standard operating procedure has been revised.

During the past year, UH Bristol's work to improve the safety of patients has been recognised in being shortlisted for the following national awards:

- Patient safety category of the British Medical Journal (BMJ) awards 2018 – for quality improvement work on paediatric resuscitation in the Bristol Royal Hospital for Children
- Patient safety category of the BMJ awards 2018 and the Health Service Journal Patient Safety awards 2018 – we have been contributors to the West of England Academic Health Science Network's system-wide work on the deteriorating patient and sepsis
- HJS Patient Safety awards 2018, in the clinical governance and risk management category – for leading the West of England Academic Health Science Network's collaborative work on Learning from Deaths
- BMJ Awards 2018, HSJ Patient Safety awards 2018 and HSJ Value awards 2018 – for our adult emergency department High Impact User Team's work to support people who frequently access the emergency department.

The first three of these initiatives are described in more detail below.

[12] World Health Organisation

3.1.1 Our Patient Safety Improvement Programme 2015-2018

UH Bristol 'signed up to safety'[13] in 2014 by making our pledges under five national themes:

- put safety first
- continually learn from feedback and by measuring and monitoring how safe our services are
- be open and honest
- collaborate with others in developing system wide improvements
- support patients, families and our staff to understand when things go wrong and how to put them right.

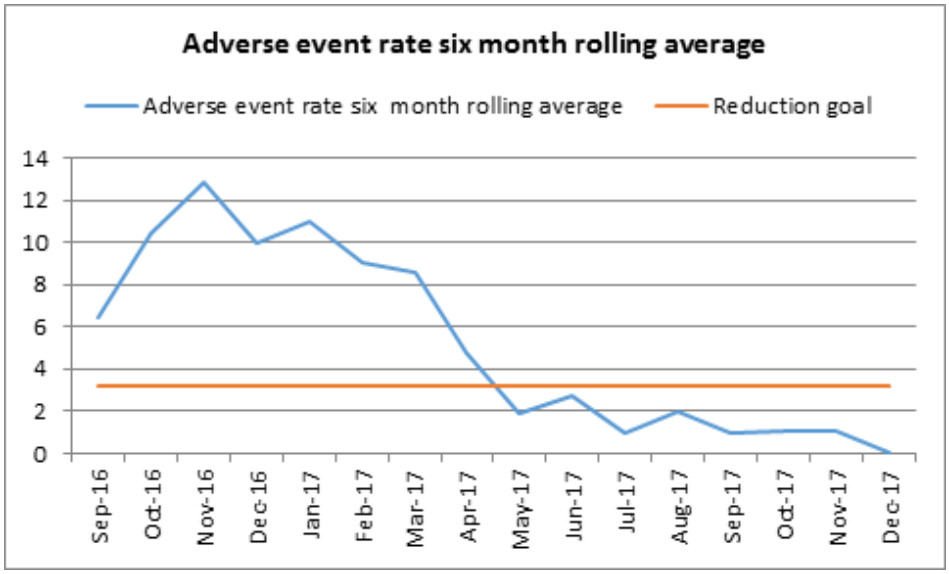
We reported last year on the progress of our 'Sign up to Safety' programme and the partnership work with colleagues in the West of England Patient Safety Collaborative to identify and develop opportunities for system wide safety improvements and to share and learn from each other.

Our current three year Patient Safety Improvement Programme will come to an end this summer. We will evaluate progress against all the quality improvement measures in our programme and review learning points from the implementation. We will also conduct a further analysis of our recent quality information, including patient and staff feedback, to inform our patient safety improvement priorities for the next three years.

In line with the national Sign up to Safety initiative, the overall aim of our programme is to reduce mortality and harm to patients. For mortality, we are aiming to achieve and sustain an upper quartile ranking of English NHS trusts for the Summary Hospital Mortality Indicator published quarterly by NHS Digital. Please see sections 3.3.2 of this report for more details of progress on mortality reduction and our learning from deaths process.

For harm reduction, we are aiming to achieve and sustain a reduction to 3.23 adverse events per 1,000 bed days over a three year period, which ends this summer. We have sustained achievement of this improvement goal since May 2017 as shown in the figure below.

Figure 1



Source: Monthly Global Trigger Tool Audits

[13] Sign up to Safety is an NHS campaign designed to help NHS staff and organisations achieve their patient safety aspirations and care for their patients in the safest possible way

We have four key work streams within our patient safety programme, described below.

3.1.1.1 Safety Culture work stream

Culture is a 'collective mindfulness' which defines how people behave and interact with others. In healthcare, the development of a positive patient safety culture ensures that staff have a constant and active awareness of the potential for things to go wrong and are enabled to acknowledge mistakes, learn from them, and take action to put things right. We chose to use a safety culture assessment tool based on the Manchester Patient Safety Framework[14] for acute trusts.

What we have done in 2017/18

We have completed our programme of face-to-face feedback to over 100 clinical teams regarding what they said about their team's and the Trust's safety culture, as reported in last year's Quality Report. Each Board – divisional and Trust – and clinical team selected one or two safety culture areas to develop depending on the detailed feedback received. We developed a safety culture toolkit containing information and resources to support teams in the areas they have chosen to develop. At the end of February 2018, we launched an on-line survey to repeat the safety culture assessments carried out in 2015/16 to see if there has been a difference.

What we will do in 2018/19

We will:

- Complete analysis of our repeat safety culture assessments.
- Feed back the repeat safety culture assessments to clinical teams.
- Review this work stream as a part of the overall evaluation of our Patient Safety Improvement Programme.
- Introduce a system for Learning from Excellence throughout the Trust.

3.1.1.2 Peri-procedure never events work stream

We are aiming to reduce the incidence of peri-procedure Never Events relating to wrong site surgery, retained foreign objects and wrong implants/prostheses by the introduction of a Trust-wide process that staff can use to identify and mitigate any risk associated with the procedure being carried out. Our improvement goal is to have no never events for a year. Much work has been done in previous years and, in 2017/18, we focused on improving and spreading our local safety standards for invasive procedures (LocSSIPs) in response to learning from incidents, making LocSSIPs more accessible for front line staff in 'out-of-theatre' settings. Unfortunately, in 2017/18, we have had seven confirmed peri-procedure never events. Please see section 3.1.3 for further details.

What we have done in 2017/18

We have:

- Made LocSSIPS for ward-based procedures integral to equipment packs required to carry out the procedure
- Integrated LocSSIPS into electronic systems in intensive care units

[14] Manchester Patient Safety Framework, University of Manchester 2006.

- Conducted an awareness raising campaign for out of theatre procedures using banners in clinical areas
- Refined our WHO surgical safety checklists to include "stop before you block" for dental procedures requiring a nerve block
- Conducted 'mystery shopper' audits of the quality of how we conduct WHO checklists, and shared the results with teams to support them in making improvements in areas where required
- Worked to embed local safety standards for invasive procedures in a number of 'out of theatre' procedures such as chest drain insertion, central line insertion, ascitic tap, lumbar puncture, endoscopy, nerve block
- Improved the use of LocSSIPs in two 'out of theatre' procedures (lumbar puncture, and abdominal paracentesis) but have been less successful for endoscopy and pleural aspiration procedures. Please note the run charts below relate to an audit sample of a small number of cases.

What we will do in 2018/19

We will:

- Continue to implement and embed LocSSIPS for all invasive procedures
- Develop a human factors approach to reducing the risk of never events in dental services and ophthalmology
- Review this work stream as a part of the overall evaluation of our Patient Safety Improvement Programme

3.1.1.3 Deteriorating patient work stream

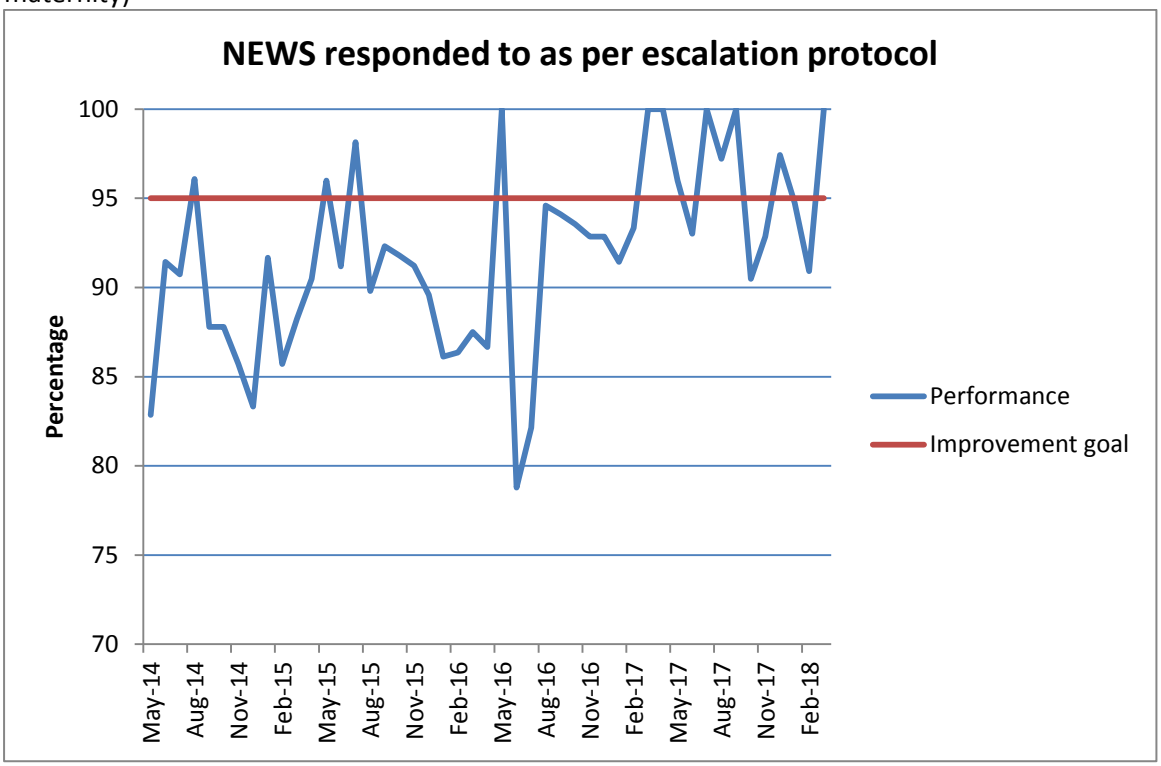
Recognition and management of deterioration in adult patients

Last year we reported that we had been working with our system-wide partners in the West of England Academic Health Science Network to use the national early warning score (NEWS) as a common language for individual patients at the points of transfer of care to help ensure the sickest patients are prioritised for clinical review, are accommodated in the most suitable environment, and have the best chance of a good outcome. We also use NEWS and as a trigger for sepsis screening.

A key measure of success is escalation of deteriorating patients in accordance with protocol. Figure 2 shows that we reached our 95 per cent goal in March 2017 but have not managed to sustain this improvement throughout 2017/18 (fluctuating between 90% and 100%).

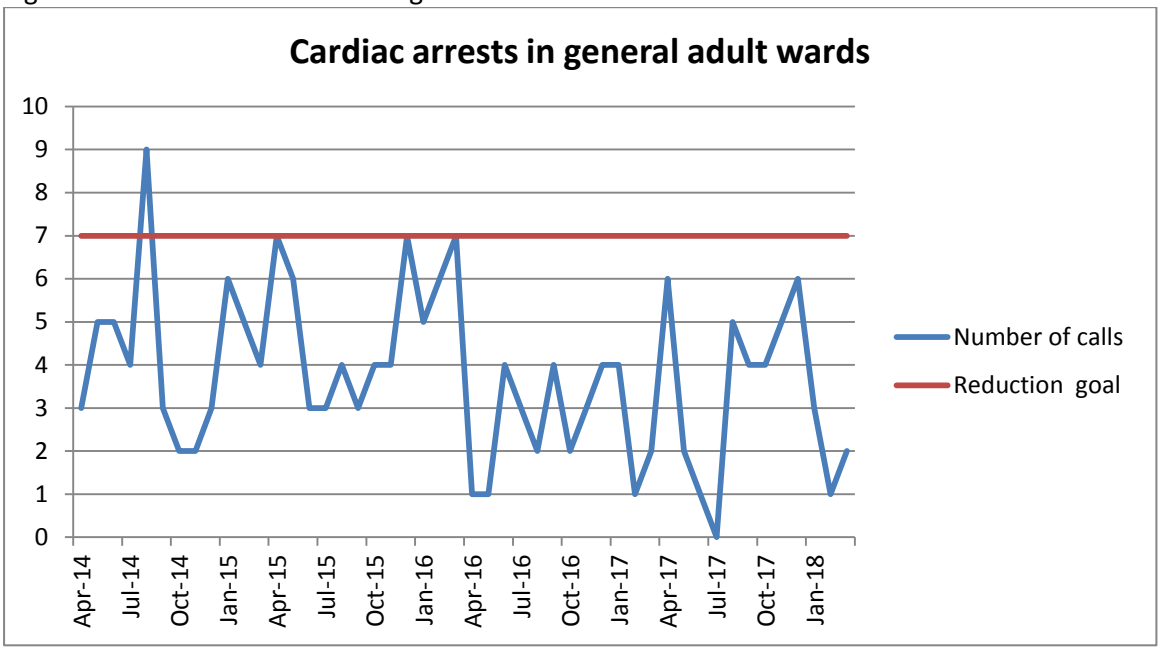
The purpose of improving recognition and escalation of deteriorating patients is to ensure prompt treatment so that patients do not go on to have a cardiac arrest. Our improvement goal is to sustain less than seven cardiac arrests per month which we have achieved as shown in Figure 3. The latest quarterly report from the National Cardiac Arrest Audit shows a continuing comparatively low incidence of in-hospital cardiac arrests in our Trust with a better than national indicator outcome.

Figure 2: Correct escalation of deteriorating patients in line with escalation protocol (adults and maternity)



Source: monthly safety thermometer point prevalence audit

Figure 3: Cardiac arrest calls from general ward areas



Source: cardiac arrest audit

What we did in 2017/18

- We reported last year that we would procure and begin implementing an electronic observations system. We have procured a system called 'Vitals' which, among other things, allows for electronic recording of physiological observations, automatic

calculation of NEWS, identification of deteriorating patients and sepsis screening. At the time of writing (April 2018), this has been implemented in the majority of adult medical and surgical wards, with a plan to implement in the remainder of adult wards (excluding maternity) by May 2018

- The Vitals function for automatic escalation of deteriorating patients has been configured to work with the Careflow electronic communication system when we are ready to implement
- We have mapped out-of-hours coverage for adult specialities and identified where further action is needed in preparation for using Careflow for automatic escalation of deteriorating patients
- We have embedded the use of NEWS in the adult Emergency Department Safety Checklist and worked with our system partners to communicate NEWS at the point of transfer of care
- We have continued targeted education on prompt recognition and escalation of deteriorating patient and the prompt recognition and management of sepsis
- We have implemented a maternal sepsis screening tool and pathway to improve early recognition and treatment of maternal sepsis
- Please see section 2.1.1 for further information about what we did to achieve our sepsis quality objective for 2017/18.

Recognition and management of deteriorating children

What we did in 2017/18

- We developed five new age-specific paediatric early warning observation charts in line with published evidence for use in acute trusts across the West of England and South West Academic Health Science Network footprint. At the time of writing (April 2018) these charts have been implemented in the Bristol Royal Hospital for Children (BRHC) and a number of other acute trusts across these two geographical areas.
- Mobile Resuscitation Carts have been launched for use throughout the BRHC, to improve compliance and competence with key skills. It is known that resuscitation skills begin to depreciate after three months following completion of a life support course. Therefore, everyone in BRHC will now have access to use the carts so they can all keep their CPR and bag-valve mask ventilation skills up-to-date
- We introduced Paediatric Rapid Review calls. This initiative formed part of a larger paediatric resuscitation quality improvement project and has improved the management and escalation process of deteriorating patients throughout the hospital. The calls enable a deteriorating child to be reviewed within 15 minutes by senior doctors and nurses. The team who introduced the rapid review system were shortlisted in the patient safety category British Medical Journal awards 2018
- We have developed and tested age specific sepsis pathways for children
- We have implemented a new-born tracker and trigger tool (NEWTT) to improve the early recognition and response to deterioration in neonates.

What we plan to do in 2018/19 (adults and children)

- We will complete the implementation of Vitals in adult areas, including the emergency department
- We will transfer from NEWS to NEWS2 for adults (excluding maternity) following the recent publication of an updated tool by the Royal College of Physicians
- We will configure and implement Vitals for Maternal and Obstetric Early Warning Scores
- We will plan implementation of Vitals for Paediatric Early Warning Scores

- We will start to implement automatic escalation of deteriorating patients using Careflow
- We will work with our system partners to implement NEWS2 in a co-ordinated fashion to preserve, as far as is possible, a common language for deteriorating patients
- We will continue with our point of care simulation training about deteriorating patients
- We will complete testing and implement an acute kidney injury pathway for adults
- Please see section 2.1.1 for information about our sepsis quality objective for 2017/18.

3.1.1.4 Medicines safety work stream

Our medicines safety work stream is a system wide initiative across the West of England Academic Health Science Network. Its stated aim is "Working together (with patients and each other) to deliver safer and better outcomes from medicines at transfer of care in the domains of patient safety, patient outcomes and patient experience". The two main areas of focus are:

- supporting patients with complex medicines to take them safely, thereby reducing hospital readmissions as a consequence of poor compliance with self-administration of medicines in the community, and
- insulin safety with emphasis on self-administration of insulin by patients and reducing harm from errors in insulin administration.

What we did in 2017/18

Community pharmacy referral

- We have embedded the linking of our electronic pharmacy noting system with communications to community pharmacies for patients with complex medicines
- We now refer patients taking the anticoagulant warfarin within compliance aids to their community pharmacist to confirm changes of dosage
- We have referred, on average, 40 patients each month to community pharmacies for ongoing review.

Insulin safety

- We continued to analyse insulin-related safety incidents in conjunction with the Diabetes Steering Group, to determine potential trends and identify areas to concentrate resource
- We implemented a series of guidelines and protocols to assist prescribers and nursing staff with insulin prescribing and recognition, particularly at admission
- The protocol to assess suitability for patients to self-administer their insulin was re-designed
- We standardised the nomenclature for insulin prescribing in our electronic prescribing systems to match national requirements
- We have implemented electronic prescribing and medicines administration in one adult specialty (the Bristol Heart Institute).

What we plan to do in 2018/19

We will take the following steps to further develop community pharmacy referrals:

- We will roll out electronic prescribing and medicines administration (ePMA) to all adult specialties in the Trust
- We will work with the Academic Health Science Network to explore further opportunities to develop referral to community pharmacies and other teams

- We will develop a business case to fund the integration required to automate community pharmacy referrals from our Medway patient administration system.

We will also take the following actions to make insulin prescribing and administration safer:

- We will audit the quality of general practice insulin prescribing information at hospital admission
- We will work together with local acute trusts and commissioners to harmonise insulin protocols and choices
- Please see section 2.1.2 for information about our insulin quality objective for 2017/18.

3.1.2 Maternity and Neonatal Patient Safety Collaborative

In 2017/18 we joined the first wave of a new national maternity and neonatal health collaborative which aims to reduce maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20 per cent by 2020, and by 50 per cent by 2030. Supported by NHS Improvement, we have developed a programme of work focusing on four national themes:

- Leadership and safety culture
- Clinical excellence
- Systems and processes
- Person-centred care

What we did in 2017/18

- Leadership and safety culture
    - We ran a week-long human factors workshop identifying the areas that need attention in St Michael's Hospital
    - We provided a human factors study day for staff working in maternity and neonatology.

- Clinical excellence
    - We reduced term admissions to the Neonatal Intensive Care Unit by two per cent by introducing training on management of respiratory issues in the early neonatal period
    - We developed a guideline for management of hypoglycaemia in the neonatal period
    - We achieved compliance with four care bundles of the Saving Babies Lives initiative.

- Systems and processes
  We implemented improved fetal monitoring in labour (to reduce neonatal morbidity) by:
    - A "fresh eyes" approach to reviews of Cardiotocograph traces
    - Improving the management of uterine hyperstimulation
    - Launching an updated fetal monitoring guideline

  We improved assessment of fetal growth by:
    - Increasing staff awareness of the importance of measuring and plotting Symphysial fundal height (SFH)
    - Introducing the practice of raising women's awareness to expect SFH measurement at each antenatal visit.

- Person-centred care
    - We improved patient experience and patient flow when discharged from hospital by introducing patient information regarding processes involved prior to them being discharged from hospital
    - We are developing ways to enable women to be more involved in caring for babies on our Neonatal Intensive Care Unit (NICU).

What we plan to do in 2018/19

- Leadership and safety culture
    - We plan to hold six-monthly human factor study days
    - We will take part in the SCORE patient safety culture survey in March 2019

- Clinical excellence
    - We will introduce a new hypoglycaemia guideline and review its impact.

- Systems and processes
    - An audit of care of women undergoing continuous fetal monitoring in labour is planned for July 2018.
    - A further audit of symphysial fundal height measurement and plotting is planned for May 2018.

- Person-centred care
    - We will review our audit findings to improve the postnatal discharge pathway.
    - We will train staff in supporting parents to care for babies on NICU.

3.1.3 Never Events

Despite the work we are doing on preventing peri-procedure never events, there were nine confirmed never events reported in our Trust in 2017/18:

- One retained piece of swab following a dental procedure
- One misplaced naso-gastric tube
- Two wrong lens implants
- One mis-selection of high strength midazolam
- One wrong side dental nerve block
- Two wrong tooth removals
- One retained nylon tape following a cardiac surgery procedure

We have investigated these cases thoroughly and have learned that a number were caused by human error which had occurred in situations where there was a difficulty or change in plan before or during the procedure.

In autumn 2017, we proactively invited NHS Improvement to conduct an independent and objective review of our dental never events. At the time of writing (April 2018) a formal report is awaited but initial informal feedback suggested no significant concerns were identified and that our focus should continue to be on cultural and human factors.

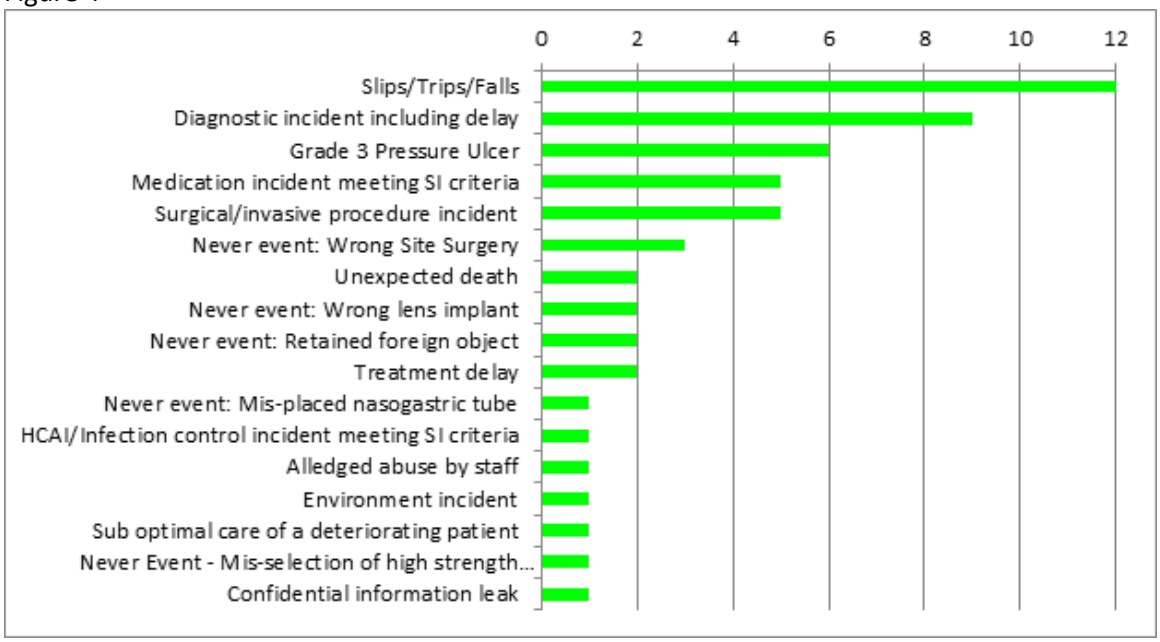
Examples of improvements we have made as a result of our investigations include:

- Refining our WHO surgical safety checklists to include “stop before you block” for dental procedures requiring a nerve block.
- Increasing the direct supervision of dental students administering dental nerve blocks and developing competencies for student assessments.
- Introducing an alternative when small pieces of swabs are required in dentistry.
- Developing a human factors approach to reducing the risk of never events in dental services and ophthalmology.
- Requiring all medical staff to complete e-learning on interpretation of X-rays to confirm naso-gastric tube placement.
- Blocking the supply of high strength midazolam in theatres.
- Changing the sterile container used for soaking nylon tapes used in surgery.
- Providing simulation training for theatre staff for surgical counts.

3.1.4 Serious incidents

The purpose of identifying and investigating serious incidents, as with all incidents, is to understand what happened, learn and share lessons, and take action to reduce the risk of a recurrence. The decision that an event should be categorised as a serious incident is usually made by an executive director. Throughout 2017/18, the Trust Board was informed of serious incidents via its monthly quality and performance report. The total number of serious incidents reported for the year was 57, compared to 50 in 2016/17. Of the serious incidents reported, two were subsequently downgraded and 15 investigations were still under way at the time of writing (April 2017). A breakdown of the categories of the 55 confirmed serious incidents is provided in Figure 4 below.

Figure 4



Source: UH Bristol Serious Incident Log

All serious incident investigations have robust action plans, which are implemented to reduce the risk of recurrence. The investigations for serious incident and resulting action plans are reviewed in full by the Trust Quality and Outcomes Committee (a sub-committee of the Trust Board of Directors).

3.1.5 Learning from serious incidents and never events

Trust-wide learning and actions arising from falls and pressure ulcer serious incidents are included in annual work plans to reduce the risk of recurrences of these types of incidents across all clinical areas.

Reducing peri-procedure never events is the aim of one of the work streams in our patient safety programme as described in section 3.1.1.2. In October 2017, we invited NHS Improvement to conduct a review of never events which had occurred in dental services. This review took place on 3 April 2018 (see section 3.1.3).

Examples of learning themes from other serious incident investigations in 2017/18 have included:

- Changes to processes in two clinical specialties for tracking patients who are at higher risk of developing cancer because of a related existing condition.
- Changes to communicating prescribing and checking of drugs given in the theatre environment to include strength and dose and not just volume.

Learning from serious incidents and never events is one of UH Bristol's quality objectives for 2018/19 (see section 2.1.2).

3.1.6 Duty of Candour

In 2017/18, we further developed our communications and systems for being open for patients and families who use our adult services. In particular, we have changed our policy to make it clearer how patients and families can be involved in an investigatory process if they want to be. We have also updated our patient information leaflet to provide more information about different investigatory processes which might be triggered after an event, e.g. a single event might trigger a complaint, incident and safeguarding investigation, as well as a mortality review and an inquest. Figure 5 below illustrates ways in which patients, their families and carers can get involved in an incident investigation involving them or their loved one if they wish to.

Figure 5: Involvement of patients/families/carers in incident investigations

3.1.7 Guardian of safe working hours: annual report on rota gaps and vacancies for doctors and dentists in training

Dr Alistair Johnstone is the Trust's Guardian of Safe Working for Junior Doctors. Our Trust Board receives quarterly reports and an aggregated annual report, all of which are available to read at: http://www.uhbristol.nhs.uk/about-us/key-publications/.

3.1.8 Overview of monthly board assurance regarding the safety of patients 2017/18

The table below contains key quality metrics providing assurance to the Trust Board each month regarding the safety of patients in our care. Where there are no nationally defined targets for safety of patients or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement or sustain already highly benchmarked performance. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable. Some patient safety metrics and targets in Table 6 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2016/17" may vary slightly from the equivalent data in our 2016/17 Quality Report due to finalisation of provisional data.

Table 6

Quality measure	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Infection control and cleanliness monitoring								
Number of MRSA Bloodstream Cases	National Infection Control data (Public Health England)	1	0	1	0	2	1	4
Number of *Clostridium difficile* Cases	National Infection Control data (Public Health England)	31	No set target	11	11	5	8	35
Number of MSSA Cases	Trust Infection Control system (MESS)	37	25	4	3	10	9	26
Hand Hygiene Audit Compliance	Monthly audit	96.60%	>=95%	98.30%	97.00%	97.10%	97.80%	97.60%
Antibiotic prescribing Compliance	Monthly audit	88.30%	>=90%	88.30%	84.30%	86.40%	86.60%	86.40%
Cleanliness Monitoring - Overall Score	Monthly audit	95%	>=95%	96%	96%	96%	96%	96%
Cleanliness Monitoring - Very High Risk Areas	Monthly audit	97%	>=98%	98%	98%	98%	97%	98%
Cleanliness Monitoring - High Risk Areas	Monthly audit	95%	>=95%	96%	97%	96%	95%	96%
Patient safety incidents, serious incidents and Never Events								
Number of Serious Incidents	Local serious incident log	52	No set target	14	17	9	15	55*
Serious Incidents Reported Within 48 Hours	Local serious incident log	94.20%	100%	100%	100%	100%	100%	100%
Serious Incidents - 72 Hour Report Completed Within Timescale	Local serious incident log	90.40%	100%	93.00%	100%	80%	100%	94.70%
Serious Incident Investigations Completed Within Timescale	Local serious incident log	98.00%	100%	91.70%	100%	100%	92.30%	96.10%

Total Never Events	Local serious incident log	2	0	3	1	2	3	9*
Number of Patient Safety Incidents Reported	Datix	14866	No set target	3848	3766	3836	4026	15656
Patient Safety Incidents Per 1000 Bed days	Datix/Medway	47.82	No set target	50.27	49.25	49.82	54.04	50.86
Number of Patient Safety Incidents - Severe Harm[2]	Datix	95	No set target	26	20	22	24	92
Falls								
Falls Per 1,000 Bed days	Datix/Medway	4.23	4.8	4.55	4.77	4.26	4.78	4.59
Total Number of Patient Falls Resulting in Harm	Datix	36	24	9	3	9	4	25
Pressure ulcers developed in the Trust								
Pressure Ulcers Per 1,000 Bed days	Datix/Medway	0.148	0.4	0.118	0.17	0.117	0.244	0.162
Pressure Ulcers - Grade 2	Datix	40	No set target	7	10	9	19	45
Pressure Ulcers - Grade 3 or 4	Datix	6	0	2	3	0	0	5
Venous Thromboembolism								
Adult Inpatients who Received a VTE Risk Assessment	Medway	99.10%	>=99%	98.80%	98.20%	98.20%	98.20%	98.40%
Percentage of Adult In-patients who Received Thrombo-prophylaxis	Monthly local pharmacy audit	96.40%	>=95%	96.30%	94.70%	94.50%	94.10%	95%
Number of Hospital Associated VTEs	ICE Order Communications/ Clinical validation	63	No set target	13	9	11	19	52
Number of Potentially Avoidable Hospital Associated VTEs	Monthly local pharmacy audit	7	0	1	0	1	0	2*
Nutrition								
Nutrition: 72 Hour Food Chart Review	Monthly local safety thermometer audit	89.60%	>=90%	89.70%	94.50%	91.30%	93%	92.10%
Fully and Accurately Completed Nutritional Screening within 24 Hours	Quarterly local dietetics audit	86.90%	>=90%	92.20%	92%	88.90%	86.30%	89.90%
WHO checklist								
WHO Surgical Checklist Compliance	Medway/Bluespier	99.10%	100%	99.70%	99.80%	99.60%	99.90%	99.70%
Medicines								
Medication Incidents Resulting in moderate or greater harm	Datix	0.37%	<0.5%	0.46%	0.64%	0.97%	0.23%	0.66%*
Non-Purposeful Omitted Doses of the Listed Critical Medication	Monthly local pharmacy audit	0.59%	<1%	0.53%	0.25%	0.24%	0.57%	0.40%
Safety Thermometer								
Harm free care	Monthly local safety thermometer audit	97.90%	>=95.7%	97.70%	97.40%	98.20%	98.40%	97.90%

No new harms	Monthly local safety thermometer audit	98.90%	>=98.3%	98.60%	98.60%	99%	98.90%	98.80%
Deteriorating patient								
National Early Warning Scores (NEWS) Acted Upon	Monthly local safety thermometer audit	92%	>=95%	96%	99%	94%	95%	96%
Timely discharges								
Out of Hours Departures (20:00 to 07:00)	Medway PAS	7%	No set target	7.10%	9.70%	9.20%	8.60%	8.70%
Percentage of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	22.30%	>25%	22.70%	22.90%	23%	21.10%	22.40%
Number of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	11063	No set target (percentage target set above)	2761	2854	2897	2626	11138
Staffing levels								
Nurse staffing fill rate combined	National Unify return	103.70%	No set target	103.70%	97.90%	97.60%	98.50%	99.3%*

*Provisional data

3.2 Patient experience

We want all of our patients to have a positive experience of healthcare, to be treated with dignity and respect and to be fully involved in decisions affecting their treatment, care and support. Our commitment to 'respecting everyone' and 'working together' is enshrined in the Trust's Values. Our goal is to continually improve by engaging with and listening to patients and the public when we plan and develop services, by asking patients what their experience of care has been and how we could make it better, and taking positive action in response to that learning.

3.2.1 National patient surveys

Each year, the Trust participates in the Care Quality Commission's national patient experience survey programme. These national surveys reveal how the experience of patients at UH Bristol compares with other NHS acute trusts in England. UH Bristol achieved consistently good results in the patient survey reports released during 2017/18. In particular, the 2016 national inpatient and children's surveys represent a positive step-change for UH Bristol:

- In the national inpatient survey, UH Bristol's performance was among the best trusts nationally, with 20 out of 65 scores being classed as better than the national average. The Trust also received the best score of any general acute trust on the survey question relating to patients' overall rating of their experience
- In the national children's survey, the Trust was recognised by the CQC as achieving among the best parent-reported experience ratings in the NHS. In particular, within the sub-group of parents of children aged 0-7 years, UH Bristol achieved the joint top score nationally on the survey question relating to whether parents felt that they were treated with respect and dignity

- In the national A&E survey, nine out of 35 UH Bristol scores were classed as being better than the national average, putting us among the top 10 of all English trusts on this measure of patient-reported experience. UH Bristol achieved the top score nationally in the section of the survey relating to the quality of care provided by doctors and nurses

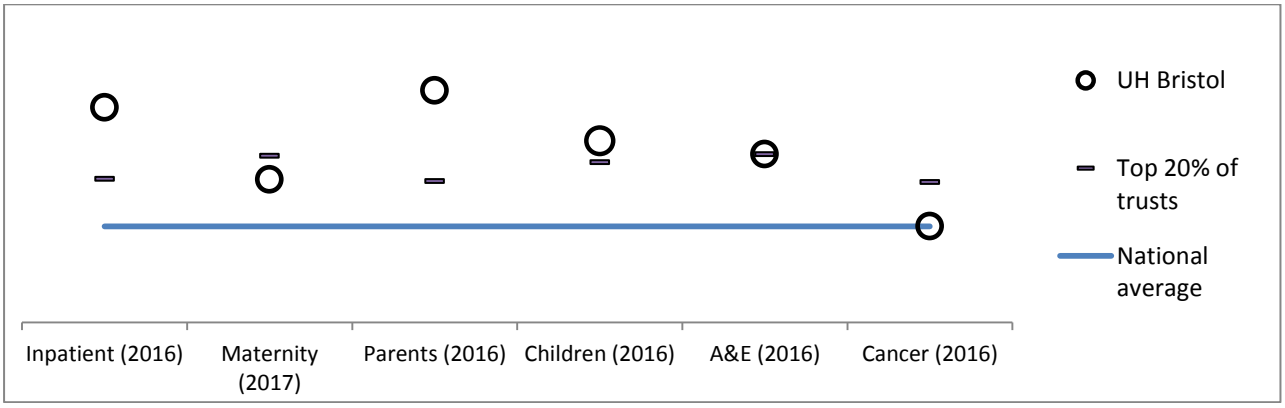
Table 7 summarises the number of scores that UH Bristol had above, below, or in line with the national average in each set of national survey results that were released during 2017/18. Figure 6 provides an indication of UH Bristol's performance relative to the national average.

Table 7: Results of national patient surveys received by the Trust during 2017/18 (number of scores above, in line with, or below the national average)

		Comparison to national average		
	Date patients attended	Above (better)	Same	Below
2016 National Accident and Emergency Survey	September 2016	9	26	0
2016 National Cancer Survey	April-June 2016	2	47	3
2016 National Children's Survey	November to December 2016	20	43	0
2017 National Maternity Survey (Labour and Birth)	February 2017	1	18	0
2017 National Maternity Survey (Community Midwifery)	February 2017	3	28	1
2016 National Inpatient Survey	July 2016	20	45	0

Source: Care Quality Commission Benchmark Report (www.nhssurveys.org)

Figure 6: UH Bristol's hospital based patient-reported experience relative to national benchmarks



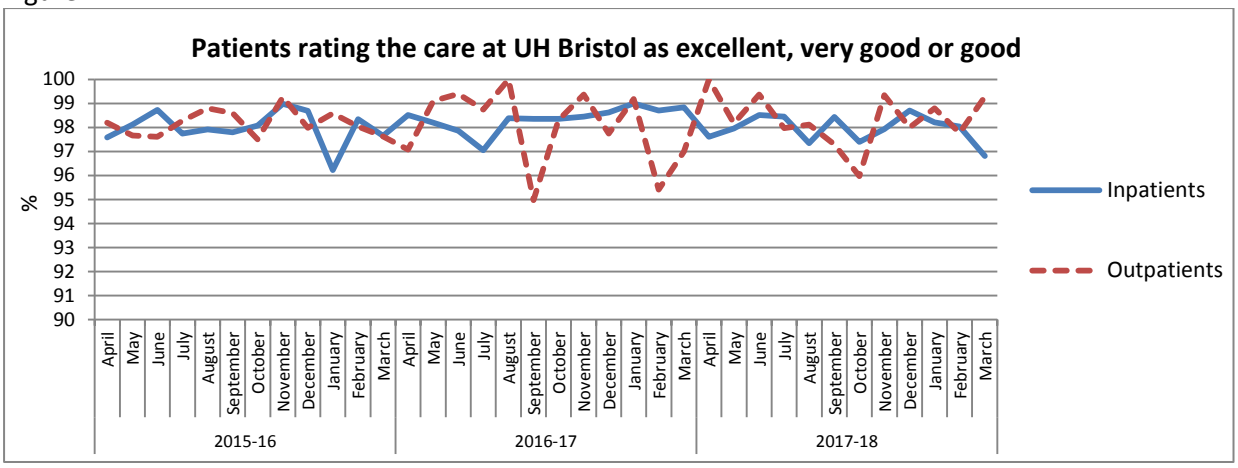
Source: UH Bristol Patient Experience and Involvement Team analysis of Care Quality Commission data

3.2.2 UH Bristol patient survey programme

UH Bristol has a comprehensive local survey programme to ensure that ongoing and timely feedback from patients forms a key part of our quality monitoring and improvement processes.

The Trust continues to receive very positive feedback from service-users, consistently achieving overall care ratings in excess of 95 per cent in our monthly postal surveys (Figure 7). Praise for our staff is by far the most frequent form of feedback that we receive.

Figure 7



Source: UH Bristol postal survey

3.2.3 Patient and Public Involvement

In addition to our surveys, we also carry out a range of engagement activities with our patients, visitors and the public. We do this in a number of ways, for example via focus groups, interviews carried out by our volunteer *Face2Face* Team, and our Involvement Network which reaches out to a wide range of community groups across Bristol and the surrounding areas. There were a number of highlights from this activity in 2017/18:

- With support from The King's Fund, UH Bristol, Bristol Community Health and North Bristol NHS Trust jointly led a patient and community leadership programme which has provided training and support to members of the public who want to shape local healthcare services. This work continues to evolve, with the development of the "Healthcare Change Maker" forum, which is now working in an advisory role to commissioners and the local Sustainable Transformation Partnership (STP). In addition, UH Bristol is directly benefiting from the programme, having placed participants in a number of roles, including our new complaints review panel, and the paediatric cardiac review steering group.
- A group of sixth form students from Ashton Park School visited UH Bristol in November. The students all had some degree of learning disability or additional educational need. Over the course of a day-long visit, these "hospital detectives" were able to give our Patient Experience and Involvement Team insights into what it feels like to visit clinical and non-clinical areas of the Trust.
- The Trust has continued to engage with the local deaf community by playing a leading role in the establishment of a new Bristol-based deaf patient experience group with input from a range of stakeholders.
- Patients and relatives were involved in the successful design of the Trust's new "butterfly" end of life personalised care plan.

In 2017/18, we were delighted that several of our patient experience initiatives were recognised in national awards:

- Our "#conversations" project at Bristol Royal Hospital for Children was a finalist in the Patient Experience National Network Awards (PENNA) in the partnership working category. This ongoing initiative which encourages staff, patients and families to develop mutual understanding on key subjects is now being extended to our maternity hospital, St Michael's.

- The Trust's Patient Experience and Involvement Team and Maternity Services were shortlisted for a Health Services Journal Value in Healthcare award, for their collaborative work on the "Patient Experience at Heart" project. Patient Experience at Heart involved a series of workshops with maternity staff, where staff were able to explore the impact of their role on delivering a positive service-user experience.
- The Trust's patient and public involvement lead and the medical director's lead for training and development designed a new approach to learning called "Patients and Doctors as Partners in Care". These workshops, which brought together junior doctors and patients to explore the relational aspects of care giving from the perspective of both parties, were shortlisted for an award by Health Education England.

3.2.4 Complaints received in 2017/8

In 2017/18, 1,817 complaints were reported to the Trust Board, compared with 1,874 in 2016/17[15]. 674 (37.1 per cent) of these complaints were investigated via the formal complaints process, with the remainder addressed through informal resolution.

Eighty-three per cent of formal complaints were responded to within the timescale agreed with the complainant: a deterioration on the 86.1 per cent we reported last year. To date (12 April 2018), 67 complainants have expressed dissatisfaction with one or more aspects of our response to their concerns (formal complaints), which is slightly more than at the equivalent point in time last year (65 cases), but represents an improvement when measured as a proportion of formal complaints (9.7 per cent in 2017/18, compared with 11.8 per cent in 2016/17).

Improvements to the complaints service in 2017/18 have included:

- The introduction of regular complaints panels where lay representatives retrospectively review complaints and how the Trust responded. Points of learning from these panels are shared with all divisions.
- Actively encouraging complainants to take up the option of meeting with Trust staff to discuss the findings of complaints investigations.
- Routinely asking complainants if they would like to be involved in designing and implementing any improvements identified as a result of their complaint.
- Changes to the Trust's formal response letter template based on feedback from dissatisfied complainants and from the Patients Association

During 2017/18, the Trust has also been working with the Patients Association to develop a best practice toolkit to help staff to respond to complaints more effectively. This toolkit includes advice and guidance about objectivity when investigating complaints. Work on the toolkit is due to be completed by the end of June 2018.

Looking ahead to 2018/19, our plans include:

- A refocus on achieving our 95 per cent target for timely complaints responses.
- A comprehensive review of our complaints training programme.
- A review of how the severity of complaints is recorded and how this information might be used to inform reporting.
- Introducing quarterly reporting to the Trust's Patient Inclusion and Diversity Group of any complaints which highlight themes

The Trust will be publishing a detailed annual complaints report, including themes and trends, later in 2018.

[15] Previously 1,941 in 2015/16, 1,883 in 2014/15, 1,442 in 2013/14 and 1,651 in 2012/13

3.2.5 Turning feedback and complaints into positive action: examples of improvements to patient care in 2017/18

Examples of positive action taken in response to complaints and patient feedback include:

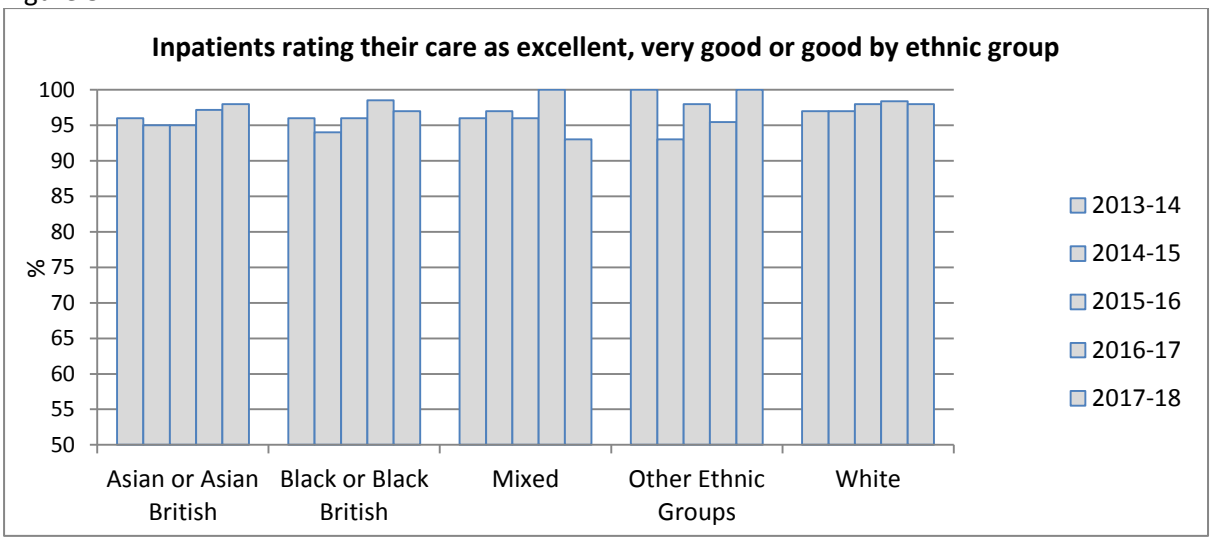
- Delirium leaflets are now given out on the wards at the Bristol Heart Institute (BHI) and in pre-operative assessment to warn patients that, following cardiac surgery, they may experience delirium for a short period of time. Cascade training of staff is taking place.
- Staff at the BHI are being trained to carry out assessments of patients' limbs following cath lab procedures in order to prevent problems with circulation. In addition, staff on our coronary care unit will be trained to use Doppler ultrasound tests instead of a manual assessment for all patients.
- A call bell system is being installed in the outpatient department at Bristol Eye Hospital (BEH).
- Silent closing bins have been checked and repaired on Ward H304 at BEH in response to patient feedback about noise at night. Projects to reduce noise at night are also being taken forward by our Coronary Intensive Care Unit and Women's Services.
- New signage has been installed in the Bristol Royal Infirmary (BRI) Emergency Department, to convey information about waiting times and how the department works, so that patients have a better understanding of how the "queuing" system works. Signage for visitors to BEH has also been improved.
- Staff dealing with Radiology appointment bookings now telephone patients for short notice appointments around Easter and Christmas (when post can take longer than usual) to ensure that these appointments are not missed.
- In Women's Services, staff have developed a traffic light poster to explain the hospital discharge process to patients and help manage expectations around this.
- Staff at Bristol Royal Hospital for Children (BRHC) have reviewed how they ensure parents of children with disabilities are made aware of the Hospital Passport on their first presentation to the BRHC; signage in the Emergency Department has been changed as part of this. 'Listening to Parents' posters are also now displayed in prominent locations throughout BRHC.

3.2.6 Equality and diversity

In a notable development for UH Bristol, 2017/18 saw the creation of a new Patient Inclusion and Diversity Group within the Trust. The focus of the Trust's existing Equality and Diversity Group is largely on workforce matters, so it was agreed to create a new 'sister' group to provide a more appropriate platform for discussion of equality issues that impact upon patients. The group met for the first time in January 2018, and has recently agreed an annual work plan for 2018/19 which will, for example, include work to strengthen the Trust's compliance with the Accessible Information Standard.

Figure 8 below shows results from the Trust's post-discharge patient survey according to ethnicity. This data indicates that patient experience at UH Bristol is consistently positive across different ethnic groups.

Figure 8



Source: UH Bristol postal survey

3.2.7 Overview of monthly board assurance regarding patient experience

The table below contains key quality metrics providing assurance to the Trust Board each month regarding patient experience. Where there are no nationally defined targets or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable. Some patient experience metrics and targets in Table 8 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2016/17" may vary slightly from the equivalent data in our 2016/17 Quality Report due to finalisation of provisional data.

Table 8

Quality measure	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Monthly patient surveys								
Patient Experience Tracker Score	Monthly postal survey	91.5	>=89	91	92	91	92	91.5
Kindness and Understanding	Monthly postal survey	95.3	>=92	96	95	95	96	95.5
Outpatient Tracker Score	Monthly postal survey	89.3	>86	88	89	90	89	89
Friends and Family Test – coverage								
Inpatient Coverage	Friends and Family Test	35.50%	>=30%	36.80%	35.40%	33.90%	33.70%	35%
ED Coverage	Friends and Family Test	16.40%	>15%	17.60%	18%	16.90%	16.80%	17.30%
Maternity Coverage	Friends and Family Test	22.50%	>15%	20.70%	18.60%	19%	17.80%	19%
Friends and Family Test – score								
Inpatient Score	Friends and Family Test	97.20%	>=92%	97.30%	97.60%	98%	98%	97.70%
ED Score	Friends and Family Test	78.20%	No set target	81.70%	81%	80.50%	82.50%	81.30%

Maternity Score	Friends and Family Test	96.80%	>=92%	96.60%	96.80%	98%	95.60%	96.90%
Patient complaints								
Number of Patient Complaints	Patient Support and Complaints Team	1,875	No set target	555	430	407	423	1815
Complaints Responded To Within Trust Timeframe	Patient Support and Complaints Team	86.10%	>=95%	80.20%	83%	85.40%	82.30%	83%
Complaints Responded To Within Divisional Timeframe	Patient Support and Complaints Team	86.60%	No set target	79.40%	85.70%	85.40%	83.40%	83.80%
Percentage of Responses where Complainant is Dissatisfied	Patient Support and Complaints Team	11.41%	<5%	18.32%	10.99%	12.68%	4.57%	11.25%*

3.3 Clinical Effectiveness

We will ensure that each patient receives the right care, according to scientific knowledge and evidence-based assessment, at the right time in the right place, with the best outcome.

3.3.1 Understanding, measuring and reducing patient mortality

Over the last year, the Trust has continued to monitor the number of patients who die in hospital and those who die within 30 days of discharge. This is done using the two main tools available to the NHS to compare mortality rates between different hospitals and trusts: Summary Hospital Mortality Indicator (SHMI) produced by NHS Digital (formerly the Health and Social Care Information Centre) and the Hospital Standardised Mortality Ratio (HSMR) produced by CHKS Limited replicating the Dr Foster/Imperial College methodology.

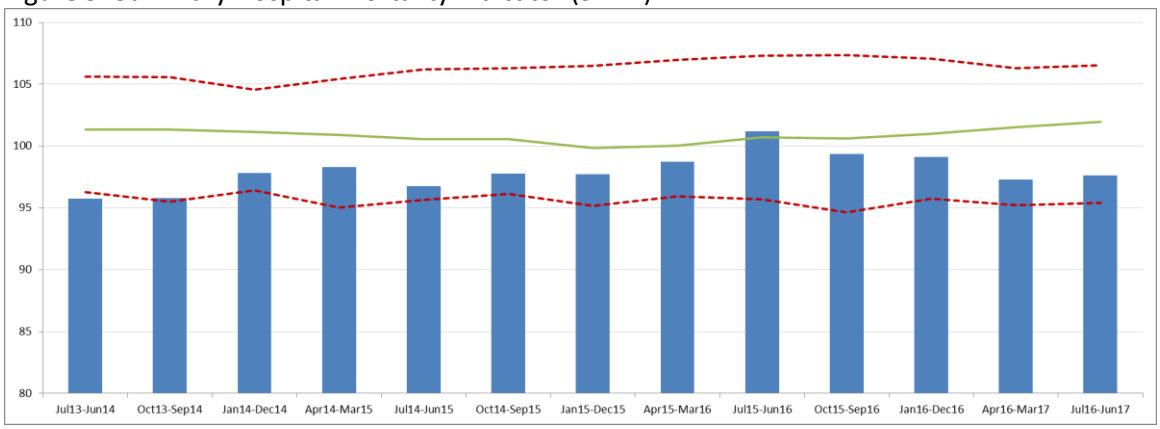
The HSMR includes only the 56 diagnosis groups (medical conditions) which account for approximately 80 per cent of in-hospital deaths. The SHMI is sometimes considered a more useful index as it includes all diagnosis groups as well as deaths occurring in the 30 days following hospital discharge.

In simple terms, the SHMI 'norm' is a score of 100 – so scores of less than 100 are indicative of trusts with lower than average mortality. The score needs to be read in conjunction with confidence intervals to determine if the Trust is statistically significantly better or worse than average. NHS Digital categorises each Trust into one of three SHMI categories: "worse than expected", "as expected" or "better than expected", based on these confidence intervals. A score over 100 does not automatically mean "worse than expected". Likewise, a score below 100 does not automatically mean "better than expected".

In Figure 9, the blue vertical bars represent UH Bristol SHMI data, the green solid line is the median for all trusts, and the dashed red lines are the upper and lower quartiles (top and bottom 25 per cent). Comparative data from July 2016 to June 2017 shows that the Trust remains in the 'as expected' category. The most recent comparative data available to us at the time of writing is for the rolling 12 month period October 2016 to September 2017[16]. In this period the Trust had 1,693 deaths compared to 1,686 expected deaths; a SHMI score of 100.4.

[16] Figure 9 is sourced from CHKS Limited and does not yet include data for the period October 2016 to September 2017

Figure 9: Summary Hospital Mortality Indicator (SHMI)



Source: CHKS benchmarking

The latest HSMR data available at the time of writing is for the period January 2017 to December 2017. This shows 1,030 patient deaths at UH Bristol, compared to 1,127 expected deaths: an HSMR of 91.4.

Understanding the impact of our care and treatment by monitoring mortality and outcomes for patients is a vital element of improving the quality of our services. To help facilitate this, the Trust has a Quality Intelligence Group (QIG) whose purpose is both to identify and be informed of any potential areas of concern regarding mortality or outcome alerts. Where increased numbers of deaths are identified in a specific specialty or service, QIG ensures that these are fully investigated by the clinical team. These investigations comprise an initial data quality review followed by a further clinical examination of the cases involved if required. QIG will either receive assurance regarding the particular service or specialty with an explanation of why a potential concern has been triggered, or will require the service or specialty to develop and implement an action plan to address any learning. The impact of any action is monitored through routine quality surveillance.

3.3.2 Learning from deaths

Section 2.1.1 of this report includes a description of the implementation of a new system for reviewing and learning from patient deaths. The information which follows here relates to that system and is a reporting requirement of NHS Improvement.

During the period of April 2017 to March 2018, 1,281 of University Hospitals Bristol NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 301 in the first quarter
- 277 in the second quarter
- 372 in the third quarter
- 331 in the fourth quarter

Of these 1,281 deaths, by 31 March 2018, 330 had been identified as requiring case records reviews, and 141 of these reviews had been completed.

The number of deaths in each quarter for which a case record review was carried out was:

- 53 in the first quarter
- 42 in the second quarter
- 46 in the third quarter
- 8 in the fourth quarter

In 11 cases, a death was subjected to both a case record review and a serious incident investigation.

Three of the patient deaths during the reporting period were judged more likely than not to have been due to problems in the care provided to the patient. This represents 0.23 of the 1,281 patients who died. In relation to each quarter, this consisted of:

- 2 in the first quarter (representing 3.8 per cent of the 53 deaths reviewed)
- 1 in the second quarter (2.6 per cent of 38 deaths reviewed)
- 0 in the third quarter (of 33 deaths reviewed)
- 0 in the fourth quarter (of 3 deaths reviewed)

These numbers have been calculated using the records of case note reviews held by the Medical Director's office at UH Bristol.

The Trust's new process for reviewing learning from deaths was instigated on 1 April 2017; no deaths prior to this date had case note reviews completed in 2017/18.

The major themes identified from case note reviews during 2017/18, also described in section 2.1.1 of this report, are:

- The need to improve early recognition of the dying patient. This has been agreed as a corporate quality objective for 2018/19 (see section 2.1.2 of this report)
- The importance of senior clinical staff involvement in the decision to move patients from physiological monitoring to symptomatic control at the end of their lives

Following the identification of these themes, a project has been instigated via the Trust's Quality Improvement Academy to implement Trust-wide learning around the provision of end of life care. Our plans are described in section 2.2.2 of this report. Feedback from the Trust's Mortality Surveillance Group is also being disseminated through our Divisional structures.

3.3.3 Seven day services

We assess ourselves against the core NHS seven day working standards (that is, standards 2, 5, 6 and 8) via six-monthly audits. This process has helped us target our work on specific areas in developing our plans to provide seven-day services. The most recent completed audit in September 2017 highlighted where compliance gaps remain. Our clinical Divisions have undertaken work to close the gaps identified within the audit.

We can confirm compliance against the November 2017 requirement for urgent care network specialist services for paediatric major trauma, heart attack and children's critical care services and we are not the local provider for major trauma or vascular services. We have, however, identified that further service developments are required to meet the standards for stroke services and also within our interventional radiology service, which contributes to the vascular network standards.

Table 9

Standard	2	5	6	8
	Percentage of patients who had an initial consultant review within 14 hours of admission*	Percentage of diagnostic tests available to patients**	Percentage of consultant directed interventions available to patients**	Percentage of patients that received ongoing daily consultant reviews*
University Hospitals Bristol NHS Foundation Trust	April 2017: 76% of patients were reviewed within the require timeframe (of 209 emergency admissions; September 2017: 58% (of 204 emergency admissions)	100% (6 out of 6) diagnostic tests are available seven days a week	April 2017: 89% (8 out of 9) consultant directed interventions are available seven days a week	April 2017: 88% of patients were appropriately reviewed (daily or twice daily depending on clinical need)

*measured by audit using methodology stipulated by NHS England
**measured by self-assessment

Our improvement plans are summarised below alongside our plans to achieve the 2020 goal for the broader roll out of seven-day services to all relevant specialties. It is also of note that a review of the model for stroke services is currently a priority project within the BNSSG (Bristol, North Somerset and South Gloucestershire) sustainability and transformation partnership; the affordable provision of seven-day services within this urgent care specialist service may be provided through a cross-system solution.

Our plans – which are subject to the necessary investment – include:

- Standard 2 (Time to consultant Review): Provision of additional consultant capacity within general surgery, trauma and orthopaedics and gynaecology services to ensure full compliance with the standard.
- Standard 5 (Access to Diagnostics): Formalisation of interventional vascular radiology arrangements with North Bristol NHS Trust and development of an in-house non-vascular interventional radiology service. A formal rota to provide in-house non-vascular intervention on a seven-day basis is being instigated.
- Standard 6 (Access to Consultant-directed Interventions): Investment in consultant capacity to allow for the delivery of two additional weekend endoscopy lists, to address the gap in our service for lower gastrointestinal endoscopy.
- Standard 8 (On-going Review): Proposals under standard 2 will provide capacity to close gaps in capability in the surgical areas specified.

Service development proposals to address the gaps in seven-day coverage have been discussed with our commissioners – Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group – via contract negotiations. Commissioners have indicated that the proposed investments will not be affordable within the 2017/18 – 2018/19 planning round and accept that the Trust will not be able to meet the standards until opportunities to improve compliance through service reconfiguration and commissioners' re-prioritisation are assessed.

The Trust currently has multiple work streams dedicated to the delivery of improved patient flow through the organisation. Whilst many services are delivered on a seven-day basis, in other service there remains a differential between week days and weekends. There is however clear clinical commitment to move towards seven-day services within our Divisions.

We have invested in three new consultant acute physicians and three consultant emergency physicians in order to close the gap to meeting the seven-day standards. The three new acute physicians have already been appointed and started employment. The additional ED consultants are due to start in August 2018 and will increase the presence of senior decision-makers to 16 hours per day, seven days a week, enabling the introduction of rapid assessment and triage.

3.3.3 Overview of monthly board assurance regarding clinical effectiveness

The table below contains key quality metrics providing assurance to the Trust Board each month regarding the clinical effectiveness of the treatment we provide. Where there are no nationally defined targets or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable. Some clinical effectiveness metrics and targets in Table 10 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2016/17" may vary slightly from the equivalent data in our 2016/17 Quality Report due to finalisation of provisional data.

Table 10

Quality measure	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Mortality								
Summary Hospital Mortality Indicator (SHMI)	NHS Digital	99.2	<100	97.6	100.4	Data not available	Data not available	99*
Hospital Standardised Mortality Ratio (HSMR)	CHKS	91.4	No set target	87.5	87.4	102.8	95.1	93.1*
Re-admissions								
Emergency Readmissions Percentage		2.66%	<2.70%	3.45%	2.71%	2.35%	2.16%	2.71%
Management of Sepsis								
Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	Casenote review	21.60%	>=90%	38.10%	29.70%	35.50%	79.70%	51.10%
Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatients)	Casenote review	65.70%	>=90%	71.40%	88.90%	75%	75%	77.40%
Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	Casenote review	100%	>=90%	100%	100%	71.40%	100%	93.3%*
Percentage of Patients Meeting Criteria Screened for Sepsis (Emergency)	Casenote review	74.40%	>=90%	80%	94%	75.80%	87.30%	83.40%
Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Emergency)	Casenote review	56.30%	>=90%	76.70%	90%	90%	83.80%	85.50%
Sepsis Patients Percentage with a 72 Hour Review (Emergency)	Casenote review	94.30%	>=90%	100%	100%	87.70%	92.90%	93.60%

Maternity								
Percentage of Low Weight Babies	Medway PAS	2.70%	No set target	2.20%	2.70%	2.50%	2.80%	2.50%
Number of Low Weight Babies	Medway PAS	137	No set target	26	32	29	32	119
Fracture Neck of Femur								
Patients Treated Within 36 Hours	National Hip Fracture Database	70.50%	>=90%	76.30%	77.80%	47.50%	54.80%	64.20%
Patients Seeing Orthogeriatrician within 72 Hours	National Hip Fracture Database	74%	>=90%	69.70%	39.50%	60%	79.50%	61.60%
Patients Achieving Best Practice Tariff	National Hip Fracture Database	51.90%	>=90%	48.70%	28.40%	26.30%	37%	34.80%
Stroke Care								
Percentage Receiving Brain Imaging Within 1 Hour	Medway PAS & Radiology Information System	58.60%	>=80%	64.90%	68.50%	59.10%	59.40%	63.5%*
Percentage Spending 90%+ Time On Stroke Unit	Medway PAS & Radiology Information System	90.20%	>=90%	84.30%	85.40%	88.20%	88.40%	86.4%*
High Risk TIA Patients Starting Treatment Within 24 Hours	Medway PAS & Radiology Information System	66.80%	>=60%	62.50%	55.90%	62.90%	34.20%	54.60%
Dementia Care								
FAIR Question 1 - Case Finding Applied	Local data collection	90.40%	>=90%	88.30%	91.50%	89.60%	88.20%	89.30%
FAIR Question 2 - Appropriately Assessed	Local data collection	97.20%	>=90%	98.30%	98.60%	96.90%	92%	96.20%
FAIR Question 3 - Referred for Follow Up	Local data collection	94.70%	>=90%	88.90%	100%	87.50%	100%	92.90%
Percentage of Dementia Carers Feeling Supported	Local data collection	75%	No target set	100%	Data not available	Data not available	50%	60%
Ward outliers								
Bed Days Spent Outlying.	Medway PAS	8,854	<9,029	1994	1409	1787	3908	9098

3.4 Performance against national priorities and access standards

3.4.1 Overview

NHS Improvement's Single Oversight Framework (SOF) has four performance metrics:

- Accident and Emergency (A&E) 4-hour waiting standard
- 62 day GP cancer standard
- Referral to Treatment (RTT) incomplete pathways standard
- 6-week diagnostic waiting times standard

The national standards are:

- 95 per cent for A&E 4 hour waits
- 85 per cent for 62 day GP Cancer
- 92 per cent for RTT incomplete pathways
- 99 per cent for 6-week diagnostic waiting times

Sustainability and Transformation Funds (STF) targets were agreed for each indicator at the start of the financial year; these were submitted to NHS Improvement as part of their monthly monitoring of acute Trusts.

In summary, the Trust improved and sustained A&E performance across half of the year, whilst maintaining relatively good performance in November and December as winter demand began to have an impact. Cancer performance has stabilised across the entire year, culminated in compliance with the national standard in the third quarter of the year. Joint working arrangements with neighbouring acute trusts have been established for 2018/19, with a focus on new cancer reporting data sets and appropriate allocation of breaches. Improved reporting and monitoring of diagnostic services has led to strong performance in 2017/18; we achieved the national standard in February 2018 and anticipate sustained compliance into 2018/19. Our RTT performance fell short of the national standard through 2017/18, however we have made significant changes to our reporting methodology; the launch of the Medway 4.8 patient administration system has been accompanied by comprehensive data validation review and a drive to reduce the time patients spend awaiting follow up appointments.

Table 11: Performance (%) against the agreed trajectories for the four key access standards in 2017/18 during each quarter.

Access Key Performance Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
A&E 4-hours	Actual	82.3	84.2	87.9	90.5	91.3	90.8	90.1	90.3	85.3	82.7	83.2	78.9
	Traj.	82.5	83.5	85	90	90	90	90	90	90	90	92	95
62-day GP cancer	Actual	76.5	77.8	81.7	75.0	85.2	80.2	84.3	88.6	82.9	78.4	81.3	87.3
		78.8			80.1			85.4			82.4		
	Traj.	81	81	81	83.6	83.6	83.6	82.5	82.5	82.5	82.6	82.6	82.6
RTT	Actual	91.1	91.1	91.0	90.2	89.9	89.4	90.0	88.9	88.3	88.1	88.4	87.0
	Traj.	92	92	92	92	92	92	92	92	92	92	92	92
6-week diagnostic	Actual	98.6	98.8	98.6	98.5	97.6	97.7	98.2	98.3	97.6	97.8	99.2	98.5
	Traj.	99	99	99	99	99	99	99	99	99	99	99	99

	National standard met
	STF trajectory met
	Neither STF or national standard met

Performance against these four SOF standards is covered in more detail in the following sections of the report.

3.4.2 Referral to Treatment (RTT)

The national compliance standard continued to be that at least 92 per cent of patients should be waiting less than 18 weeks between referral to treatment. During the year 2017/18, the volume of patients waiting over 18 weeks for treatment grew in a number of our specialities and the overall standard was not delivered in any single month. Our non-compliance has resulted from a growth in outpatient referrals and the high volume of elective cancellations during the prolonged winter pressure period.

The management of unanticipated growth and the change in RTT compliance for 2018/19 will be monitored weekly through our RTT, Diagnostic and Cancer performance meetings. Guidance from our regulators requires a steady state to be delivered month-on-month and the Trust has

committed to deliver a performance percentage month-on-month of no less than 87 per cent, whilst striving to deliver an aggregate performance across all Divisions of 92 per cent.

3.4.3 Accident & Emergency 4-hour maximum wait

The Trust failed to meet the national A&E 95 per cent standard for the proportion of patients discharged, admitted or transferred within four hours of arrival in our emergency departments, in any month in 2017/18. For the three emergency departments:

- Bristol Royal Hospital for Children achieved the 95 per cent standard in six out of 12 months, and achieved 94.9 per cent for the year as a whole
- Bristol Eye Hospital achieved the 95 per cent standard in five months, and achieved 96.6 per cent for the year
- Bristol Royal Infirmary did not achieve the 95 per cent standard in any month, and achieved 79.6 per cent for the year

This year, a Sustainability and Transformation Fund (STF) improvement trajectory was put in place with the aim of getting performance up the required standard by March 2018. For quarters 2 and 3, the target trajectory was 90 per cent at Trust level. The Trust achieved 90.9 per cent in quarter 2 and so achieved the associated funds for that quarter. For quarter 3, the Trust achieved 88.6 per cent; however, in agreement with NHS England and NHS Improvement, each acute trust was apportioned activity from Walk-In Centres and Minor Injury Units in their region (this was to enable more accurate comparisons to be made with areas of the country where this activity is owned by acute trusts). For the Trust, this was for the Bristol, North Somerset and South Gloucestershire (BNSSG) region. The result of this apportionment was published by NHS England as “Acute Trust Footprint” data. This data is being used to assess whether a Trust achieved the STF target for quarter 3. The Trust’s performance after apportionment was 92.8 per cent, therefore, for the purposes of assessing achievement at national level, the Trust achieved the STF target of 90 per cent for quarter 3. The Trust achieved 81.5 per cent in quarter 4; apportionment for quarter 4 has yet to be published, however the Trust will not achieve the 90 per cent target.

Overall, A&E attendance levels were up 2.7 per cent in 2017/18 compared to 2016/17 (a 3.5 per cent increase at the BRI and a 2.4 per cent increase at BRHC). However, the proportion of patients admitted to an inpatient bed as a result of their emergency department attendance remained the same at 25.5 per cent (34 per cent at BRI and 24 per cent at BRHC). The proportion of patients arriving at A&E by ambulance remained steady at 26.5 per cent (39 per cent at BRI and 19 per cent at BRHC).

There was a significant increase in emergency admissions to inpatient beds coming via direct GP referrals, as opposed to through A&E. This figure rose from 3,890 in 2016/17 to 5,672 in 2018/19. This 45 per cent increase was driven by changes in the Acute Physician model and the use of the Acute Medical Unit (A300) to accept increased numbers of GP expected patients. One four bed bay in AMU was converted to initially four, and then six trolleys to support expected patients being assessed and, where possible, discharged home in the same day, resulting in a rise in short stay (<24 hours) admissions. Following the overnight closure of the A&E department at Weston General Hospital, we received additional ambulance activity during the overnight period: on average, six attendances and three admissions to adult services.

The number of Delayed Transfers of Care (DToC) patients rose slightly in 2017/18. Last year, on average, there were 32 DToC patients at each month-end compared to 33 this year. Total bed

days lost to DToC patients fell from 12,399 to 11,572, however bed days lost to patients from Bristol City Council area rose slightly from 9,520 to 9,675.

This year, there was continued focus on ensuring that as many patients as possible were managed in the correct specialty ward. The number of bed days spent outlying rose from 8,854 to 9,098. Outlier bed days showed an almost two-fold increase in January-March 2018 due to winter pressures. Looking at quarters 1 to 3 only, the reduction this year compared to last year was near to 15 per cent. Ward A518 was added to the Trust's inpatient bed base in Medicine to offset the withdrawal of the virtual ward model and the impact of Weston's overnight closure, however this meant there was no additional inpatient capacity to open to support winter demand, leading to running at high levels of occupancy. Broadly in line with expectations, we relied heavily on extreme escalation capacity, particularly the Medical Rehabilitation Unit and Queen's Day Unit.

3.4.4 Cancer

The Trust performed well against the 31 day subsequent treatment standards for radiotherapy and chemotherapy, and the two week wait first appointment standard. These were achieved in every quarter of the year. The 31 day first definitive treatment standard was achieved in quarters two and three, but fell below the 96 per cent threshold in the first and last quarters of the year. This was due primarily to cancellations of surgery, which remains a significant challenge for the Trust. Likewise, the 31 day subsequent surgery standard was non-compliant in quarters one and four for the same reason.

The 62 day standard for treatment after a GP referral for suspected cancer was subject to a contract performance notice in July 2017 following a challenging start to the year. The impact of cancellations again was a significant factor, along with a number of other more minor issues. The Trust case-mix for this standard remains very challenging compared to the average provider, due to the absence of breast surgical and diagnostic services, and the high proportion of complex services such as those for thoracic surgery, specialist head and neck cancer, and specialist upper gastrointestinal cancer. This is acknowledged by our commissioners.

Following the performance notice, a recovery trajectory and targeted action plan were put in place and delivered good results. The trajectory was achieved in every month up to and including December and in quarter three the national 85 per cent standard was achieved for the first time since 2012. This was a significant achievement by the organisation, particularly in a quarter where nationally only 82.9 per cent was achieved. Quarter four saw a rise in cancellations, along with other factors including high levels of patient choice after Christmas, which in February manifested itself as an unusually high proportion of late referrals from other providers. These factors caused a dip below the recovery trajectory and the national standard. The organisation is now focussing on improving performance back to the 85 per cent standard, through rapid recovery from cancellations and work with other providers through a virtual waiting list meeting to reduce late referrals.

The 62 day standard for treatment following referral from a screening programme was compliant in quarter two only. This standard has extremely low numbers and most breaches are unavoidable – commonly due to patient choice to delay diagnostics. Again, an unusual case-mix hampers the Trust, with the majority of cases being colorectal screening and very few of the naturally high performing breast and cervical screening cases.

Overall, whilst significant challenges are still present for achievement of the cancer standards, during 2017/18 the Trust has made positive steps to improving performance against these

targets and has strong plans to build on this during 2018/19. A corporate quality objective has been agreed for the year (see section 2.1.2).

3.4.5 Diagnostic waiting times

This standard covers the top 15 high volume diagnostic tests. The expectation is that, at each month-end, 99 per cent of patients waiting for these tests should have been waiting for less than six weeks. The Trust achieved this standard at the end of February 2018, but did not achieve it for any of the other months during 2017/18. However, the following test areas did achieve the standard for each month: Audiology, Echocardiography, DEXA Scans, Peripheral Neurophysiology, Colonoscopy, Flexi Sigmoidoscopy and Cystoscopy. The Trust averaged 98.3 per cent at each month-end across 2017/18,

Sleep Studies experienced higher demand than expected and this test area averaged 83 per cent for the year. Demand management plans are being developed with commissioners and additional capacity is being developed through use of GPs with a Special Interest[17], additional consultant capacity and in-house waiting list initiatives. Computed Tomography (CT) averaged 96 per cent, with increase in Cardiac demand (24 per cent average growth in the last three years), long-term sickness in the department and general radiographer staff vacancies resulting in under performance against the standard. Magnetic Resonance Imaging (MRI) averaged 98.7 per cent with loss of capacity and increased acuity in paediatric General Anaesthetic cases contributing to under-performance and also high demand for Cardiac MRI tests. Non-obstetric Ultrasound achieved for the year on average, but saw a drop in performance from quarter four due to loss of capacity due to adverse weather and sonographer absences.

[17] A general practitioner with additional training and experience in a specific clinical area who takes referrals for patients who may otherwise have been sent directly to a secondary care consultant, or one who provides an enhanced service for particular conditions or patient groups.

Table 12: Performance against national standards

National standard	Target	2015/16	2016/17	2017/18	Notes
A&E maximum wait of 4 hours	95%	90.4%	85.0%	86.5% Ⓐ	Target not met in each quarter
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	99.0%	97.6%	97.9%	Target met in each quarter
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	52.8%	52.6%	52.2%	Target met in each quarter
A&E Unplanned re-attendance within 7 days	<5%	3.0%	2.6%	2.8%	Target met in each quarter
A&E Left without being seen	<5%	2.4%	2.2%	1.9%	Target met in each quarter
Cancer - 2 Week wait (urgent GP referral) *	93%	95.9%	94.8%	94.5%	Target met in each quarter
Cancer - 31 Day Diagnosis To Treatment (First treatment) *	96%	97.5%	96.7%	95.8%	Target met in Quarter 2 and 3
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery) *	94%	96.8%	94.4%	92.8%	Target met in Quarter 2 and 3
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy) *	98%	98.9%	98.7%	98.6%	Target met in each quarter
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy) *	94%	97.1%	96.6%	96.3%	Target met in each quarter
Cancer - 62 Day Referral To Treatment (Urgent GP Referral) *	85%	80.6%	79.3%	81.2%	Target met in Quarter 3
Cancer - 62 Day Referral To Treatment (Screenings) *	90%	68.6%	69.4%	78.1%	Target met in Quarter 2
Cancer - 62 Day Referral To Treatment (Upgrades) *	85%		87.9%	84.9%	Target met in Quarter 1 and 4
18-week Referral to treatment time (RTT) incomplete pathways	92%	91.3%	91.7%	89.6% Ⓐ	Target not met in each quarter
Number of Last Minute Cancelled Operations	<0.8%	1.03%	0.98%	1.19%	Target not met in each quarter
Last Minute Cancelled Operations Re-admitted within 28 days	95%	88.7%	90.8%	94.2%	Target met in Quarter 2
6-week diagnostic wait	99%	98.97%	97.79%	98.29%	Target not met in each quarter
Primary PCI - 90 Minutes Door To Balloon Time	90%	93.3%	91.7%	93.3%	Target met in each quarter

* Cancer data does not include March 2018 data, so Quarter 4 is incomplete

Ⓐ data subjected to external audit scrutiny as part of the process of producing this report

Achieved for the year and each quarter

Achieved for the year, but not each quarter

Not achieved for the year

Target not in effect

APPENDIX A – Feedback about our Quality Report

a) Statement from the Council of Governors of the University Hospitals Bristol NHS Foundation Trust

The Council of Governors welcomes this annual opportunity to comment on the Trust's quality report, which covers all key aspects of patient safety and experience, clinical effectiveness, the trust's performance against national priorities and its own key quality objectives. In doing so we acknowledge the increasingly challenging environment in which all NHS Trusts currently operate and the recent prolonged period of winter pressure experienced at UH Bristol.

We believe that this is an open and comprehensive report that clearly identifies both the trust's successes and areas of weaker performance over the last 12 months. Importantly, the trust has continued to demonstrate evidence of robust response to concerns raised as a result of public and patient consultation and independent enquiries; while also identifying learning and appropriate actions following internal investigations into all serious incidents.

Governor involvement
There is a Public Meeting of the Trust Board held every month, with a review of the Quality and Performance report for the previous month along with a report from the Non-executive Director Chair of the Trust Quality and Outcomes Committee on the agenda every time. Governors attend these meetings as observers and have the opportunity to raise questions following the board's own discussion on each topic.

There is also a specific Governor Focus Group for Quality that meets every two months, attended by the Non-executive Director Chair of the Trust Quality and Outcomes Committee, the Medical Director and the Chief Nurse, which supports further discussion about the quality reports and allows time for presentations on quality issues by other senior trust staff. This group reports back to the full Council of Governors who may then identify topics of concern for their regular meetings with the Non-executive Directors or individual questions to be raised on the Governors' Log of Communications.

Last summer we experienced a considerable turnover in our Council of Governors with a significant number of very experienced governors coming to the end of their terms of office and a reciprocal number of new governors joining the trust. The framework outlined above, along with our quarterly governor development seminars, has supported these new governors in their learning about quality and performance issues and their desire to raise questions and offer challenges about many of the issues referred to in this report.

Quality objectives
This report examines the trust's performance against the quality objectives it set itself at the beginning of the year and outlines the key objectives for service improvement over the next year. The successful creation of a Quality Improvement (QI) Academy over 2017/18, along with the higher-than-target staff attendance levels for the bronze programme, offers cause for celebration. Governors were among the attendees at the trust's first QI Forum last July and were able to see for themselves the impressive range and standard of posters on display. The on-going development of QI resources and encouragement of staff initiative and innovation in QI should now become embedded in the day-to-day workings of the trust.

The introduction of the new mortality review programme has also been a success and we welcome the fact that learning from this has fed directly into the objectives for the coming year. However, it is clearly disappointing to note the deterioration in last minute cancellations of operations for 2017/18 and this will require continued close scrutiny over the coming year along with on-going effort around cancellations of outpatient appointments and the management of

sepsis. In addition, it is to be hoped that the delayed procurement and implementation of a new system for gathering patient feedback at the point of care will move forward smoothly in early 2018/19 and produce the more effective reporting that is sought.

In setting the objectives for 2018/19, we note that the trust is carrying forward two key objectives relating to the development of a 'customer service mind set' and further improvement in staff engagement and satisfaction. Success has been achieved in these objectives over the past year, but we acknowledge the continued importance of both as the trust pursues its efforts to offer a genuinely individual, effective and caring approach to all patients and staff. Indeed, the governors have given a great deal of attention to all data relating to staff recruitment, retention, engagement and training over the past year and are aware that the newly appointed Director of People has identified a number of priority actions to pursue over the coming year.

Among the new objectives for 2018/19 we particularly welcome the aims to improve learning from Serious Incidents and Never Events and to improve early recognition of the dying patient. We know how important it is for patients and families that have been involved in serious incidents to believe that learning will be gained from the investigations into such incidents and that future patients will benefit from this. Work to improve the recognition of patients approaching the end of their life and, thereby, to achieve appropriate choices for them and their families is also of key importance. Within the mandated quality indicators (see 2.3) this should also result in an increased percentage of UH Bristol patient deaths with 'palliative medicine' or palliative care' within their coding in future reports.

Patient safety

UH Bristol is due to complete the current three-year Patient Safety Improvement Programme this summer and must be congratulated on the reduction in adverse events per 1000 bed days that has been achieved. Rigorous evaluation of progress against all the relevant quality improvement measures within the programme, as planned, must now inform the setting of patient safety improvement priorities for the next three years. Sustaining the positive safety culture that is referred to in this report will clearly require on-going two-way communication with the clinical teams; and the commitment to repeating and feeding back on safety culture assessments is very welcome.

The timing and thoroughness of investigations following serious incidents and never events continue to be closely monitored by the Quality and Outcomes Committee, and evidence has been regularly presented over the past year of learning from these investigations leading to the necessary action plans. Further emphasis on such learning within the quality objectives for the coming year should, therefore, become apparent within this committee.

Continued emphasis on the recognition and management of deteriorating patients (both adults and children), supported by further implementation of electronic observation systems and pathways, demonstrates a sustained commitment to improvement in this area. Similarly, the roll out of electronic prescribing and medicines administration to all adult specialties and planned actions to make insulin prescribing and administration safer also demonstrates an on-going emphasis on supporting the safer management of medicines both in hospital and following discharge.

Patient experience

Listening to previous, current and potential patients in a variety of settings has continued via the patient stories presented at the Public Board Meetings, the work of the *Face2Face* volunteer interview team, patient focus groups, national and local patient surveys and visits from external organisations.

Governors continue to place considerable emphasis on these activities and regularly volunteer to participate when appropriate. In addition, we now have two governor representatives attending the Patient Experience Group meetings and giving feedback from these meetings to the Quality Focus Group. Over the past year, we have also appreciated the opportunity to review the trust's results within the most recent National Inpatient Survey and National Cancer Patient Experience Survey via presentations from senior members of staff at the Quality Focus Group. As noted in this report, the national inpatient and children's surveys demonstrated that UH Bristol's performance was among the best in the country in a significant number of the scores .

The specific projects pursued over the past year to achieve further engagement with the local deaf community and people with learning disability are very welcome, as are the involvement of patients in the design of the trust's new end of life personalised care plan and in workshops bringing together patients and junior doctors. The reported deterioration in response times for formal complaints will clearly require attention over the coming year; while the plan to introduce quarterly reporting to the trust's Patient Inclusion and Diversity Group of complaints which highlight themes should offer an opportunity for further action.

Clinical effectiveness, audit and research
The trust continues to closely monitor performance in key areas of clinical effectiveness and staff work incredibly hard in their attempts to achieve the nationally or locally agreed targets despite increasing levels of demand.

Disappointingly, the performance of the trust in relation to the Best Practice Tariff for Fractured Neck of Femur continues to cause significant concern and is under close scrutiny at the Quality and Outcomes Committee and the governors' Quality Focus Group. Stroke Care also requires on-going scrutiny over the coming year. Governors have regularly raised questions about the actions plans relating to these topics and will continue to challenge them if progress is not achieved.

Failure to achieve the planned target for outlying bed days is, perhaps, not surprising given the increased number of patients presenting at the trust over the past year and on-going difficulties with appropriate discharge arrangements resulting in persistently high numbers of 'green to go' patients on the wards. We must hope that work will be achieved within the Sustainability and Transformation Plan for Bristol, North Somerset and South Gloucestershire that will support progress with all of these issues.

The trust continues to demonstrate impressive levels of participation in national clinical audits, national confidential enquiries and clinical research, all of which strongly supports innovation and professional development within the clinical teams. Governors have been delighted to have the opportunity to hear about the wide range of research being pursued at the trust annual research showcase event and via research newsletters.

Performance against national priorities and access standards
The data relating to the trust's performance against the four key nationally determined standards clearly demonstrates increasing periods of time when these could not be achieved, as has been the case for many acute trusts across the country. Trajectories for these targets have been affected by increasingly high levels of overall demand, emergency admissions and increased numbers of elderly patients with complex needs, as was the case last year. In addition, the trust faced a prolonged winter pressure period this year.

The inability to discharge treated patients to suitable care in the community has continued, despite the development of an integrated discharge team at the trust in collaboration with

community service providers. These targets will require continued focus and regular review over the coming year and are likely to continue to offer considerable challenge.

Summary
The governors share the deep sense of pride felt by our chief executive, Robert Woolley, and the whole Board at UH Bristol in the achievements of all staff at the trust over the past year. In addition we have felt particular admiration and gratitude for the remarkable resilience shown by staff during the severe weather conditions experienced earlier this year during the height of the winter pressure period.

The Quality and Outcomes Committee has continued to sharpen their focus on, and strengthen the trust's responses to, key areas of performance across all areas of the trust. Monthly quality and performance reports that contain Increasingly detailed data supports them in this work, and the governors also receive these reports. New governors who were elected last summer have put a great deal of effort into developing their understanding of these reports in order to enable them to offer informed and appropriate challenges to the trust's Non-executive Directors. Further plans are in place to build on the governors' current awareness and understanding of quality and performance issues in the coming year and we will continue to strive to offer both support and challenge to the trust. In reflecting on all the work completed or on-going over 2017/18 we believe this report is honest and open in acknowledging the objectives that proved challenging to meet alongside those for which the outcomes were successfully achieved.

Progress on quality has clearly been achieved during the year. However, there are areas where the data is disappointing and we are well aware that financial pressures, national requirements and ever-increasing patient numbers and complexity can only increase the challenges faced by everyone at the trust. Collaboration with our partners in the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan may provide further integration and innovation within services to ease the current and anticipated pressures; but this work also requires an input of time and money. Similarly, our partnership work with other local acute trusts must continue to develop but adds to the workload of senior trust staff.

In acknowledging these many challenges the governors continue to recognise that the trust's quality agenda is ultimately delivered by dedicated staff. They offer a hugely impressive commitment to their patients every day and must be valued for this and constructively supported in every way possible.

Carole Dacombe (current chair of the Quality Focus Group)
Rashid Joomun
(in consultation with their fellow governors)

May 2018

b) Joint statement from Healthwatch Bristol and Healthwatch South Gloucestershire

Healthwatch Bristol and Healthwatch South Gloucestershire agreed that University Hospitals Bristol NHS Foundation Trusts (UH Bristol) performance against their 2017/2018 quality priorities had been very good. We agreed that the document evidences a culture of learning from the experiences and feedback of patients and the public. It was good to see that objectives from 2017/2018 that had been only partly met were being carried through to the 2018/2019 Quality Account. Healthwatch Bristol and Healthwatch South Gloucestershire believe the trust's quality objectives for the coming year are ambitious enough to drive improvement.

Healthwatch Bristol and Healthwatch South Gloucestershire made the following comments and recommendations about UH Bristol's Quality Account 2017/2018. The document suggested that quality improvement at UH Bristol's had been good with four of the eight priorities for 2017/18 being RAG rated green. For example:

- UH Bristol had more than doubled their initial target for creating a new Quality Improvement Academy with nearly 200 members of staff completing the 'Bronze' programme. A good green RAG rating.
- The introduction of the new mortality programme is RAG rated green, Healthwatch are interested to follow the implementation and find out more about how patients are reviewed following discharge.
- UH Bristol have developed a set of 'Customer Service Principle' and Healthwatch are keen to follow how this firm foundation will be built on in 2018/19.
- Healthwatch noted that despite the green RAG rating the BAME staff experience is unchanged at 28 per cent, higher than the national average and hope that this can be addressed in the coming year.
- Healthwatch are interested to view the breakdown of outpatient appointments cancelled and note that the amber RAG rate reflects that the target for this was not met during the year.
- Sepsis is a national concern and Healthwatch congratulates UH Bristol on the improvement to put the Trust in the top 20 per cent of all NHS Trusts. The amber RAG rating reflects the partial achievement of the CQUIN goals.
- The red rating is disappointing for the objective to reduce the number of last minute cancelled operations as Healthwatch often hear that the consequences for the patient can be drastic.
- The implementation of the new system to gather patient feedback at the point of care has been delayed giving an amber rating, Healthwatch look forward to seeing how this will change over the coming year.

Healthwatch Bristol and Healthwatch South Gloucestershire noted the Quality objectives for 2018/19:

- Healthwatch would like to see better tele communication in the coming year, particularly around the appointment system at the Dental Hospital.
- Healthwatch welcome the objective to improve compliance with the 62 day standard from GP referral to first definitive cancer treatment
- The Mystery Shopper programme is a great idea and Healthwatch look forward to the evaluation at the end of 2018/19.
- Never events should never happen, Healthwatch welcome the improvements being made through the learning to ensure that the event will never happen again in the future.
- In improving the early recognition of the dying patient, Healthwatch noted that the 'weekend sticker' term was used. A breakdown of how this system works will be useful for patient and public understanding.
- Healthwatch noted the objective to explore maternity services, where the standard has dropped, Healthwatch are very aware that maintaining excellence is difficult and welcome the monitoring of this service.

Healthwatch has found UH Bristol to be a high performing local provider with a Care Quality Commission (CQC) rating as 'Outstanding' and note there were no further CQC actions in 2017 – 2018.

Healthwatch are aware that UH Bristol recognises serious incidents as their weaknesses and wonder how many of the slips, trips and falls could have been prevented. The high incidence of grade three pressure ulcers is also a concern.

The term Duty of Candour may need an explanation for patient and public awareness so that everyone knows that every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care, and how this can cause harm or distress for patients, families and carers.

Healthwatch welcomes the paragraph on patient experience as it shows the Trust has a commitment to improving the patient experience.

The Trust is pursuing comprehensive and innovative consultation and engagement activities, involving the communities and groups they serve in the development of their services. Healthwatch were delighted to see the range of Patient and Public Involvement highlights from 2017/18.

Working with the Patient Association to develop a best practice tool kit to help staff respond to complaints more effectively is to be commended and Healthwatch will look forward to seeing the completed toolkit at the end of June 2018.

Healthwatch are hoping to see improvement in the Bristol Royal Infirmary achievement to meet the four hour wait in accident and emergency in 2018/19.

Healthwatch Bristol and Healthwatch South Gloucestershire welcome further opportunities to work with UH Bristol, for example Accident and Emergency may be an area where Healthwatch can both observe the service and talk to patients in the coming year.

26 April 2018

c) Statement from Healthwatch North Somerset

Healthwatch North Somerset welcomes the opportunity to provide a statement in response to the University Hospitals Bristol NHS Foundation Trust Quality Account produced by for the year 2017/2018.

Overall the UH Bristol Quality Account provides a comprehensive reflection on quality performance during 2017/18 and demonstrates a good listening and learning approach.
We note the quality objectives for 2017-18 and commend the fact that four of them were directly related to the patient experience. Some of the objectives were rated as amber or red in achievement but we note the continued commitment of UH Bristol to achieving those objectives.

The Quality Account evidences a culture of collecting, reflecting upon and learning from the experiences and feedback of patients and the public. Patient feedback data overall indicates that patients are reporting good levels of care and positive experiences. We welcome that for 2018-19 that there is ongoing commitment to improving the patient experience including the first stated priority to “develop a consistent customer service mind set in all our interactions with patients and their families” and hope that significant progress will be achieved on this over the year.

Healthwatch North Somerset collects feedback from patients in North Somerset and experience of hospitals within the UHB group during 2017-18 based on public feedback was:

- 43 positive comments commending care quality, staff attitudes, co-ordination of care, continuity and communication
- 26 negative comments citing:
    - Cancelled operations and waiting times in ED and clinics (8)
    - Concerns about quality of care (7)
    - Communications and complaints (5)
    - Discharge concerns (3)
    - Transport and access issues (3)

d) Statement from Bristol City Council People Scrutiny Commission

The Bristol City Council People Scrutiny Commission holds the statutory health scrutiny function for Bristol City Council. The Commission received a presentation on the 8th May and Members were satisfied with the contents of the University Hospitals Bristol NHS Foundation Trust Quality Report.

Members commended UHB for its staff development programmes and for its progress with staff wellbeing initiatives; and Members welcomed the creation of the Quality Improvement Academy which enabled innovations such as the Virtual Fracture Clinic. This demonstrated that UHB was open to working in different ways, empowering and investing in its staff.

Members noted that operational targets in respect of bed occupancy had worsened, but understood the role that winter pressures had played as well as the national context around delayed discharge and bed occupancy. However, Members expressed particular concern that issues linked to levels of bed occupancy have an adverse impact on the causes of last minute cancelled operations.

e) Statement from South Gloucestershire Health Scrutiny Committee

The South Gloucestershire Health Scrutiny Committee received a presentation on UH Bristol's draft Quality Account at a meeting in common with the Bristol People Scrutiny Commission on 8th May 2018. Members of the Committee also visited the Trust on 1st May 2018 to learn about the QI programme and examples related to tissue donation, as well as a visit to the Bristol Children's Hospital to hear about staff engagement.

These comments are based on matters raised by Members of the South Glos Committee at the meeting in common. Members were interested in changes to the optimisation of the BRI Acute Fracture Clinic and noted that the assessment of fractures after the initial operation could now be managed at home, resulting in reduced clinic waiting times for those that do not have to return to hospital. Information was received on the reSPECT process involving the collaboration of 6 Trusts, noting that this involved person-centred decision making in emergency situations and at the end of life. Members wished to ensure medicine allocation procedures were stringent and effective. Information on learning and development for staff was noted. Assurances were sought and given that appropriate business continuity plans are in place as part of the move to electronic patient records.

In addition, the Committee engaged with the Trust at a meeting in common with the Bristol People Scrutiny Commission on 30th January 2018. UH Bristol's Chief Executive attended to update Members on the Trust's actions in response to the 'Independent Review of Children's Cardiac Services in Bristol'; and the 'Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's

Hospital'. The South Glos Health Scrutiny Committee was satisfied that the review of services had been conducted thoroughly and in great depth by the CQC and through the independent specialist investigation by Verita. Members were satisfied that families had taken part in the review process. They noted the progress in implementing the recommendations identified by the Trust and noted that many of them had been completed and were already part of standard practice. The Committee expressed every sympathy with the family and wished to be kept informed of progress following the outcome of on-going litigation, professional review by the GMC and an independent investigation by the PHSO. A further meeting in common was requested, to reconvene in 12 months' time.

Councillor Marian Gilpin, Chair
Councillor Sue Hope, Lead Member
Councillor Ian Scott, Lead Member

f) Statement from North Somerset Health Overview and Scrutiny Panel (QA Sub Committee) Response to United Hospitals Bristol Trust QA

Overall the Health Overview and Scrutiny Panel were very encouraged by the closer relationship with Weston General Hospital.

It was noted that the Trust seeks to build on earlier programmes and there is a case for more opportunities to work together to support innovation and improvement. The Panel would like to know more about how this it to be implemented.

The Panel were particularly encouraged by the 97% positive experience of care as indicated by the feedback forms from patients and their friends and families but would be interested to hear the reasons for dissatisfaction.

In conclusion, the Panel felt that the Trust had made good progress against its 2017/18 priorities and that the priority areas identified for 2018/19 were appropriately targeted.

Roz Willis
Chairman, Health Overview & Scrutiny Panel
North Somerset Council
2 May 2018

g) Statement from Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Report 2017/18 is made by Bristol, North Somerset & South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG).

BNSSG CCG welcomes UH Bristol's quality account, which provides a comprehensive reflection on the quality performance during 2017/18. The data presented has been reviewed and is in line with data provided and reviewed through the monthly quality contract performance meetings.

BNSSG CCG noted that of the eight quality objectives for 2017/18 four were fully achieved and three partially achieved though noting significant progress in elements within these three. The CCG acknowledges the work put in place for these objectives and is pleased to note the plans to continue this work for most of the objectives into 2018/19. The CCG supports the chosen areas

for quality improvement for 2018/19, especially the inclusion of an objective that works across primary care to improve patient safety and experience. However we would question why the objectives to reduce late cancellation of operations, which was not achieved in 2017/18, is not being taken forward for 2018/19.

BNSSG CCG commends the excellent quality improvement work relating to the 'Sign up to Safety' programme of work, including recognition and management of the deteriorating patients, embedding a patient safety culture and medicines safety. UH Bristol's partnership working as demonstrated through the trust's engagement with the West of England Academic Health Science Network's (AHSN) Patient Safety Collaboratives is also noteworthy.

Within the quality account UH Bristol have demonstrated continued good progress in reducing the number of inpatient falls, pressure ulcers and sustaining compliance with VTE assessments against the national target, all of which are to be commended. The CCG also acknowledges the continued work in the early identification and management of sepsis and welcomes the continued focus on sepsis for 2018/19. The trust achieved compliance with the C Difficile target, however, as noted in the 2016/17 statement by Bristol CCG, BNSSG CCG again would have welcomed more detail on the management of healthcare associated infections particularly in relation to the MRSA blood stream infections performance this year and the trust's plans to improve on this for 2018/19. The CCG also notes there is minimal analysis regarding the fractured neck of femur poor performance as this has not improved over the year. The high number of reported Never Events during 2017/18 was also noted, and the CCG supports the plans to learn from these to prevent further occurrences.

BNSSG CCG commends the excellent performance regarding the NHS inpatient survey and CQC patient survey results and notes the ongoing patient experience work within the Trust, acknowledging the significant amount of positive feedback that is received from service-users. The CCG is aware that patient stories are regularly presented to the Trust Board and would encourage the Trust to include these in the annual Quality Account to highlight the patient experience work.

UH Bristol's performance against the quality improvement and innovation goals (CQUINs) is noted and the high level of achievement is acknowledged and commended.

BNSSG CCG is aware of the considerable work undertaken by UH Bristol during 2016/17 and 2017/18 to action the outcomes and recommendations from the Independent Review of Children's Cardiac Services, however we would like to have seen this referenced in this year's Quality Account noting the improvements made as a result.

Going forward BNSSG CCG will continue to work closely with the Trust in areas which need either further improvement or development. These include:

- Closer working with primary care and community partners to help support the reduction in incidences of healthcare associated infections, namely MRSA, C Difficile Infection, and E coli bacteraemias.
- Improvement in performance against the best practice tariff for patients who have sustained a fractured neck of Femur.
- Focused work to review themes and embed learning arising from Serious Incidents and Never Events to improve patient safety.

BNSSG CCG acknowledges the good work within the Trust and the quality account clearly demonstrates this. We note the areas that have been identified by the Trust for further improvement and we look forward to working with the Trust in 2018/19 to deliver those improvements.

APPENDIX B – Performance indicators subject to external audit

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

Source of indicator definition and detailed guidance

The indicator is defined within the technical definitions that accompany Everyone Counts: planning for patients 2014/15 - 2018/19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf. Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https://www.england.nhs.uk/statistics/wpcontent/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf.

Numerator

The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as: (Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge).

Denominator

The total number of unplanned A&E attendances.

Accountability

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wpcontent/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

Indicator format

Reported as a percentage.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

Source of indicator definition and detailed guidance

The indicator is defined within the technical definitions that accompany Everyone Counts: planning for patients 2014/15 - 2018/19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf. Detailed rules and guidance for measuring referral to treatment (RTT) standards can be found at http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waitingtimes/rtt-guidance/

Numerator. The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks.

Denominator

The total number of patients on an incomplete pathway at the end of the reporting period

Accountability

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-21content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

Indicator format

Reported as a percentage.

APPENDIX C – Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2017 to March 2018
    - papers relating to Quality reported to the board over the period April 2017 to March 2018
    - feedback from commissioners received 16/5/2018
    - feedback from governors received 9/5/2018
    - feedback from local Healthwatch organisations received 9/5/2018 and 10/5/2018
    - feedback from Overview and Scrutiny Committees received 14/5/2017 and 16/5/2017
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009[18]
    - the 2016 national patient survey published 31/5/2017[19]
    - the 2017 national staff survey published 6/3/2018
    - the Head of Internal Audit's annual opinion over the trust's control environment dated 24 May 2017
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with Monitor's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

[18] This report is due to be received by the board later in 2018
[19] The 2017 survey results have not yet been published

By order of the board

Jeff Farrar, chairman
24 May 2018

Robert Woolley, chief executive
24 May 2018

APPENDIX D – External audit opinion

Independent Auditors' Limited Assurance Report to the Council of Governors of University Hospitals Bristol NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of University Hospitals Bristol NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Bristol NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement ("NHSI")):

Specified Indicators	***Specified indicators criteria*** (exact page number where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients with incomplete pathways at the end of the reporting period.	See Appendix B to the Quality Report, page 78
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	See Appendix B to the Quality Report, page 78

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2017/18" issued by NHSI.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18"; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the financial year, April 2017 and up to the date of signing this limited assurance report (the period);

- Papers relating to quality report reported to the Board over the period April 2017 to the date of signing this limited assurance report (the period);

- Feedback from the Commissioners Bristol, North Somerset and South Gloucestershire CCG dated 16 May 2018;

- Feedback from Governors dated 9 May 2018;

- Feedback from Local Healthwatch organisations Healthwatch North Somerset dated 9 May 2018 and Healthwatch Bristol and Healthwatch South Gloucestershire dated 8 May 2018;

- Feedback from Overview and Scrutiny Committee dated 16 May 2018;

- The 2016 national and local patient survey dated 31 May 2018;

- The 2016 national and local staff survey dated 26 April 2018;

- Care Quality Commission inspection, dated 2 March 2017; and

- The Head of Internal Audit's annual opinion over the Trust's control environment dated 16 May 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospitals Bristol NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospitals Bristol NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospitals Bristol NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";

- reviewing the Quality Report for consistency against the documents specified above;

- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;

- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;

- making enquiries of relevant management, personnel and, where relevant, third parties;

- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;

- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and

- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2017/18"and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by University Hospitals Bristol NHS Foundation Trust.

Basis for Disclaimer of Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The 18 week indicator is calculated each month based on a snapshot of incomplete pathways. In our testing we found two instances of a patient being included in monthly reporting which did not meet the inclusion criteria and three cases where patients were not included in an applicable month in error. Additionally, for three pathways tested, no evidence was found of the relevant clock start date.

As the Trust has not reviewed or updated the underlying data set, we were unable to access accurate and complete data to check the waiting period from referral to treatment reported across the year.

Conclusion (including disclaimer of conclusion on the Incomplete Pathways indicator)

Because the data required to support the indicator is not available, as described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the Incomplete Pathways indicator.

Based on the results of our procedures, nothing else has come to our attention that causes us to believe that for the year ended 31 March 2018,

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";

- The Quality Report is not consistent in all material respects with the documents specified above; and

- The Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge indicator has not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

PricewaterhouseCoopers LLP
Bristol
29 May 2018

The maintenance and integrity of the University Hospitals Bristol NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Appendix D – Annual Accounts 2017/18

University Hospitals Bristol
NHS Foundation Trust

Accounts for the year ended 31 March 2018

Paul Mapson
Director of Finance and Information
CPFA

Finance Department
Trust Headquarters
Marlborough Street
PO Box 3214
BRISTOL BS1 9JR

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Accounts for the year ended 31 March 2018

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2018 have been prepared by the University Hospitals Bristol NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Services Act 2006.

Signed ……

Robert Woolley
Chief Executive

Statement of Comprehensive Income for the year ended 31 March 2018

	Note	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Income from patient care activities	3	570,203	529,543
Other operating income	4	113,939	109,281
Operating expenses	5-6	(654,255)	(620,177)
OPERATING SURPLUS/(DEFICIT)		**29,887**	**18,647**
Finance income	8.1	189	189
Finance expenses	8.2	(2,954)	(3,178)
Public dividend capital dividends payable		(8,601)	(8,100)
NET FINANCE COSTS		**(11,366)**	**(11,089)**
Other gains/(losses)		(16)	(76)
SURPLUS/(DEFICIT) FOR THE YEAR		**18,505**	**7,482**
OTHER COMPREHENSIVE INCOME/(EXPENDITURE)			
Revaluations		6,143	(13,848)
TOTAL COMPREHENSIVE INCOME/(EXPENDITURE) FOR THE YEAR		**24,648**	**(6,366)**
ADJUSTED FINANCIAL PERFORMANCE			
Surplus / (deficit) for the year		18,505	7,482
Adjustment in respect of capital donations		366	(1,364)
Adjustment in respect of net impairments		1,032	10,412
Adjustment in respect of (loss)/gain on sale of assets*		-	76
Adjusted financial performance		**19,903**	**16,606**

** From 2017/18 losses and gains are included within operating surplus and deficit in line with NHS Improvement reporting requirements*

The Trust's financial performance is reported on its surplus/(deficit) per the Statement of Comprehensive Income adjusted for the above technical accounting adjustments. These are not part of the Trust's operating position when reporting outside of the annual accounts in line with NHS Improvement. Further details are provided in note 2 to the accounts.

The notes on pages 6-36 form part of these accounts

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Statement of Financial Position as at 31 March 2018

	Note	31 March 2018	31 March 2017
		£000	£000
NON CURRENT ASSETS			
Intangible assets	9	12,124	6,792
Property, plant and equipment	10	369,821	368,464
Trade and other receivables	12	1,050	1,050
TOTAL NON CURRENT ASSETS		**382,995**	**376,306**
CURRENT ASSETS			
Inventories	11	13,490	12,185
Trade and other receivables	12	49,354	36,046
Other financial assets	13.1	104	104
Cash and cash equivalents	18	71,092	65,441
TOTAL CURRENT ASSETS		**134,040**	**113,776**
CURRENT LIABILITIES			
Trade and other payables	14	(65,394)	(65,857)
Borrowings	16.1	(6,170)	(6,160)
Provisions	17	(199)	(191)
Other liabilities	15	(5,918)	(4,576)
TOTAL CURRENT LIABILITIES		**(77,681)**	**(76,784)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**439,354**	**413,298**
NON CURRENT LIABILITIES			
Borrowings	16.2	(74,744)	(80,913)
Provisions	17	(245)	(96)
TOTAL NON CURRENT LIABILITIES		**(74,989)**	**(81,009)**
TOTAL ASSETS EMPLOYED		**364,365**	**332,289**
EQUITY			
Public dividend capital		203,650	196,222
Revaluation reserve		41,211	37,963
Other reserves		85	85
Income and expenditure reserve		119,419	98,019
TOTAL EQUITY		**364,365**	**332,289**

The accounts on pages 2 to 36 were approved by the Board on 24 May 2018 and signed on its behalf by:

Signed …… Date: 24 May 2018

Robert Woolley, Chief Executive

Statement of Changes in Equity for the year ended 31 March 2018

Changes in Equity in the current year	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	Total Equity £000
Equity at 1 April 2017	196,222	37,963	85	98,019	332,289
Surplus/(deficit) for the year	-	-	-	18,505	18,505
Revaluations on property plant and equipment and intangible assets	-	6,143	-	-	6,143
Transfers between reserves	-	(2,895)	-	2,895	-
PDC Received	7,428	-	-	-	7,428
Equity at 31 March 2018	**203,650**	**41,211**	**85**	**119,419**	**364,365**

Changes in Equity in the previous year	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	Total Equity £000
Equity at 1 April 2016	194,156	55,859	85	86,489	336,589
Surplus/(deficit) for the year	-	-	-	7,482	7,482
Revaluations on property plant and equipment and intangible assets	-	(13,848)	-	-	(13,848)
Transfers between reserves	-	(4,048)	-	4,048	-
PDC Received	2,180	-	-	-	2,180
PDC Repaid	(114)	-	-	-	(114)
Equity at 31 March 2017	**196,222**	**37,963**	**85**	**98,019**	**332,289**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves

Relates to historical balances held since 1990 and will not move.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows for the year ended 31 March 2018

	Note	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus/(deficit) from continuing operations		29,887	18,647
OPERATING SURPLUS/(DEFICIT)		**29,887**	**18,647**
NON CASH INCOME AND EXPENDITURE			
Depreciation and amortisation	9-10	23,788	22,552
Impairments	8.3	1,032	10,412
Income recognised in respect of capital donations		(1,204)	(256)
(Increase)/decrease in trade and other receivables	12	(13,663)	(11,419)
(Increase)/decrease in inventories	11	(1,305)	(743)
Increase/(decrease) in trade and other payables	14	3,318	(1,188)
Increase/(decrease) in other liabilities	15	1,342	8
Increase/(decrease) in provisions	17	157	(59)
Other movements in operating cash flows		(3,389)	(1)
NET CASH GENERATED FROM OPERATIONS		**39,963**	**37,953**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		192	190
Purchase of property, plant and equipment	10	(20,180)	(30,853)
Purchase of intangible assets	9	(5,554)	(235)
Receipt of cash donations to purchase capital assets		1,204	256
Sales of property plant and equipment		18	-
NET CASH USED IN INVESTING ACTIVITIES		**(24,320)**	**(30,642)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		7,428	2,180
Public dividend capital repaid		-	(114)
Loans repaid to the Department of Health		(5,834)	(5,834)
Capital element of finance lease rental payments		(328)	(300)
Interest paid		(2,741)	(2,949)
Interest element of finance leases		(268)	(296)
PDC dividend paid		(8,249)	(8,568)
NET CASH GENERATED/(USED) IN FINANCING ACTIVITIES		**(9,992)**	**(15,881)**
INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**5,651**	**(8,570)**
CASH AND CASH EQUIVALENTS AT START OF YEAR	18	**65,441**	**74,011**
CASH AND CASH EQUIVALENTS AT END OF YEAR	18	**71,092**	**65,441**

Notes to the Accounts

1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2017/18 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to NHS foundation trusts, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DH Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

The annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Income

The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Income in respect of services is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable.

At the year-end income is accrued for activity delivered in the year. Where a patient care spell is incomplete at the year-end, revenue relating to the partially complete spell is accrued on a pro-rata basis based on the expected length of stay and agreed with the commissioner.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income recognised in the accounts relating to the Sustainability and Transformation Funding for quarter 4 core funding and the incentive and bonus payments is based on the values notified by NHS Improvement following the Trust exceeding its surplus control total. These values are indicative and the final amount receivable by the Trust will be notified by NHS Improvement following submission of the final accounts.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 Expenditure on employee benefits

Employee benefits - short term

Salaries, wages and employment-related costs are recognised in the year in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the year is recognised in the financial statements. See 1.19 for further details.

An assessment of annual leave owing to staff at 31st March 2018 has been calculated using a sample of staff across all staff groups of a size sufficient to ensure above 95% confidence in the value of the liability. The average annual leave owed to staff groups in the sample has been used to calculate the total number of hours owed to all staff in post in March 2018. An average hourly cost has been

applied to each staff group to calculate the cost of annual leave owed.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.5 Expenditure on other goods and services

Other operating expenses are recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services.

1.6 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- individually its cost is in excess of £5,000; or
- it forms a group of similar assets with an aggregate cost in excess of £5,000 (where the assets have an individual cost in excess of £250, are functionally interdependent, have broadly similar purchase dates, are expected to have similar lives and are under single management control); or
- it forms part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of individual or collective cost;
  and
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be provided to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably.

Where a significant asset includes a number of components with different economic lives, then these components are treated as separate assets within the asset's classification and depreciated over their individual useful economic lives.

Measurement (Valuation)

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Land and buildings

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

Assets in the course of construction are initially recorded at cost. Costs include professional fees

and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued by professional valuers every year end through a desktop exercise, as part of the five year review, or, for significant properties, when they are brought into use and then depreciation commences.

Other assets

Other assets including plant, machinery, IT and equipment,that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Depreciation

Freehold land, assets under construction and assets held for sale are not depreciated. Freehold land is considered to have an infinite life, assets held for sale cease to be depreciated upon the reclassification and assets in the course of construction are not depreciated until the asset is brought into use.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis as a change in estimate under IAS 8. The Trust's valuers, the Valuation Office, assess the estimated remaining useful life of buildings, installations and fittings.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

The remaining maximum and minimum economic lives of property, plant and equipment assets held by the Trust are as follows:

Asset Type	Minimum Life	Maximum Life
Buildings excl. dwellings	15 years	49 years
Dwellings	18 years	25 years
Plant and machinery (incl. medical equipment)	1 year	18 years
Transport equipment	1 year	7 years
Information technology	1 year	7 years
Furniture and fittings	1 year	10 years

When assets are revalued, the accumulated depreciation at the date of revaluation is eliminated against the gross carrying amount of the asset, and the net amount is restated to the revalued amount of the asset.

Revaluation gains and losses

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as a charge to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

The Trust transfers the difference between depreciation based on the historical amounts and revalued amounts from the revaluation reserve to retained earnings.

Impairments

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment have suffered an impairment loss. If there is indication of such an impairment, the

recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are netted against any impairment charges within Operating Expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve.

Donated, government grant and other grant funded assets

Donated and grant funded non-current assets are capitalised at their current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income receipt.

Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised where they have a cost in excess of £5,000, where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets acquired separately are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at current value in existing use by reference to an active market, or, where no active market exists, the lower of amortised replacement cost and the value in use where the asset is income generating.

Intangible assets are held at amortised historical cost which is considered to be an appropriate proxy for fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The remaining maximum and minimum economic lives of intangible assets held by the Trust are as follows:

Asset type	Minimum life	Maximum life
Software (purchased)	1 year	7 years

Purchased computer software licences are amortised over the shorter of the term of the licence and their estimated economic lives.

1.8 Government grants

Government grants are grants from Government bodies other than income from commissioners or NHS trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match that expenditure.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of inventories.

1.10 Financial instruments (financial assets and liabilities)

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.11 below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Loans from the Department of Health are recognised at historic cost. Other Financial liabilities and Financial assets are initially recognised at fair value.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method as described in loans and receivables. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to 'Finance Costs'. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income.

1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Lessee accounting:

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. Lease payments are apportioned between finance charges and

reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses on a straight-line basis over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Lessor accounting:

Operating leases

Assets acquired and held for use under operating leases are recorded as fixed assets and are depreciated on a straight line basis to their estimated residual values over their estimated useful lives. Operating lease income is recognised within operating income.

1.12 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of:

Expected cash outflows	Years	HMT real rate (%)	
		2017/18	2016/17
Short term	1-5	-2.42	-2.70
Medium term	6-10	-1.85	-1.95
Long term	10 or more	-1.56	-0.80

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. The contribution is charged to the Statement of Comprehensive Income. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 17.2.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Contingencies

Contingent assets (from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) not recognised as assets, but disclosed in note 21.1 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but disclosed in note 21.2, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.14 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance which represents the Department of Health's investment in the Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. At any

time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated assets
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund deposits, excluding cash balances held in GBS accounts that relate to a short term working capital facility
- Any PDC dividend balance receivable or payable and
- the final incentive elements of the Sustainability and Transformation Funding.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.15 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in note 25 to the accounts.

1.17 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note 27 is compiled directly from the losses and compensations register which reports on a cash basis with the exception of provisions for future losses.

1.18 Accounting standards that have been issued but not yet been adopted

The GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

Standards and Interpretations	Financial year for which the change first applies
IFRS 9 *Financial Instruments*	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
IFRS 15 *Revenue from Contracts with Customers*	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
IFRS 16 *Leases*	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

Standards and Interpretations	Financial year for which the change first applies
IFRS 17 *Insurance Contracts*	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 22 *Foreign Currency Transactions and Advance Consideration*	Application required for accounting periods beginning on or after 1 January 2018.
IFRIC 23 *Uncertainty over Income Tax Treatments*	Application required for accounting periods beginning on or after 1 January 2019.

The Trust has not adopted any new accounting standards, amendments or interpretations early. The new standards set out above will have no significant impact on the Trust other than IFRS 16 which will see a number of operating leases currently included within note 5.2 operating lease expenses being included in the statement of financial position. As this change is expected from 2019/20 detailed work has not yet been undertaken to quantify the impact.

1.19 Critical accounting estimates and judgements

Estimates and judgments are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Critical judgements in applying the entity's accounting policies

The Trust has made no judgements in applying the accounting policies other than those involving accounting estimates.

Critical accounting estimates and assumptions

The Trust makes estimates and assumptions concerning the future. The resulting accounting estimates will, by definition, seldom equal the related actual results. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are addressed below.

a) Depreciation

Depreciation is based on automatic calculations within the Trust's Fixed Asset Register and is calculated on a monthly basis throughout the year. When an asset is added to the Fixed Asset Register, it is given a useful economic life by the capital accountant, depending on the class of asset (i.e. vehicle, IT equipment etc). Buildings can be assigned a useful economic life of up to 50 years by the District Valuer as part of their valuations, depending on their state of repair and intended use. Useful economic life can be adjusted on the Fixed Asset Register if required, for example following an external valuation by the District Valuer. This judgement will take into account past experience. Typically more expensive items have a longer lifespan which reduces the degree of sensitivity of charges.

b) Revaluation

The Trust's assets are subject to the quinquennial revaluation by the Trust's approved valuers. In the interim years the Trust's assets are revalued using desktop revaluations undertaken by the Valuation Office. The Valuation Office is an expert therefore there is a high degree of reliance on the valuer's expertise.

c) Impairment

Impairments are based on the Valuation Office's revaluation, on application of indices or on revaluation of individual assets e.g. when brought into operational use, or identified for disposal. Assumptions and judgments are that valuations and the assumptions used are applicable to the Trust's circumstances. Additionally, management reviews would identify circumstances which may indicate where an impairment has occurred.

d) Month 12 income from activities

As the NHS Annual Accounts and invoicing deadlines fall before actual month 12 activity data is available, it is necessary to make an estimate for the accounts.

Forecast outturn activity and value is calculated throughout the year using established profiles in combination with year to date activity as the basis for estimating the full year activity. Profiles are set up at the beginning of the year to reflect the anticipated spread of activity throughout the

year and are used to spread the annual plan as well as to forecast the activity. The main profiles used are:

- Twelfths – used for block contracts.
- Actual days – (calendar days in month) used for non-elective and emergency work.
- Working days – (excludes weekends and bank holidays plus an additional day at Christmas) used for elective work and outpatients.
- Specific profiles – more detailed profiles are set up for example where it is known that particular activity is not planned to start until part way through the year, e.g. date of service transfer, commencement of new development.

The Trust's approach to this estimate for month 12 incorporates the following additional considerations:

- Bone Marrow Transplants – given this is a high value, low volume income stream, specific information relating to March transplants already undertaken, or anticipated, has been used to inform the forecast outturn.
- Commissioning for Quality and Innovation (CQUIN) – the CQUIN performance used for the month 11 financial reporting was based on data to the end of January, which was the most up to date information available at the time. For estimating year end income for the accounts this performance estimate was updated in early March to inform the year end estimate.
- General activity –experience has shown that a better estimate for general March activity is achieved by basing the forecast outturn on the activity within the later part of the year, reflecting that the impact of any planned growth in activity, or new developments, tends to be weighted towards the end of the financial year once resource changes have been fully implemented. However it is also recognised that December is not a typical month given the holiday period. Therefore, March activity has been estimated based on activity in October, November, January and February.

Where Month 12 interim activity data is available prior to closing the month 12 position this will be reviewed to assess whether changes are required. If the assessment is deemed significant the estimates will be replaced with the actual data and the commissioners will be notified of the changes.

The value of uncoded activity will be estimated using an average tariff basis.

e) Partially completed spells

This is an estimate of income due in relation to patients admitted before the year end, but not discharged. It is calculated at spell level and is based on a realistic estimate of the number of unfinished days at the end of the financial year, calculated using data available from previous month ends. This is necessary due to the timing of the final accounts, which means that the actual figure will not be available. The day of admission counts as an unfinished day.

The valuation of unfinished activity will use specialty bed day rates. The rates are weighted to ensure they are consistent with the proportion of actual income that is received, using information gleaned from previous months incomplete spells. In calculating the proportion of actual income, the first two days of each spell will attract a disproportionate amount of the income in recognition that some costs are heavily weighted towards the beginning of the spell. For 16/17 and 17/18 surgical specialties 45% of the income is allocated to the first 2 days with the remaining 55% apportioned equally over the total length of stay. For medical specialties the figures are 25% and 75% respectively.

In making this estimate the volume of unfinished activity is calculated using an average of the first 11 months of the year. The rates used are calculated at specialty level, the greatest level of detail that can be determined for unfinished activity, and reflect the distribution of costs through the spell in recognition of the early days of the spell generally being the most expensive.

The income is accrued and agreed with local Clinical Commissioning Groups and with NHS England.

f) Maternity pathway (incomplete antenatal spells)

This is an estimate of income received in advance in relation to patients who commenced their antenatal pathway in one financial year but who will not finish it until after the end of the financial year. It is calculated on the following basis:

- Assume the length of an ante natal pathway is 182 days (c 6 months).
- Estimate the proportion of pathways that will be incomplete at the end of the financial year. The position at 28th February 2018 has been used as a proxy, as the month 12 activity was not available.
- Using the ante natal booking date, calculate how many days of the ante natal period are likely to occur after 28th February 2018.
- Value these days as a proportion of the pathway tariff.

1.20 Changes in accounting policy

Foundation Trusts may change an accounting policy only where it is required by a new standard or interpretation (including any revisions to the GAM) or voluntarily only if it results in the Trust's financial statements providing reliable and more relevant information about transactions, events, conditions, or the financial position, financial performance or cash flows.

The changes arising from the introduction of a new standard or interpretation will be implemented in accordance with the specific transitional provisions, if any, of that standard or interpretation. Where no such specific transitional provisions exist, or where the Trust changes an accounting policy voluntarily, the changes will be applied retrospectively i.e. through a prior period adjustment. In accordance with IAS 8 any prior period adjustments will be effected by restating each element of equity (reserves) at the start of the prior year as if the accounting policy had always applied.

2 Segmental analysis

The Trust operates only one healthcare segment.

The healthcare segment delivers a range of healthcare services, predominantly to Clinical Commissioning Groups and NHS England. The Trust is operationally managed through five clinical divisions and three corporate functions, all of which operate in the healthcare segment. Internally the finance, activity and performance of these areas are reported to the Trust Board. They are consolidated, as permitted by IFRS 8 paragraph 12, into Trust wide figures for these accounts.

Expenditure and non-service agreement income is reported against the operational areas for management information purposes. The out-turn position reported for 2017/18 is shown below with comparator figures for 2016/17.

	Year Ended 31 March 2018 £000	Year Ended 31 March 2017 £000
Corporate income (excluding Sustainability & Transformation Funding)	593,021	569,052
Net Expenditure		
Diagnostic and Therapies	(51,336)	(51,228)
Medicine	(83,389)	(81,517)
Specialised Services	(111,431)	(105,805)
Surgery, Head and Neck	(114,269)	(110,297)
Women's and Children's	(129,490)	(125,311)
Facilities and Estates	(37,049)	(36,107)
Trust Services	(27,802)	(26,456)
Corporate Services	(3,728)	2,691
Total net expenditure	(558,494)	(534,030)
Earnings before Interest, Tax, Depreciation & Amortisation	**34,527**	**35,022**
Financing costs	(33,584)	(32,086)
Net surplus before S&T funding and technical accounting adjustments	**943**	**2,936**
Sustainability & Transformation Funding	18,960	13,670
Net surplus before technical accounting adjustments	**19,903**	**16,606**
Technical accounting adjustments		
Donations received for Property Plant and Equipment	1,204	2,919
Depreciation on donated assets	(1,570)	(1,555)
Impairment charge when assets brought into use	(1,281)	(8,564)
Impairment reversal / (charge) from revaluation	249	(1,848)
Gain / (loss) on sale of asset	-	(76)
Total Technical accounting adjustments	(1,398)	(9,124)
Surplus/(deficit) for year	**18,505**	**7,482**

Notes to the Accounts

3. Income from patient care activities

3.1 Income by nature

	Year ended 31 March 2018 £000	Year ended 31 March 2017 (Restated*) £000
Elective income * *(note 1)*	96,686	86,880
Non elective income * *(note 1)*	129,546	109,635
First outpatient income	33,653	28,445
Follow up outpatient income	44,069	50,413
Accident and emergency income	18,271	16,006
High cost drug income from commissioners	68,060	60,323
Other NHS clinical income (see significant items below) * *(note 1)*	167,774	158,496
Private patients	1,701	1,799
Other clinical income	10,443	17,546
Total	**570,203**	**529,543**
Other NHS Clinical Income - Significant items include:		
Critical care bed days	45,379	41,267
'Payment by results' exclusions * *(note 2)*	20,590	20,429
Bone marrow transplants	8,708	7,361
Radiotherapy inpatient treatments	7,591	8,733
Diagnostic imaging	5,983	5,898
Direct access	6,069	6,384
Regular day attenders	1,361	1,240
Rehabilitation	5,647	5,811
Audiology, Cochlear implants, bone anchored aids * *(note 3)*	7,339	7,221
Contract penalties and rewards	10,785	10,001
Cystic fibrosis pathways	5,148	4,399
Maternity pathways	7,314	6,937
'Soft' facilities management and LIFTCO* *(note 3)*	3,034	2,920
Bowel Cancer & Bowel Scope Screening	2,868	2,884
Chemotherapy Delivery	3,650	3,635
Community Dental	1,330	1,329
Retrievals	2,787	2,691
Winter Pressure funding	1,863	-

***Restated**

There is no change in total income. The restatements are within headings, as noted below.

Note 1
In 2016/17 Excess bed days (£7m) and Non Elective Inpatients (£1.6m) were included within Other Clinical Income and disclosed separately within significant items. In 2017/18 in line with NHS Improvement reporting arrangements the income is now disclosed within Elective and Non Elective Income.

Note 2
In 2016/17 Payment by Results exclusion included High Cost drugs from Commissioners. In 2017/18, in line with NHS Improvement reporting arrangements, high cost drugs are reported as a separate line.

Note 3
In 2016/17 Audiology, Cochlear implants and bone anchored hearing aids and Soft facilities management and LITFCO were reported at £4.8m and £9.4m respectively. Following a review of coding these have been adjsuted to £7.221m and £2.920m respectively.

3.2 Income by source

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
NHS England	279,004	243,990
Clinical Commissioning Groups	265,339	263,552
NHS Foundation Trusts	270	241
NHS Trusts	2,328	2,415
Local Authorities	8,566	4,564
Department of Health - Other	67	62
Non-NHS private patients	1,701	1,799
Non-NHS overseas patients	406	649
NHS Injury Scheme	777	698
Territorial Bodies	11,745	11,573
Total	**570,203**	**529,543**

3.3 Income from patient care activities arising from Commissioner Requested Services

The majority of the Trust's income should be derived from prior agreements, including contracts and agreed intentions to contract with service commissioners. This is described as Commissioner Requested Service income. Of the total income from patient care activities, £550.5m (2016/17: £514.9m) is from Commissioner Requested Services and £19.7m (2016/17: £14.6m) is from all other services.

3.4 Income from overseas visitors

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Income recognised this year	406	649
Cash payments received (invoices raised in this and previous years)	212	219
Increase to provision for impairment of receivables (invoices raised in this and previous years)	194	356
Amounts written off (invoices raised in this and previous years)	93	51

4. Other operating income

4.1 Other operating income

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Research and development	24,303	24,682
Education and training	35,216	34,747
Donated assets - property, plant & equipment (income & physical asset)	1,204	2,919
Charitable and other contributions to operating expenditure	945	802
Non-patient care services to other bodies	14,106	14,010
Sustainability and Transformation funding	18,960	13,670
Salary recharges	4,986	4,861
Rental income from operating leases	1,573	1,650
Other**	12,646	11,940
Total	**113,939**	**109,281**

**Significant items include:

	£000	£000
Clinical excellence awards	3,103	3,154
Trading services income	2,488	2,436
Clinical testing	432	312
Catering	386	398
Staff accommodation rentals	172	42
Car park income	988	944
Staff contribution to employee benefit schemes	1,410	1,417
Property rentals	137	373

The Trust's trading services income totals £2.488m and comprises of Medical Equipment Management Organisation £0.928m (2016/17: £0.876m), Pharmacy income £1.157m (2016/17:£1.213m) and IT income £0.403m (2016/17: £0.347m).

4.2 Operating lease income

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Rental income – minimum lease receipts	1,573	1,650

4.3 Future minimum lease receipts due to the Trust

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
- no later than one year	1,501	1,524
- between one and five years	1,757	1,674
- after five years	1,767	2,031
Total	**5,025**	**5,229**

5. Operating expenses

5.1 Operating expenses by type

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Services from other bodies:		
- NHS & DHSC bodies	11,301	9,251
- non NHS & non DHSC bodies	1,593	1,280
Purchase of healthcare from non NHS bodies	4,279	4,334
Employee expenses excluding Board members	383,607	366,602
Employee expenses – Board members	1,362	1,416
Trust chair and non-executive directors	197	181
Supplies and services: clinical	66,234	64,242
Supplies and services: general	7,132	7,293
Drug costs	85,971	77,658
Establishment costs	8,443	7,542
Premises costs	14,918	12,305
Transport – business travel	928	836
Transport – other (including patient travel)	1,317	1,435
Change in provision for impairment of receivables	5,476	395
Depreciation on property plant and equipment	21,931	20,980
Amortisation on intangible assets	1,857	1,572
Net Impairments	1,032	10,412
Auditor's remuneration - statutory audit	61	60
Auditor's remuneration – other non audit services	10	22
Internal audit	263	231
Clinical negligence	8,771	6,377
Research and development – hosting payments	7,459	7,630
Research and development – other	6,665	6,216
Rentals under operating leases	6,616	6,314
Other**	6,832	5,593
Total	**654,255**	**620,177**
**Significant items include:		
Consultancy	373	615
Inventories written down	26	-
Training, courses and conferences	2,375	1,944
External contractors' services	82	175
Childcare vouchers	1,261	1,267
Legal fees	163	443
Parking and security	451	460
Insurance	280	263

There is a limitation of liability of £2 million in respect of external audit services unless unable to be limited by law.

5.2 Operating lease expenses

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Land	34	52
Buildings	5,308	5,056
Plant and machinery	1,274	1,206
Total	**6,616**	**6,314**

Future minimum lease payments due under operating leases	**£000**	**£000**
Before one year	1,782	1,760
Between one and five years	3,783	3,387
After five years	5,084	3,148
Total	**10,649**	**8,295**

The Trust leases various equipment and buildings. The most significant was the South Bristol Community Hospital which the Trust leased for a 5 year period from April 2012. The Overarching Agreement and the Under Lease Plus Agreement for acute services with the Commissioners and the Community Health Partnership expired on 29th March 2017. However the Trust continues to occupy and pay expenses while ongoing arrangements and future lease costs and payments are currently being re-negotiated.

6. Employee benefits

Further detail on senior manager remuneration, fair pay multiple, employee data and benefits and exit packages can be found in the Remuneration and Staff Report sections of the Annual Report.

6.1 Employee expenses

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Salaries and wages	313,385	298,684
Social security costs	28,595	26,859
Apprenticeship levy	1,505	-
Pension costs	36,851	34,631
Termination benefits	80	99
Agency/contract staff	8,863	11,229
Gross employee expenses	**389,279**	**371,502**
Income in respect of salary recharges netted off	(2,730)	(2,406)
Employee expenses capitalised	(1,580)	(979)
Net employee expenses	**384,969**	**368,117**

6.2 Retirement benefits

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The employer contribution rates for 2018/19 will remain at the 2016/17 rate of 14.3%.

6.3 Early retirements due to ill health

During the year ended 31 March 2018 there were 6 (2016/17: 6) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill-health retirements will be £0.349m (2016/17: £0.406m). The cost of these ill health retirements will be borne by the NHS Business Services Authority – Pensions Division.

7. Other Gains/Losses

The net loss on the disposal of property, plant and equipment of £0.016m (2016/17: net loss of £0.076m) related exclusively to non-protected assets. No assets used in the provision of Commissioner Requested Services have been disposed of during the year.

8. Financing

8.1 Finance income

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Interest on loans and receivables	189	189
Total	**189**	**189**

8.2 Finance expenses

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Loan interest from the Department of Health for capital loans	2,686	2,884
Finance leases	268	294
Total	**2,954**	**3,178**

In both years, there was no interest payable arising from claims made under the late payment of commercial debts (interest) act 1998 and no other compensation was paid to cover debt recovery cost under this legislation.

8.3 Impairments

Net impairment of property plant and equipment, intangibles and assets held for sale	**Year ended 31 March 2018 £000**	**Year ended 31 March 2017 £000**
Impairment of enhancements to existing assets	1,281	8,553
Other impairments	-	11
Changes in valuation	1,669	1,848
Reversal of impairments	(1,918)	-
TOTAL	**1,032**	**10,412**

Property impairments occur when the carrying amounts are reviewed by the District Valuer through formal valuation. Plant and equipment impairments are identified following an assessment of whether there is any indication that an asset may be impaired e.g. obsolescence or physical damage.

Property reviews are undertaken to ensure assets are reflected at fair value in the accounts, when they are brought into use or when they are identified as assets held for sale. At the first valuation after the asset is brought into use any write down of cost is treated as an impairment and charged into the Statement of Comprehensive Income. The impairment losses charged to the Statement of Comprehensive Income relate to the following:

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Impairment of enhancements to existing assets		
Queen's Building	1,281	2,503
King Edward Building	-	6,050
	1,281	**8,553**
Change in valuation		
District Valuer's revaluation of land & buildings	(249)	1,848
Impairment due to damage loss		
Insurance write-off of vehicle	-	11
Total	**1,032**	**10,412**

Where a revaluation increases an asset's value and reverses a revaluation loss previously recognised in operating expenses it is credited to operating expenses as a reversal of impairment and netted against any impairment charge.

9. Intangible assets

	Software licences £000	Assets under construction £000	Total £000
Cost at 1 April 2017	12,315	43	12,358
Additions - purchased	837	4,807	5,644
Reclassifications with PPE	1,545	-	1,545
Reclassifications within intangibles	4,536	(4,536)	-
Disposals	(29)	-	(29)
Cost at 31 March 2018	19,204	314	19,518
Accumulated amortisation at 1 April 2017	5,566	-	5,566
Charged during the year – purchased	1,831	-	1,831
Charged during the year – donated	26	-	26
Disposals	(29)	-	(29)
Accumulated amortisation at 31 March 2018	7,394	-	7,394
Net book value at 31 March 2018			
Purchased	11,654	314	11,968
Donated	156	-	156
Total net book value at 31 March 2018	**11,810**	**314**	**12,124**

	Software licences £000	Assets under construction £000	Total £000
Cost at 1 April 2016	10,097	116	10,213
Additions - purchased	177	50	227
Additions – donated	16	-	16
Reclassifications with PPE	1,902	-	1,902
Reclassifications within intangibles	123	(123)	-
Cost at 31 March 2017	12,315	43	12,358
Accumulated amortisation at 1 April 2016	3,994	-	3,994
Charged during the year - purchased	1,549	-	1,549
Charged during the year – donated	23	-	23
Accumulated amortisation at 31 March 2017	5,566	-	5,566
Net book value at 31 March 2017			
Purchased	6,593	43	6,636
Donated	156	-	156
Total net book value at 31 March 2017	**6,749**	**43**	**6,792**

10. Property, plant and equipment

The District Valuer undertook a desktop exercise at the 31 March 2018 which valued the Trust's land and buildings on a depreciated replacement cost, Modern Equivalent Asset valuation (MEA). The valuation resulted in a net increase at 31 March 2018 of £6.392m compared to the book values.

The valuation has been undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the HMT Treasury FReM compliant Department of Health and Social Care Manual for Accounts (DoH GAM). The valuations also accord with the requirements of the professional standards of the Royal Institute of Chartered Surveyors: RICS Valuation - Global Standards 2017 and the RICS Valuation – Professional Standards UK (January 2014, revised April 2015), commonly known together as the Red Book, including the International Valuation Standards, in so far as these are consistent with IFRS and the above mentioned guidance; RICS UKVS 1.14 refers.

The following are the agreed departures from the RICS Professional Standards and special assumptions:

- The Instant Building approach has been adopted, as required by the DoH GAM and HM Treasury for the UK public sector. Therefore, no building periods or consequential finance costs have been reflected in the costs applied when the depreciated replacement cost approach is used.
  (a) It should be noted that the use of the terms 'Existing Use Value', 'Fair Value' and 'Market Value' in regard to the valuation of the NHS estate may be regarded as not inconsistent with that set out in the RICS Professional Standards, subject to the additional special assumption of no adjustment has been made on the grounds of a hypothetical "flooding of the market" if a number of properties were to be marketed simultaneously

Notes to the Accounts

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	23,778	286,693	3,524	9,383	88,249	823	20,007	991	**433,448**
Additions – purchased	-	1,416	-	10,975	5,068	86	1,470	31	**19,046**
Additions – donated	-	21	-	-	689	-	-	-	**710**
Impairments	-	(1,281)	-	-	-	-	-	-	**(1,281)**
Reclassifications with intangibles	-	-	-	(1,545)	-	-	-	-	**(1,545)**
Reclassifications within PPE	-	9,041	-	(14,184)	3,176	-	1,967	-	**-**
Revaluations	670	(4,054)	(945)	-	-	-	-	-	**(4,329)**
Disposals	-	-	-	-	(1,052)	-	(813)	(10)	**(1,875)**
Cost or valuation at 31 March 2018	24,448	291,836	2,579	4,629	96,130	909	22,631	1,012	**444,174**
Accumulated depreciation at 1 April 2017	-	-	-	-	53,598	460	10,078	848	**64,984**
Charged during the year – purchased	-	10,001	164	-	6,939	82	3,133	68	**20,387**
Charged during the year – donated	-	556	-	-	946	8	34	-	**1,544**
Revaluations	-	(10,557)	(164)	-	-	-	-	-	**(10,721)**
Disposals	-	-	-	-	(1,018)	-	(813)	(10)	**(1,841)**
At 31 March 2018	-	-	-	-	60,465	550	12,432	906	**74,353**
Net book value at 31 March 2018									
Purchased	24,448	269,207	2,579	4,629	30,299	311	10,009	106	**341,588**
Donated	-	16,119	-	-	5,362	48	190	-	**21,719**
Finance leases	-	6,510	-	-	4	-	-	-	**6,514**
Total at 31 March 2018	**24,448**	**291,836**	**2,579**	**4,629**	**35,665**	**359**	**10,199**	**106**	**369,821**
Total at 31 March 2017	**23,778**	**286,693**	**3,524**	**9,383**	**34,651**	**363**	**9,929**	**143**	**368,464**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	22,861	299,621	3,436	12,049	88,922	681	17,502	1,078	**446,150**
Additions – purchased	-	1,685	-	23,410	3,183	191	942	-	**29,411**
Additions – donated	-	-	-	-	184	56	-	-	**240**
Impairments	-	(8,553)	-	-	-	(11)	-	-	**(8,564)**
Reclassifications with intangibles	-	-	-	(1,902)	-	-	-	-	**(1,902)**
Reclassifications within PPE	-	20,979	-	(24,174)	1,550	-	1,645	-	**-**
Revaluations	917	(27,039)	88	-	-	-	-	-	**(26,034)**
Disposals	-	-	-	-	(5,590)	(94)	(82)	(87)	**(5,853)**
Cost or valuation at 31 March 2017	23,778	286,693	3,524	9,383	88,249	823	20,007	991	**433,448**
Accumulated depreciation at 1 April 2016	-	-	-	-	51,241	480	7,538	860	**60,119**
Charged during the year – purchased	-	9,656	154	-	6,897	74	2,593	74	**19,448**
Charged during the year – donated	-	528	-	-	975	-	29	-	**1,532**
Revaluations	-	(10,184)	(154)	-	-	-	-	-	**(10,338)**
Disposals	-	-	-	-	(5,515)	(94)	(82)	(86)	**(5,777)**
At 31 March 2017	-	-	-	-	53,598	460	10,078	848	**64,984**
Net book value at 31 March 2017									
Purchased	23,778	264,446	3,524	9,383	29,034	307	9,760	143	**340,375**
Donated	-	15,737	-	-	5,599	56	169	-	**21,561**
Finance leases	-	6,510	-	-	18	-	-	-	**6,528**
Total at 31 March 2017	**23,778**	**286,693**	**3,524**	**9,383**	**34,651**	**363**	**9,929**	**143**	**368,464**
Total at 31 March 2016	**22,861**	**299,621**	**3,436**	**12,049**	**37,681**	**201**	**9,964**	**218**	**386,031**

10.1 Net book value of assets held under finance leases

The net book value of assets held under finance leases and hire purchase contracts was:

	Year ended 31 March 2018 £000	Year ended 31March 2017 £000
Cost or valuation at 1 April	6,581	6,581
Additions	232	-
Revaluation	(232)	-
Reclassifications	-	-
Cost or valuation at 31 March	**6,581**	**6,581**
Accumulated depreciation at 1 April	53	39
Provided during the year	561	522
Revaluation	(547)	(508)
Accumulated depreciation at 31 March	**67**	**53**
Net book value at 31 March	**6,514**	**6,528**

10.2 Net book value of land building and dwellings

The net book value of land, buildings and dwellings comprises:

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Freehold	312,353	307,485
Long leasehold	6,510	6,510
TOTAL	**318,863**	**313,995**

11. Inventories

Year ended 31 March 2018	Drugs £000	Consumables £000	Energy £000	Totals £000
Carrying value at 1 April 2017	3,508	8,551	126	12,185
Additions	51,362	49,805	40	101,207
Write down of inventory recognised as expense	-	(26)	-	(26)
Consumed – recognised in expenses	(51,092)	(48,752)	(32)	(99,876)
Carrying value at 31 March 2018	3,778	9,578	134	13,490

Year ended 31 March 2017	Drugs £000	Consumables £000	Energy £000	Totals £000
Carrying value at 1 April 2016	3,637	7,723	82	11,442
Additions	47,804	49,011	59	96,874
Consumed – recognised in expenses	(47,933)	(48,183)	(15)	(96,131)
Carrying value at 31 March 2017	3,508	8,551	126	12,185

12. Trade and other receivables

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Current:		
NHS receivables	30,186	18,548
Other receivables	9,472	8,953
Provision for impaired receivables	(10,111)	(4,718)
PDC Dividend receivable	49	401
Prepayments	2,947	3,702
Accrued income	16,811	9,160
Total current:	**49,354**	**36,046**
Non current:		
Other receivable	1,050	1,050

The non-current receivable relates to the sale of the Old Building and not due before March 2018.

12. Trade and other receivables

Provision for irrecoverable debts (impairment of receivables):	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Balance at start of year	**4,718**	**4,375**
Utilised in year	(83)	(52)
Movement in provision balance	5,476	395
Balance at end of year	**10,111**	**4,718**

Ageing of impaired receivables	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
0-30 days	6,751	7,820
30-60 days	1,087	1,654
60-90 days	4,088	1,306
90-180 days	2,108	1,803
Over 180 days	5,312	4,130
Total	**19,346**	**16,713**

Ageing of non-impaired receivables	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
0-30 days	-	-
30-60 days	840	1,857
60-90 days	3,569	1,332
90-180 days	384	-
Over 180 days	38	-
Total	**4,831**	**3,189**

13. Other assets

13.1 Other financial assets

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Loans and receivables	104	104
Total	**104**	**104**

This relates to a section 106 deposit paid to Bristol City Council.

14. Trade and other payables

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Current amounts:		
NHS payables – revenue	10,861	9,033
Amounts due to related parties – revenue	5,250	4,943
Other payables – revenue	16,357	15,491
Capital payables	2,090	2,592
Tax and social security	7,863	7,629
Accruals	22,973	26,169
TOTAL	**65,394**	**65,857**

Non-current amounts:
There are no non-current trade and other payables in either year.

Outstanding pension contributions of £5.247m (2016/17: £4.941m) to the NHS Pension scheme and £0.003m (2016/17: £0.002m) for National Employment Savings trust (NEST) local pensions are included in amounts due to related parties. PAYE of £3.601m (2016/17: £3.552m) and £4.261m National Insurance (2016/17: £4.077m) are included in tax and social security.

15. Other liabilities

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Current liabilities:		
Deferred income – goods and services	5,918	4,576
Total	**5,918**	**4,576**

16. Borrowings

16.1 Current borrowings:

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Capital loans from Department of Health and Social Care	5,834	5,834
Finance lease obligations	336	326
Total	**6,170**	**6,160**

16.2 Non-current borrowings:

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Capital loans from Department of Health and Social Care	70,426	76,260
Finance lease obligations	4,318	4,653
Total	**74,744**	**80,913**

16.3 Finance lease obligations

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Payable:		
Before one year	578	593
Between one and five years	2,300	2,303
After five years	3,115	3,690
Sub-total	**5,993**	**6,586**
Less finance charges allocated to future years	(1,339)	(1,607)
Net obligation	**4,654**	**4,979**

The finance lease arrangement relates to buildings comprising the Education Centre which will expire in September 2028 and catering equipment which is being leased until 2018.

16.4 Net finance lease obligations

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Payable:		
Before one year	336	326
Between one and five years	1,573	1,479
After five years	2,745	3,174
Net obligation	**4,654**	**4,979**

16.5 Finance lease commitments

There are no finance lease commitments at 31 March 2018 (31 March 2017 £nil.)

17. Provisions for liabilities and charges

17.1 Provision for legal claims:

	Legal Claims £000
At 1 April 2017	287
Arising during the year	293
Utilised during the year	(63)
Reversed unused	(73)
Unwinding of discount	-
At 31 March 2018	**444**

At 1 April 2016	346
Arising during the year	106
Utilised during the year	(78)
Reversed unused	(87)
Unwinding of discount	-
At 31 March 2017	**287**

The expected timing of any resulting outflows of economic benefits is set out below:

	Legal Claims
Timing of economic outflow	**£000**
Before one year	199
Between one and five years	245
After five years	-
Total	**444**

The provision for legal claims at 31 March 2018 includes the following:

a) Provision for staff injuries

A staff injuries provision of £0.277m, (2017: £0.127m) in respect of staff injury allowances payable to the NHS Business Services Authority (Pensions Division).

b) Provision for liabilities to third parties

A provisions for liabilities to third parties of £0.167m (2017: £0.160m) representing the excess payable by the Trust, under the NHS Resolution Liabilities to Third Parties Scheme.

There are no other provisions.

17.2 Clinical negligence

NHS Resolution has included a £242.475m provision in its accounts (2017: £198.009m) in respect of clinical negligence liabilities of the Trust.

18. Cash and cash equivalents

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Cash with the government banking service	70,900	65,273
Commercial bank and cash in hand	192	168
Total cash and cash equivalents	**71,092**	**65,441**

19. Capital commitments

Commitments under capital expenditure contracts at 31 March 2018 are £4.8m (2016/17: £nil) for the Global Digital Exemplar and Software licensing schemes in Information Management & Technology (IM&T) department.

20. Post-Statement of Financial Position (SoFP) events

There are no post-Statement of Financial Position events.

21. Contingencies

21.1 Contingent assets

The Trust has no contingent assets at 31 March 2018 (2016/17: £nil).

21.2 Contingent liabilities

At 31 March 2018 the Trust has contingent liabilities in relation to any new claims that may arise from past events under the NHS Resolution "Liability to Third Parties" and "Property Expenses" schemes. The contingent liability will be limited to the Trust's excess for each new claim.

22. Related party transactions

The University Hospitals Bristol NHS Foundation Trust is a Public Benefit Corporation authorised under the National Health Service Act 2006.

During the year, none of the Board members or members of the key management staff of the Trust, or parties related to them has undertaken any material transactions with the Trust. Board members have declared interests in a number of bodies. Material transactions between the Trust and these bodies are shown below.
All bodies within the scope of Whole of Government Accounting are related parties to the Trust. This includes the Department of Health and its associated departments. Such bodies where income or expenditure, or outstanding balances as at 31 March, exceeded £500,000 are listed below.

Related parties arising from Trust Board members:

	31 March 2018 (£m)		31 March 2017 (£m)		2017/18 (£m)		2016/17 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
University of Bristol	-	2.25	0.26	1.48	1.89	9.58	1.98	8.95
University of the West of England	-	0.07	-	-	0.40	0.46	-	-
West of England Academic Health Sciences Network	-	-	-	-	0.02	0.01	0.02	-
Care Quality Commission	-	-	-	-	-	0.33	-	0.22
Above and Beyond Charity	See notes below							
Health Education England	See WGA table below							

Related parties within the scope of Whole of Government Accounting:

	31 March 2018 (£m)		31 March 2017 (£m)		2017/18 (£m)		2016/17 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Avon and Wiltshire Mental Health Partnership NHS Trust					0.83	0.95	0.63	1.14
Bristol City Council	0.90				9.13	-	3.85	
Community Health Partnerships				1.86		4.94		4.52
Department of Health			0.56	0.21	21.68		21.21	0.15
Gloucestershire Hospitals NHS FT		0.54				3.05		3.04
Great Western Hospitals NHS FT						0.63		0.62
Health Education England	0.56				35.07		34.49	
HM Revenue and Customs	1.12	7.86	0.77	7.63		30.10		26.84
NHS Bath and North East Somerset CCG					8.61		9.16	
NHS Blood and Transplant		0.74		0.97		5.79		5.67
NHS Bristol CCG	4.22	1.94	2.57	1.56	161.45		156.60	
NHS England - Core	12.30		5.01		22.35		13.88	
NHS England - South Central Local Office	0.58				2.30		2.30	
NHS England - South West Commissioning Hub	13.87		4.48		254.73		221.76	
NHS England - South West Local Office		0.96	3.45		17.82		19.47	
NHS England - Wessex Commissioning Hub	1.15				3.71		4.59	
NHS Gloucestershire CCG					4.02		4.44	
NHS Kernow CCG					1.12		1.09	
NHS North Somerset CCG	2.49		0.75		45.37		42.84	

	31 March 2018 (£m)		31 March 2017 (£m)		2017/18 (£m)		2016/17 (£m)	
NHS North, East, West Devon CCG					1.65		1.75	
NHS Pension Scheme		5.26		4.94		36.84		34.56
NHS Property Services		1.04				0.67		
NHS Resolution						8.77		6.40
NHS Somerset CCG			0.55		8.32		8.93	
NHS South Devon and Torbay CCG					0.70		0.63	
NHS South Gloucestershire	0.67		0.73		30.41		31.57	
NHS Swindon CCG					0.79		0.92	
NHS Wiltshire CCG					3.70		4.34	
North Bristol NHS Trust	3.47	6.45	4.00	4.82	5.64	13.46	6.09	12.55
Northern Health and Social Care Trust (N. Ireland)					0.97		0.56	
Public Health England (PHE)						3.19		3.13
Plymouth Hospitals NHS Trust						0.77		
Royal Devon and Exeter Foundation Trust						1.27		1.15
Royal United Hospital Bath NHS Foundation Trust	0.56				0.99	1.67	0.85	1.60
South Gloucestershire Council							0.86	
Taunton & Somerset NHS Foundation Trust					0.73			
Welsh Assembly Government					8.91		9.47	
Welsh Health Bodies – Aneurin Bevan Local Health Board					0.67		0.61	
Welsh Health Bodies – Velindre NHS Trust					0.52			
Weston Area Health NHS Trust	1.52	0.84	0.93		3.73	2.32	2.91	0.90

In addition the Trust pays HM Revenue and Customs tax and national insurance on behalf of employees which totalled £65.166m in 2017/18 (£63.12m in 2016/17). The Trust also pays the NHS Pension Scheme for employees' contributions which totaled £24.930m in 2017/18 (£23.47m in 2016/17).

The Trust also has transactions with charitable bodies including Above and Beyond which is the official charity for all hospitals within the Trust and the Grand Appeal which is the Bristol Children's Hospital Charity

These are as follows:

	31 March 2018 (£m)		31 March 2017 (£m)		2017/18 (£m)		2016/17 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Above and Beyond	0.40	-	1.00		1.77	0.31	3.90	0.29
Grand Appeal	0.08	-	0.01		0.24	-	0.14	0.01

23. Private Finance Initiative (PFI) transactions

At 31 March 2018 the Trust has no PFI schemes (2017: none).

24. Financial Instruments

24.1 Financial risk management

IFRS 7, 'Financial Instruments: Disclosures', requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities.

The Trust's activities expose it to a variety of financial risks: market risk (including interest rate risk, and foreign exchange risk), credit risk and liquidity risk. Risk management is carried out by the Trust's Treasury Management Department under policies approved by Trust Board.

a) Market risk

i. Interest-rate risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only elements of the Trust's assets that are subject to variable rate are short-term cash investments. The Trust is not,

exposed to significant interest-rate risk. These rates are reviewed regularly to maximise the return on cash investment.

ii. Foreign currency risk

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the year in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

The Trust has negligible foreign currency income and expenditure.

b) Credit risk

Credit risk arises from cash and cash equivalents and deposits with financial institutions, as well as outstanding receivables and committed transactions. The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. This means that there is little risk that one party will fail to discharge its obligation with the other. However disputes can arise, around how amounts are calculated, particularly due to the complex nature of the Payment by Results regime. For financial institutions, only independently rated parties with a minimum rating (Moody) of P-1 and A1 for short-term and long-term respectively are accepted.

c) Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. Therefore the Trust has little exposure to liquidity risk. Loans are serviced from planned surpluses.

24.2 Carrying Value of Financial assets by category

	31 March 2018 £000	31 March 2017 £000
Trade and other receivables with NHS and DH bodies	38,652	23,985
Trade and other receivables with other bodies	7,637	8,236
Other financial assets	104	104
Cash and cash equivalents	71,092	65,441
Total	**117,485**	**97,766**

Receivables are held at amortised cost.

Maturity of financial assets

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Less than one year	116,435	96,716
In more than one year but not more than two years	1,050	1,050
Total	**117,485**	**97,766**

At 31 March 2018 all financial assets were due within one year with the exception of outstanding funds in relation to the sale of the Old Building which has been classified as a non-current receivable in note 12.

24.3 Carrying Value of Financial liabilities by category

	31 March 2018 £000	31 March 2017 £000
Borrowings	76,260	82,094
Obligation under Finance lease	4,654	4,979
Trade and other payables with NHS and DH bodies	12,894	10,891
Trade and other payables with other bodies	44,634	47,337
Total	**138,442**	**145,301**

Financial liabilities are held at amortised cost.

Maturity of financial liabilities

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Less than one year	63,698	64,388
In more than one year but not more than two years	6,191	6,170
In more than two years but not more than five years	18,719	18,646
In more than five years	49,834	56,097
Total	**138,442**	**145,301**

24.4 Fair values

At 31 March 2018 and 31 March 2017 there was no significant difference between the fair value and the carrying value of the Trust's financial assets and liabilities which are all classified as current assets.

25. Third party assets

At 31 March 2018 the Trust held £nil (2017: £nil) cash and cash equivalents relating to third parties.

26. Intra-government balances

At 31 March 2018	Receivables: current £000	Payables: current £000	Borrowing: current £000	Borrowing: non-current £000
Foundation Trusts and NHS Trusts	7,616	9,244	-	-
Department of Health & Social Care	314	140	5,834	70,426
NHS England & Clinical Commissioning Groups	37,474	3,514	-	-
NHS WGA bodies	657	1,967	-	-
TOTAL NHS	**46,061**	**14,865**	**5,834**	**70,426**
Other WGA bodies	2,856	13,931	-	-
TOTAL at 31 March 2018	**48,917**	**28,796**	**5,834**	**70,426**

At 31 March 2017	Receivables: current £000	Payables: current £000	Borrowing: current £000	Borrowing: non- current £000
Foundation Trusts and NHS Trusts	7,370	6,618	-	-
Department of Health & Social Care	556	1,001	5,834	76,260
NHS England & Clinical Commissioning Groups	18,914	2,519	-	-
NHS WGA bodies	548	3,002	-	-
TOTAL NHS	**27,388**	**13,140**	**5,834**	**76,260**
Other WGA bodies	2,729	13,820	-	-
TOTAL at 31 March 2017	**30,117**	**26,960**	**5,834**	**76,260**

There are no non-current receivables or payables for intra government bodies in either year.

27. Losses and special payments

Losses and special payments were made during the year as follows:

	2017/18		2016/17	
	Number	£000	Number	£000
Cash losses	13	13	28	9
Fruitless payments	1	10	-	-
Bad debts and claims abandoned	45	97	93	55
Stores losses inc. damage to buildings	3	139	1	129
Ex gratia payments	45	6	54	9
Severance payments	3	13	-	-
Total	**110**	**278**	**176**	**202**

The amounts reported are prepared on an accruals basis and exclude provisions for future losses.

Statement of the Chief Executive's responsibilities as the Accounting Officer of University Hospitals Bristol NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Direction which require University Hospitals Bristol NHS Foundation Trust to prepare for each financial year a statement of accounts in the forms and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Bristol NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual and the Department of Health and Social Care Group Accounting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed ……

Robert Woolley, Chief Executive Date: 24 May 2018

Appendix E – Independent Auditor's Report to the Board of Governors

Independent auditors' report to the Council of Governors of University Hospitals Bristol NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, University Hospitals Bristol NHS Foundation Trust's financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of the Trust's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have audited the financial statements, included within the Annual Report and Accounts 2017/18 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2018; the Statement of Comprehensive Income for the year then ended; the Statement of Cash Flows for the year then ended; the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

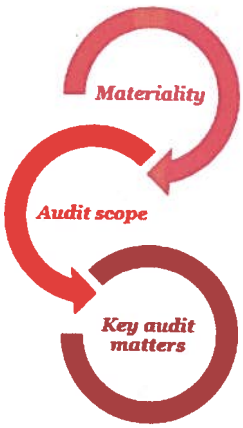
We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Our audit approach

Context

Our audit for the year ended 31 March 2018 was planned and executed having regard to the fact that the Group's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and areas of focus was largely unchanged.

Overview



- Overall materiality: £13.7m which represents 2% of total revenue.
- Our approach to the audit in terms of scoping and areas of focus was largely unchanged. The audit was conducted at the Trust's Headquarters in Bristol, which is where the Trust's finance function is based.
- Management override of control and fraud in revenue and expenditure recognition;
- Valuation of property, plant and equipment

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

We found valuation of property, plant and equipment and fraud in revenue and expenditure recognition to be key audit matters, and these are discussed further below. As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. This is not a complete list of all risks identified by our audit.

Key audit matter	***How our audit addressed the Key audit matter***
Management override of controls and fraud in revenue and expenditure recognition *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of income and expenditure.* We have focussed on this area as there is pressure on NHS bodies to meet or to exceed the financial targets set for them by regulators. In particular there is pressure this year because the achievement of the key financial target triggers additional payments from the Sustainability and Transformation Fund. As a result of the national pressures there is an incentive for management to manipulate the timing of recognition of both revenue and expenditure to defer costs to 2018/19 and to recognise revenue incurred in respect of 2018/19 in these financial statements. *Income* The Trust's principal source of income was from Clinical Commissioning Groups ("CCGs") and NHS England, which together accounted for over 95% of income during the year. Contracts are renegotiated annually and consist of standard monthly instalments, based on contract values. The payments are 'trued up' on a quarterly basis to reflect the actual activity of the Trust. The Trust's next largest sources of income include research and development income and education and training income (see note 4.1 to the accounts). These balances include multi-year contracts, where income is recognised in line with delivery of the contract or once performance criteria are satisfied. Because of the size of these sources of income and the incentives to manipulate income recognition, these sources of income are an area of focus. *Expenditure* Our work on expenditure focussed on the areas most susceptible to manipulation in order to increase the Trust's reported surplus. These were primarily unrecorded liabilities and journals transactions, which could be used to impact upon the surplus reported by the Trust.	*Income* For CCGs and NHS England income we confirmed the value of debtors from these bodies to NHS Improvement (Monitor)'s mismatch reports, which provides the amounts recorded by NHS bodies as debtors and the corresponding creditors with NHS counterparties, to agree that the amounts matched. Differences were identified and amounts were traced to supporting documentation. We tested a sample of patient activity included in the quarterly "true ups", and agreed the activity to patient records. We tested a sample of income transactions and traced these to invoices or correspondence from commissioners and other bodies and used our knowledge and experience of the industry to determine whether the income was recognised in the correct period. Our work did not identify any transactions or contracts that were indicative of manipulation in the timing of the recognition of income. We also obtained and read contract variations with commissioners and considered their terms to ensure that income was recognised in the correct period. *Expenditure* We selected a sample of payments made by the Trust and invoices received from the period following the end of the financial year and traced these to supporting documentation and agreed that the expenditure had been recognised in accordance with the Trust's accounting policies and in the correct accounting period. We tested a sample of accruals at the year end and traced them to supporting documentation and agreed that they has been appropriately accounted for in accordance with the Trust's accounting policies. Our work did not identify any transactions that were indicative of manipulation in the timing of the recognition of expenditure. *Journals* We selected a sample of journal transactions that had been recognised in either income or expenditure. We tested journals throughout the year, tracing them to supporting documentation to check that their impact on the income statement was appropriate. Our work did not identify any issues. Our work did not identify any transactions that were

Key audit matter	How our audit addressed the Key audit matter
	indicative of fraud in the recognition of income or expenditure, in particular to overstate income or understate expenditure.
Valuation of land and buildings *Management's accounting policies, key judgements and use of experts relating to the valuation of the Trust's estate are disclosed in note 1 to the financial statements.* *The Trust is regularly required to revalue its estate in line with the Department of Health and Social Care Group Accounting Manual.* Property, plant and equipment ("PPE") represents the largest asset balance in the Trust's statement of financial position, with a value of £369.821m. The Trust reassesses the value of its land and buildings each year, which involves applying a range of assumptions and the use of external expertise. The value of land and buildings at 31 March 2018 is £318.863m (see note 10 to the financial statements). We focussed on this area because the value of the properties and the related movements in their fair values recognised in the financial statements are material. Additionally, the value of properties included in the financial statements is dependent on the reliability of the valuations obtained by the Trust, which are themselves dependent on: - the accuracy of the underlying data provided to the valuer by the directors and used in the valuation; - assumptions made by the directors, including the likely location of a "modern equivalent asset"; and - the selection and application of the valuation methodology applied by the valuer, including assumptions relating to build costs and the estimated useful life of the buildings.	We confirmed that the valuer engaged by the Trust to perform the valuations had relevant professional qualifications and was a member of the Royal Institute of Chartered Surveyors (RICS). We obtained and read the relevant sections of the valuation performed by the Trust's valuer. Using our own valuations expertise, we determined that the methodology and assumptions applied by the valuer were consistent with the market practice in the valuation of hospital buildings. The value of the Trust's specialised operational properties in the financial statements is based upon the modern equivalent asset being based in Bristol city centre and the land is, therefore, valued accordingly. The Trust could, however, have chosen to base the valuation on a location outside of the city centre, which would have impacted the land value. We engaged our internal valuation expertise to consider these assumptions made by the Trust. We consider the approach taken to be an acceptable basis for valuation. We confirmed the accuracy of the information provided by the Trust to the external valuer by: - checking and finding that the portfolio of properties included in the valuation was consistent with the Trust's fixed asset register, which we had audited; - agreeing a sample of the gross internal areas used by the valuer to floor plans for the properties valued; - agreeing for a sample of properties that the Trust holds the legal title to the property; and - physically inspecting a sample of properties. We agreed that the values provided to the Trust by the valuer had been correctly included in the financial statements and that valuation movements were accounted for correctly and in accordance with the Trust's accounting policies.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the accounting processes and controls, and the environment in which the Trust operates. The Trust comprises a single entity with all books and records retained at Trust Headquarters in Bristol. We performed full scope audit procedures on the Trust and focused our work on the key audit matters described above.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£13.7m (2017: £12.8m)
How we determined it	2% of revenue (2017: 2% of revenue)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £300,000 (2017: £250,000), as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which ISAs (UK) require us to report to you when:

- the directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2017/18 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 32, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

As part of an audit in accordance with ISAs (UK), we exercise professional judgement and maintain professional scepticism

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

We will prepare an annual audit letter which will cover the Trust's key risks in securing economy, efficiency and effectiveness in its use of resources, how these have been discharged by the Trust, and our actions to review these. The Trust is responsible for publishing this annual audit letter, and ensuring that it is available to the public.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of University Hospitals Bristol NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Opinions on other matters prescribed by the Code of Audit Practice

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018. We have nothing to report as a result of this requirement.

Other matters on which we report by exception

We are required to report to you if:

- information in the Annual Report is:
    - materially inconsistent with the information in the audited financial statements; or
    - apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
    - otherwise misleading.
- the statement given by the directors on page 36, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for members to assess the Trust's performance, business

model and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.

- the section of the Annual report on page 74, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- we have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Lynn Pamment (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Bristol
29 May 2018