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University Hospitals Bristol NHS Foundation Trust

Annual Report and Accounts 2018/19

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

University Hospitals Bristol NHS Foundation Trust
Annual Report and Accounts 2018/19

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 2018 to 31 March 2019.

I joined the Trust in December 2017 and in my first year with the organisation I've been privileged to meet and work alongside so many people who are committed to providing exceptional care to our patients.

Our services are complex and take in many departments and hospitals but despite this our outstanding staff remain patient focused every single day and continue to innovate with forward-thinking ideas to improve healthcare.

A key part of this innovation is the digitisation of our hospitals with new technologies being used to bring improvements to patients and staff. These include mobile devices to record patient observations, and an app which allows our doctors and nurses to communicate securely about a patient's care wherever they are in our hospitals.

Last year I said one of our central pillars going forward had to be working towards the concept of one public service and continuing to build our relationships – nationally, regionally and locally – with other health and social care providers.

This is still the case. Working together in a more effective and integrated way will be pivotal to ensuring we continue to provide the best healthcare going forward and ensuring we're always patient and public focused.

This is not just about improving the way we work across services and from department to department within our hospitals, but also about working more effectively with partners in health and social care outside of our hospitals.

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 2018/19 we continued to strengthen our partnership with Weston Area Health NHS Trust (WAHT) with colleagues from both organisations working more closely together, and this is something that we will continue to build on.

Our amazing staff are central to everything we do and the priority over the past 12 months has been a focus on our staff's wellbeing, personal development and engaging with them. We've made some positive progress on this in the past 12 months which saw an increase in the number of staff completing their staff survey, but there's much more to do. I'm committed to ensuring all our staff have a voice, feel engaged with and receive the best support for their development and wellbeing. This means that our commitment and drive towards fairness, diversity and inclusion has to be at the centre of everything we do.

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 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.

Finally, I'd like to thank everyone who has provided, and will continue to provide, outstanding care to our communities.

Thank you.

Jeff Farrar QPM, OStJ
Chairman
24 May 2019

2. Chief Executive's Foreword

During 2018/19, University Hospitals Bristol NHS Foundation Trust joined the nation in celebrating the 70th anniversary of the NHS. It's a great privilege to be part of an institution that symbolises a remarkable public consensus about the kind of caring and inclusive society we want to live in.

Caring for the 11,000 staff who work here was top of the four priorities I set for senior leaders in the Trust at the start of the year. It is a fundamental principle that our staff should feel properly engaged and that their wellbeing and development should be supported. There is now plenty of research evidence confirming what UH Bristol has demonstrated and should be obvious to us all – that staff who feel cared for give the best care to others.

I was pleased therefore that we saw the number of responses to the NHS Staff Survey rise significantly to 4,500 employees. I was even more pleased to see that our staff engagement score had increased for the fifth year running and that we performed better than the national average against the great majority of questions in the survey. To stay responsive to the needs of our staff, we held a number of 'You said, we did' weeks to share how we'd listened to their feedback and we also introduced a new, improved version of our innovative Happy App, which allows staff to register their mood at any time and share matters of pride or concern. The new version of the Happy App allows me and senior divisional managers to monitor how well and how promptly local leaders are responding to the issues raised by their teams.

It is the quality of local leadership that will make a continuing difference to the experience of staff across the Trust. For the same reason, we introduced new leadership and management training, which is compulsory for all new managers and will cover all existing managers in time. This builds on the explicit Leadership Behaviours we launched two years ago, which themselves derive from our Trust values of Respecting Everyone, Embracing Change, Recognising Success and Working Together.

Ensuring we're an organisation that works equally for all staff, irrespective of race, gender, sexual orientation or disability, is a major commitment of the Trust Board. During the year, we continued our involvement in the Bristol Race Equality Manifesto Leadership Group but we also sought advice from the race equality implementation team at NHS England about our own potential to make faster progress, which has fed directly into our new plan for improving diversity and inclusion inside the Trust.

The second of the leadership priorities I set for the year was about further improvement in the quality of care we give to patients. We completed our three-year Sign up to Safety programme with some remarkable achievements, including a 50 per cent reduction in the number of adverse events in the Trust. Working with partners through the West of England Academic Health Science Network, we also contributed to a major reduction in the number of deaths attributable to sepsis across the South West of England.

We aim not only to keep patients safe while they are in hospital but to do so while demonstrating the highest levels of care and compassion. In February, we launched our new customer service principles, which were developed in collaboration with staff and are designed to ensure that everyone who comes into our hospitals has a consistently positive experience. In early 2019, we also started to install new, real time feedback points for patients and visitors, as part of a new programme called 'Here to Help'.

My third leadership priority for the year was about planning better and earlier for the challenges that winter always brings and I am pleased to say that, despite unprecedented levels of urgent and emergency demand on the Trust last winter, our preparations (which included recruiting additional staff, providing a small number of extra beds and reviewing the way that different clinical teams work together) meant that we saw fewer medical patients being displaced into inappropriate wards than the previous year and fewer cancellations of planned surgery.

We were supported in this by the new systems we've been introducing as a Global

Digital Exemplar, one of 16 Trusts in England leading the way in the use of technology. As a result, we can monitor the status of every inpatient's care in our hospitals and react to any issues or delays we uncover. Around 200 teams are also using a new communications tool, allowing doctors, nurses and other healthcare staff – wherever they happen to be in the Trust – to message each other securely about a patient's care.

Our electronic observations software – which allows staff to take and share patient observations such as blood pressure and heart rate using mobile devices – has been in place for a year and nearly 40 wards and 6,000 staff are now using the system to help keep their patients as safe as possible. This is just the start, with more exciting digital innovations planned this year and next.

My final leadership priority was about working smarter, supporting the efforts of local teams to eliminate waste and delays and deliver even better value for the taxpayer's investment in our services.

Staff across all the divisions embraced the principle of working smarter and delivered many excellent initiatives in the course of the year. Examples include improving the flow of emergency patients, optimising our use of diagnostics, increasing the number of CT scans for cardiac patients and introducing a streamlined antenatal booking system for mothers-to-be.

In addition to these four internal priorities, we put special effort last year into building productive relationships across the health and care system, not least through our joint leadership role in Healthier Together, the Sustainability and Transformation Partnership for Bristol, North Somerset and South Gloucestershire. Of particular note was our deepening partnership with Weston Area Health Trust, following our joint announcement in January 2018 of our intention to merge the Trusts.

With the engagement and support of those external partners, as well as extensive input from our own staff, we conducted a major review of the Trust's long term strategy, which has recently concluded. This has strongly reinforced our view that it critical for us to work with our colleagues in primary and community services to manage the health of the local population as proactively and as close to home as possible, so that scarce hospital capacity can be used for delivery of specialised services to the wider region, as well as for exceptional professional education and leading edge clinical research.

On the subject of clinical research, I would like congratulate our Professor of Rheumatology Nursing, Sarah Hewlett, who led a clinical trial ending in 2018 which found that multiple measures of fatigue in patients with rheumatoid arthritis can be improved by cognitive behaviour interventions. I would also like to offer congratulations to Dr Karen Luyt, Consultant in Neonatal Medicine at St Michael's Hospital, who was awarded a Health Foundation Scaling-up Improvement award of £457,000 for a study known as 'PReCePT2' – Prevention of Cerebral Palsy in PreTerm Labour. PReCePT2 builds on work Karen has led since 2014 on the benefits of giving magnesium sulphate to expectant mothers during labour to help reduce cerebral palsy in babies and will help to establish and evaluate the approach in maternity units across the UK. More information about these studies and all the other research we do can be found later in this Annual Report.

At Board level, it was my pleasure to welcome our new Medical Director, Dr William Oldfield, who joined us during the year from Imperial College Healthcare Trust. The terms of office for two long-standing Non-executive Directors, John Moore and Guy Orpen, were extended for a further year. We also announced the appointment of Neil Kemsley as our new Director of Finance and Information. Neil will join us in July 2019 and will succeed Paul Mapson, who is retiring after 28 years in the Trust and 17 successful years in the Director role.

We also said a sad farewell to two Non-executive Directors, Jill Youds and Alison Ryan, who both left us at the end of March 2019. We are enormously grateful to them both for their commitment and contribution to the Trust over many years.

Finally, I want to make special mention of the invaluable contribution made by the thousands of staff, family and carers, hospital volunteers, Trust governors and members, and supporters of Above and Beyond and our other charities, without whose help none of our proud achievements last year would have been possible.

With best wishes

Robert Woolley
Chief Executive
24 May 2019

3. Performance Report

3.1 Overview

2018/19 built on the strong performance from the previous year and although there were significant increases in demand, particularly in urgent and emergency care, the Trust was able to continue to deliver high quality care to our patients.

In particular the revised approach to winter planning has resulted in improved patient flows and the maintenance of surgical activity which would normally have had to be reduced to cope with the seasonal fluctuation.

This improved approach to planning was coupled with a number of key productivity improvements such as ensuring theatres started on time, and the scheduling of CT cardiac patients to minimise the time patients spent on the table. A further major development was the implementation of the Clinical Utilisation Review (CUR). CUR is an evidence based initiative which helps to ensure that patients get to the right place to receive the right care. It also helps the Trust understand where the delays are in the patient's pathway and whether these are internal or external, and supports having conversations which help to remove the delays.

In relation to access standards, the Trust delivered the Cancer 62 day GP target in eight out of 12 months and fully achieved the standard in quarters two (July to September) and three (October to December). The Trust maintained its performance against the 18 week Referral to Treatment target, although this was below the national standard. Performance against the six week wait for diagnostics standard was however not at the expected level and was not achieved during 2018/19. This related to three main areas – Echocardiography, Non-obstetric ultrasound and CT Cardiac, and was due to a mixture of issues which included availability of staffing and increasing demand for some tests. A recovery plan has been developed with the forecast that the target would be achieved in quarter two 2019/20.

Performance against the Trust's quality metrics continued to be good, with the Trust's Summary Hospital Mortality Indicator and Hospital Standardised Mortality Ratio both within the expected range.

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 2018, 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 10,000 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 the National Institute for Health Research 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

During the last year we have renewed our strategy and developed 'Embracing Change, Proud To Care – Our 2025 Vision'. We have confirmed our core purpose in our mission, which is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. We have updated our vision, which is to improve patient and population health by:

- Anchoring our future as a major specialist service centre and a beacon of excellence for education
- Working in partnership and where appropriate leading, within an Integrated Care System, extending the scope of service delivery outside our hospitals, locally, regionally and beyond
- Excelling in world-class health services research and our culture of innovation.

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 which we have updated in our new strategy. Our priorities going into 2019/20 are:

- Our Patients: We will excel in consistent delivery of high quality, patient centred care, delivered with compassion
- Our People: We will invest in our staff and their wellbeing, supporting them to care with pride and skill, educating and developing the workforce for the future
- Our Portfolio: We will consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focusing on core areas of excellence and pursuing appropriate, effective out of hospital solutions
- Our Partners: We will lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve
- Our Potential: We will be at the leading edge of research and transformation that is translated rapidly into exceptional clinical care and embrace innovation
- Our Performance: We will deliver financial sustainability for the Trust and contribute to the financial recovery of our health system to safeguard the quality of our services for the future.

We are committed to addressing the aspects of care that matter most to our patients, and during 2018/19 we have updated our strategy so that it is responsive to the changing needs of our patients and significant changes within both the national and local planning environment. Our new strategy will support progress towards the objectives of the NHS Long Term Plan as well as the vision of the Healthier Together system partnership and provide us with a significant opportunity to progress our strategic priorities at pace by working together with our partners to resolve some of the system-wide challenges we face.

Over the coming year, we will formally launch our new strategy and ensure that it sets a clear direction for everything we do at UH Bristol. While the NHS has significant challenges to overcome, we are confident that keeping focused on our mission, vision and values will enable us to develop our organisation and our local health and care system to be fit for the future.

3.1.4 Transforming Care

Our focus is unrelentingly on delivering best care and ensuring our patients' needs are at the heart of all that we do. In order to lead and run a successful organisation, we focus on continually improving all we do around 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.

To support further transformation of our outpatient services, the Trust has adapted the City Hospitals Sunderland model to create our real time outpatient programme. The purpose of the programme is to improve the management of a patient's pathway, through on the day completion of clinic letters (ensuring key information is available to required health professionals) and, where possible, diagnostics/follow ups are booked before a patient leaves the clinic.

Embedding our Innovation and Quality Improvement (QI) culture has remained a priority. Key successes during 18/19 have included 65 submissions to our second QI poster forum, our first internal QI Network event, and the establishment of an Innovation Hub for staff to submit ideas.

During 2018/19 implementation of our Customer Care programme continued. Following a successful pilot for advanced customer care training, work is underway to establish a roll out schedule for key staff groups over the next two years. To share the customer care principles Trustwide, our 'Here to Help' campaign was launched in January 2019.

We are increasingly using digital systems to improve the safety and quality of our care. For example, during 2018/9, our new electronic observations system has assisted us to achieve 100 per cent appropriate sepsis screenings for our adult inpatients, which has supported system-wide work with our partners in community, primary and social care to reduce mortality associated with suspicion of sepsis.

- 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 2018/19

The roll out of a clinical utilisation initiative, which assesses if a patient is receiving care in the appropriate location for their care needs, has been a key focus this year. Since September 2018, 37 inpatient areas have been completing daily reviews and recording delays in patient pathways. Work is ongoing to drive the accuracy of delays recorded and embed the use of the data into our daily operational flow processes and strategic planning.

To improve discharge planning, the Trust has participated in a new way of working with our local partners by introducing a digital single referral form that is completed by a patient's multi-disciplinary team, and then assessed by an Integrated Care Bureau of community

partners to agree the best pathway for the patient following their acute hospital admission.

A theatre programme focusing on theatre start times and utilising list capacity launched in autumn 2018. The improvements made in theatre efficiency and increased activity of our main adult theatre suite, have resulted in a reduction in on the day cancellation of patient procedures.

- 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 2019. We achieved an income and expenditure surplus of £29.854m before technical items, efficiency savings of £25.983m, a year-end cash position of £99.855m, and we have a strong balance sheet resulting in a Use of Resources risk rating of one.

Model hospital data is being used to drive improvements in a variety of areas: Nursing and Midwifery, Pharmacy and Estates. A training programme to enable staff to use Model hospital data, alongside Getting It Right First Time data to identify productivity opportunities is being rolled out.

A series of 'Working Smarter' workshops were held with senior clinical and non-clinical staff from all our divisions. The workshops generated a series of improvements which are being implemented by divisional teams and monitored through our Savings Board.

The Trust is implementing a Managed Inventory Solution across all hospitals. The project has gone 'live' in Trauma and Orthopaedics in two theatres in the Bristol Royal Infirmary. Initial savings have been realised from this and also from the preparation for the next phase of the programme. Additional savings will be delivered as the project progresses.

- 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 2018/19, the Trust Board approved a significant strategic capital investment programme to both upgrade our existing infrastructure and invest in expanding our capacity and create fit for purpose environments for our staff and patients. Potential schemes to be completed are in development.

To improve the environment for our patients and staff, an Arts and Culture programme has been established under the leadership of an Arts Programme Director who has been appointed on a fixed term contract, funded by Above & Beyond to October 2019. An Arts and Culture Strategy is being developed through a programme of action research following monthly themes and cross cutting strands. The themes enable investigation of the sensory environment – sound, sight, smell, taste, touch – from the perspective of staff and patients to inform a process of Design Thinking towards potential improvements to the physical environment. Through strategic use of networks, the programme is also benefitting from 'best practice' from Arts Programme colleagues in other Trusts and civic partnerships with academic, cultural and business organisations in the city.

The programme has already helped introduce a noise@night campaign, aimed at reducing noise when patients stay overnight to improve patient experience and recovery; the arts in medical training; improving windowless environments; best practice in the design and use of staff rooms and ward kitchens; addressing patient boredom; and framing narratives of experience.

As a Global Digital Exemplar, during 2018/19 we have continued to expand our use of digital systems to deliver clinical care and communicate with patients and are working to become a Digital Hospital.

All adult inpatient wards are using our electronic observations system, and use of

our Electronic prescribing and medicines administration system has been expanded into the inpatient wards within the Bristol Haematology and Oncology Centre.

A variety of clinical teams are using a new secure communication tool which is available on mobile devices or desktops. The tool enables teams to have secure patient focused conversations, record patient handover, and co-ordinate team worklists.

A small cohort of patients have been receiving their appointment letters by email, with approximately 80-100 emails sent per month. A structured roll out to offer email as an option to all patients is underway.

- Pillar 5: Building capability

Our staff are our greatest asset and it is essential that we attract and nurture a capable, compassionate and diverse workforce, support their development, recognise them for their good work and retain their expertise within our services.

During 2018/19, growth of the Quality Improvement (QI) Academy has continued with an additional 350 staff attending the Bronze programme, which teaches basic QI methods and tools. A further two cohorts of the silver programme, which provides training and support to deliver a QI project have been held. The QI Gold programme to support the delivery of complex projects is in development.

To support the development of our leaders, since August 2018, all newly appointed or promoted managers are required to complete appropriate management and development training within six months.

In autumn 2018, we delivered the inaugural Executive Leadership programme, as part of our leadership and management journey. We have continued to successfully deliver this programme throughout 2018/19, to develop our managers and leader and help to build a confident and competent workforce.

- 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 the people we serve. 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.

Throughout 2018/19, 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, 'Healthier Together'. Key areas of collaboration in 2018/19 included working together to develop a shared vision for sustainable, quality care for the population of Weston and Worle through the Healthy Weston programme; including Mental Health, Primary Care, Acute Care Collaboration, Urgent Care, Prevention, Maternity, Workforce and Digital.

As a partnership, we have agreed to focus on three priority areas for 2019/20 which are improving the delivery of urgent care, resolving workforce issues, and delivering financial sustainability for the whole system. These priorities have been used in our planning for the new year to agree where we make investments in our local system for the future.

We continue to work directly through our Partnership Management Board with Weston Area Health NHS Trust to pursue an organisational merger via acquisition with Weston Area Health NHS Trust. Progress has been made with a number of clinical specialties who have adopted the Clinical Practice Group model to bring the clinical teams from both Trusts together to plan how their services can inform the development of enhanced models of care, to reduce variation, identify priorities and improve patient care.

Progress has also been made in a number of non-clinical areas: Human Resources and recruitment, Facilities and Finance where resource, expertise and systems have been shared in order to align with the existing services at Weston.

The Trust successfully won the bid and has mobilised the delivery of a Sexual Assault Referral Centre (Centre of Excellence for Paediatrics and Adults) for Bristol, Gloucestershire, Wiltshire and North Somerset, and we are working in partnership

with Devon and Cornwall area to improve patient pathways.

UH Bristol is also working in partnership with North Bristol NHS Trust and Weston Area Health NHS Trust to develop an Acute Care Collaboration strategy, ensuring that we work together to make best use of all our specialist skills and resources to achieve the best outcomes for our patients.

3.1.5 Key risks to delivering our objectives

The Board Assurance Framework was updated during 2018/19 to improve the reporting of strategic risk. The Board monitors the risks quarterly, alongside progress of the achievement of the Trust's Strategic Priorities, the controls and assurances in place and the actions being taken to minimise risk.

A summary of the risks to our strategic plans are outlined below:

- That government policy changes affect the NHS and social care funding
- That national shortages of specific occupations affect recruitment
- That public perception of Trust activities may be negatively affected
- That digitalisation of clinical systems fails to deliver the required levels of efficiencies
- That clinical services are not commissioned at levels of forecasted demand
- That capital funding for maintaining and modernising the Trust estate is insufficient
- That the STP fails to deliver a system strategy
- That a local or regional provider failing to maintain viability of services increases unplanned demand
- That the Trust fails to retain sufficient management and leadership capacity and capability
- That the Trust's workforce is insufficiently motivated and engaged
- That the Trust fails to establish and maintain robust governance processes
- That Research is unable to sustain activity
- That Brexit causes disruption to the delivery of goods and services
- That benefits of transformation, improvement and innovation are not realised.

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 University Hospitals Bristol NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. The Trust has a long term financial plan. It has set a surplus budget for 2019/20 of £12.815m, it is planning to receive income of £726.048m and is forecasting cash balances of £81m at the end of March 2020. Therefore, the Trust continues to adopt the going concern basis in preparing the accounts.

3.1.7 Overview of financial performance

The Trust continues to operate in a challenging financial environment. Control totals introduced by NHS Improvement as a response to the significant underlying deficit in the NHS provider sector continue to be operated. In recognition of a Trust accepting its control total it is able to earn Provider Sustainability Funding, and have the risk of core performance fines removed.

The Trust submitted its Operational Plan on the 30 April 2018 to achieve a surplus of £18.480m (before technical items) for the 2018/19 financial year. The plan was to deliver a £3.000m core control total surplus and receive £15.480m Provider Sustainability Funding

Provider Sustainability 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 and bonus Provider

Sustainability Funding is allocated once the final year end performance is known.

The Trust delivered a surplus of £18.337m (excluding technical items), which is a major achievement considering the unprecedented financial and operational pressures both locally and nationally. This included £13.855m of Provider Sustainability Funding. Excluding the Provider Sustainability Funding the surplus was £4.482m compared to the planned surplus of £3.000m. This was a good financial performance and was the 16th 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 £10.836m core finance Provider Sustainability Funding available. The A&E performance year to date target was achieved at quarters one, two and three (92.05 per cent, 91.77 per cent and 90.84 per cent respectively against a target of 90 per cent) but was not achieved at quarter four (89.84 per cent against a target of 90 per cent). Performance Provider Sustainability Funding of £3.019m was earned out of the £4.644m available.

In recognition of the Trust's financial performance, NHS Improvement allocated the Trust Incentive Provider Sustainability Funding of £11.517m. This increased the Trust surplus from £18.337m to £29.854m, excluding technical items.

The 2018/19 plan required savings of £25.474m 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 including improving theatre utilisation and efficiency, reducing length of stay, capacity and demand planning and improving outpatient utilisation and efficiency. The Trust delivered savings of £25.983m.

The Trust's statement of financial position remained strong with net current assets of £84.291m and a year-end cash and cash equivalent balance of £99.855m.

The Trust invested £25.662m 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 2019, the Trust had a risk rating of one.

3.2 Performance Analysis

NHS Improvement's Single Oversight Framework (SOF) has four patient access 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 RTT incomplete pathways
    - Additional requirement to maintain total wait list below March 2018 levels
- 99 per cent for six week diagnostic waiting times.

Provider Sustainability Funding (PSF) 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 the 62 day cancer standard was achieved for eight months in a row and also achieved for quarters two and three overall. Referral to Treatment performance consistently achieved the NHSI recovery trajectory each month and the total wait list has remained below the March 2018 level of 29,207. A&E performance achieved the improvement trajectory in quarters one, two and three. The six week wait for diagnostics has remained below the national standard, but plans are in place with a trajectory to return to achieving the standard in quarter two 2019/20.

3.2.1 Referral to Treatment (RTT)

The national standard for Referral to Treatment (RTT) is 92 per cent. During the commissioning contract period for 2017/18 and 2018/19, we agreed with our local commissioners a month-by-month trajectory for Trust compliance during 2018/19. This trajectory was delivered across 12 consecutive months from April 2018 to March 2019.

The number of patients on our waiting list is monitored and reported on a monthly basis to NHS Improvement and NHS England. At the end of each month in 2018/19, the total waiting list size was required to remain below the March 2018 level of 29,207, for eight months of the annual year the waiting list size was below this level and at the end of March 2019 we reported 28,481 and achieved the target set.

3.2.2 Accident & Emergency four hour maximum wait

The Trust did not 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. For the three emergency departments (EDs):

- The Bristol Royal Hospital for Children (BRHC) achieved the 95 per cent standard in five months, and achieved 93.0 per cent for the year
- The Bristol Eye Hospital (BEH) achieved the 95 per cent standard in eleven months, and achieved 97.4 per cent for the year
- The Bristol Royal Infirmary (BRI) did not achieve the 95 per cent standard in any month of 2018/19, and achieved 78.4 per cent for the year.

For the financial year 2018/19 there was a Sustainability and Transformation Fund improvement trajectory in place with NHS Improvement. This combined Trust data with data from local Walk-In Centres to give an 'Acute Trust Footprint' performance figure. This data was published by NHS England and was then used by Trusts and NHS Improvement to assess whether a Trust had achieved the trajectory.

For UH Bristol, the trajectory required the organisation to achieve 90 per cent performance, year-to-date, at the end of each quarter. The Trust achieved this trajectory in quarters one, two and three.

Table 1: Trust Trajectory

	Trust Level	Footprint Level	Trajectory
Quarter 1 (Apr-Jun)	89.3%	92.1%	90%
Quarter 2 (Apr-Sep)	88.9%	91.8%	90%
Quarter 3 (Apr-Dec)	87.7%	90.8%	90%
Quarter 4 (Apr-Mar)	86.4%	89.8%	90%

Overall, A&E attendance levels were up 6.5 per cent in 2018/19 compared to 2017/18; a 3.5 per cent increase at the BRI, 11.2 per cent increase at BRHC and 7.0 per cent at BEH. However, the proportion of patients admitted to an inpatient bed as a result of their A&E attendance remained the same at 26 per cent (35 per cent at BRI and 23 per cent at BRHC). The proportion of patients arriving by ambulance remained steady at 26 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 the emergency departments. This figure rose from 6,215 in 2017/18 to 6,988 in 2018/19, which is a 12 per cent increase.

During this financial year, the Trust has supported Weston General Hospital's (WGH) A&E service; patients who would have attended WGH's A&E from 10pm each evening have been re-directed for care to UH Bristol and other local providers. Analysis of the 2018/19 data shows:

- 153 ED additional attendances at UH Bristol, on average, per month
- 88 ED admissions, on average, per month (58 per cent conversion rate)

The number of Delayed Transfers of Care (DToC) patients reduced this year. In 2017/18, DToC patients averaged 32 at each month end; 2018/19 averaged 25. Total bed days lost to DToC patients fell from 11,572 to 9,344.

3.2.3 Cancer

The Trust achieved the 62 day GP referral to treatment standard in eight months during the 2018/19 financial year (June 2018 to January 2019). This is the best performance since 2012, when changes to services left the Trust with a high proportion of complex cancer and treatment types. This achievement is in the context of non-compliance with the standard at national level. February and March saw an increase in delays at other providers impacting on the Trust's position, causing non-compliance in those months despite ongoing good internal performance of 92.8 per cent for quarter four.

In May, a fire in the Bristol Haematology and Oncology Centre (BHOC) caused some treatments to be delayed, and lower compliance with the standards in quarter one. BHOC recovered impressively from this major incident, although specialist deep cleaning following the fire has affected our performance in quarter four. The minimal impact of this unprecedented event and rapid recovery from it highlight the strong processes in place within the Trust to manage cancer pathways and ensure patients are treated promptly whenever possible.

The 31 day standard for first and subsequent cancer treatments was met in quarters two, three and four. The two-week-wait standard for first appointment after GP suspected cancer referral was met in every quarter of the year. The Trust is preparing to submit data from April 2019 for the new standard of 28 days from referral to diagnosis or ruling out of cancer; this standard will be measured from April 2020.

The main cause of 'breaches' of the 62 day standard remains late referrals from other providers, which usually accounts for around half of all breaches of this standard. New national rules for allocating the performance accountability between providers were expected in October 2018, but have been delayed until April 2019. These rules should benefit the Trust's performance by more fairly reflecting the amount of a patient's pathway for which each provider involved was accountable.

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 have been waiting under six weeks. Month-end performance varied from 93.3 per cent to 98.4 per cent across 2018/19 and the average month-end performance was 96.7 per cent.

As at end of March 2019, Neurophysiology, Audiology, DEXA Scans and Sleep Studies are currently achieving the 99 per cent standard, with MRI slightly below at 98.9 per cent. Endoscopy services (Gastroscopy, Flexi Sigmoidoscopy and Colonoscopy) are at 95 per cent.

A reduction in staffing capacity through vacancies and staff absence prevented achievement of the standard for Endoscopy services, Non-obstetric Ultrasound and Echocardiographies. These services are utilising additional capacity through waiting list initiative sessions whilst staffing levels are restored. The services expect the standard to be achieved by quarter two 2019/20. Computed Tomography (CT) services are not achieving the standard due to Cardiac CT experiencing a 30 per cent growth in referrals (October-January 2018/19 compared with April-September 2018). A new CT scanner is planned for end of quarter two.

The Trust has submitted a recovery trajectory to NHS Improvement showing compliance with the 99 per cent standard by end of September 2019.

3.2.5 Outpatients

The Trust has an active programme of transformation within outpatients; this is overseen by the outpatient steering group which is sponsored by the Deputy Chief Executive and Chief Operating Officer.

During 2018/19 a significant validation programme was undertaken to improve patient pathways and reduce delays and to instil, on a monthly basis, active and responsive validation of all patient pathways beyond a six month time period.

On 1 October 2018 NHS England changed the standard contract to mandate that all GP referrals must be received via e-referrals into consultant led first outpatient appointments or the Trust will not be paid for the appointment. All GP referrals to first outpatient appointments are now being received via e-referrals, this enables patients to choose where and when they would like to be seen.

The Trust has been exploring ways to improve the outpatient experience for patients – focusing on 'doing today's work, today'. A real time outpatient project was launched in October 2018 which is focused on making sure that everything is done on the day of a patient's appointment where possible, rather than notes and letters being typed up in the following days. The objective is to turn clinic letters around on the day, booking follow-up appointments or diagnostics (if within six weeks) in person at reception following clinic, and performing blood tests and plain film X-rays on the day.

In 2018/19 a patient journey training video was designed which gives new staff an insight into all the steps in the patient journey from referral to treatment and then discharge. This will form part of the induction package for all new admin staff and may be rolled out to newly qualified clinical staff.

3.2.6 Important events since the end of the financial year

There have been no important events since the end of the financial year.

Table 2: Performance against national standards

National standard	Target	2016/17	2017/18	2018/19
A&E maximum wait of four hours	95%	85.0%	86.5%	86.3% Ⓐ
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	97.4%	97.7%	95.6%
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	52.6%	52.2%	49.3%
A&E Unplanned re-attendance within seven days	<5%	2.6%	2.8%	3.3%
A&E Left without being seen	<5%	2.2%	1.9%	1.7%
Cancer - Two week wait (urgent GP referral)	93%	94.8%	94.3%	95.3%
Cancer - 31 Day Diagnosis To Treatment (First treatment)	96%	96.7%	95.8%	97.2%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94%	94.4%	92.0%	96.1%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	98%	98.7%	98.6%	98.4%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	94%	96.6%	96.3%	95.8%
Cancer - 62 Day Referral To Treatment (Urgent GP Referral)	85%	79.3%	81.7%	85.6% Ⓐ
Cancer - 62 Day Referral To Treatment (Screenings)	90%	69.4%	74.8%	66.7%
Cancer - 62 Day Referral To Treatment (Upgrades)	85%	87.9%	85.4%	83.7%
18-week Referral to Treatment Time (RTT) incomplete pathways	92%	91.7%	89.6%	89.0%
Number of Last Minute Cancelled Operations	<0.8%	0.98%	1.19%	1.31%
Last Minute Cancelled Operations Re-admitted within 28 days	95%	90.8%	94.2%	93.4%
Six week diagnostic wait	99%	97.8%	98.3%	96.7%
Primary PCI - 90 Minutes Door To Balloon Time	90%	91.7%	93.2%	92.5%

Ⓐ data subjected to external audit scrutiny as part of the process of producing this report

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 Trust Board and Audit Committee of key issues.

The Trust reported a surplus before technical items of £29.854m. This included Provider Sustainability Funding of £25.372m of which core and performance Provider Sustainability Funding was £13.855m and incentive funding was £11.517m. The Operational Plan was to deliver a surplus of £18.480m (before technical items), consisting of a £3.000m core surplus with receipt of £15.480m Provider Sustainability Funding. The core surplus was exceeded by £1.482m and Incentive Provider Sustainability Funding was received. The performance against the Operational Plan is shown below:

Table 3: Performance against operational plan

	Plan £m	Actual £m	Variance favourable/(adverse) £m
Clinical income	581.582	591.126	9.544
Non clinical income - excluding PSF	90.156	100.856	10.700
Total operating income (excluding PSF)	671.738	691.982	20.244
Employee expenses	(391.732)	(408.751)	(17.019)
Non pay expenses	(240.778)	(244.374)	(3.596)
Total operating expenses	(635.510)	(653.125)	(20.615)
Depreciation	(24.339)	(23.324)	1.015
Interest receivable	0.244	0.598	0.354
Interest payable	(2.749	(2.732)	0.017
Public dividend capital dividend	(9.384)	(8.917)	0.467
Total financing costs	(36.228)	(34.375)	1.853
Net surplus/(deficit) before technical items excluding PSF	**3.000**	**4.482**	**1.482**
Provider Sustainability Transformation Funding:			
- Core	10.836	10.836	-
- Performance	4.644	3.019	(1.625)
- Incentive	-	11.517	11.517
Net surplus/(deficit) before technical items including PSF	**18.480**	**29.854**	**11.374**
Depreciation on donated assets	(1.519)	(1.580)	(0.061)
Donations re assets	3.000	1.279	(1.721)
Net impairments	0.629	0.515	(0.114)
Total technical items	2.110	0.214	(1.896)
Net surplus/(deficit) after technical items	**20.590**	**30.068**	**9.478**

The Trust delivered a surplus of £29.854m, excluding technical items. There are a number of items classified as technical which are excluded when considering the Trust's financial performance. Technical items comprise depreciation on donated assets, donated income in respect of assets, impairments and reversal of impairments.

Excluding Provider Sustainability Funding the Trust achieved a surplus of £4.482m against a planned surplus of £3.000m.

3.3.2 Sustainability

Provider Sustainability Funding (PSF) has three elements; core, performance and incentive.

Core Provider Sustainability Funding income is dependent on the Trust delivering its control total. This was achieved given the surplus was £4.482m compared with the planned surplus of £3.000m. Therefore, the Trust earned all of the £10.836m funding available.

Performance Provider Sustainability Funding is dependent on delivering A&E performance standards. The A&E performance year to date target was achieved at quarters one, two and three (92.05 per cent, 91.77 per cent and 90.84 per cent respectively against a target of 90 per cent) but was not achieved at quarter four (89.84 per cent against a target of 90 per cent). Performance Provider Sustainability Funding of £3.019m was earned out of the £4.644m available.

Incentive Provider Sustainability Funding was allocated by NHS Improvement following the Trust's submission of its key data return on 15 April 2018. The Trust received £11.517m as follows:

	£m
Incentive PSF (finance)	1.804
Incentive PSF (bonus)	2.635
Incentive PSF (general distribution)	7.078
	11.517

Incentive PSF (finance) rewards providers that have delivered a financial position which is better than their control total. The Trust received £1.804m.

Incentive PSF (bonus) is paid from a capped national pot to those providers who delivered their control total, with a further element relating to the level of recurring efficiency schemes delivered. The Trust received £2.635m.

Incentive PSF (general distribution) uses the balance of unused PSF to pay all providers that signed up to a control total in 2018/19. It is paid based on the achievement of the control total, providers who fail to achieve their control total have the payment reduced proportionately £1 for £1. The Trust received £7.078m.

3.3.3 Savings

The Trust achieved £25.983m of savings against its plan of £25.474m. Specific work streams were established focusing on transactional efficiencies such as obtaining best value through purchasing, controlling spend and use of technology as well as productivity projects focusing on improving theatre utilisation and efficiency, reducing length of stay, capacity and demand planning and improving outpatient utilisation and efficiency. Savings were achieved as follows:

Table 4: Savings achieved during 2018/19

	Plan	Actual	Variance favourable/ (adverse)
	£m	£m	£m
Allied Healthcare Professionals			
Productivity	0.779	0.767	(0.012)
Blood	0.046	0.042	(0.004)
Diagnostic Testing	0.156	0.000	(0.156)
Estates & Facilities	0.746	0.791	0.046
Healthcare Scientists Productivity	0.120	0.108	(0.012)
HR Pay and Productivity	0.097	0.067	(0.030)
Income, Fines and External	2.290	2.280	(0.009)
Medical Pay	0.625	0.311	(0.313)
Medicines	0.751	1.244	0.493
Non Pay	5.019	5.042	0.023
Nursing Pay	1.061	0.722	(0.338)
Other / Corporate	7.874	7.874	-
Productivity	3.267	4.155	0.888
Support Funding	1.936	1.936	-
Trust Services	0.653	0.643	(0.010)
Unidentified	0.055	0.000	(0.055)
Total savings	**25.474**	**25.983**	**0.509**

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 2019 of £84.291m. This included year end cash and cash equivalents of £99.855m. This represents an increase in cash over the year of £28.763m. The table below shows the use of cash during the year.

Table 5: Use of cash 2018/19

	£m	£m
Opening cash balance		71.092
Use of cash:		
Net cash flow from operating activities	62.826	
Capital expenditure	(22.404)	
Other net cash flows from investing activities	1.959	
Public Dividend Capital received	4.106	
Capital loan repayments to the Department of Health	(5.834)	
Interest (on capital loan) payments to the DoH	(2.557)	
Public Dividend Capital dividend payment	(8.754)	
Finance lease payments	(0.579)	
Increase in cash balance	28.763	
Closing cash balance		99.855

3.3.5 Capital

The Trust's planned capital expenditure for 2018/19 was £47.089m. This included ambitious strategic investment plans that the Trust recognised would move into future years. Therefore the Trust revised its forecast capital expenditure plans accordingly. 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 2018/19 the Trust spent £25.662m on capital schemes with net overspends on completed schemes totalling £0.155m and slippage on current schemes accounting for £21.582m. The table below provides a summary of the Trust's capital income and expenditure for 2018/19.

Table 6: Funding and expenditure on capital schemes

	Operational Plan 2018/19 £m	Actual 2018/19 £m	Variance 2018/19 £m
Source of Funding:			
Public Dividend Capital	1.600	4.105	2.505
Borrowings	3.189	-	(3.189)
Donations - cash	3.000	1.178	(1.822)
Donations - direct	-	0.101	0.101
Depreciation	24.338	23.323	(1.015)
Insurance claim	-	1.315	1.315
Cash balances	14.962	(4.360)	(19.322)
Total funding	47.089	25.662	(21.427)
Expenditure:			
Strategic schemes	(13.143)	(2.306)	10.837
Medical equipment	(17.620)	(7.953)	9.667
Information technology	(7.493)	(6.026)	1.467
Estates replacement	(2.367)	(2.321)	0.046
Operational capital	(14.865)	(7.056)	7.809
Planned slippage	8.399	-	(8.399)
Total expenditure	(47.089)	(25.662)	21.427

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 Counter Fraud Authority (CFA) national strategy on countering fraud and to ensure the Trust is working with the LCFS in fully complying with NHS CFA 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 policy and legislative background, is also available on the Trust's intranet, along with contact details for the LCFS and the NHS CFA.

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, the dissemination of Counter Fraud newsletters and regular articles in the Trust's staff newsletter.

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 staff, contractors, suppliers or patients. 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
- Local Counter Fraud, Bribery and Corruption 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 or the NHS CFA Fraud and Corruption Reporting Line.

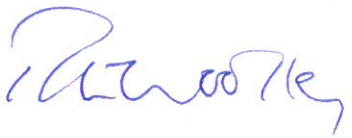
3.3.9 Overseas Visitors (patients who are not ordinarily resident in the UK)

The Trust is committed to fulfilling its obligations under the Overseas Visitors NHS Hospital Charging Regulations 2015, updated 2017.

The Overseas Visitors Team 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 for advising clinicians on their obligations to provide treatment or not under the regulations.

In 2018/19, approximately 8,500 patients were investigated by the team with approximately 10 per cent determined as being charge liable. We are one of the top 10 trusts for the reporting of EHIC cards and S2 certificates.

The Trust's Non NHS Patient Income Manager is Co-Chair of the National Overseas Visitors Advice Group.



Robert Woolley
Chief Executive
24 May 2019

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, and, 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 requests that Boards of all NHS organisations approve such a plan.

It is our duty to contribute towards the ambition set in the 2014 Sustainable Development Strategy, 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. The Trust seeks to align its target with the One City Plan to make the city of Bristol carbon neutral by 2030.

4.2 Policies

We have reviewed our Sustainable Development policy and continue to embed sustainability in our process and procedures.

Table 7: 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 reviewed progress with 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 articulated.

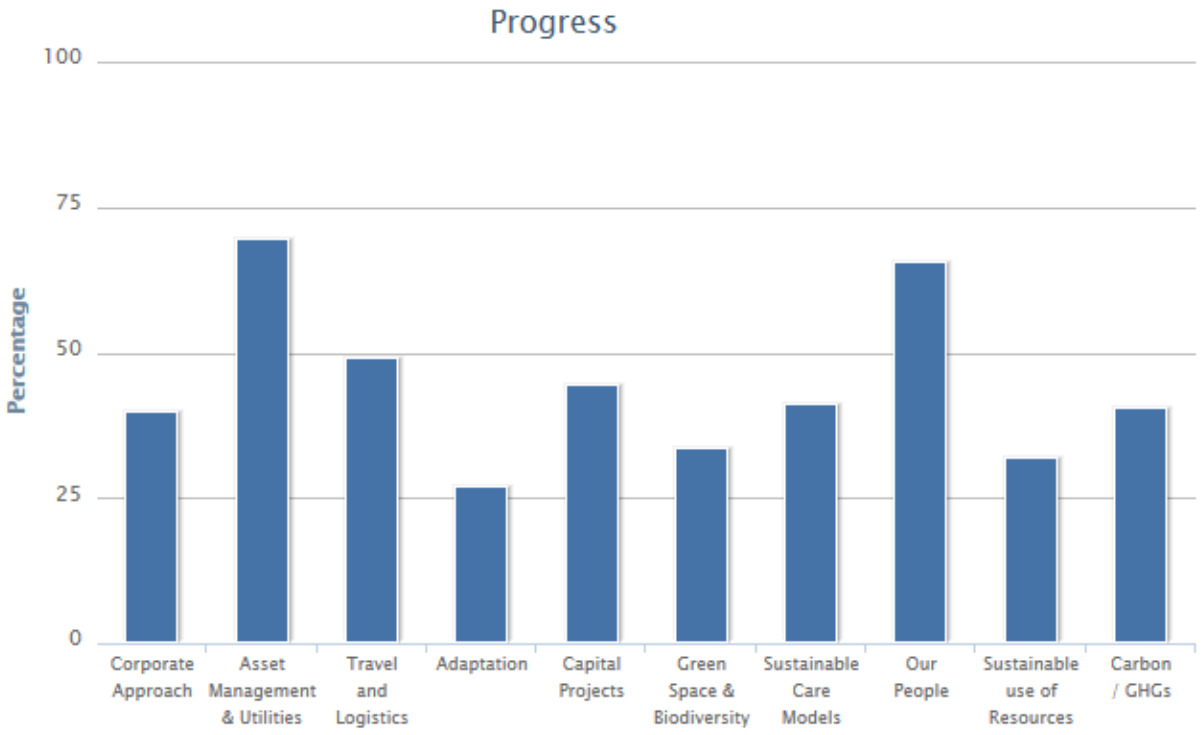
Collectively as an organisation we recognise the contribution that commissioning, procurement and commercial activities can have in delivering sustainability and social value, and our duty under the Public Services Value Act. We are working with Bristol and Weston Purchasing Consortium to develop a Sustainable Procurement Strategy to address the environmental and social impacts of procurement.

We measure our impact as an organisation on corporate social responsibility through the use of the Sustainable Development Assessment Tool. Our most recent application of the Sustainable Development Assessment Tool was in October 2018, scoring 44 per cent (see table 8), improving on our March 2018 score of 30 per cent. Plans to improve this further in 2019/200 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. The Trust Board also approved plans to address the potential need to adapt the delivery of 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 required. 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.

We are undertaking risk assessments and reviewing our sustainable development management plan to take account of UK Climate Projections 2018. This ensures the Trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Table 8: SDAT Assessment Score 44 per cent



The UN Sustainable Development Goals (SDGs) form a global action plan to end extreme poverty, inequality and climate change by 2030, and have been signed by every member of the UN, including the UK. The 17 goals have been agreed globally as a framework for sustainable development and the Department of Health has incorporated the UN SDGs into the single departmental plan and embedded them in relevant policy areas.

The UN SDGs give an international context against which to align the Trust's sustainable development plans. The SDAT assessment shows the Trust is starting to contribute to these Sustainable Development Goals at a local level:

We are improving green spaces across our estate to support patients, public and staff health, wellbeing and biodiversity. Green spaces help to offset our negative environmental impacts by improving local biodiversity, air quality and absorbing carbon dioxide.

We have worked in partnership with Incredible Edible, Avon Wildlife Trust and Bristol University students to improve green spaces including our woodland walkway, allotment, Bristol Heart Institute roof garden and the makeover of a garden at St Michael's Hospital.

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 explains how both the organisation and its performance on sustainability has changed over time.

Table 9: Performance on sustainability

	2015/16	2016/17	2017/18	2018/19
Floor Space (m2)	206,310	195,044	195,044	183,211
No. of Staff	8,249	8,496	8,677	8,934

We have supported the Climate Change Act targets as follows:

4.3.1 Energy

UH Bristol has spent £4,888,945 on energy in 2018/19, which is an 18 per cent increase on energy spend in 2017/18. We have reduced our carbon emissions from energy use year on year. We have significantly reduced our emissions in 2018/19 through changing to 100 per cent renewable electricity under our new supply contract.

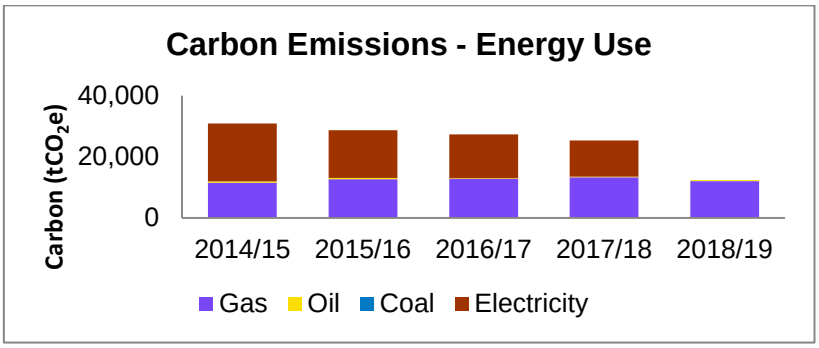


Table 10: Energy use and spend

Resource		2014/15	2015/16	2016/17	2017/18	2018/19
Gas	Use (kWh)	54,742,120	60,496,985	60,701,598	62,552,655	56,729,051
	tCO_2e	11,485	12,661	12,686	13,262	12,027
Oil	Use (kWh)	1,126,981	1,198,427	868,669	727,117	737,045
	tCO_2e	361	383	275	238	241
Coal	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Electricity	Use (kWh)	30,616,820	27,233,690	27,665,724	26,547,528	0
	tCO_2e	18,962	15,657	14,298	11,833	0
Green Electricity	Use (kWh)	43,766	52,520	55,804	42,964	26,223,729
	tCO_2e	27	30	29	19	0
Total Energy CO_2e (Carbon dioxide equivalent)		30,835	28,731	27,288	25,352	12,268
Total Energy Spend		£4,698,461	£4,289,488	£3,847,783	£4,148,595	£4,888,945

Our carbon emissions from energy consumption have reduced by 13,083 tonnes (52 per cent) in the past year. The majority of the reduction is due to our electricity being 100 per cent green from certified renewable sources. 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 – not only to our staff, but also to the patients and public who 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 11: Average travel levels

Category	Mode	2014/15	2015/16	2016/17	2017/18	2018/19
Patient and visitor travel	miles	28,017,099	28,992,086	30,005,436	30,856,225	32,023,650
	tCO_2e	10,294.30	10,484.57	10,844.28	10,994.84	11,410.82
Business travel and fleet	miles			762,008	136,688	144,000
	tCO_2e			275.40	48.71	51.31

Staff commute	miles	7,246,899	7,924,134	8,164,656	8,335,279	8,582,157
	tCO_2e	2,662.72	2,865.65	2,950.79	2,970.07	3058.04
Owned electric and PHEV mileage	miles				15,048	14,024
	tCO_2e				1.71	1.59

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). In addition, 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 and all the team are now using the e-bikes, putting fewer cars on the road for short local journeys, improving the health of the staff and being more efficient as journey times are the same or less than travelling by car.

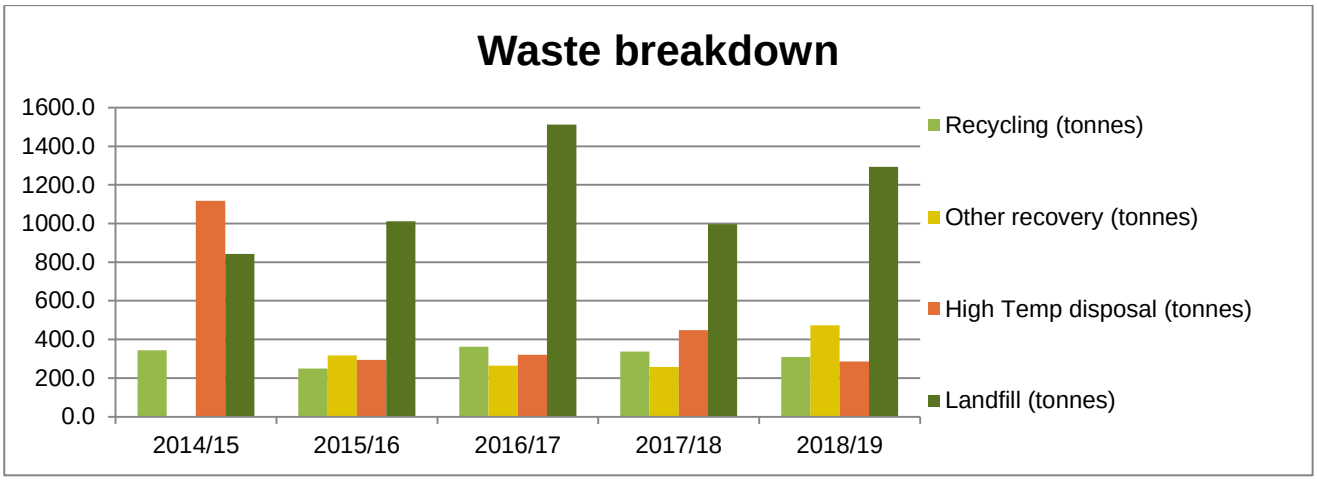
4.3.3 Waste

Overall, waste has increased due to higher levels of activity. We have conducted waste audits to support areas in improving their waste management and we continue to roll out Dry Mixed Recycling to further areas across the site. We have trialled the removal of general waste bins, which 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, the reduction in emissions from procuring and delivery of new goods and can provide social value when items are reused in the community. We are increasing re-use through supplying the Children's Scrapstore and partnering with local organisations (Collecteco).

Table 12: Waste management

Waste		**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Recycling	(tonnes)	344.45	249.00	363.00	336.68	309.64
	tCO_2e	7.23	4.98	7.62	7.33	6.74
Other recovery	(tonnes)	0.00	317.00	264.00	258.00	472.48
	tCO_2e	0.00	6.34	5.54	5.61	10.28
High Temp disposal	(tonnes)	1117.00	294.00	320.00	448.00	285.91
	tCO_2e	245.74	64.39	70.40	98.56	62.90
Landfill	(tonnes)	842.17	1012.00	1512.00	996.41	1292.66
	tCO_2e	205.84	247.35	468.72	343.25	445.31
Total Waste (tonnes)		2303.62	1872.00	2459.00	2039.09	2360.69
% Recycled or Re-used		15%	13%	15%	17%	13%
Total Waste tCO_2e		458.81	323.06	552.29	454.75	525.23



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 a number of IT programmes to enable paperless working, e.g. paperless patient observation charts. More than 2,000 staff are now using some of our new digital innovations such as electronic observations, our CareFlow Connect messaging app, Clinical Utilisation Review (CUR) and electronic prescribing.

Table 13: Use of paper

Paper		**2017/18**	**2018/19**
Volume used	Tonnes	126	118
Carbon emissions	tCO_2e	120	112

4.3.4 Water

Despite increased activity, we have reduced our consumption of water in 2018/19. We have repaired steam and condensate leaks in pipes across the precinct significantly reducing the demand for water at our boiler house.

Table 14: Consumption of water

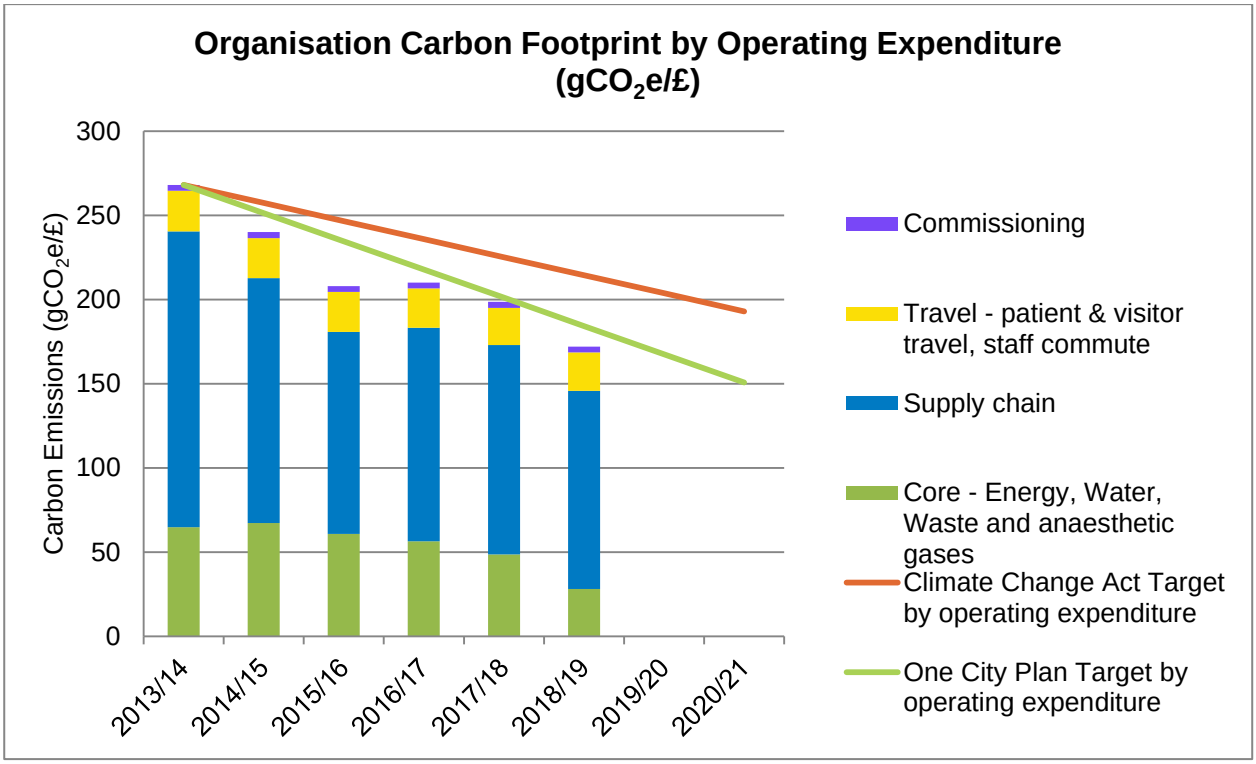
Water		**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Mains	m^3	233,323	234,553	250,457	233,033	223,504
	tCO_2e	213	214	228	227	218
Water & Sewage Spend		£375,289	£412,357	£485,126	£461,650	£426,917

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 106,165 tonnes of CO_2e for the Trust. Our carbon intensity is 170 grams of CO2e emissions per pound of operating expenditure (gCO2e/£) and is better than the average emissions for acute services nationally, which is 200 grams per pound of operating expenditure.

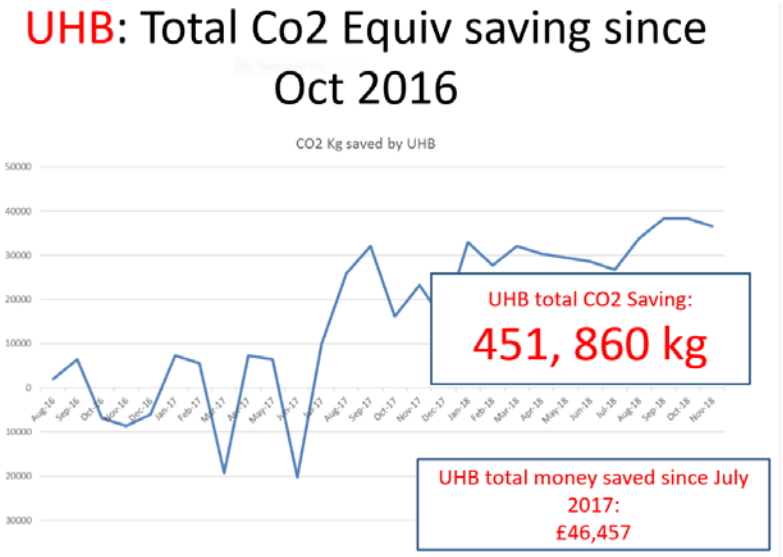
Carbon Footprint Category	% CO_2e
Core – Energy, Water, Waste & Anaesthetic gases	12%
Supply Chain	72%
Commissioning	2%
Travel – Patient, Visitor and Staff commute	14%



We are monitoring our Sustainable Development Action Plan to ensure we are contributing to Climate Change Act targets and look to align our targets with the One City Plan target of carbon neutrality by 2030.

4.4.1 Anaesthetics and the environment

The impact of anaesthetic gases on global warming has been recognised. The NHS and PHE Sustainable Development Unit estimates that total emissions for volatile anaesthetic gases (VAGs) equates to 2.5 per cent of the NHS carbon footprint for England. As most anaesthesia is used in an acute setting, this rises to 5 per cent of the carbon footprint of an acute trust, comparable with half the emissions from gas used for building energy use. Desflurane is a commonly used VAG; it is however significantly more harmful to the environment, with a global warming potential 20 times greater and tropospheric lifetime 14 times greater than other volatiles. The vaporisation of one bottle of Desflurane creates the same GWP100 effect as 886kg of carbon dioxide,18 times that of other VAGs. Desflurane also has a significantly higher financial cost than other VAGs. An anaesthetist from UH Bristol set about educating his colleagues about the environmental and financial implications of Desflurane and encouraging them to use other VAGs instead.



A total reduction of 451,860kg has been seen since July 2017. This is equivalent to the amount of CO2 emitted from an average passenger car driven for 1,104,792 miles and would take 7,472 trees 10 years to sequester this CO2e from the atmosphere.

In addition to the high environmental cost, Desflurane also has a high financial cost compared to other VAGs. Therefore, even with the increased use of other volatile anaesthetic gases due to the decrease in Desflurane use, a saving of £46,457 has been achieved. Rotating trainees mean similar results have been achieved in hospitals in Gloucester and North Bristol.

5. Accountability Report

5.1 Directors' 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 15: Board of Directors – terms of office

Board Member
Jeff Farrar, Chairman
Appointment 1 December 2017
End of first term 30 November 2020
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
John Moore, Non-executive Director
Appointment 1 January 2011
End of first term 31 December 2013
End of second term 31 December 2016
1 January 2017 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 31 March 2019
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 End of second term 31 March 2019
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
William Oldfield, Medical Director Appointed 1 August 2018
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 until 31 July 2018

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.

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 divisions and Trust Services corporate division 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 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 16: Performance against Prompt Payments Code:

	Year ended 31 March 2019	Year ended 31 March 2018
Total invoices paid within 60 days	154,956	164,464
Total invoices paid in the year	162,205	173,258
Percentage of invoices paid within 60 days	95.5%	94.9%

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 17: Performance against Better Payment Practice Code:

	Year ended 31 March 2019			Year ended 31 March 2018		
	NHS contracts	Other invoices	Total	NHS contracts	Other invoices	Total
No. invoices paid within 30 days	3,127	136,721	139,848	2,933	134,204	137,137
No. invoices paid	4,810	157,395	162,205	4,692	168,566	173,258
Proportion paid within 30 days - number	65.0%	86.9%	86.2%	62.5%	79.6%	79.2%
Value of invoices paid within 30 days	£52.47m	£169.48m	£221.95m	£54.18m	£168.60m	£222.78m
Value of invoices paid	£74.12m	£200.65m	£274.76m	£78.21m	£206.19m	£284.40m
Proportion paid within 30 days - value	70.8%	84.5%	80.8%	69.3%	81.8%	78.3%

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 Chair 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 Chair 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 Chair and Directors, and through the forums of governors' focus groups (dealing with matters of constitution and membership engagement; 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 usually 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 four Council meetings in the year, and also the Annual Members' Meeting, which in addition to being attended by governors and the Board of Directors, were also open to Foundation Trust 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. Updates from the Chair and Chief Executive are standing agenda items. These provide 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.

An internal audit report on governor roles and responsibilities, completed in April

2018, resulted in a significant assurance rating.

At the Council meeting in April 2018 governors approved the appointment of the lead governor as a joint role between Malcolm Watson and Mo Phillips.

In October 2018 the Council approved changes to the Trust Constitution. These changes, which had been proposed and discussed through the governor's Constitution Focus Group and the Council of Governors over the course of 12 months, included the merger of the public and patient membership constituencies. This was effected by removing the patient and carer constituency classes and re-categorising these members as 'public members'.

This merger provided an opportunity to a review of the overall number of governors for the first time in a number of years. Governors developed a proposal to keep the number of staff governor seats as six, but to revise the number of appointed governor seats from eight to six (removing the Avon & Wiltshire Mental Health Partnership seat and the South West Ambulance Service seat – as these organisations are represented through the Sustainability and Transformation Partnership).

Governors reviewed various options for public governor numbers, taking into account the geographical spread of patient admissions and first outpatient GP referrals in 2017/18; the geographical location of all Foundation Trust members and ratios of members to governors. The decision was taken to revise the total number of public governor seats to 17: nine for Bristol, three for North Somerset, three for South Gloucestershire and two for Rest of England & Wales. (There had previously been 11 public governors and 10 patient governors).

These changes resulted in a reduction in the overall size of the Council of Governors from 35 to 29. All changes were drafted into the Constitution and approved by the Council of Governors in October 2018, and ratified by the Board of Directors in November 2018. Members were informed of the changes through January and February 2019, either via email or post. The changes were to be implemented to coincide with the 2019 governor elections, with all patient governor seats to be removed on 31 May 2019 and governors in these seats given the option to stand for re-election as public governors.

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 18: Membership and attendance at Council of Governors meetings 2018/19

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 absence and other reasons for non-attendance are not recorded in the Annual Report.

Number of Council of Governors meetings in the period 1 April 2018-31 March 2019	**4**
Chair: Jeff Farrar	**C4(4)**
Governors: Public – South Gloucestershire	
Pauline Beddoes	1(4)
Malcolm Watson	2(4)
Public – North Somerset	
Penny Parsons	1(4)
John Rose	4(4)
Public Bristol	
Carole Dacombe	3(4)
Tom Frewin	2(4)
Jenny James	1(3)
Mo Phillips	3(4)
Mary Whittington	3(4)
Public (Rest of England and Wales)	
Jonathan Seymour-Williams	2(4)
Local Patient Governors	
Kathy Baxter	1(4)
Rashid Joomun	3(4)
Ray Phipps	3(4)
John Sibley	3(4)
Tony Tanner	3(4)

Carers of patients 16 years and over	
Sue Milestone	0(4)
Garry Williams	3(4)
Carers of patients under 16 years	
John Chablo	2(4)
Graham Papworth	4(4)
Staff Non-clinical	
Barry Lane	2(3)
Neil Morris	0(1)
Jane Westhead	1(2)
Staff Other Clinical Healthcare Professional	
Andy Coles-Driver	3(4)
Staff Medical and Dental	
Jane Sansom	2(3)
Staff Nursing and Midwifery	
Florene Jordan	3(4)
Jo Roberts	0(2)
Appointed Governors	
Sujan Canagarajah	1(1)
Siobhan Coles	0(4)
Aishah Farooq	0(3)
Sophie Jenkins	3(4)
Carole Johnson	0(4)
Astrid Linthorst	3(4)
Marty McAuley	0(4)
Sally Moyle	1(4)
Non-executive Directors	
Emma Woollett	0(0)
Jill Youds	1(0)
David Armstrong	3(0)
Madhu Bhabuta	2(0)
Julian Dennis	3(0)
John Moore	1(0)
Anthony (Guy) Orpen	1(0)
Alison Ryan	2(0)
Martin Sykes	3(0)
Steven West	0(0)
Executive Directors	
Robert Woolley	3(0)
Mark Smith	4(0)
Mark Callaway	0(0)
Paula Clarke	4(0)
Matthew Joint	3(0)
Paul Mapson	3(0)
Carolyn Mills	4(0)
William Oldfield	2(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 Chair and Non-executive Directors. There are 12 governor members.

The Committee met on four occasions. During the year, the Committee supported the re-appointment of Non-executive Director Guy Orpen for a third and final three-year term of office, subject to annual review and annual re-appointment in line with the Foundation Trust Code of Governance. The Committee also reviewed the process for non-executive director recruitment, with the view to recruiting new Non-executive Directors in spring 2019.

The Committee's work also included reviewing activity records and annual performance appraisals for each of the Non-executive Directors. The Committee conducted a self-review and review of its terms of reference in June 2018.

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 Non-executive Director-governor engagement sessions held eight times a year. These interactions allow for open discussion and relationship building at regular intervals.

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. 2018 was not an election year, though a by-election was held to fill a vacancy in the Medical and Dental staff seat in April/May 2018.

In the year, one public governor resigned from her role, and three staff governors left the Trust. One public governor, representing the constituency Rest of England and Wales sadly passed away. Details of all changes are reflected in the table below.

Planning was undertaken in the latter half of the year to support governor elections scheduled for 2019, in which four staff governor seats and 13 public governor seats were to be available. The outcome of the elections will be declared on 28 May 2019 with new appointments starting from 1 June 2019.

The Membership Team worked with the Trust's Youth Involvement Group to support the appointment of two young governors, Siobhan Coles (reappointed) and Aishah Farooq. They began a one year term of office on 1 September 2018.

Table 19: Governors by constituency – 1 April 2018 to 31 March 2019

As at 31 March 2019, there were 29 governors in post and five vacancies, with 35 seats in total (11 public, 10 patient, six staff and eight appointed). A decision was taken in the year to reduce the Council of Governors to 29 seats in total from 1 June 2019 (17 public, six staff and six appointed), and terms of office below have been adjusted accordingly.

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 2019	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	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 January 2019	Elected
Public Bristol	Mary Whittington	June 2017 to May 2020	Elected
Public – Rest of England and Wales	Hussein Amiri	June 2016 to July 2018	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	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	Tony Tanner	June 2017 to May 2019 June 2013 to May 2016	Elected
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	John Sibley	June 2017 to May 2019	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 2019	Elected
Carers of patients under 16 years	Graham Papworth	June 2017 to May 2019	Elected
Staff Governors			
Nursing and Midwifery	Florene Jordan	June 2010 to May 2019	Elected
Nursing and Midwifery	Jo Roberts	June 2017 to July 2018	Elected
Non-clinical Staff	Jane Westhead	June 2017 to November 2018	Elected
Non-clinical Staff	Neil Morris	June 2017 to June 2018	Elected
Non-clinical Staff	Barry Lane	July 2018 to May 2020	Elected
Other Clinical Healthcare Professional	Andy Coles-Driver	June 2016 to May 2019	Elected
Medical and Dental	Jane Sansom	June 2018 to May 2020	Elected
Appointed Governors			
University of Bristol	Astrid Linthorst	June 2017 to May 2020	Appointed
University of the West of England	Sally Moyle	June 2017 to May 2020	Appointed
Bristol City Council	Carole Johnson	September 2016 to May 2020	Appointed
South Western Ambulance Service NHS FT	Marty McAuley	June 2017 to May 2019	Appointed
Joint Union Committee	Sophie Jenkins	June 2017 to May 2020	Appointed
Youth Involvement Group	Sujan Canagarajah	October 2017 to August 2018	Appointed
Youth Involvement Group	Siobhan Coles	October 2017 to August 2019	Appointed
Youth Involvement Group	Aishah Farooq	September 2018 to August 2019	Appointed
Avon and Wiltshire Mental Health Trust	*Vacancy – post to be removed 31/5/19*		*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 (see analysis of current membership below). Following changes to its Constitution in 2019, the Trust now has two membership constituencies as follows:

- A public constituency comprising Bristol; North Somerset; South Gloucestershire; and Rest of England and Wales
- 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 and are seven years of age and above. 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 continued to be actively reduced in 2018/19 as a result of a proactive approach through the year in seeking updated contact information from members for whom the membership office only holds a postal address. At 31 March 2019 the merged public and patient membership totalled 8,066 (see breakdown below) and staff membership 10,658.

Table 20: Members of the Foundation Trust

Public constituency	**2018/19**	**2018/19 combined public/patient numbers (for comparison going forward as constituencies merge in 2019)**
At year start (April 1 2018)	5,315	8,947
New members	88	98
Members leaving	578	979
At year end (March 31 2019)	4,825	8,066
Patient constituency	**2018/19**	
At year start (April 1 2018)	3,632	
New members	10	
Members leaving	401	
At year end (March 31 2019)	3,241	
Staff constituency	**2018/19**	
At year start (April 1 2018)	10,365	
At year end (March 31 2019)	10,658	

5.1.14 Membership strategy

The main focus through 2017/2018 was a thorough review of our membership structure, which resulted in the decision by governors and the Board in autumn 2018 to remove the split between public and patient members and revise governor numbers. Governors agreed a framework for governor-member interaction around the themes of 'recruit', 'inform', 'engage' and pledged their support to a defined and measurable set of activities. These activities include:

- regular health information talks for members (10 a year), with governors taking an active role in introducing the events as well as attending to hear from and talk to members
- a monthly e-newsletter to members, which includes an update from one of the governors on their role and recent activities alongside a summary of UH Bristol and local health news, upcoming events etc.

Governors also have contact with members through the public edition of the Trust's Voices magazine (issued twice a year to members) – and members are invited to offer feedback on the magazine or our hospital services in general, which is shared with governors. In the year members and governors were invited to share their views on perceptions of the Trust as an accessible organisation as part of the development of the Trust's Diversity and Inclusion Strategy and choice of organisational quality priorities for 2019/20.

Members and governors also had the opportunity to input into refreshing the overarching Trust Strategy through focus groups and a public event.

Work continues to review the direction for membership in terms of the large proportion of Trust members who are not actively engaged with a view to finalising a membership strategy in the second half of 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 21: Analysis of current membership (merged public and patient constituencies)

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	228*	190,785
17-21	399	63,991
22+	7,242	706,734
Ethnicity:		
White	6,911	806,242
Mixed	106	21,138
Asian or Asian British	272	32,531
Black or Black British	202	28,584
Other	6	5,072
Socio-economic groupings:		
AB	2,281	72,696
C1	2,374	91,716
C2	1,611	56,721
DE	1,778	63,324
Gender analysis		
Male	3,388	477,187
Female	4,449	482,736

This analysis excludes public members with no date of birth (197), public members with no stated ethnicity (569) and no stated gender (229), and public members outside Bristol, North Somerset and South Gloucestershire. *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 focused 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

During 2018 we completed our 'Sign up to Safety' three year improvement programme, achieving some tangible improvements in the programme work streams including achieving a 50 per cent reduction in our adverse event rate, a reduction in the number of term infants admitted to Neonatal Intensive Care and, working with our partners of the West of England AHSN, a system-wide reduction in mortality due to suspicion of sepsis.

The Trust's Quality Improvement Academy has enabled us to increase the capacity and capability of frontline staff to take forward the patient safety improvements locally and within our programme work streams.

In October 2018 a detailed evaluation report of our 2018-2015 programme was presented to the Trust Board along with the results of an analysis from a number of sources of feedback to inform our patient safety improvement priorities for 2019-2021.

We will continue our focus on recognition and management of deteriorating patients (including sepsis), reduction of invasive procedure never events, leadership and culture for keeping people safer, improving medicines safety and the objectives of our Maternity and Neonatal Health Safety Collaborative programme. The Trust's digital exemplar programme will support some elements of the programme by making systems for care delivery safer e.g. deteriorating patients and medicines safety, and also provide opportunities to take forward further improvement work. We also have a new innovative work stream to try and better understand how interruptions and distractions contribute to human error in our hospitals and to consider new ways to reduce their frequency and impact.

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 to support any major changes in services for our patients.

As part of our focus to improve the quality of the care we offer we continue to work in partnership with local Healthwatch organisations. This includes offering additional external scrutiny to our Patient Experience assurance process through the Trust's Patient Experience Group and by responding to feedback from patients and community groups about our services. Such processes enable us to reflect the needs of the diverse population we serve.

We also support and participate in engagement exercises that are led by Healthier Together, our local Sustainability and Transformation Partnership, on matters which affect our wider health and care system.

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

5.2.3 Research and Innovation

Research is one of the key pillars of the trust's business, and provides us with the opportunity to deliver cutting edge services to our patients and contribute to generating evidence to improve the care the NHS will provide in the future. Our mission remains to provide exceptional healthcare, research and teaching every day. During 2018/19, more than 8,000 of our patients and staff gave their time to take part in the research that we lead and host at UH Bristol.

As we see our hospitals' services adapt to respond to NHS changes, we reflect on previous years and plan for the future – in particular considering the collaborative work we have done over the last year under the umbrellas of our two large National Institute for Health Research (NIHR) infrastructures – the Bristol Biomedical Research Centre and the Collaboration for Leadership in Applied Health Research and Care West. These partnerships of clinicians, academics and research professionals enable regional and national co-operation, helping us to translate early research into health improvements, and to conduct applied health research and implement research evidence.

Our NIHR grant income continues to increase year on year: this comprises the NIHR BRC, NIHR CLAHRC West, 15 NIHR project or programme grants and two NIHR Fellowships.

New grants starting in 2018 include:

- Lyvonne Tume: A Feasibility Study of No Routine Gastric Residual Volume measurement in mechanically ventilated Infants and Children: the GASTRIC Study
- Emma Dures: The development of a one-to-one fatigue self-management intervention delivered by nurses in the rheumatology team to patients with inflammatory arthritis
- Pauline Humphrey, a prestigious NIHR Doctoral Fellowship: Development of an intervention to reduce distress during and after brachytherapy for locally advanced cervical cancer
- Maria Pufulete: Effectiveness and cost-effectiveness of INSPIRatory musclE training (IMT) for reducing postoperative pulmonary complications (PPC): a sham-controlled randomised controlled trial (RCT) (INSPIRE).

We have worked with researchers to submit 11 grant applications for NIHR funding, and whilst not all will be successful, this is a measure of the Trust's engagement with research.

Two particular highlights are:

- Professor Sarah Hewlett's RAFT clinical trial ended in 2018. RAFT, 'Reducing Arthritis Fatigue – clinical Teams using cognitive-behavioural approaches', aimed to determine whether a group course delivered by rheumatology teams using cognitive-behavioural approaches could reduce the impact of fatigue in patients with rheumatoid arthritis (RA); this is a lifelong inflammatory condition affecting most joints, with fluctuating pain and swelling leading to joint damage and disability. Medication aims to control the pain, but 70 per cent of patients are fatigued on most days – fatigue is much worse than normal tiredness, and as bad as their RA pain, but few studies have addressed this, it is rarely asked about in clinic, and support is not routinely offered – patients generally pick up a leaflet.

  The cognitive-behavioural course was delivered by the usual rheumatology clinical team, and recently published conclusions from the study are that multiple measures of fatigue in patients with rheumatoid arthritis can be improved for the two years by the CBT intervention. Next steps will be to

implement the practice and train clinicians across the UK.

RAFT "Reducing Arthritis Fatigue - clinical Teams using cognitive-behavioural approaches (RAFT)" is a £1.3m grant funded by the National Institute for Health Research, and collaboration between UH Bristol, University of the West of England and University of Bristol.

- Dr Karen Luyt was awarded a Health Foundation Scaling up Improvement award of £457,000 for PReCePT2: Reducing brain injury through improving uptake of magnesium sulphate in preterm deliveries, which started in 2018.

  Preterm birth is the leading cause of brain injury and Cerebral Palsy (CP) with lifelong impact on children and families. Dr Luyt had shown in a previous clinical trial that magnesium sulphate given to mothers during preterm birth is an effective treatment for protecting the babies' brain, and showing that CP can be reduced in a third of cases. However, two-thirds of UK babies were not receiving this effective and low cost treatment (approx. £1 per dose). A quality improvement package, PReCePT1, was co-designed with patients and staff and implemented across five maternity units in West-England, increasing average uptake of magnesium sulphate from 21 per cent to 85 per cent. The Scaling up Improvement award PReCePT2 will scale this work to 10 maternity units across the UK and evaluate the effectiveness of a supported versus a self-engaged implementation in a prospective comparison. The objective is optimal uptake of MgSO4 in preterm deliveries; and ultimately a reduction in brain injury. The study is a flagship collaboration with NIHR CLAHRC West and the NIHR West of England Academic Health Science Network in order to maximise and evaluation adoption across the UK.

We have continued to develop our relationships with the NIHR Local Clinical Research Network (LCRN) core team, as well as the partner organisations. With new leadership in the LCRN there has been renewed focus on performance in delivering portfolio research, including increasing the number of participants recruited to research. This financial year, by early March, we had recruited well over 8,000 participants, a 25 per cent increase over last year. This has been achieved through a huge effort by our research teams across the trust. In particular we saw very high recruitment in paediatric immunology, in cardiac surgery, in dementia research and as part of the 100,000 genomes study. Research improves the care we provide and our aim is for research to be consistently embedded across all our clinical divisions.

We continue to work closely with industry partners and strive to increase our contract commercial activity, as this brings novel treatments to our patients and generates income that we can use flexibly to support non-commercial research. We approved more than 50 new contract commercial studies, increasing our activity by a fifth over last year's figures. Our research teams successfully recruited the first UK patient to 10 different contract commercial studies this year, with one of those being the first in Europe, a significant achievement in an environment where we are measured on our set-up times and time to recruit participants. We also completed recruitment to our first commercial trial in adult immunology, surpassing our target of 50 and recruiting 65 participants into the CONSTANT Hepatitis B vaccine trial, which our Medical Research Team is still carrying out.

Some of our flexible income generated last year through delivery of contract commercial research was used to fund maternity and sick leave cover in our research teams, and we were also able to pump prime posts in areas identified for growth. One example is funding staff time within the Sexual Health Team which has allowed us to deliver three NIHR-adopted studies: PREP Impact, CHOP and Safe Text; for all of these we successfully exceeded our initial recruitment targets. We hope to continue to support specialties where we have potential to increase our research activity, such as Sexual Health, through

collaboration and business planning with the LCRN.

As we move into 2019/20 we look forward to new challenges and opportunities, and start to plan for renewals of our large NIHR infrastructures and to develop new research ideas with our clinical and academic partners that will bring advances to the NHS locally and nationally.

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 2018 to 31 March 2019.

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. The Committee was chaired by the Trust Chairman and was 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, the skills and knowledge mix of the Board of Directors, current remuneration levels and appointments for the Medical Director and Director of Finance and Information. The Committee reviewed and approved the Trust's Fit and Proper Persons Policy, and received updates on compliance with the 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 considered the succession planning for the Director of Finance and Information and oversaw the process to appoint into the role.

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 very senior managers' (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 five 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 2018/19 and 2017/18. 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 22: Remuneration for the senior managers of the Trust 2018/19

Directors remuneration for 2018/19 (£'000)	Salary	Pension Related Benefits	Total
	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Chair:			
Jeffrey Farrar	50-55	n/a	50-55
Executive Directors:			
Robert Woolley, Chief Executive	240-245	125-127.5	370-375
Mark Smith, Chief Operating Officer	155-160	15-17.5	175-180
Paula Clarke, Director of Strategy and Transformation	135-140	42.5-45	180-185
Paul Mapson, Director of Finance and Information	155-160	n/a	155-160
Carolyn Mills, Chief Nurse	140-145	60-62.5	200-205
Matthew Joint, Director of People	150-155	32.5-35	180-185
William Oldfield, Medical Director from 1 Aug 2018	140-145	0	140-145
Mark Callaway, Medical Director until 31 July 2018 (notes 1)	65-70	0	65-70
Non Executive Directors			
David Armstrong	15-20	n/a	15-20
Julian Dennis	15-20	n/a	15-20
John Moore	10-15	n/a	10-15
Guy Orpen	10-15	n/a	10-15
Alison Ryan from 3 September 2018	5-10	n/a	5-10
Jill Youds	15-20	n/a	15-20
Steven West	10-15	n/a	10-15
Martin Sykes	15-20	n/a	15-20
Madhu Bhabuta	5-10	n/a	5-10
Emma Woollett until 31 May 2018	0-5	n/a	0-5

***Note 1* - £30-35k of Mark Callaway's salary from 1 April 2018 to 31 July 2018 related to a clinical role.**

Table 23: 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	30-35	n/a	30-35
Jeffrey Farrar, from 1 December 2017	15-20	n/a	15-20
Executive Directors:			
Robert Woolley, Chief Executive	190-195	0	190-195
Mark Smith, Chief Operating Officer	155-160	30-32.5	185-190
Paula Clarke, Director of Strategy and Transformation	130-135	27.5-30	160-165
Paul Mapson, Director of Finance and Information	145-150	0	145-150
Carolyn Mills, Chief Nurse	135-140	37.5-40	175-180
Alex Nestor , Acting Director of Workforce until 31 October 2017	60-65	5-7.5	70-75
Matthew Joint, Director of People from 1 November 2017	60-65	0-2.5	60-65
Sean O'Kelly, Medical Director until 19 September 2017	90-95	0	90-95
Mark Callaway, Medical Director from 20 September 2017 (note 1)	100-105	25-27.5	130-135
Non Executive Directors			
David Armstrong	10-15	n/a	10-15
Julian Dennis	15-20	n/a	15-20
Lisa Gardner until 30 November 2017	10-15	n/a	10-15
John Moore	15-20	n/a	15-20
Guy Orpen	10-15	n/a	10-15
Alison Ryan until 31 July 2017	5-10	n/a	5-10
Emma Woollett	15-20	n/a	15-20
Jill Youds	10-15	n/a	10-15
Steven West from 3 July 2017	5-10	n/a	5-10
Martin Sykes from 4 September 2017	5-10	n/a	5-10
Madhu Bhabuta from 3 July 2017	5-10	n/a	5-10

***Note 1* - £50-55k of Mark Callaway's salary from 20 September 2017 to 31 March 2018 related to a clinical role.**

There were no payments made for loss of office in either 2018/19 or 2017/18.

There were no payments to past senior managers in either 2018/19 or 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.

The following tables show the pension benefits for the senior managers of the Trust for 2018/19 and 2017/18. 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 24: Pension benefits for the year ended 31 March 2019

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 2019	Lump sum at age 60 related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Real Increase in Cash Equivalent Transfer Value
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000
Robert Woolley	7.5-10	22.5-25	70-75	215-220	1,767	1,420	267
Mark Smith	0-2.5	5-7.5	35-40	115-120	897	761	95
Paula Clarke	2.5-5	2.5-5	50-55	120-125	1,000	832	128
Paul Mapson *(Note 1)*	-	-	-	-	-	-	-
Carolyn Mills	2.5-5	10-12.5	55-60	165-170	1,194	981	169
Matthew Joint	2.5-5	-	0-5	-	56	16	18
William Oldfield	0-2.5	-	50-55	75-80	873	752	91
Mark Callaway	0-2.5	-	65-70	165-170	1,335	1,156	139

***Note 1* – No pension benefits as no longer a member of an NHS Pension scheme.**

This table includes details for the directors who held office at any time in 2018/19.

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 and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Table 25:Pension benefits for the year ending 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
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000
Robert Woolley	-	-	60-65	185-190	1,420	1,377	-
Mark Smith	0-2.5	2.5-7.5	35-40	105-110	761	677	45
Paula Clarke	0-2.5	-	0-5	-	55	26	9
Paul Mapson	-	-	-	-	-	-	-
Carolyn Mills	2.5-5	7.5-10	50-55	150-155	981	859	82
Matthew Joint	0-2.5	-	0-5	-	16	-	5
Alex Nestor	0-2.5	-	30-35	75-80	523	481	17
Sean O'Kelly	0-2.5	0-2.5	65-70	200-205	1,500	1,424	30
Mark Callaway	2.5-5	2.5-5	60-65	160-165	1,156	1,031	73

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.

Table 26: 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 banded remuneration of the Trust's highest paid director in 2018/19 was £210k - £215k (2017/18, £195k - £200k). This was 6.8 times (2017/18, 6.6 times) the median remuneration of the workforce, which was £31,447 (2017/18, £29,839). In 2018/19, no (2017/18, nil) employees received total remuneration in excess of the highest paid director. Remuneration ranged from £17,460 to £210,827, (2017/18, £15,408 to £198,454).

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.

The change in the banded remuneration of the highest paid Director reflects a substantive appointment in year. The change in the lowest remuneration from £15,408 to £17,460 reflects the increase in national pay scales.

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 2018 the Committee reviewed the current remuneration of Non-Executive Directors and recommended no changes to their current remuneration.

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 27: Expenses paid to Governors and Directors

Year	Directors			Governors		
	No. in office	No. reimbursed	Amount (£)	No. in office	No. reimbursed	Amount (£)
2018/19	18	13	28,114	35	10	2,892
2017/18	22	14	33,744	51	16	3,293

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 2019

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 Accounting Consolidated Schedules (TACs) 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 28: Analysis of staff costs

	2018/19			2017/18		
	Total £'000	Permanent £'000	Other £'000	Total £'000	Permanent £'000	Other £'000
Salaries and wages	332,064	305,927	26,137	313,385	288,778	24,607
Social security costs	30,019	28,760	1,259	28,595	27,501	1,094
Pension costs	39,237	37,981	1,256	36,851	35,809	1,042
Apprenticeship levy	1,588	1,588	-	1,505	1,505	-
Termination benefits	182	182	-	80	80	-
Agency/contract staff	9,075	-	9,075	8,863	-	8,863
Total Gross Staff Costs	412,165	374,438	37,727	389,279	353,673	35,606
Income in respect of salary recharges netted off expenditure	(2,932)	(2,932)	-	(2,730)	(2,730)	-
Employee expenses capitalised	(681)	(562)	(119)	(1,580)	(871)	(709)
Net employee expenses	408,552	370,944	37,608	384,969	350,072	34,897

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 2018/19 and 2017/18 is shown in the table below. The information uses the categories required by the Trust Accounting Consolidated Schedules (TACs) 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 29: Average staff numbers (whole time equivalents)

Staff category	2018/19			2017/8		
	Total	Permanent	Other	Total	Permanent	Other
Medical and dental	1,235	1,153	82	1,185	1,107	78
Administration and estates	1,842	1,737	105	1,842	1,659	183
Healthcare assistant and other support	812	755	57	831	767	64
Nursing, midwifery & health visitors	3,401	3,027	374	3,366	2,992	374
Scientific, therapeutic and technical	1,243	1,202	41	1,221	1,185	36
Healthcare science staff	156	156	0	146	145	1
Total staff	8,689	8,030	659	8,591	7,855	736

5.4.3 Education, Learning and Development

Education remains one of our strategic enablers aimed at providing high quality learning for all staff groups that supports the delivery of exceptional patient care. Our education incudes both the provision of internal development and external procurement that collectively aims to create a highly skilled, adaptable and competent workforce.

As one of the UK's leading teaching hospital Trusts we have formed close relationships with local, national and global academic institutes. As a result, the Trust hosts a large number of trainees both at under graduate and postgraduate levels (for example, medical, dental, nursing, midwifery, allied health professions and health care scientists). Clinical education is supported through a number of post graduate opportunities such as a locally run preceptorship programme, multi-disciplinary simulation, workshops, ELearning, seminars and conferences. These are all aimed at enhancing the skills and competency of our staff whilst upholding patient safety and quality improvement. Working with our local academic institutes of the University of Bristol and the University of the West of England, we support continuous professional development that is aligned to our clinical service needs and workforce transformation priorities. The Trust continues to build on excellent relationships with Health Education England inclusive of the Severn Deanery.

In addition, we also support a wide number of non-clinical training initiatives such as customer care. Consequently, the Trust has been successful in developing both clinical and non-clinical careers and this is an area that will continue to be enhanced over the forthcoming year.

All new staff who join the Trust participate in a welcoming, informative induction programme and a learning plan of essential and essential-to-role specific training. The essential training and induction programme is based on the core skills framework and is now increasingly aligned to a South West England passporting system. The passporting system will improve efficiency of training across the South West especially for those staff groups that work across a number of organisations such as junior doctors.

The Trust continues to work toward offering a high quality apprenticeship offer for clinical and non-clinical staff through a model of internal provision and external procurement. The apprenticeship strategy is being actively supported through the collaborative working with Healthier Together that has successfully secured a number of collaborative apprenticeships focused on specific workforce development priorities. Consequently, to date Advanced Clinical Practice and Nursing Associates have been successfully awarded as a collaborative employer led model with the University of

the West of England. It is anticipated that the apprenticeship programmes will offer new models of training whilst also boosting recruitment and retention of our health care staff.

A new role of Associate Director of Education has been recently appointed to the Trust and the role will be focused on leading a future focused strategy of education as part of the Trust's refreshed vision and strategy. The Associate Director of Education, since starting in post in November 2018, has undertaken a number of staff engagement methods such as an education survey, focus groups and one to one interviews. The staff engagement has provided valuable information about what staff value and where further improvement can be made. The results of the engagement exercises have directly informed the proposed Education strategy and its key priorities.

5.4.4 Equality and Diversity

The Trust recognises that the experiences and needs of every individual are unique and strives to respect and value the diversity of its patients, service users and staff. We are committed to creating a culture in which equality, diversity and human rights are promoted actively and unlawful discrimination is not tolerated.

Everybody has a right to be treated with dignity and respect, and the Trust recognises its legal duties under the Human Rights Act 1998 and the Equality Act 2010, and is committed to undertaking action under the Public Sector Equality Duty as defined within the Act.

Our 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. Delegated responsibility for the delivery of the programme of work sits with Organisational Development.

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. Progress against objectives is monitored through the Trust's People Committee.

A range of equalities information is published by the Trust on its public website, including an annual Equality and Diversity Report, demographic information in relation to its workforce and service users, and measures to improve equality. Included in these measures are the Workforce Race Equality Standard (WRES) and the NHS Equality Delivery System (EDS2). Both the WRES and EDS2 are included in the Standard NHS Contract, which also requires NHS Trusts and Foundation Trusts to publish Workforce Disability Equality Standard information for the first time in August 2019.

Our vision is to demonstrate our commitment to inclusion in everything we do. To this end we are building on work already undertaken in respect of the WRES, the EDS2 and our current strategic objectives to develop an overarching strategy by the end of April 2019. The Strategy is being developed in partnership with the National WRES team and over 70 stakeholders who attended a Diversity & Inclusion workshop to commence this work in an inclusive way.

5.4.5 The NHS Equality Delivery System (EDS2)

The EDS2 is a toolkit which helps organisations identify best practice and potential areas for improvement in relation to the experience of staff and service users from protected groups.

The Trust has completed the work required for the self-assessment of the two goals which relate to the workforce, and

carried out a review of the service-based goals. The Trust's Patient Inclusion and Diversity Group is supporting systematic and robust evidence gathering leading to grading.

Alongside this, a panel of independent equality advisors from Healthwatch Bristol will be invited to comment on and validate the Trust's EDS2 evidence.

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 in an organisation, including the average difference in bonus payments. 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

The Trust's Equality, Diversity & Human Rights training has been developed in accordance with the UK Core Skill Framework. It is one of our Essential training requirements, undertaken as part of Corporate Induction and updated every three years for all staff at all levels. It is available online and face-to-face (on request).

Compliance is monitored through monthly divisional performance reviews as part of the overall governance for Essential Training across the organisation. Trustwide compliance has been at over 90 per cent since May 2018.

5.4.8 Equality and diversity in the workplace

The Trust recognises that everyone is different and has something unique to offer. The Trust respects these differences and works to support and harness the individual talents of its workforce.

The Trust's Equality & Diversity Group is key to delivery of our ambitions to improve staff experience. Its membership includes representation from each of the Trust's Staff Forums:

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

The forums meet regularly to provide peer support and discuss issues relating to Trust policy and procedure. Their programmes of work are integral to the delivery of our existing objectives and development of our future strategy in relation to diversity and inclusion.

The experiences of staff from different demographic groups are indicated by the responses to the National Staff Survey. Some of these responses form a part of the Workforce Race Equality Standard and, from 2019, will contribute to the Workforce Disability Equality Standard.

The Trust's HR Policies further underpin our commitment to Equality, Diversity & Inclusion, including:

- Recruitment: reflects the requirement to advance equality of opportunity, and includes a commitment to interview all applicants with a disability who meet the minimum criteria for a job vacancy.
- Supporting Attendance: 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 is also an accredited 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

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 2019. 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 30: Staff with permanent contract	**March 2019**	
Gender – All staff with a permanent employment contract	**Total**	**%**
Male	2,194	22.86%
Female	7,402	77.14%
TOTAL	9,596	100.00%

Table 31: Directors by gender	**March 2019**	
Gender – Directors (Executive and non-Executive)	**Total**	**%**
Male	12	80.00%
Female	3	20.00%
TOTAL	15	100.00%

Table 32: Senior Managers by gender	**March 2019**	
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 33: Ethnicity (staff with a permanent contract)

	March 2019	
Ethnicity	**Total**	**%**
A - White - British	6,981	72.75%
B - White - Irish	123	1.28%
C - White - Any other White background	860	8.96%
D - Mixed - White & Black Caribbean	41	0.43%
E - Mixed - White & Black African	21	0.22%
F - Mixed - White & Asian	45	0.47%

	March 2019	
Ethnicity	**Total**	**%**
G - Mixed - Any other mixed background	72	0.75%
H - Asian or Asian British - Indian	339	3.53%
J - Asian or Asian British - Pakistani	38	0.40%
K - Asian or Asian British - Bangladeshi	7	0.07%
L - Asian or Asian British - Any other Asian background	129	1.34%
M - Black or Black British - Caribbean	160	1.67%
N - Black or Black British - African	225	2.34%
P - Black or Black British - Any other Black background	74	0.77%
R - Chinese	48	0.50%
S - Any Other Ethnic Group	195	2.03%
Z - Not Stated	238	2.48%
TOTAL	9,596	100.00%

Table 34: Disability	**March 2019**	
Disability	**Total**	**%**
No	8,943	93.20%
Not Declared	393	4.10%
Yes	260	2.71%
Total	9,596	100.00%

Table 35: Age profile	**March 2019**	
Age profile	**Total**	**%**
16 – 20	125	1.30%
21 – 25	851	8.87%
26 – 30	1,451	15.12%
31 – 35	1,459	15.20%
36 – 40	1,254	13.07%
41 - 45	1,063	11.08%
46 – 50	981	10.22%
51 – 55	1,016	10.59%

Age profile	Total	%
56 – 60	853	8.89%
61 – 65	438	4.56%
66 – 70	80	0.83%
71 - 75	23	0.24%
76 - 80	2	0.02%
Total	9,596	100.00%

Table 36: Religious belief **March 2019**

Religious belief	Total	%
Atheism	1,464	15.26%
Buddhism	52	0.54%
Christianity	3,596	37.47%
Hinduism	95	0.99%
Islam	191	1.99%
Jainism	3	0.03%
Judaism	10	0.10%
Sikhism	17	0.18%
Other	659	6.87%
I do not wish to disclose my religion/belief	3,436	35.81%
Undefined	73	0.76%
Total	9,596	100.00%

Table 37: Sexual orientation **March 2019**

Sexual orientation	Total	%
Bisexual	61	0.64%
Gay or Lesbian	134	1.40%
Heterosexual	6,739	70.23%
Other sexual orientation not listed	3	0.03%
Not stated (person asked but declined to provide a response)	2,582	26.91%
Undecided	5	0.05%

Undefined	72	0.75%
TOTAL	9,596	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.

APOHS provided significantly increased levels of support in the form of counselling during the year as well as increasing the self-help tools available on the APOHS website.

APOHS has also continued the move 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. The Trust workplace wellbeing provision is another area of policy direction that has strengthened over the past year.

We have further developed the range of services and interventions which support the psychological and physical needs of colleagues and to aid this direction, we contribute to a number of national programmes to drive local level improvements.

Our contribution to the NHS Improvement; Sickness Absence Programme has led us to benchmark our entire wellbeing offer against national best practice and deliver an action plan to address gaps in existing provision for colleagues.

Last summer, we launched a new network of Workplace Wellbeing Advocates to act as the nominated wellbeing advisor within their respective team. This voluntary role is proving popular with individuals and managers alike and we are experiencing an uptake of initiatives available.

The Trust continues to fulfil requirements of the NHS England Commissioning for Quality and Innovation (CQUIN) 2017/19 for Staff Health and Wellbeing. In this concluding year of this CQUIN, we strive to make improvements to:

- Healthy food and drink available to staff, patients and visitors
- The number of frontline workers receiving a seasonal flu vaccine
- Gain better awareness of the menu of workplace wellbeing initiatives.

Potentially, the most significant action we have taken over the past year is to become a completely smoke free Trust. We do not permit smoking on any part of our property and support those who wish to stop smoking by signposting to appropriate local service provision.

5.4.11 A safe and healthy working environment

The Trust recognises its legal duty to ensure suitable arrangements are in place to manage health and safety. And, that such arrangements are monitored for effectiveness and regularly reviewed.

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 is integral to the Trust's Risk Management Strategy, from which a five-year Health and Safety Action Plan 2018 – 2023 has been developed. Progress against this is subject to annual review via an independent auditor – The British Safety Council. Progress against any actions identified by the independent auditor is monitored within the Trust Health and 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 fourth consecutive year.

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.

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

An annually reviewed risk management training prospectus includes all risk management training programmes. Coverage of this is monitored by the Trust Health and 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 e.g. enhancement to training for Manual Handling Link Practitioners which gives clinical staff more responsibilities including competency training for hoist and falls equipment.

5.4.12 Sickness absence

The table below shows average sickness for 2018/19.

Table 38: Average sickness for 2018/19

Figures converted by DHSC to Best Estimates of Required Data Items		**Statistics published by NHS Digital from ESR Data Warehouse**		
Average FTE 2018	**Adjusted FTE days lost to Cabinet Office definitions**	**Average Sick Day per FTE**	**FTE-Days Available**	**FTE-Days Lost to Sickness Absence**
8,149.19	71,578.55	8.78	2,974,454	116,116

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 2018/19 the Trust's expenditure on consultancy was £0.836m (2017/18: £0.373m). The increase reflects work in support of Healthy Weston.

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 2018/19 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 39: All off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2019	0
Of which…	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 40: All new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that have reached six months in duration, between 1 April 2018 and 31 March 2019.	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to the Trust) and are on the Trust’s payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 41: Any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. 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.	33

Officers with significant financial responsibility are defined by the Trust as executive directors, divisional directors, and clinical chairs.

5.4.15 Exit packages

The table below shows the number and cost of staff exit packages (termination benefits) in 2018/19. 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 2017/18 are shown in brackets. This information has been subject to audit.

Table 42: 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	1 (-)	6 (8)	7 (8)
£10,000 - £25,000	2 (1)	2 (2)	4 (3)
£25,001 - £50,000	1 (-)	1 (-)	2 (-)
£50,000 - £75,000	- (-)	1 (-)	1 (-)
Over £75,000	- (-)	- (-)	- (-)
Total number of exit packages by type	**4 (1)**	**10 (10)**	**14 (11)**
Total cost (£'000)	57 (20)	139 (60)	196 (80)

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

Table 43: Analysis of non-compulsory departures

	2018/19		2017/18	
	No.	£'000	No.	£'000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignation contractual costs (MARS)	2	96	0	0
Contractual payments in lieu of notice	7	28	7	47
Non-contractual payments requiring HMT approval	1	15	3	13
Total	10	139	10	60

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 Trust values and leadership behaviours are integral to the culture of the organisation and set the expectation and accountability across the hospital community.

The delivery of the leadership and management development agenda supports the values culture and builds a solid foundation for leaders to grow and enable them to influence a real cultural change within their areas for the benefit of their teams, services and 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 Trust 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 focused on staff issues on the frontline.

5.4.17 NHS staff survey

The Trust takes part in the annual National Staff Survey for all staff and subsequently develops action plans to improve staff experience at a local level. The 2018 National Staff Survey response rate was 52 per cent with 4,813 staff completing the online survey. This was a 9 per cent increase in response rate from 2017 and above the average response rate for acute trusts which was 44 per cent. The 2018 staff engagement figure has risen for the fifth consecutive year to 7.2, which is a real reflection of the hard work and commitment at all levels to improving staff experience across the organisation.

The results indicate that staff continue to feel more engaged further demonstrated by the following three indicators:

- If a friend /relative needed treatment you would be happy with the standard of care provided by the organisation
- Would recommend the organisation as a place to work
- Organisation ability to provide adequate adjustments to enable me to carry out work

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.

In 2018 the National Staff Survey co-ordination centre reporting methods changed. The results from questions are grouped to give scores in 10 indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The following table demonstrates the Trust's results in relation to the Survey 10 Indicators and comparative to the national Average for Acute Trust for the past three surveys:

Table 44: NSS 2018 10 Indicator Scores

	2018/19		2017/18		2016/17	
10 Indicators	Trust	National Average for Acute Trusts	Trust	National Average for Acute Trusts	Trust	National Average for Acute Trusts
Equality Diversity and Inclusion	9.2	9.1	9.1	9.1	9.2	9.2
Health and well Being	6.0	5.9	6.1	6.0	6.2	6.1
Immediate Managers	6.8	6.7	6.7	6.7	6.7	6.7
Morale	6.3	6.1	N/A*	N/A*	N/A*	N/A*
Quality of Appraisal	5.5	5.4	5.3	5.3	5.2	5.3
Quality Of Care	7.3	7.4	7.3	7.5	7.4	7.6
Safe Environment Bullying and Harassment	8.2	7.9	8.1	8.0	8.1	8.0
Safe environment Violence	9.6	9.4	9.4	9.4	9.4	9.4
Safety Culture	6.8	6.6	6.7	6.6	6.6	6.6
Staff Engagement	7.2	7.0	7.1	7.0	7.1	7.0

***Information not available from the NHS Co Ordination Centre**

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.

Staff engagement is key to improving staff experience at work and as such we continue to strive to provide opportunities for staff to be listened to, communicated with; and receive feedback from the organisation, their service and manager on where improvements have been made.

In 2018 the Trust ran two 'You said….we did' weeks; the first to communicate the staff survey results at a local level to support the development of local improvement plans, the second to share improvements that have been made and to encourage staff to complete the survey to continue to learn and improve staff experience at work.

We continue to look at ways of improving staff experience both across the organisation and locally through strategic and local planning. In response to the findings in the survey our areas of focus will include some of the following priorities.

Working together to improve our organisational approach to appraisal by taking next steps to deliver more focused positive conversations and how we can work together to improve how staff carry out their role. It is anticipated that this will create an environment where staff feel they can deliver the care they aspire to as well as having the ability to meet the conflicting demands on their time at work.

The Trust is also focusing on the Happy App, which is a real time tool designed to capture staff comments on staff experience at work, both positive and negative. This rich data source compliments the staff survey data, and provides local teams with the ability to respond in real time to areas of concern whilst also recognising success.

Staff engagement is reviewed quarterly at the Trust's People Committee which is a sub-committee of the Board.

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:

- Consultation on the revised Pay Scales under Agenda for Change (Removal of Band 1)
- 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
- Decommissioning of the Homeopathy service, which the Trust will cease to provide from March 2019
- Partnership engagement with Weston Area Health NHS Trust to support long-term service sustainability.

5.4.20 Staff policies and actions applied during the financial year

Following the implementation of a new Supporting Attendance Policy in 2018 to better reflect our aims of positively supporting staff health and wellbeing, the Trust has completed a review of its effectiveness and the evaluation has provided positive results both in terms of user feedback and sickness absence rates. Revisions of policies to support the new Agenda for Change pay framework are in progress which includes Supporting Performance, Appraisal and Linking Pay to Progression policies. The Trust is also agreeing a Fixed Term Contracts Policy to provide greater assurance that practices meet legislative requirements. 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

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 and Leadership Behaviours.

The Trust's Dignity at Work Policy emphasises the positive behaviours expected of its entire 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 recognises that some staff are subjected to unacceptable behaviour from colleagues or service users and this is indicated in responses to questions about bullying and harassment in the National NHS Staff Survey.

There is a range of support available to staff:

- The Employee Services Team and a Human Resources Business Partner in each Division.
- An established mentor who can give advice and offer support to medical trainees.
- The Joint Union Office and local Staff Side representatives
- The Freedom to Speak Up Guardian and Advocates operating across the organisation.

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 public sector employers with more than 49 employees will be expected to report annually on use of facility time provided to trade union officials.

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 2018/19	Full-time equivalent employee number
50	8591

Table 46: Percentage of time spent on facility time

Percentage of time	No of employees
0%	-
1-50%	46
51%-99%	-
100%	4

Table 47: Percentage of pay bill spent on facility time

The total cost of facility time	£140,075
The total pay bill	£403,090,000
The percentage of the total pay bill spent on facility time	0.035%

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 2018/19 there were 32 referrals to the Freedom to Speak Up Guardian (up from 13 in 2017/18), all of which were investigated and responses provided to the individual's raising the concerns. Where possible learning to ensure issues were not repeated was 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. During the year the Board of Directors considered its self-assessment against the tool developed by the National Guardian's Office. The review identified a number of areas for improvement which included the development of a Speaking Up Strategy and continuing to build awareness of Speaking Up across the Trust.

Further actions are planned during 2019/20 to ensure that a positive speaking up culture is maintained and developed. The Guardian is ensuring that he is visible across the Trust by attending key meetings and talking to staff groups to promote the messages. The Advocate network is promoting Speaking Up locally and at Trust wide events; the Trust's desktop PC background, on over 6000 devices, has been changed to promote Speaking Up. A Speaking Up Strategy was drafted during 2018/19 and was subject to consultation with staff. The final version will be developed and presented to the Board for approval during 2019/20.

5.5 NHS Foundation Trust Code of Governance

University Hospitals Bristol NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board considers that it was fully compliant with the provisions of the Code in 2018/19, with the exception of paragraph A.5.12. Governors of UH Bristol are not provided with copies of the minutes of Board meetings held in private 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 focused 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 15.

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 2018/19. Good governance is essential if we are to continue providing safe, sustainable and high quality care for patients.

The Board has considered its own performance through the use of a number of different tools. These included analysing the business undertaken by the Board to identify the balance between strategic and operational issues that were considered, using the Good Governance Institute's Maturity Matrix for Boards and asking that all Board members completed an individual questionnaire. The results of these actions were then combined and considered by the Board to identify further actions for improving the functioning of the Board.

The Board also 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 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 identified, following a review of the assurance activities delegated to its Committees, that there was a gap in a number of areas which could generate a risk to the Trust. This included ensuring clarity around how the Board was assured in relation to estates compliance, information governance as well as estates and digital strategy implementation. Changes to the Board's Committees were made to ensure there was full coverage across all of the organisation's activities.

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 undertaken 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 constitute three additional designated committees to augment its monitoring, scrutiny, and oversight

functions, particularly with respect to quality and outcomes, financial management and people. These are the Quality and Outcomes Committee, the Finance Committee and the People Committee. The role, functions and summary activities of the Board's committees are described below.

Table 49: Board and Sub-Committee Attendance 2018/19

The Board of Directors discharged its duties during 2018/19 in 10 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	People Committee	Finance Committee
No. of meetings	10	6	5	12	6	12
Chairman						
Jeff Farrar	10 (C10)	6 (C6)	5	11 (C1)	3	10
Chief Executive						
Robert Woolley	9	4	3	(0)	(0)	11
Non-executive Directors						
David Armstrong	9	4	5 (C5)	10	6	11
Madhu Bhabuta	7	1	(0)	(0)	4	(0)
Julian Dennis	10	5	5	12 (C11)	(0)	7
John Moore	7	4	(0)	(0)	3	3
Anthony (Guy) Orpen	7	4	(0)	(0)	(0)	(0)
Alison Ryan	6	2	1	4	6 (C6)	2
Martin Sykes	10	5	5	(0)	(0)	12 (C12)
Steven West	5	1	(0)	4	(0)	(0)
Emma Woollett	1	1 (C1)		2		
Jill Youds	5	3	4	10	1	4
Executive Directors						
Mark Callaway	3	(0)	(0)	4	(0)	(0)
Paula Clarke	8	(0)	(0)	(0)	5	(0)
Matthew Joint	9	6	(0)	5	5	(0)
Paul Mapson	9	(0)	5	(0)	2	12
Carolyn Mills	10	(0)	(0)	10	6	(0)
William Oldfield	6	(0)	(0)	5	4	(0)
Mark Smith	9	(0)	1	10	(0)	10

5.5.5 Remuneration and Nomination and Appointments Committees

The purpose of the Directors' Remuneration, 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 Trust Chairman 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.

Further details of the activities of the Committee are included in the Remuneration Report.

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 provided through the Quality and Outcomes Committee, Finance Committee and People Committee and information is triangulated from all four 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 includes in its membership 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.

The Non-executive Director members also serve on the Quality and Outcomes Committee, Finance Committee or People 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 2018/19, 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.

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, the Audit Committee is responsible for evaluating the Trust's systems of Governance, Assurance and Risk Management, especially with respect to the adequacy and effectiveness of our Financial Control mechanisms, independent Internal and External Audit programme, Strategic and Operational Risk Identification and Mitigation and activities to counter Fraud.

The Committee has met on a regular basis throughout the year with good representation from both the Executive team and from the Non-executive Directors. In addition, both the Internal Audit Team and External Auditors have unrestricted access to the Chair of the Audit Committee and have met on a regular basis.

At every Audit Committee, an evaluation of the Trust's Risk Registers, both Strategic and Operational, is undertaken with regard to the Trust's stated objectives detailed in the Board Assurance Framework and our Strategic and Operational Plans. In addition, as part of our standing Agenda, the Committee reviews the results of Internal Audit, Counter Fraud activity and key Financial indicators.

From the information supplied, the Committee has formed the opinion that there is a mature and robust framework of control in place to provide effective assurance of The Trust's Systems of Governance and of the management of risk.

During the course of this year the Committee has sought to further improve its effectiveness and so the Assurance it can offer to the Trust Board by:

- Supporting the development of the Committee's Terms of Reference, based on a detailed analysis of its Stakeholders and their respective requirements. As a result of this work the Annual Business Cycle, detailing the requirements for each Audit Committee meeting, has been developed to ensure the Committee addresses all of its responsibilities in timely fashion.
- Supporting the development of the review process for Internal Audit reports, specifically working in partnership with the Executive and with the Chairs of the Quality and Outcomes Committee, Finance Committee and People Committee to ensure findings are effectively reviewed by the appropriate teams. In addition the quarterly Internal Audit Report has been further developed to provide greater focus on overdue actions and to ensure that recommendations are described in terms of the benefits to the Trust.
- Supporting the development of the risk identification and mitigation reporting, for both strategic and

operational risks, in order to provide greater assurance that risks are identified and associated with respect to the Trust's Strategic and Operational Objectives.

- Supporting the development of a regular Estates and Facilities Report which provides assurance of status and wellbeing with regard to associated Legislation and Regulatory requirements.
- Establishing mechanisms to ensure the Governors are fully sighted on the Committee's activities, primarily by the Chair attending the Governors' Constitution Focus Group, whenever possible.

In summary, the Audit Committee has been encouraged by the drive and ambition of The Trust to further develop its approach to Governance, Assurance and Improvement, from what is already a mature and largely effective position. The Committee is likewise committed to seeking further opportunities to increase the Committee's effectiveness and value to the Trust and especially to its Accountable Officer. A report on its activities and findings is provided to the Board after every Audit Committee meeting.

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, and Chief Operating Officer/deputy Chief Executive. 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 2018/19, 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.

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 committee's membership includes two Non-Executive Directors, and is usually attended by the Director of Finance and Information, Chief Executive, and Chief

Operating Officer and Deputy Chief Executive.

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 People Committee

The People Committee was constituted by the Board of Directors in 2018/19 to recognise the need for greater Board level assurance on the issues affecting the organisation from a people and workforce perspective.

The key responsibilities of the committee include:

- Ensuring that the strategic workforce needs of the Trust are understood and plans are in place to deliver these
- Provide oversight of workforce performance
- Understand the risks to the workforce and seek assurance that mitigating actions are in place
- Support the development of enabling strategies including the Education Strategy.

The committee held its first meeting in September 2018 and met six times in total during 2018/19. The Chair of the committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

5.5.11 Single Oversight Framework

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

- Accident and Emergency four hour waiting standard
- 62 day GP cancer standard
- Referral to Treatment 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 incomplete pathways
- 99 per cent for six week diagnostic waiting times.

Sustainability and Transformation Funds 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 2018/19 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 2018/19 during each quarter

Access Key Performance Indicator		Quarter 1 2018/19			Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19		
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
A&E 4-hours Standard: 95%	Actual	83.96%	91.14%	92.84%	90.26%	90.07%	85.00%	89.16%	84.24%	83.05%	84.50%	81.05%	81.23%
	"Trust Footprint" (Year To Date)	92.05%			91.77%			90.84%			89.84%		
	Trajectory	90%	90%	90%	90.53%	91.26%	90.84%	90.06%	90.33%	87%	84%	87%	90%
	"Trust Footprint" Trajectory	90.0%			90.0%			90.0%			95.0%		
Cancer 62-day GP Standard: 85%	Actual (Monthly)	84.1%	82.4%	86.0%	85.7%	88.9%	87.4%	85.5%	87.9%	86.5%	85.1%	83.5%	82.9%
	Actual (Quarterly)	84.2%			87.3%			86.6%			83.8%		
	Trajectory (Monthly)	81%	83%	79%	83%	85%	85%	85%	85%	85%	85%	85%	85%
	Trajectory (Quarterly)	82.5%			85%			85%			85%		
Referral to Treatment Standard: 92%	Actual	88.2%	89.1%	88.6%	88.9%	88.7%	88.5%	89.6%	90.1%	89.3%	89.4%	89.1%	89.2%
	Trajectory	88%	88%	88.5%	88.5%	88.7%	88.5%	88.5%	88.0%	87.0%	86.0%	87.0%	87.0%
6-week wait diagnostic Standard: 99%	Actual	96.8%	97.6%	97.8%	97.9%	97.1%	98.1%	98.4%	96.9%	93.8%	93.3%	96.9%	95.5%
	Trajectory	97.9%	97.9%	97.9%	98.4%	99.0%	98.0%	98.0%	98.0%	98.0%	98.0%	99.0%	99.0%

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved (with Walk In Centre uplift for A&E 4 Hour standard).
RED rating = national standard not achieved, the STF trajectory not achieved

Note on A&E "Trust Footprint":
In agreement with NHS England and NHS Improvement, each Acute Trust was apportioned activity from Walk In Centres (WIC) and Minor Injury Units (MIU) in their region. This apportionment is carried out and published by NHS England as "Acute Trust Footprint" data. This data is being used to assess whether a Trust achieved the recovery trajectory for each quarter. The A&E "Trust Footprint" data above relates to Trust performance after WIC and MIU data has been added.

5.5.12 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 2018/19, 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 2018/19

Metric	Weighting	Metric performance	Metric rating
Liquidity	20%	40.7 days	1
Capital servicing capacity	20%	3.6 times	1
Income and expenditure margin	20%	4.2%	1
Variance in income and expenditure margin	20%	1.5%	1
Variance from agency ceiling	20%	23.39%	1
Overall URR rounded			1

5.5.13 2019/20 Financial Outlook

The Trust submitted its 2019/20 Operational Plan to NHS Improvement on 4 April 2019. The Trust's plan is a surplus of £12.815m excluding technical items.

The headlines for the 2019/20 Operational Plan are:

- Acceptance of the 2019/20 Control Total of £12.815m surplus advised by NHS Improvement
- Inclusion of Provider Sustainability Funding (PSF) of £9.576m
- A planned net income and expenditure surplus of £12.8m surplus before technical items, £13.7m surplus after technical items
- A savings requirement of £16.8m or 3.6 per cent of recurring budgets
- A planned year end cash balance of £80.8m
- Planned capital expenditure of £57.9m
- A Use of Resources Rating (URR) of one, the highest rating.

The 2019/20 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 £16.9m
- 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 2019

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
- confirm 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
- 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 2019

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 2019 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.

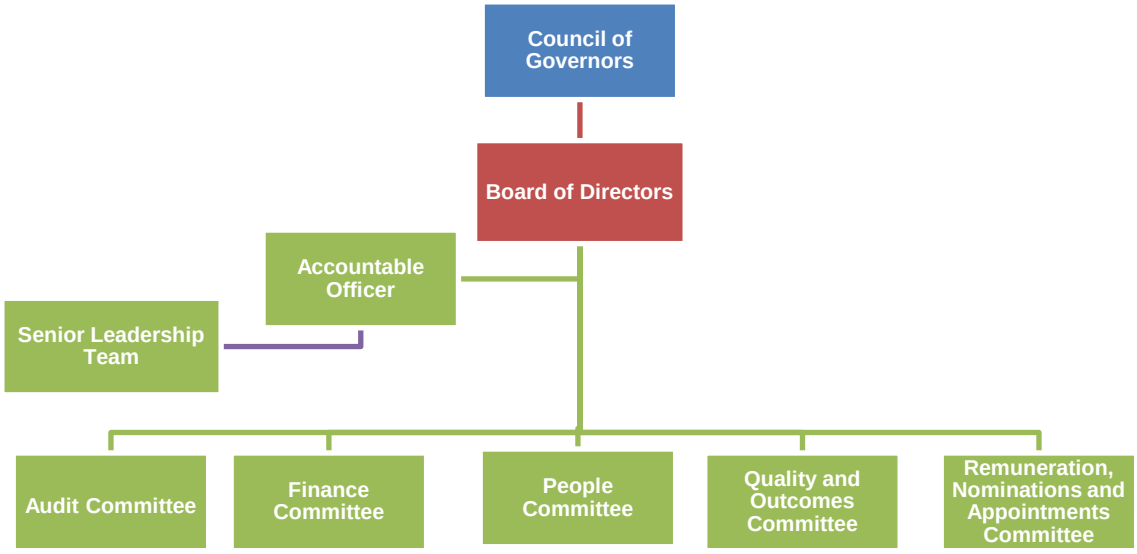
The Board committee structure is detailed earlier in the annual report and summarised below.

The Trust performance report is reviewed by the Finance Committee, the People 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 experience, patient safety and clinical performance. Indicators relating to workforce, including the staff experience, are reviewed by the People Committee.

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



This process 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 2019

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 Trusts risk management strategy and policy describes our approach to risk management and outlines the risk architecture in place to support this approach. The policy is updated every three years to ensure that it continues to reflect best practice in risk management methodologies and 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 and Risk Management Group.

The risk management strategy is approved by the Board on an annual basis and includes a review of the Trust's risk appetite statement and thresholds of individual risks (risk tolerance levels) that are deemed acceptable. All corporate risks are reviewed by one of the Board assurance committees.

At UH Bristol, risk is considered from the perspective of enterprise-wide risk management, with the approach to managing quality, operational, regulatory 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.

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, NHS Improvement, the Health and Safety Executive, NHS Resolution (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 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 is formed of two key documents, the first details the principle strategic risks to the achievement of the Trusts objectives and the second the progress towards the delivery of the objectives. These are received by the Board on a quarterly basis along with the corporate risk register.

Responsibility for the controls pertaining to each risk is assigned to an executive director with oversight by a designated Board committee. As at the year end, the corporate risk registers tracked 14 strategic risks and 23 operational risks. A summary of the top strategic risks for 2018/19 are outlined below:

- That government policy changes affect the NHS and social care funding
- That national shortages of specific occupations affect recruitment
- That public perception of Trust activities may be negatively affected

- That digitalisation of clinical systems fail to deliver the required levels of efficiencies
- That clinical services are not commissioned at levels of forecasted demand
- That capital funding for maintaining and modernising the Trust estate is insufficient
- That the STP fails to deliver a system strategy
- That a local or regional provider failing to maintain viability of services increases unplanned demand
- That the Trust fails to retain sufficient management and leadership capacity and capability
- That the Trust's workforce is insufficiently motivated and engaged
- That the Trust fails to establish and maintain robust governance processes
- That Research is unable to sustain activity
- That Brexit causes disruption to the delivery of goods and services
- That benefits of transformation, improvement and innovation are not realised.

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.

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust has a number of key mechanisms to ensure that the short, medium, and long-term workforce strategies and staffing systems are in place to assure the Board that staffing processes are safe, sustainable and effective. These include the following:

- The development of a new People Strategy (and Strategic Workforce Plan) to support the Trust's capacity to deliver staff processes, to ensure the appropriate resources and people systems are in place to support its delivery, and to act as an enabling strategy to the Trust's 2025 Strategy.
- The Trust's 2025 Strategy, Embracing Change, Proud to Care commits to investing in staff, their wellbeing and development, and sets out strategic objectives including the development of a new Trust-wide Strategic Workforce Plan enabling the recruitment and retention of staff and the development of leadership and management capability.

The Board receives regular updates on key strategic staffing issues, including staff wellbeing and systems to support staffing processes. From September 2018, the Board approved the creation of a new People Committee of the Board, with an explicit remit of considering the Trust's workforce strategy and processes, seeking assurance these were appropriate and effective, and in particular seeking assurance that the Trust's people strategy was clearly aligned with its overall strategic goals.

The Quality and Outcomes Committee of the Board receives Monthly Safe Staffing Reports, as well as a six-monthly review report, to provide assurance that the Trust has discharged its responsibility to ensure safe nurse staffing across key clinical areas.

The Chief Nurse also leads an Annual Staffing Review on nurse staffing. In 2019

six-monthly safe staff reporting will be broadened to include reporting on other medical practitioners and allied health professionals.

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 focused 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 & 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 2018/19.

UH Bristol has published on its website an up-to-date register of interests for decision-making staff within the past 12 months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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 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 relevant monthly finance and performance reports to the Finance, People, and Quality and Outcomes Committees, the Executive Team, the Senior Leadership Team, 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 provides 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 (IRMG) chaired by the Medical Director, who is the Senior Information Risk Owner for the Trust. IRMG is the principal body overseeing IG compliance and the management of information risks. This group has a reporting line into the Senior Leadership Team, via the Risk Management Group. It also oversees submission of the Trust's Data Security and Protection 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 Trust's systems containing all patient and staff personal data
- a trained Caldicott Guardian, a trained Senior Information Risk Owner and a trained Data Protection Officer
- a risk management and incident reporting process
- staff training
- information governance risk register
- review of compliance with the new Data Security and Protection Toolkit

- internal audit review of the evidence provided to comply with the criterion of the Data Security and Protection Toolkit.

During 2018/19 progress has continued to be made to raise staff awareness about information governance issues. Key activity has included the following:

- Staff information including posters, guidance and articles has 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 site: the Trust has a positive culture in relation to incident reporting, and the lessons learned from all incidents are shared to support staff education
- The Information Management and Technology Board, in conjunction with the Information Risk Management Group, identifies, assesses and monitors data, cyber, and infrastructure threats to the organisation. All information risks are managed through IRMG and escalated to the Trust's overall Risk Management Group
- Work to continue embedding the requirements of the European General Data Protection Regulation and the subsequent Data Protection Act 2018 continues, with the Trust focusing on standardising and embedding processes to undertake Data Protection Impact Assessments, and ensure all necessary contractual arrangements are in place with third parties.

Three cases recorded in the Information Governance Incident Reporting Tool were reported to the Information Commissioner's Office in 2018/19. The details are provided in the following table.

Table 53: Incidents reported to the Information Commissioner's Office 2018/19

Date of Incident	Incident description	Number affected	How individuals were informed	Lessons Learned
November 2018	Two sets of information were mixed up and sent to the family of the other patients	2	Both families were informed verbally and in writing by senior clinicians.	The administrative team now use standard letter templates and windowed envelopes when sending information by post.
February 2019	A child's address was included on a clinical letter to her estranged father.	2	Child's mother was informed verbally and in writing by a senior clinician.	Safeguarding controls under review to prevent a reoccurrence.
February 2019	A complaint letter was sent to the wrong individual	1	Patient contacted verbally and in writing by senior member of staff.	Complaints teams to double check all information on correspondence and a formal letter sending has been drafted for trust-wide publication.

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.

Our assurance that the Quality Account presents a balance view comes in part from the fact that the published Account mirrors a significant proportion of the data reported to the Board on a monthly basis covering priority quality themes agreed by the Board. We also receive assurance from the scrutiny our Quality Account receives from stakeholders; for example, our governors and commissioners would challenge us if they felt that our Quality Account did not present a balanced story of our progress during the year.

In respect of data accuracy, our quality data follows a set pattern each month. Data is processed on tenth working day from the agreed sources. Prior to this, most areas undergo data checks and each data source is overseen by a senior responsible officer in the relevant Trust team. Once the data is ready, the Scorecards and key performance indicator reports are uploaded to our InfoWeb 'How We Are Doing' page. These data are reviewed by the various leads; exception reports and commentaries are compiled, collated and signed-off by Chief Nurse before being reported to the Trust Board.

For Elective waiting lists (Referral To Treatment) the approach is the same. We validate the data up to the 'freeze date' and have perform a series of data quality checks prior to publication. The NHSI's Intensive Support Team (IST) have reviewed our processes and are satisfied with our approach to reporting waiting times.

5.7.9 Significant Internal Control Issues

In December 2018 the Trust was issued with an unsatisfactory progress report from an OFSTED Monitoring Visit of its internal apprenticeship provision, inclusive of the following programmes:

- Health Care Support Worker level 2 and 3
- Customer care
- Leadership and management

- Dental Nursing (regional contract)
- Planned Level 2 pharmacy (regional contract).

This resulted in a suspension of any new recruitment of apprentices until the issues identified as unsatisfactory were resolved. The Trust has been in active dialogue with OFSTED to address these findings and has taken a number of mitigating actions, including the development of the OFSTED Quality Improvement Plan. The People Committee of the Board is receiving regular assurance updates on the Trust's progress to effectively manage this issue, to successfully address OFSTED's concerns, and to end the suspension of new recruitment. The development of the new Education Strategy will support the Trust's broader management of a successful education programme, including an effective and embedded system of education leadership and management.

5.7.10 Externally Facilitated Well-led Review

During 2018/19 the Trust commissioned an externally facilitated review against the Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts.

The review was undertaken by the Good Governance Institute between October 2018 and January 2019. This was to support the Board's understanding of how well-led the organisation was and to meet the requirements of the Foundation Trust Code of Governance which sets the expectation that Foundation Trust's would have an evaluation of the board, externally facilitated at least every three years, and that this should be carried out against the board leadership and governance framework set out by Monitor.

The Good Governance Institute have no other connections with the Trust and are thus considered to be sufficiently independent to undertake the review.

The headline findings of the well-led review were:

- There was no reason, in the view of the Good Governance Institute, why the Trust should not maintain its overall rating of 'outstanding'
- The Trust had in place a strong platform on which to build a forward-looking approach to its future strategy and sustainability based on what well-led means for UH Bristol and the local health and care system.

There were a small number of areas where further action by the Trust would strengthen the case including:

- articulation of a longer-term ambition beyond current dynamics
- clarity of future role in the local integrated health and care system and the wider health service
- further investment in leadership and management development to drive a long-term capability and succession plan
- reframing risk appetite to reflect future dynamics and to grow understanding of its implications more widely
- articulation of the distinctive contribution of the People Committee and its modus operandi.

In recognising that the majority of the recommendations related to developing and delivery of the Trust's strategy and how the Trust worked within the local and regional system, the Trust has reviewed and updated its Board Development Plan to cover the suggested topics. The plan will be delivered through 2019/20 and the outcomes considered as part of the Board's review of its own effectiveness at the end of the year.

5.7.11 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 2018/19 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, assessed, 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 2018/19 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.

5.7.12 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 unsatisfactory progress report from an OFSTED Monitoring Visit of its internal apprenticeship provision. The Board will keep progress to address the issues identified by OFSTED under review during 2019/20.

Robert Woolley
Chief Executive
24 May 2019

Appendix A – Biographies of Members of the Board of Directors

Jeff Farrar – Chairman

Jeff Farrar has been the Chairman of University Hospitals Bristol Foundation Trust since December 2017. Prior to this he had a 35 year career in the police service reaching the rank of Chief Constable in Gwent Police. He has a Master's 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. The themes of his research have been on equality, citizens centred models of delivery, and accountability and performance management in public services.

He is a Non-Executive Director on the Welsh Government Board and Chair of the Welsh Government Remuneration Committee. He is a member of the Cardiff University Business School International Advisory Board and was the Chair of the Welsh Government Effective Services Board.

During his policing career he planned and commanded some of the most high profile events in the UK, including the NATO summit (2014), two FA Cup and League Cup finals, The Ryder Cup (2010), Rugby Internationals, International Cricket and World Championship Boxing events and led a number of large organisational change programmes. He was seconded to Her Majesty's Inspectorate of Constabulary as part of the team that inspected the Metropolitan Police after the death of Stephen Lawrence, and was also part of the team that inspected all 43 police forces in England & Wales on equality and diversity. He has held a number of national roles including, the National Policing Lead for Crime Statistics, a member of the Police National Performance Board, the Home Secretary's Crime Statistics Advisory Group, the National Counter Terrorism Cadre and Chair of the All Wales Policing Group.

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 also an Officer of St John Ambulance.

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 the Trust since 2010, having served on the Trust Board since 2002. In that time, the Trust has completed a major redevelopment programme, become the first Trust to be rated Outstanding by the Care Quality Commission after a previous rating of Requires Improvement, achieved Biomedical Research Centre status in partnership with the University of Bristol and maintained a positive financial position in every year.

Robert is Co-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.

Before moving to Bristol, he spent nine years at Barts and the London NHS Trust (now Barts Health) in a range of senior planning and operational roles.

He has an English degree from Lincoln College, Oxford, 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 16 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 permanent Director of Finance in February 2005. Paul serves on the Finance Committee of the Board.

Mark Callaway – Interim Medical Director

Mark was the Interim Medical Director of the Trust until August 2018, 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.

William Oldfield – Medical Director

After undertaking studies in Pharmacology, and subsequently Human and Applied Physiology, Bill studied Medicine, before entering the North-West Thames Training Programme in General and Respiratory Medicine. During this time, he was awarded a Ph.D. Degree from the National Heart and Lung Institute at Imperial College, London, and gained sub-specialty experience in both Allergy and Critical Care Medicine. He was appointed as Consultant in Respiratory Medicine to St. Mary's Hospital, London, and the Royal Brompton Hospital in 2003, and subsequently developed clinical interests in High Dependency Medicine and Pulmonary Embolic Disease. He held a variety of clinical management positions at Imperial College Healthcare NHS Trust including Lead Clinician, Chief of Service, Deputy Medical Director and Interim Medical Director before joining University Hospitals Bristol NHS Foundation Trust in 2018.

Carolyn Mills – Chief Nurse

Carolyn is an experienced nurse whose career in the NHS spans over 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.

Paula Clarke – Director of Strategy and Transformation

Paula joined the NHS as a General Management trainee and over the last 25 years, has held senior manager posts in commissioning, provider and primary care organisations, working predominantly in the integrated health and social care system in Northern Ireland. Paula has over 10 years' experience at Board level, including serving as the interim Chief Executive of Southern Health and Social Care Trust in 2015/16, providing all health and social care services to the 360,000 local population and managing an operating income of £550m.

Paula joined UH Bristol in April 2016, bringing extensive experience in strategic planning and delivery, continuous improvement, partnership working and service redesign.

Key priorities for Paula are enabling improvement in individual and population health and wellbeing through strategic transformation, collaboration and inclusion and by supporting every member of staff to take personal ownership for improving what they do, no matter how small.

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 (Left on 30 April 2018)

Emma was appointed as a Non-executive Director on 1 June 2008, and was 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 was 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 in November 2013.

After graduating from Southampton University in 1980 with First Class Honours in Mathematics and its Applications, David initially worked in the banking sector before taking up a position as a Systems Engineer with GEC-Marconi in 1983.

During the early part of his career he worked internationally, both in Project Management and Function Management roles. In 1999 he was appointed as Business Improvement, IT and Quality Director at Alenia Marconi Systems Ltd and since that time has held board level positions in a number of GEC-Marconi and BAE Systems businesses, usually with responsibility for Governance, Risk, Assurance and Improvement. During his career 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.

In 2014 David left the Aerospace and Defence Sector to pursue Interim and Non-executive Director roles, including a secondment as "Head of Profession" at the Chartered Quality

Institute, where he was responsible for developing the Quality Profession, both within industry and the academic sector and also through development of its individual members.

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

Anthony (Guy) Orpen – Non-executive Director

Guy Orpen is the Deputy Vice-Chancellor, New Campus Development, having previously served as the Deputy Vice-Chancellor and Provost at the University of Bristol since 2014.He serves on and is past Chair of the Board of the GW4 research alliance with Bath, Exeter and Cardiff universities and is a non-executive director of the University Hospitals Bristol NHS Foundation Trust and of the Bristol Green Capital Partnership. He has chaired the UK National Composites Centre and the Board of Trustees of the Cambridge Crystallographic Data Centre and been a member of the Natural Environment Research Council. He has previously served as Deputy Vice-Chancellor and Provost (2014-18), Pro Vice-Chancellor (Research and Enterprise) (2009-14), Dean of the Faculty of Science (2006-09) and Head of the School of Chemistry (2001-06) at Bristol.

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. John served as our Chair of Audit Committee between 2012 and 2018.

John is also a Trustee of Bristol Dementia Action Alliance - a charity that aims to make Bristol the most dementia friendly city in the UK. Additionally John is an executive director of Home Instead Senior Care in Bristol North - an award winning team that delivers unrushed, relationship-centred support.

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. He is the Senior Independent Director (SID) on the Board.

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 also an advisor to The Quality and Environment committee of Welsh Water.

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 in Computing and PhD in Quantitative Methods, both from Imperial College, London and an MBA from London Business School. She specialises in Cutting edge technology, Change and Transformation.

She started her career as a research scientist at Imperial College and then moved to industry where she led the design of Orange's networks from a voice-centric to a data- centric network. Madhu then joined Rolls-Royce Plc to spearhead the formulation of RR's IT strategy and transformation from an engine manufacturer to a service provider of "power by the hour". She was then appointed Chief Information Officer of the UK Hydrographic Office, leading a team of 200 IT staff and delivering a wide-ranging modernisation and digitisation programme through 2013/2014. She was judged in UK's top 100 CIOs for the transformation she affected. Madhu promoted to the role of Chief Technology Officer for the UK armed forces. Madhu is now managing director of Brinnovate Ltd, a Change, Technology and Transformation startup she founded in 2018.

Appendix B – Contact Details

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

Trust Secretary
University Hospitals Bristol NHS Foundation Trust
Trust Headquarters
Marlborough Street
BRISTOL
BS1 3NU

Telephone: 0117 34 21577
Email: Trust.Secretariat@UHBristol.nhs.uk

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

Membership Office
University Hospitals Bristol NHS Foundation Trust
Trust Headquarters
Marlborough Street
BRISTOL
BS1 3NU

Telephone: 0117 34 23764
Email: FoundationTrust@UHBristol.nhs.uk

Appendix C – Quality Report

University Hospitals Bristol
NHS Foundation Trust

Quality Report 2018/19

Contents

Part 1

1.1 Statement on quality from the chief executive

Welcome to this, our 11th 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 important way 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 Trust's performance during the last year, its successes and the challenges we face.

Quality is our key consideration when planning and delivering patient services at University Hospitals Bristol; it is what matters most to the people who use our hospitals and what motivates and unites everyone who works for the Trust. Our renewed Trust Strategy "Embracing Change, Proud to Care - Our 2025 Vision", launched in May 2019, makes clear our continued commitment to improving the quality of our care and maintaining our outstanding clinical services, whilst working smarter to maximise finite resources. The Trust's Board and Senior Leadership Team have a critical role in leading a culture of learning which promotes the delivery of high quality services; this requires both vision and action to ensure all of our efforts are focussed on creating an environment which enables and encourages continuous learning and improvement. As I write to you, we are in the middle of our latest inspection by the Care Quality Commission. We understand that the CQC's report about our services will be published in August.

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
24 May 2019

1.2 Introduction from the medical director and chief nurse

We are pleased to introduce the University Hospitals Bristol NHS Foundation Trust Quality Report for 2018/19. The report shows how we have continued to deliver high quality care that is:

- safe, where people are protected from avoidable harm and abuse and when mistakes occur, lessons are learned
- effective, where the treatment and care people receive achieves the consistently excellent outcomes, promotes quality of life, and is based on the best available evidence
- caring, where patients are treated with compassion, dignity and respect, and are equal partners in their care
- equitable, where patients receive high quality care regardless of their gender, race, disability, age, sexual orientation and religion.

We have strong foundations to build on but there is also much more for all of us to do; we are proud to work within a team that is constantly striving to improve quality.

Carolyn Mills
Chief nurse
24 May 2019

William Oldfield
Medical director
24 May 2019

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 2018/19

Twelve months ago, the Trust identified eight specific areas of practice where we committed to improve quality in 2018/19. A progress report is set out below, including a reminder of why we selected each theme, the improvement objective/s and an overall 'RAG' (Red/Amber/Green) rating of the extent to which we achieved each ambition. Overall, we achieved our stated quality improvement objectives in six areas and made significant progress in another. In the case of our final objective – improving the safe prescribing and use of insulin – our investigations identified a data error which had misdirected the Trust in selecting this objective.

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 marked the second 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?	During 2018/19, we wanted to 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 were four key areas of focus in 2018/19: **Customer service staff training and development** Our aim for this work stream was to support the training and development of UH Bristol staff in delivering effective customer service. We wanted to embed UH Bristol's Principles of Excellent Customer Service, which were developed in collaboration with service users, staff, governors and external experts during the first year of this quality objective, into the following training and development activities: • corporate induction • customer service training • volunteer induction • apprenticeship programme • nursing preceptorship programme. We also committed to developing and piloting an advanced customer service training module, based on a successful model developed by Sheffield Teaching Hospitals NHS Foundation Trust. We wanted to develop a way to test our services against established best practice in customer service, which we refer to as customer service accreditation. This is an ambition in the Trust's Quality Strategy (2016-2020) and would help us recognise wards and departments in our hospitals that achieve this standard. By the end of 2018/19 our aim was to have scoped out and developed the accreditation process for piloting and formal roll-out

	during 2019/20 onwards. **Communications** We recognised the 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 wanted our staff and service users to see our organisation as one that's increasingly focused on delivering consistently excellent customer service. To this end, our third work stream was to develop a communications strategy. This included a further staff workshop to be held 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 by responsive, competent and friendly staff. We wanted to review the Trust's Outpatient Service Standards to incorporate the UH Bristol customer service principles. Staff recruitment and competency evaluation processes were also to be reviewed to incorporate a customer service element. Finally, to ensure that we are monitoring customer service satisfaction effectively, we committed to re-designing the Trust's outpatient satisfaction survey around key points of contact with our organisation (known as customer service "touch points"). **Telecommunications** This work stream was about ensuring that people who phone the Trust receive an efficient response from our staff. In 2017/18, the Trust's Transformation Team undertook detailed analyses to identify good practice, key barriers and "hot-spots" around the Trust. In 2018/19, using this insight, the Transformation Team set out an ambition to work with ten UH Bristol departments that required specific support to enhance their telephone management.
How did we get on?	Following the development of UH Bristol's Principles of Excellent Customer Service in the first year of this corporate quality objective (2017/18), we have been embedding the Principles into Trust recruitment, training and induction programmes, including: - Nursing assistant assessment centres - Volunteer assessment centres, induction and competencies - Corporate induction - Customer service training - Preceptorship programme - Administration update days - Relevant apprenticeship programmes - Trust standard competency-based interview template (to commence during Quarter 1 2019) The customer service Principles also form the basis of a new one-day training course that has been designed for Trust staff in roles involving daily transactions with service users (e.g. ward clerks, clinic coordinators). In September 2018 we piloted a training day facilitated by an external expert who developed a successful customer service training course with Sheffield Teaching Hospitals NHS Foundation Trust. Feedback from attendees was positive and we have developed a proposal for implementing this training at UH Bristol during 2019/20. We are currently seeking funding for this

	proposal. We reviewed options for a customer service accreditation programme and discussed this at the staff workshops in 2018/19. We decided that the most effective approach to reach a breadth of services would be to develop a set of easy-to-use customer service resources - rather than undertake a formal accreditation programme. These resources will be housed on the Trust's intranet and aimed primarily at managers and service leads. They will set out steps to achieve consistently excellent customer service (based on our learning from national accreditation programmes and customer service experts), along with case studies and support tools. This collection of resources will be developed and promoted during 2019/20. To maximise the impact of this quality objective, we have worked with a professional design agency to develop promotional materials for the customer service work streams. These are an extension of the Trust's new "Here to help" imagery that was recently launched to promote patient feedback opportunities. Thus, our work streams have become our key mechanism for ensuring that we deliver on our "Here to help" promise to service users. Using the new designs, the UH Bristol Principles of Excellent Customer Service were formally launched to staff in Quarter 4 2018/19 via Trust-wide multimedia communications (internally referred to as the "Here to help" programme). To ensure our outpatient services reflect a customer service approach, we identified channels and processes to incorporate our Principles. These include outpatient standard operating procedures, audit templates and new competencies for administrative staff (which were developed in 2018 for a separate project). These changes will be complete by the end of Quarter 1 2019/20. We have also re-designed the Trust's main outpatient experience survey to better monitor key customer service experiences – from pre-appointment information through to finding the clinic and explaining what will happen next. We published our first data set from this survey in Quarter 3 and it provided a useful new way of understanding our patients' experience. This data will now build up over time to provide us with insight to monitor and improve our outpatient services. This objective has included a specific work stream to improve the Trust's responsiveness to inbound telephone calls. The strapline "#TakePhonership" was originally developed at Bristol Dental Hospital and was subsequently adopted to market the campaign across the Trust. This campaign receives regular promotion via the Trust's internal communication channels and provides staff with newly-developed good practice guides and case studies. Our Transformation Team has also directly supported areas of the Trust where call management has been a particular challenge, especially in high volume services. Between April 2018 and March 2019 our poorest performing departments received 53 per cent fewer complaints and queries about telecommunications than in the same period in 2017/18. Trust-wide, we received 32 per cent fewer complaints and queries about telecommunications in the same comparison period. We are currently developing a governance strategy to embed routine monitoring within the Trust's Clinical Divisions.

RAG rating	Green – We delivered the majority of our customer service project milestones for the year and have seen significant improvements in patient-reported experience of telephoning into the organisation.

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 acute trusts to work for.
What did we say we would do?	Our plans for 2018/19 included: • A bespoke leadership development programme for our 'Top' 100 leaders to 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 also said we would prioritise our efforts and interventions to improve our lower ranking scores within the NHS Staff Survey as follows: • Introduce mandatory "how to be a manager" training for new joiners and staff who are promoted into management roles. • Review the quality of non-mandatory training across the Trust. • Continue to focus on improving staff motivation through the 'Improving staff engagement plans' which are delivered at Divisional level to encourage positive cultural change. • Use 'You said… We did week' in May 2018 to focus on the topic of how we can continue to improve staff communications. Finally, we said we would 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 year on year improved staff engagement score as measured by the National Staff Survey. At the start of the year, this meant working towards a score of 7.6 by 2020 – however, as explained below, the national scoring system has changed this year.
How did we get on?	Key achievements: • A review and relaunch of our management and leadership development offer took place in January 2018; implementation has continued throughout 2018/19. The strategic approach is to influence and bring consistent leadership across the organisation by delivering a leadership and management journey that engages in the development of our managers and leaders, builds confident and competent work force, and delivers succession and stability. • The Trust ran an inaugural Executive Leadership Development programme with over 20 multi-professional leaders; the programme ran for six days over three months and has been positively evaluated. • In August 2018, the Trust mandated a management and leadership development programme for all newly appointed and promoted managers; during 2018/19, over 700 managers attended one of the

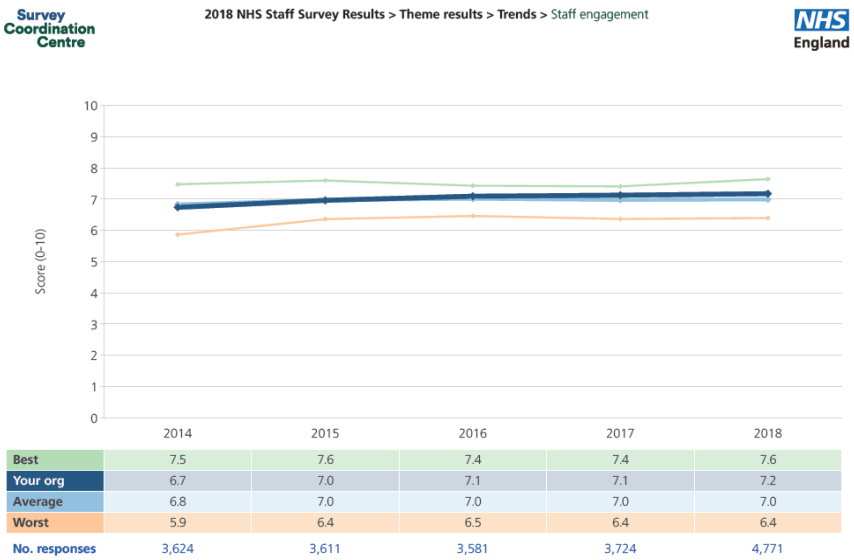
available programmes.

- Over 500 staff attended two events to launch the NHS long service badges as part of the NHS 70 celebrations.
- The Trust ran a senior leaders workshop to further develop its Dignity at Work programme and ensure good practice is further introduced into the organisation.
- The Happy App staff feedback tool was refreshed in March 2019 with an improved reporting system enabling local managers to better understand and respond to real-time feedback data (see our quality objectives for 2019/20).
- Our focus on engagement work has included using 'You said… We did' weeks on a six-monthly basis to ensure staff are clear that their voice is being heard and the organisation is responding in a timely way

The 2018 NHS Staff Survey:
Overall:

- This year, the National Co-ordination Centre has reframed how the survey results are presented, adopting a 0-10 scale. Our overall staff engagement score has risen 7.2, which places us in the top 20 NHS acute Trusts, which is our stated ambition (the best score by an acute Trust was 7.6).
- Our score for whether staff would recommend the Trust as a place to work improved to 70.7 per cent, from 68.6 per cent in 2017; our score for whether staff would recommend a friend or relative to receive treatment provided by the organisation also improved to 84.8 per cent from 82.9 per cent in 2017.
- The number of Trust respondents to the survey also increased by 28 per cent – in itself another positive indication of staff engagement.

Staff engagement scores, calculated under the framework, for the past five years are as follows:



Quality and patient safety measures:

- 33.3 per cent of staff said that in the last month they had seen errors, near misses or incidents that could have hurt patients /service users (this compares with 28.6 per cent in 2017, and the 2018 NHS average of 30.3

	per cent) • 89.2 per cent of staff said that the Trust encourages them to report errors near misses or incidents (this compares with 88.5 per cent in 2017, and the 2018 NHS average of 88 per cent). Equality measures: • 24 per cent of staff said that they had experienced harassment and bullying or abuse from colleagues, which is an unchanged result compared to 2017. The comparable reported experience of BAME (Black, Asian and Minority Ethnic) staff improved slightly from 28 per cent in 2017 to at 26.5 per cent in 2018. • 84.6 per cent of our staff said that they believed that the organisation provides equal opportunities for career progression or promotion, compared to a national average of 83.9 per cent and a Trust score of 88 per cent in 2017. The score for BAME staff was 67.5 per cent in 2018 compared to 69 per cent in 2017 (previously 77 per cent in 2016); the average score in our benchmark group in 2018 was 72 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. And finally, in line with the commitment we made at the start of the year, we identified 'hot spots' within the Trust where staff were dissatisfied with opportunities for flexible working. We offered supportive intervention which included ensuring managers have a clear understanding of the use of the flexible working policy and that they give consideration to flexible working patterns when making workforce changes. Early signs are positive: our national survey score in 2018 improved to 50.2 per cent compared to 48.5 per cent in 2017.
RAG rating	Green – We implemented our plan for 2018/19. Our NHS staff engagement rating has continued to improve and is above the national average for acute trusts.

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 had 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 and a lower proportion of high volume higher performing cancer sites such as breast. The Trust had made significant improvements in performance and achieved the 85 per cent threshold in Quarter 3 of 2017/18. However, following surgical cancellations due to winter pressures and other unavoidable factors (patient choice and late referrals from other providers) performance had dropped to around 80 per cent in the final quarter of 2017/18.
What did we say we would do?	Key actions in our plan to deliver improved performance included: • 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 were: • 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 did we get on?	The Trust has achieved and exceeded the first part of the objective, with the 85 per cent standard delivered in eight months out of 12. We achieved >85 per cent against the 62 day standard for 'non-shared' patients in every quarter.
RAG rating	Green – We implemented our key actions and met our targets.

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.
What did we say we would do?	We said that during 2018/19 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, we planned that a programme of mystery shopping would be developed for the interview team; to have begun by the end of 2018, with an initial evaluation of the programme taking place at the end of 2018/19. We said that a second work stream would focus on exploring the potential to develop more in-depth mystery shopping, such as patients giving detailed feedback after a planned hospital appointment (with an initial focus on elective care). We recognised that this needed to be carefully scoped out with a range of stakeholders, including senior clinical leads and staff-side representatives.
How did we get on?	Working with colleagues from the Customer Services Steering Group, the Trust's outpatient services manager and staff side representatives, we co-designed a process and protocol for mystery shopping called, "My Journey." Working with Trust staff and volunteers, the "My Journey" process follows a patient journey to an outpatient setting and combines traditional mystery shopping techniques with the NHS 15 Step methodology; and, in doing so, encompasses a variety of patient and carer touch points. Part of the co-design process included testing the methodology as part of the Trust's apprenticeship programme and subsequently with the Trust's *Face2Face* team in the Bristol Eye Hospital and Bristol Dental Hospital. In collaboration with the Trust's Outpatient Steering Group, the "My Journey" process was launched in March 2019 with a focus on Dermatology and Cardiac outpatient departments. A review and evaluation of the process will take place in April 2019. In addition, we undertook a scoping exercise to explore how other Trusts have developed a more in-depth mystery shopping process whereby patients

	or carers are recruited to give detailed feedback following a real-time planned hospital appointment. This form of mystery shopping is less common in the NHS and it has become evident that developing this approach will require further detailed scoping with stakeholders. These discussions will be taken forward within the Trust's medical director's team during 2019/20.
RAG rating	Green – We successfully planned and launched the "My Journey" programme during the year, including the establishment of appropriate protocols; this has provided a firm foundation for us to build on in 2019/20.

Objective 5	**To improve learning from serious incidents and Never Events**
Rationale and past performance	It is a stated aim in our Quality Strategy (2016-2020) that we want to improve learning from serious incidents. We had also reported nine Never Events in 2017/18: • One retained piece of swab following a dental procedure • One misplaced nasogastric tube • Two wrong lens implants (ophthalmology) • 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 investigate all serious incidents thoroughly; examples of learning from these Never Events were outlined in last year's annual Quality Report. In addition, we learned that a number of serious incidents were caused by human error which had occurred in situations where there was a difficulty or change in plan before or during the procedure.
What did we say we would do?	In 2018/19, we said we would: • Hold multidisciplinary summits for staff to share learning from incident themes and look for organisational improvements. • 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. • 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. • 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. • 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. • 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 did we get	• In 2018/19, there have been no invasive procedure Never Events in

on?	ophthalmology or dental services and there have been no Never Events involving midazolam and misplaced nasogastric tubes. Section 3.1 of this report provides further information regarding serious incidents and Never Events which were reported in 2018/19. • At our request, in April 2018, NHS Improvement conducted an external review of Never Events in dental services and provided some helpful insights and recommendations to support further learning. Staff at Bristol Dental Hospital (BDH) responded to these in 2018/19 by strengthening team briefs prior to an operating list, and by introducing 'time outs' prior to every clinical procedure which are protected from interruptions. BDH also have introduced human factors awareness simulation training for multi-disciplinary clinical teams and focussed on improving safety culture and engagement though a sequence of events and initiatives to support more effective communication and teamwork. • We have held three successful multi-disciplinary summits in 2018/19 (see section 3.1.5). • We have amended our root cause analysis template to include a guide to enable investigators to assess the strength of actions identified in response to learning from investigations, to encourage the development of actions likely to have the most impact. • We introduced an audit of the quality of our daily safety briefs as a vehicle for local sharing of learning from incidents and are now in the process of reviewing the results to identify best practice which can be shared with all clinical areas. We will take this continuous improvement forward in 2019/20 and beyond. • We held our third annual safety conversations week with staff across the Trust during the national Sign up to Safety campaign's "National Kitchen Table Week" in March 2019, which was well received by front line staff. We are currently collating their comments and ideas to take forward in 2019/20. • Spreading Learning from Excellence is part of the leadership and culture work stream of our patient safety improvement programme from 2019 to 2021 (see sections 3.1.1 and 3.1.5). • We sourced patient information leaflet "Making your stay with us safe"[1] and have been distributing widely to our wards and departments. These leaflets provide information to patients and families about eight simple steps they can take to help keep themselves/their loved one safe in hospital. We also have sourced a complimentary video[2] and are working with our IT department and communications team to show this on large screens in public and outpatient areas in our hospitals.
RAG rating	Green – We implemented our plan for the year and had no further invasive procedure Never Events in ophthalmology or dental services, and no Never Events involving midazolam and misplaced nasogastric tubes. We did, however, have other Never Events in 2018/19, which are described in Section 3.1 of this report.

[1] and [2] Acknowledgment to Haelo Innovation and Improvement Science Centre

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 section 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)[3], however we 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 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 do we say we would do?	We said we would use a multi-faceted approach to improving the confidence of junior doctors in recognising the dying patient. We said we would use a pro-forma to ask the screening question "is this patient so unwell they might die on this admission?" for all admissions through the emergency department and acute medical unit. We also planned to adapt the existing weekend sticker to ask the question "For patients at ceiling of treatment, when should a move to end of life care be considered?"
Measurable target/s for 2018/19	We said that our measure of success would 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 is in use for longer. We said we would collect baseline data in April 2018.
How did we get on?	Baseline data was collected as planned in April. Data on the use of the end of life tool is now routinely gathered for all adult deaths in the Trust, irrespective of Division, each month, for the first seven days of that month. We have used the data to plot run charts and look for trends. During the course of the year, we became aware of similar historical data, previously collected by palliative care nurses, which suggests a gradual shift in the care of dying patients, so that a smaller proportion may now be missing out on appropriate symptom relief. Between April 2016 and July 2017, 55 per cent of patients whose death was anticipated were on the end of life care tool; in the period October 2018 to February 2019, this had increased to 75 per cent. We piloted the screening question, "is this patient so unwell they might die on this admission?" in over 150 patients admitted through the Bristol Royal Infirmary Emergency Department (ED). Use of the screening question has since continued in ED and has been extended to all admissions to Ward A300 (AMU) and A400 (OPAU). There is statistical evidence that the response to the question used on inpatient wards and in ED has been an accurate predictor of whether a patient has died. Uptake of the weekend sticker was variable, confirmed by a snapshot audit. This is, in part, because wards continue to have stocks of old stickers to use up. There has also been variable senior input to the information that is written on the stickers. The additional end of life part of the sticker was meant to prompt a move to end of life care if required, but cannot be used by junior doctors to make judgements if they have been poorly written. We are

[3] 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.

	aiming to enlist the help of a Care of the Elderly registrar to help promote the effective use of the sticker. Other relevant progress: • We are currently considering the use of magnets to flag up on morning board rounds any patient who has been reviewed overnight to ensure senior review in the morning; this may prompt end of life decisions based on the developments overnight. • We have explored the use of NEWS2 stickers to flag the deteriorating patient earlier. • As part of the 'Dying matters' project, posters are being produced to empower patients as well as clinical staff; we hope to launch these posters in May 2019. Overall, although some progress has been made towards achieving this objective, we have been hampered by staffing issues (the project lead left the Trust and her successor later went on maternity leave). Engaging junior doctors with the project has also proved more difficult than anticipated. We said that our measure of success would be an increase in the length of time for which the end of life care tool is used for patients. Use of the tool has increased, so that approximately 75 per cent of dying patients benefit from at least partial use of the tool, however, we need to not only sustain this change but encourage further uptake. During 2019/20, we are working with partners in the West of England Patient Safety Collaborative to implement Recommended Summary Plan for Emergency Care and Treatment (ReSPECT[4]) which will improve advanced care planning in the future.
RAG rating	Amber – We made progress towards our goal but the project was hampered by key staff availability during the year

Objective 7	**To improve patients' experiences of maternity services**
Rationale and past performance	Our maternity services were rated as the best in the 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 was designed to explore what improvements we needed to be making in order to return to the top of the pack in the 2019 survey and beyond.
What do we say we would 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

[4] ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning

	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 the birth of the child. In addition, we set out 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, we planned that the maternity department and LIAISE[5] service would replicate this event at St Michael's Hospital. • '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. We committed to holding further workshops in 2018/19 to draw in staff who had 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 therefore committed to undertaking a specific review of discharge processes in maternity services during 2018/19.
Measurable target/s for 2018/19	At the time of writing this objective, targets for the BNSSG transformation plan were in development, however a key system-wide target was for 20 per cent of all women across BNSSG to receive continuity of care by a team of midwives by March 2019. Ultimately, our goal is to return a top quartile performance in the 2019 national maternity survey.
How did we get on?	BNSSG-wide improvements: - Throughout 2018/19, the maternity service continued to work with our commissioners to deliver the Maternity Transformation Plan for BNSSG. The five BNSSG work streams are all in place in order to implement the transformation plan for Better Births. - UH Bristol has become a pilot site for continuity of care: 278 UH Bristol patients were placed on a continuity of care pathway when the pilot commenced in March 2019, contributing significantly to achievement of the over BNSSG target (28.5 per cent of women were on a continuity of care pathway in March 2019).

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

	- Paperwork to be included in the hand-held yellow notes is still being developed to enable the documentation of personalised choice for women and to encourage women to write more freely in their notes. This is currently being developed across BNSSG, Swindon, Bath, Gloucester and Salisbury maternity services. - The use of electronic discharge information between wards and community midwives has been piloted and rolled out to all bases within BNSSG. - Other work streams include the bereavement care pathway and postnatal ward experience. At St Michael's Hospital: - A central booking system is now in place for women to book their antenatal appointment (previously, women contacted their community midwife directly). - 'Patient Experience at Heart' workshops were held in January 2019 - feedback from the workshops is currently in the process of being analysed and written up. Whilst we would expect the quality improvements we have carried out this year to be reflected, later on, in the National Maternity Survey scores for 2019 (published in 2020), there was also positive news in the 2018 results: - UH Bristol's scores were particularly positive in the section of the survey relating to care during labour and birth, with a "better than national average" rating across this aggregate set of questions. There were also positive results in respect of giving women a choice of where to give birth (achieving the best score nationally) and enabling partners to stay overnight (which has been an improvement focus for the service). - No UH Bristol scores were worse than the national average.
RAG rating	Green – We have been closely involved in BNSSG system-wide service improvements and have implemented local service improvements over and above this. Our survey scores in the latest national maternity survey were better than the national average for patient experience during labour and birth.

Objective 8	**To improve the safe prescribing and use of Insulin**
Rationale and past performance	Last year, we reported that whilst the Trust had put in place a number of measures in recent years to improve the safety of insulin prescribing and administration, this had not led to a reduction in numbers of reported insulin-related incidents. These improvements had 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 did we say we would do?	In 2018/19, we said we would: • Roll-out Medway electronic prescribing (EPMA) to adult wards (timescale was anticipated as 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 was that unintentional omission of insulin prescribing on the Acute Medical Unit (Ward A300) and Older People's Assessment Unit (Ward A400) would 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 did we get on?	The 2017/18 baseline data was determined to be 12 occurrences of omitted insulin prescriptions at medicines reconciliation, as recorded by pharmacy staff during the process of obtaining a medication history and reconciliation. Our target for 2018/19 was therefore to have no more than nine occurrences, representing a 25 percent reduction in unintentional insulin omission on admission. Patients who had insulin omitted on admission were identified electronically from Medway medicines notes, where pharmacy staff record medicines reconciliation. The number of cases identified in the period April to November 2018 was 22; this was significantly higher than anticipated, prompting an investigation to validate the findings. The investigation has identified over reporting of omitted doses of insulin. Of 12 cases reviewed to date, only two instances of actual insulin omission have occurred, with no documented harm; an assessment which is consistent with insulin incidents recorded on our Datix risk management system. Over-reporting occurred because of a flaw in data collection methodology: specifically, the use of the word 'omitted' as a search field did not distinguish between those patients whose insulin had been unintentionally omitted from the drug chart (the target data), and those patients who regularly took insulin but were currently having other treatment e.g. with intravenous insulin, so their insulin, although recorded as omitted, was actually 'held' or 'withheld' on purpose while they received an alternative treatment.

	The anomaly in data recording prompted the introduction of a standardised set of data definitions; this information was disseminated in December. There were no reported omitted doses of insulin on admission in the three months following the introduction of the standardised data definitions. The analysis of the target data also drew into question the validity of the baseline data that was used to set our target. The 12 reported incidences of omitted insulins at medicines reconciliation in 2017/18 have also been reviewed, and it has been verified that there were only two confirmed omitted doses of insulin on admission in that year.
RAG rating	Not applicable. Our investigation identified over-reporting occurred resulting from a flaw in our data collection methodology. Based on the corrected baseline data, this topic would not have been selected as a corporate quality objective. Nonetheless, the actions taken by the Trust in 2018/19 will have strengthened patient safety and reduced the likelihood of omitted insulin doses in the future.

2.1.2 Quality objectives for 2019/20

The Trust is setting eight quality objectives for 2019/20.

Two of these objectives – reducing the risk of Never Events, and improving staff engagement (this year, specifically through use of the Happy App tool) – represent a continuation of existing annual quality objectives. In addition, we have agreed six new quality objectives for 2019/20.

All of 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 2019 (an annual consultation event aimed at our Involvement Network, Trust members and governors);
- feedback from an online survey which was open to our staff, members and governors in February 2019
- review of performance against key quality performance metrics over the last year.

Objective 1	**Enabling improvements in patient safety through the use of digital technology**
Rationale and past performance	In 2016, UH Bristol was selected as a 'digital exemplar' site, trialling pioneering digital technology to drive radical improvements in the care of patients. For 2019/20, we have identified three specific patient safety themes where we believe digital technology can play a vital role in improving patient safety. These themes are: **Improving the management of intravenous cannulas** Until now, intravenous cannulas have been documented on drug charts, with inspections carried out once per shift. In reality, practice has been inconsistent, with no reporting mechanism to enable visibility of those cannulas that need a check and those that are due for removal. Documenting all intravenous cannulas in our Vitals e-observation system enables this visibility.

	Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores) Performance used to be sampled as a monthly audit via the patient safety thermometer, however, implementation of the Vitals system supports a full sample of all patients in real time, highlighting patients who do not get their observations taken on time as recommended by the NEWS2 escalation plan and ensuring that there is the correct oversight of observations by registered nurses. **Improving compliance with VTE (Venous thromboembolism) assessment** Previously, VTE assessment compliance has been measured from paper records when patients are discharged; we recognise that this has not provided a true measure of VTE assessment compliance rates. Use of an electronic VTE risk assessment in Medway on admission will support a full sample survey of all patients in real time.
What will we do?	**Improving the management of intravenous cannulas** During 2019/20, we will implement the use of the electronic system Vitals to document all peripheral intravenous cannulas. By using real time data, we will improve compliance with IV line monitoring, line related infection surveillance and reduce the number of line infections. **Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores)** During 2019/20, we will work to embed the routine use of the e-observation system including improving ward managers' understanding of the ability to monitor patients' NEWS in real time and to identify any overdue observations. We will also work at divisional level and Trust level to ensure that prompt action is taken in response to any overdue observations. **Improving compliance with VTE (Venous thromboembolism) assessment** During 2019/20, we will implement and embed the use of the proposed digital tool to improve performance. We will also embed the use of dashboards and ward-view screens to highlight any patients who need a VTE assessment.
Measurable target/s for 2019/20	**Improving the management of intravenous cannulas** We will measure the number of cannulas/lines that are left in beyond the date for removal and will reduce and the number of infections related to cannulas left in beyond the time they should have been. **Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores)** We will reduce the number of incidents where adverse variations in observations have not been acted on as per Trust policy. **Improving compliance with VTE (Venous thromboembolism) assessment** We will meet the national standard, which requires at least 95 per cent of appropriate inpatients to have a VTE risk assessment.
How progress will be monitored	Progress will be monitored by the Trust's Infection Prevention and Control Committee, and through the Divisional Review process.
Board sponsor	Improving the management of intravenous cannulas – Chief Nurse Improving compliance with taking patient observations on time as

	recommended by NEWS2 (National Early Warning Scores) – Chief Nurse Improving compliance with VTE (Venous thromboembolism) assessment – Medical Director
Implementation lead	Improving the management of intravenous cannulas – Heads of Nursing Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores) – Heads of Nursing Improving compliance with VTE (Venous thromboembolism) assessment – Consultant Haematologist Lead for VTE, and Chief Clinical Information Officer

Objective 2	**Reducing the risk of Never Events**
Rationale and past performance	Never Events are defined as "serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers" (NHS Improvement January 2018). Recent serious incident investigations, including those conducted by the independent Healthcare Safety Investigation Branch (HSIB), have concluded that the implementation of guidance and safety recommendations does not, on its own, prevent certain Never Events because of the human elements and human interactions within the system designed to prevent them happening. In 2018/19, 496 never events were reported nationally across the NHS. There were five Never Events which were reported by UH Bristol during 2018/19: • Retained broken off tip of a central venous line guidewire (child) (August 2018) • Alleged retained vaginal swab -occurring during care by a sub-contracted third party provider (November 2018) • Wrong side nerve block for a hip procedure (December 2018) • Wrong side laparoscopic testicular surgery (child) (December 2018) • Left ovary removed during laparoscopic hysterectomy when the plan was to conserve both ovaries (March 2019)
What will we do?	We will: • Work with surgical teams / Local Safety Standards for Invasive Procedures work stream leads to identify guidance for when additional "stop checks" time outs should be called. "Stop checks" are where the team pauses and refocuses, for example reconfirming the patient, procedure and laterality if a team member changes or an unexpected event happens during a procedure. • Incorporate into patient safety training awareness of the impact of hierarchical behaviours on calling time outs. By hierarchical behaviours we mean behaviours that belittle or embarrass team members and juniors, leading to, for example, them not feeling able to speak up if they see something that might be about to go wrong. • Training in high risk specialties about high risk Never Events, e.g. laparoscopic procedures where laterality is relevant, to include foresight and simulation training. • Test physical barriers to proceeding with nerve blocks until 'Stop before

	you Block' has been completed, and implement if effective barrier identified. • Commence three year work stream to understand and reduce the frequency and impact of interruptions and distractions on human error. • Conduct a "review and check" exercise to proactively revisit and recheck implementation of patient safety alerts designed to reduce the risk of Never Events. • Conduct a "review and check" exercise to ensure Local Safety Standards for Invasive Procedures incorporate the latest local learning and HSIB investigations. • Participate in system-wide collaborative work on reducing Never Events.
Measurable target/s for 2019/20	We will judge success by the completion of the above actions.
How progress will be monitored	The 2019/20 Never Events action plan will be updated quarterly and reported to Trust's Clinical Quality Group.
Board sponsor	Medical director
Implementation lead	Head of quality (patient safety) and associate medical director for patient safety

Objective 3	**Improving the provision of information and support to meet the needs of young carers across the Trust**
Rationale and past performance	Following the re-launch of UH Bristol's carers strategy in 2018, this objective sets out to re-focus and improve support provided to young carers at UH Bristol. The objective also supports a pledge made in the NHS Long Term Plan (2019) to maintain the focus on identifying and supporting carers.
What will we do?	During 2019/20, we will: • Work to identify young carers as early as possible when they are in contact with our services. • Review the information and signposting available for young carers across the Trust. • Review the information available to young carers on the Trust's website and through social media. • Re-launch carers awareness training across the organisations. • Continue to work with Bristol Young Carers' Voice support group. • Work in partnership with young carers to improve our understanding of their experiences of our services • Deliver a UH Bristol site tour for young carers from Young Carer Voice to attend. • Plan and deliver a Health Matters event on the topic of supporting carers including young carers in secondary care.
Measurable target/s for 2019/20	We will measure success by delivery of the actions listed above.
How progress will be monitored	Via quarterly reports to Patient Experience Group
Board sponsor	Chief nurse
Implementation lead	Senior nurse quality and patient and public involvement lead

Objective 4	**Driving positive staff engagement through expanded use of the Happy App**
Rationale and past performance	This is the fourth consecutive year that the Trust has set a quality objective relating directly to staff experience. This is because we fundamentally believe that great staff experience goes hand in hand with great patient care. One of the specific improvement goals of our Quality Strategy 2016-2020 has been to roll out the 'Happy App' to measure real-time staff experience in all clinical teams by 2020. Launched in the autumn of 2016, Happy App serves as an anonymous, self-reporting communication tool to collect and measure mood and morale, and to capture inter-team experience via anecdotal comments. This platform allows colleagues to voice opinions without fear of retribution and enables managers to gain insight and understanding on colleagues' behaviour, values, motives, intent, actions, frustrations, goals and desires.
What will we do?	We want to extend and improve the organisational reach, functionality and reporting capability of Happy App. Specifically, we will: • Introduce an 'Insights' text analysis tool to search keywords within any data range. This tool will enable us to generate word clouds based on five reporting categories: Emotion Lens; Employers Branding; System Themes; Benchmarking; and Improvement. • Supplement current dashboard report with longitudinal data analysis to help identify and deliver appropriate local engagement and improvement activities within each Division. • Explore additional report functionality with system provider. • Develop and deliver a communications plan to ensure high levels of awareness and engagement with Happy App across all staff groups, including targeted promotion with hard-to-reach teams. • Consult with internal stakeholders to identify and exploit opportunities to promote the Happy App and to resolve staff engagement issues raised. • Evaluate the effectiveness of marketing efforts and internal advertising channels of Happy App.
Measurable target/s for 2019/20	In 2019/20, our target is to increase the number of clinical and non-clinical teams registered for Happy App by 10 per cent against a baseline which we will measure on or around 1st June 2019, i.e. three months on from our refresh of the system. We will also be monitoring moderator responses to comments as a measure of the effectiveness of the feedback process.
How progress will be monitored	Via People Committee
Board sponsor	Director of people
Implementation lead	Head of organisational development

Objective 5	**Improving the availability of information about physical access to our hospitals to ensure patients and visitors know how to get to services in the easiest possible way, particularly patients with disabilities.**
Rationale and past performance	The hospitals which make up UH Bristol's main site are built on a hill and have grown and developed over the past hundred years. We receive consistent feedback that our estate can be challenging to navigate, particularly for patients and visitors with a physical disability. In January 2019, we held a 'Quality Counts' engagement event; this year, the event had an equality theme and the issue of difficult physical access for some patients/visitors was highlighted as an area that had a negative impact on patients' experience and should be improved.
What will we do?	We will improve the information that we provide to patients and visitors on how to get to the various hospital sites on the main campus and within the sites. As part of this work we will identify where we should be prioritising our resources to improve physical access to our hospitals in the future.
Measurable target/s for 2019/20	We will measure the success of this objective by the creation of: • a detailed web-based access guide for patients and the public, providing visual and descriptive information about our estate. • a 'recommendations matrix' to guide decisions about how and where we could improve access, as and when funds permit this.
How progress will be monitored	Via Patient Inclusion and Diversity Group, reporting to Patient Experience Group
Board sponsor	Chief nurse
Implementation lead	Patient experience and involvement team manager

Objective 6	**Improving patient experience through roll out of the real time outpatients initiative**
Rationale and past performance	We recognise the inconvenience and stress caused to patients when there are delays to communication and booking of next steps following an outpatient clinic attendance. From a Trust operational perspective, delays in sending out the clinic letter also result in failure to meet the national seven-day clinic letter turnaround target. Missing or incorrect outcomes and delays in booking next steps increase the risk of breaching referral and treatment targets and the possibility of the patient coming to harm. The real time outpatients (RTOP) initiative is designed to allow all of the administrative tasks relating to a patient's clinic appointment to take place on the day of the visit. This means that patients will leave the clinic knowing what the next step in their treatment is, and when that will take place. It will significantly reduce waste within the system by shortening the turnaround time for clinic letter production, enabling diagnostics, follow- up and 'to come in' (TCI) dates to be booked in a more timely manner. Finally, it will enable the appointment outcome, next steps on the patient pathway, and discharge (if applicable) to be confirmed as correct, known as validation in real time. Real time outpatients has been agreed as a corporate objective for the Trust and the aim is to roll out to all specialities and Divisions by 2021. This will:

	• Ensure the clinic letter turnaround time meets the national seven-day target; performance in January 2019 was only 70 per cent across the Trust. Where possible letters will be dictated, checked and approved within 24 hours of the appointment. • Allow patients to have plain film X-Ray and blood tests on the same day as their appointment and book a date for complex imaging before they leave the hospital. • Ensure all outcomes are accurately recorded on the day of clinic and updated following approval of the letter, ensuring patients' next steps are booked in a timely manner. This will reduce the time spent validating missing or inaccurate outcomes, and hopefully reduce the 'Did not attend' rate in participating specialities, by improving patients' understanding of the importance of their appointment.
What will we do?	During 2019/20, we will roll out real time outpatients to a number of specialities within each division. Cardiology went 'live' in November 2018, as did Rheumatology in April 2019, whilst discussions are ongoing with Women's and Children's services, Surgery, and Diagnostics and Therapies to identify early adopters. All Divisions have signed up to the initiative and have included real time outpatients in their operating plans for 2019/20. Each Division has identified a real time outpatients champion within the management team to support the central outpatients team. Each speciality will have an implementation plan. Real time outpatients will also support further digitalisation of outpatient clinics and administrative processes. Roll out in each Division will include the following: • Ensuring that clinic letters are dictated on the same day as clinic, either after each patient or at the end of the clinic. • Ensuring there is secretarial support linked to the clinic so that the letter can be checked and ready for approval on the same day. • Approving letters between patient appointments, or soon after clinic. • Direct booking at reception of all follow-ups within six weeks. • Discharging the patient from Medway (the Trust's patient administration system) by the secretary if a discharge letter is proof-read. • Checking that any complex scans are booked on ICE (our radiology booking system) by the secretary when proof-reading the letter. • Accurately recording the outcome when the patient leaves clinic; checked by the secretary. We will also work with radiology to pilot and then formally introduce booking of radiological scans immediately following an outpatient appointment; we will begin by trialling this with adult CT scans.
Measurable target/s for 2019/20	Our targets are to: • Achieve seven day turnaround for all appropriate letters in specialities where real-time outpatients is implemented. • Improve the number of letters that are dictated checked and approved within 24 hours of the clinic appointment. • Reduce the number of letters sent out 14 days after clinic. • Reduce the number of missing outcomes (at the end of each appointment, an outcome must be recorded on the Trust patient administration system Medway; this is how the next step for the patient is booked) and the time spent by staff validating outcomes each month. • Reduce the 'Did not attend' rate for outpatient clinics.
How progress	Via Outpatient Steering Group

will be monitored	
Board sponsor	Deputy chief executive / chief operating officer
Implementation lead	Outpatient services manager (Trust-wide)

Objective 7	**Planning and overseeing implementation of the Medical Examiner System**
Rationale and past performance	From April 2019, a national system of Medical Examiners (MEs) is being introduced to provide support for bereaved families and to improve patient safety. Overseen by a National Medical Examiner, MEs will be specifically trained independent senior doctors from any speciality. They will scrutinise all deaths that do not fall under the coroner's jurisdiction. The introduction of MEs in this Trust will support our aims for transparency and improving the experience of patients and their families at the end of life. Implementation will provide opportunity to consider further ways of improving our services. At the same time, we know that support for families in adult care is not of the same level as the wrap-around support offered in, for example, children's services.
What will we do?	During 2019/20, we will: • Work closely with local Trusts within the Academic Health Service Network to agree a standardised implementation strategy for the ME system; this will include provisions for outside office hours to take account of religious requirements for burial within a set timeframe. • Meet with interested medical staff initially as an engagement and information sharing event, but then to help shape the business plan and understand how to provide the required ME service by job planning. • Visit and learn from early implementation sites. • Ensure that the current bereavement office is suitably prepared and equipped for the introduction of MEs and Medical Examiners Officers (MEOs) to work alongside existing systems, staff and roles. • Train and prepare our existing bereavement officers in the role of MEOs via the completion of online training modules. • Consider the introduction of a bereavement survey to compliment ME conversations with families to ensure we are obtaining feedback and providing an excellent service. As part of this objective, we will also use the year to develop our understanding of what outstanding bereavement care and support looks like in the adult service setting, learning from trusts who are rated by the CQC as outstanding in this area of practice; we will also consider how learning might be applied from our own children's services.
Measurable target/s for 2019/20	By the end of the 2019/20, we will have successfully implemented the new Medical Examiners system, in partnership with local acute Trusts. We will also have completed our scoping exercise for adult bereavement care as a platform for future service improvement.
How progress will be monitored	Progress of implementation of Medical Examiners to be monitored via Clinical Quality Group. Scoping exercise in adult bereavement care to be reported via Patient Experience Group.
Board sponsor	Medical director
Implementation leads	Associate medical director for patient safety (ME implementation), chaplaincy team leader (scoping of bereavement care)

Objective 8	**Developing and implementing a training programme for Trust lay representatives to support and develop their participation in Trust groups and committees**
Rationale and past performance	This objective sets out to influence and develop the practice of lay partner involvement in UH Bristol as part of a growing move in the NHS to develop the concept and practice of patient leadership. This represents a continuation of a journey which commenced in 2016 with the patient and community leadership programme, "Healthcare Change Makers", which was a collaboration between UH Bristol, North Bristol NHS Trust and Bristol Community Health, with additional input from the local Clinical Commissioning Group and Healthier Together, with facilitation provided by the Centre for Patient Leadership and The King's Fund.
What will we do?	During 2019/20, we will: • Review the process for recruiting lay representatives and use this as the basis upon which to develop a new approach to working with lay representatives in the Trust. • Map existing lay representation in steering groups and committees across the Trust. • Scope out the core features and learning objectives for a training package, drawing from the Healthcare Change Makers patient and community leadership model and other models of good practice including The King's Fund. This will include an assessment of resource implications and how such training may be accredited. • Explore opportunities to partner with other local providers so that the training is shared across organisations. • Design, deliver, evaluate and review training. • Establish an annual on-going support and development process for lay representatives in the Trust.
Measurable target/s for 2019/20	Our targets for 2019/20 are: • Delivery of a training programme to Trust lay representatives including an annual ongoing support and development process. • Creation of at least six new opportunities for lay representation in Trust groups and committees.
How progress will be monitored	Via quarterly reports to Patient Experience Group
Board sponsor	Chief nurse
Implementation lead	Patient and public involvement lead

2.2 Statements of assurance from the Board

2.2.1 Review of services

During 2018/19, UH Bristol provided relevant health services in 70[6] specialties via five clinical divisions (Medicine; Surgery; Women's and Children's Services; Diagnostics and Therapies; and Specialised Services).

During 2018/19, 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 2018/19 therefore, in these terms, represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2018/19.

2.2.2 Participation in clinical audits and national confidential enquiries

For the purpose of the Quality Report/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 2018/19, 51 national clinical audits and six 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 98 per cent (50/51) national clinical audits and 100 per cent (6/6) 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 2018/19, and whether it did participate, are as follows:

Table 1

Name of audit / programme	Participated
Acute, urgent and critical care	
Sentinel Stroke National Audit programme (SSNAP)	Yes
Adult Community Acquired Pneumonia	Yes
Case Mix Programme (CMP)	Yes
Feverish Children (care in emergency departments)	Yes
Major Trauma Audit (TARN)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Emergency Laparotomy Audit (NELA)	Yes
Seven Day Hospital Services	Yes
Vital Signs in Adults (care in emergency departments)	Yes
VTE risk in lower limb immobilisation (care in emergency departments)	Yes

[6] 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)

Blood and infection	
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes
Use of fresh frozen plasma and cryoprecipitate in neonates and children	Yes
Management of massive haemorrhage	Yes
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes
Surgical Site Infection Surveillance Service	Yes
Cancer	
National Audit of Breast Cancer in Older People (NABCOP)	Yes
National Bowel Cancer Audit (NBOCA)	Yes
National Lung Cancer Audit (NLCA)	Yes
National Oesophago-gastric Cancer (NAOGC)	Yes
National Prostate Cancer Audit (NPCA)	Yes
Elderly care	
Fracture Liaison Service Database (FLS)	Yes
National Audit of Inpatient Falls (NAIF)	Yes
National Hip Fracture Database (NHFD)	Yes
National Audit of Dementia (NAD)	Yes
National Joint Registry (NJR)	Yes
End of life care	
National Audit of Care at the End of Life (NACEL)	Yes
Heart	
Adult Cardiac Surgery (ACS)	Yes
Cardiac Rhythm Management (CRM)	Yes
Myocardial Ischaemia National Audit Project (MINAP)	Yes
National Audit of Cardiac Rehabilitation (NACR)	Yes
National Audit of Percutaneous Coronary Interventions (PCI)	Yes
National Congenital Heart Disease (CHD)	Yes
National Heart Failure Audit (NHF)	Yes
Long term conditions	
National Asthma Audit	Yes
National COPD Audit	Yes
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes
National Diabetes Core Audit (NDA)	Yes
National Diabetes Foot Care Audit (NDFA)	Yes
National Diabetes Inpatient Audit (NaDIA)	Yes
National Pregnancy in Diabetes Audit (NDIP)	Yes
National Ophthalmology Audit (NOD)	Yes
UK Cystic Fibrosis Registry	Yes
Non-Invasive Ventilation	Yes
Inflammatory Bowel Disease programme / IBD Registry	No
Women's & Children's Health	
National Audit of Seizures and Epilepsies in Children and Young People	Yes
National Maternity and Perinatal Audit (NMPA)	Yes
National Neonatal Audit Programme (NNAP)	Yes
National Paediatric Diabetes Audit (NPDA)	Yes

Neurosurgical National Audit Programme (NNAP)	Yes
Paediatric Intensive Care (PICANet)	Yes
Confidential enquiries/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
Mental Health Clinical Outcome Review Programme	Yes
National Mortality Case Record 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 2018/19, 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 / programme	
Acute, urgent and critical care	
Sentinel Stroke National Audit programme (SSNAP)	>90% (473)
Case Mix Programme (CMP)	100% (2314)
Feverish Children (care in emergency departments)	100% (121)
Major Trauma Audit (TARN)	100% (589)
National Cardiac Arrest Audit (NCAA)	84*
National Emergency Laparotomy Audit (NELA)	>85% (131)
Seven Day Hospital Services	100% (215)
Vital Signs in Adults (care in emergency departments)	100% (173)
VTE risk in lower limb immobilisation (care in emergency departments)	100% (127)
Blood and infection	
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	100%
Use of fresh frozen plasma and cryoprecipitate in neonates and children	35*
Management of massive haemorrhage	8*
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	673*
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	100% (19)
Surgical Site Infection Surveillance Service	1413*
Cancer	
National Audit of Breast Cancer in Older People (NABCOP)	158*
National Bowel Cancer Audit (NBOCA)	>100% (235)
National Lung Cancer Audit (NLCA)	196*
National Oesophago-gastric Cancer (NOGCA)	61-70% (142)
Elderly care	
Fracture Liaison Service Database (FLS)	99% (1573)
National Hip Fracture Database (NHFD)	100% (278)
National Audit of Dementia (NAD)	100% (50/50)
National Joint Registry (NJR)	60% (33)
End of life care	
National Audit of Care at the End of Life (NACEL)	39*

Heart	
Adult Cardiac Surgery (ACS)	100% (1259)
Cardiac Rhythm Management (CRM)	100% (1419)
Myocardial Ischaemia National Audit Project (MINAP)	805*
National Audit of Percutaneous Coronary Interventions (PCI)	100% (2183)
National Congenital Heart Disease (CHD)	100% (1130)
National Heart Failure Audit (NHF)	300*
Long term conditions	
National COPD Audit	575*
National Diabetes Core Audit (NDA)	393*
National Diabetes Foot Care Audit (NDFA)	64*
National Pregnancy in Diabetes Audit (NDIP)	32*
National Ophthalmology Audit (NOD)	100% (3960)
UK Cystic Fibrosis Registry	Data unavailable
Women's & Children's Health	
National Neonatal Audit Programme (NNAP)	100% (1022)
National Paediatric Diabetes Audit (NPDA)	100% (485)
Neurosurgical National Audit Programme (NNAP)	Data unavailable
Paediatric Intensive Care (PICANet)	100% (787)
Confidential enquiries/outcome review programmes	
Child Health Clinical Outcome Review Programme	2*
Learning Disability Mortality Review Programme (LeDeR)	47% (7/15)
Maternal, Newborn and Infant Clinical Outcome Review Programme	100% (66)
Medical and Surgical Clinical Outcome Review Programme	3*
Mental Health Clinical Outcome Review Programme	Data unavailable

*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 eight national clinical audits were reviewed by the provider in 2018/19. University Hospital Bristol NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

BTS Paediatric Pneumonia audit
Local pneumonia guidelines have been reviewed and disseminated. The team are liaising with the paediatric emergency department to establish processes to limit initial investigations to patients with severe or complicated disease, and with general paediatrics to agree thresholds for chest x-rays at follow-up.

National Neonatal Audit Programme
Changes have been made to the Badger and Phillips (electronic patient record) systems to ensure that the details of parental discussion are recorded appropriately, along with education to junior doctors to highlight the importance of these discussions.

Falls and Fragility Fracture Audit Programme: Physiotherapy Hip Fracture Sprint Audit
A Sunday physiotherapy service will be established to increase the number of patients seen on the weekend and on day one post operation.

National Audit of Inpatient Falls (NAIF)
A high risk falls medication list and cognitive assessment/delirium care plan is in development and the Trust's fall e-learning has been updated. Falls awareness week was used to highlight current issues to staff. The Trust falls steering group has agreed further work as part of the group work plan.

British Association of Dermatologists (BAD) National Clinical Audit on Bullous Pemphigoid
Baseline and monitoring checklists are to be updated to reflect the BAD guidance and clinic proformas will be developed to capture information on new and follow up patients.

National small bowel obstruction audit
A nutrition assessment is to be built into the enhanced recovery pathway for emergency laparotomy patients.

National Chronic obstructive pulmonary disease (COPD) Audit
Dedicated resource has been agreed to improve data capture and entry into the audit and the Medway clinical note has been redesigned to capture the new dataset. A new respiratory inpatient referral has been implemented on Medway to improve the referral process to respiratory nurses.

National Audit of Dementia
A new cognitive impairment care plan is being developed. This will reflect a more holistic approach to cognitive impairment and is in line with the frailty project work which is being developed. The Abby Pain Score has been relaunched and is part of the new electronic observation system and awareness of its use raised through additional trainings / board rounds / communications. The Trust dementia steering group has agreed further work as part of the group work plan.

National Clinical Audit Benchmarking (NCAB)

The Healthcare Improvement Partnership (HQIP) produce benchmarking information based on the data that trusts submit to national audits. Along with the national reports produced, this allows trusts to see how they compare to national results and those of other organisations. In 2018/19, the Trust reviewed the following benchmarking summaries:

- National Emergency Laparotomy Audit
- Intensive Care Audit
- National Bowel Cancer Audit
- National Hip Fracture Database
- National Lung Cancer Audit
- National Oesophago-Gastric Cancer Audit
- National Prostate Cancer Audit
- Paediatric Intensive Care Audit
- National Maternity and Perinatal Audit
- National Audit of Dementia

The outcome and action summaries of 241 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2018/19; 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 2018/19[7].

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

2.2.3 Participation in clinical research

UH Bristol is a top-20 research-intensive teaching hospital, working closely with its partner universities. Its mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. In pursuit of improving the care the NHS provides, we strive to offer patients the opportunity to take part in research routinely.

The number of patients receiving relevant health services provided or subcontracted by UH Bristol in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 10,236. This compares with 6,925 in 2017/18.

As of 31 March 2019, the Trust had 746 active studies, 37 of which are sponsored by UH Bristol. At the equivalent point 12 months before, the Trust had 730 active studies. Our sponsored research includes trials of investigational medicinal products, investigational devices and surgical interventions.

In a snapshot taken on 31 March 2019, the number of research studies and recruited participants were as follows (March 2018 comparator in brackets):

Table 3

Number of active non-commercial (portfolio) studies	498 (480)
Number of active non-commercial (non-portfolio) studies	122 (112)
Commercial studies registered	143 (138)
Number of recruits in portfolio non-commercial trials	8,370 (5,640)
Number of recruits in non-portfolio non-commercial trials	1,565 (1,001)
Number of recruits in commercial trials	301 (284)

We have continued to develop our relationships with the National Institute for Health Research (NIHR) Local Clinical Research Network (LCRN) core team and partner organisations. With new leadership in the LCRN there has been renewed focus on performance in delivering portfolio research, including increasing the number of participants recruited to research. This financial year, by early March we had recruited well over 8,000 participants, a 25 per cent increase over last year. This has been achieved through a huge effort by our research teams across the Trust. In particular, we saw very high recruitment in paediatric immunology, cardiac surgery, dementia research, and as part of the 100,000 genomes study. Research improves the care we provide and our aim is for research to be consistently embedded across all our clinical divisions.

We continue to work closely with industry partners and strive to increase our contract commercial activity, as this brings novel treatments to our patients and generates income that we can use flexibly to support non-commercial research. We approved more than 50 new contract commercial studies in 2018/19, increasing our activity by a fifth over last year's figures. Our research teams successfully recruited the first UK patient to ten different contract commercial studies this year, a significant achievement in an environment where we are measured on our set-up times and time to recruit participants. One of those patients was the first in Europe to be recruited to a global trial looking at immuno-therapy, specifically LN-145 from Iovance, which works by attacking cancer cells directly through the patient's own immune system to effectively fight the cancer. LN-145 is made from the patient's own cells, referred to as tumour-infiltrating lymphocytes or TIL. The Trust has recruited five patients and is currently the joint top recruiter in Europe for this global study. We have a second trial with LN-145 looking at a different group of cancer patients currently in set-up.

We also completed recruitment to our first commercial trial in adult immunology, surpassing our target of 50 and recruiting 65 participants into the CONSTANT Hepatitis B vaccine trial, which our Medical Research Team is still carrying out.

Some of our flexible income generated last year through delivery of contract commercial research was used to 'pump prime' posts in areas identified for growth. One example is funding staff time within the Sexual Health Team which has allowed us to deliver three NIHR-adopted studies: PREP Impact, CHOP and Safe Text; for all of these we successfully exceeded our initial recruitment targets. We hope to continue to support specialties where we have potential to increase our research activity, such as sexual health, through collaboration and business planning with the LCRN.

We have recently completed the second year of our NIHR Biomedical Research Centre (BRC), 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 (£8.2 million in 2018/19) continues to increase year on year, comprising the NIHR BRC, NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRC) West, 15 NIHR project or programme grants and two NIHR Fellowships.

New grants starting in 2018 have included:

- A Feasibility Study of No Routine Gastric Residual Volume measurement in mechanically ventilated Infants and Children: the GASTRIC Study.
- The development of a one-to-one fatigue self-management intervention delivered by nurses in the rheumatology team to patients with inflammatory arthritis.
- A prestigious NIHR Doctoral Fellowship: Development of an intervention to reduce distress during and after brachytherapy for locally advanced cervical cancer.
- Effectiveness and cost-effectiveness of INSPIRatory musclE training (IMT) for reducing postoperative pulmonary complications (PPC): a sham-controlled randomised controlled trial (RCT) (INSPIRE).

In 2018/19 we have worked with researchers to submit 11 grant applications for NIHR funding, and whilst not all will be successful, this is a measure of the Trust's engagement with research. Two particular highlights are:

- RAFT clinical trial, which ended in 2018.

"Reducing Arthritis Fatigue – clinical Teams using cognitive-behavioural approaches (RAFT)" was a £1.3 million grant funded by the National Institute for Health Research, and collaboration between UH Bristol, University of the West of England and University of Bristol. The study aimed to determine whether a group course delivered by rheumatology teams using cognitive-behavioural approaches could reduce the impact of fatigue in patients with rheumatoid arthritis (RA), a lifelong inflammatory condition affecting most joints, with fluctuating pain and swelling leading to joint damage and disability. The recently published conclusions from the study are that multiple measures of fatigue in patients with rheumatoid arthritis can be improved by the CBT intervention. Next steps will be to implement the practice and train clinicians across the UK.

- PReCePT2 trial, which started in 2018.

A Health Foundation Scaling up Improvement award of £457,000 was received for PReCePT2: Reducing brain injury through improving uptake of magnesium sulphate in preterm deliveries. Preterm birth is the leading cause of brain injury and Cerebral Palsy (CP) with lifelong impact on children and families. A previous clinical trial had shown that magnesium sulphate given to mothers during preterm birth is an effective treatment for protecting the babies' brain, and showing that CP can be reduced in a third of cases. However, two-thirds of UK babies were not receiving this effective and low cost treatment (approximately £1 per dose). A quality improvement package, PReCePT1, was co-designed with patients and staff and implemented across five maternity units in West-England, increasing average uptake of magnesium sulphate from 21 per cent to 85 per cent. A Scaling up Improvement award means that PReCePT2 will be extended to 10 maternity units across the UK. The study is a 'flagship' collaboration with NIHR CLAHRC West and the NIHR West of England Academic Health Science Network aimed at maximising and evaluating adoption across the UK.

2.2.4 CQUIN framework (Commissioning for Quality and Innovation)

A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2018/19 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 was 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 was 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 2018/19 for quality improvement and innovation goals was approximately £11.85 million based on the sums agreed in the contracts (this compares to £11.05 million in 2017/18).

CQUIN was set as a two year scheme in 2016/17 however a number of schemes were removed and new schemes introduced. The following 12 CQUIN targets were agreed, with the Trust estimating to achieve 85 per cent of the £11.85m total potential income:

- supporting local areas
- 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
- preventing ill health by risky behaviours – alcohol and tobacco
- improving HCV (Hepatitis C) treatment pathways through Operational Delivery Networks
- nationally standardised dose banding for adult intravenous anticancer therapy
- optimising Palliative Chemotherapy Shared Decision making
- clinical Utilisation Review
- hospitals medicines optimisation
- 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 2018/19. The Trust was not subject to an inspection of its core services during 2018/19, having been rated as 'Outstanding' following an inspection in November 2016.

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: 99.3 per cent for admitted patient care; 99.7 per cent for outpatient care; and 97.81 per cent for accident and emergency care.
- which included the patient's valid general practice code was: 99.8 per cent for admitted patient care; 100 per cent for outpatient care and 99.8 per cent for accident and emergency care.

(Data source: NHS number, Trust statistics. GP Practice: NHS Information Centre, SUS Data Quality Dashboard, April 2018 – January 2019 as at month ten inclusion date)

University Hospitals Bristol's Information Governance Assessment report is no longer available and the system has been replaced by the "Data Security & Protection Toolkit (DSP Toolkit). The new toolkit demonstrates that the Trust is working towards the 10 National Data Guardian's data security standards as set out in the Data Security and Protection Standards for health and care. There are no longer attainment levels, instead the toolkit works on either 'standards met' or 'standards not met'. All organisations are expected to achieve 'Standards Met' on the DSP Toolkit. With this being the first year of the DSP Toolkit Standard, NHS Foundation Trusts have been allowed to publish a DSP Toolkit if they are approaching a level of 'Standards Met' in all but a few areas. University Hospitals Bristol's toolkit publication for 2018/19 was "Standards not met". Due to this, we were required to provide an Improvement plan of how we are going to bridge the gap between our current position and meeting the DSP Toolkit 'Standards Met'. NHS Digital has reviewed and agreed this plan, and our publication is displayed as "Standards not fully met (Plan Agreed)".

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 February 2019, the Trust commissioned an External Clinical Coding Audit. The audit reviewed a total of 300 episodes from three hospital sites: St Michael's Hospital, Bristol Royal Hospital for Children and Bristol Royal Infirmary. The audit reviewed April to June 2018 data, focussing on depth of coding including comorbidities in addition to primary diagnoses and procedures. These percentages achieved meet the mandatory level of attainment for an acute trust in line with HSCIC's Data Security Standard 1. The following levels of accuracy were achieved:

- Primary diagnosis accuracy: 90.67 per cent
- Primary procedure accuracy: 90.80 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 clinical coding team have a plan in place to follow through on the recommendations from the External Audit to improve the quality of coding.

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 2018/19 (or, in some cases, latest available information which predates 2018/19) 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 4

Mandatory indicator	UH Bristol Most Recent	National average	National best	National worst	UH Bristol Previous
Venous thromboembolism risk assessment	98.3% Apr18-Dec18	95.6%	100%	70.9%	98.4% Apr17-Mar18
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)*	13.1 Apr17-Mar18	13.2	0.0	91.0	11.6 Apr16-Mar17
Rate of patient safety incidents reported per 1,000 bed days	60.1 Oct17-Mar18	43.6	17.6	158.3	56.0 Apr17-Sep17
Percentage of patient safety incidents resulting in severe harm or death	0.35% Oct17-Mar18	0.40%	0.0%	1.55%	0.30% Apr17-Sep17
Responsiveness to inpatients' personal needs	71.2 2017/18	68.6	85.0	60.5	73.4 2016/17
Percentage of staff who would recommend the provider	85% 2018 survey	72%	95%	41%	83% 2017 survey
Summary Hospital-level Mortality Indicator (SHMI) value and banding	105.0 (Band 2 "As Expected") Oct17-Sep18	100.0	69.2	126.8	105.6 (Band 2 "As Expected") Jul17-Jun18
Percentage of patient deaths with specialty code of 'palliative medicine' or diagnosis code of 'palliative care'	31.3% Oct17-Sep18	33.8%	59.5%	14.3%	29.2% Jul17-Jun18
Patient Reported Outcome Measures	UH Bristol does not carry out any procedures covered by the national PROMs programme: hip and knee replacements				
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%.				
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%.				

* 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. "Please note that this indicator was last updated in December 2013. There is an ongoing review by NHS Digital of emergency readmissions indicators across frameworks, and it is intended that the Compendium of Population Health readmissions indicators will be updated and published in April/May 2019. As part of the update, certain elements of the existing specification will be updated to align with other frameworks (NHS Outcomes Indicator Set and CCG Outcomes Indicator set), e.g. length of time to readmission will be 30 days and mental health admissions will not be excluded.

Part 3

Review of services in 2018/19

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.

3.1.1 Our Patient Safety Improvement Programmes

3.1.1.1 Sign up to Safety Programme 2015 to 2018

UH Bristol 'signed up to safety'[8] 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 2015-2018 Patient Safety Improvement Programme came to an end in July 2018.

This section of our Quality Report summarises the key achievements from this programme and our patient safety improvement priorities for our next three-year programme which will run from 2019 to the end of 2021. Straddling the timeframe of both our "old" and "new" patient safety improvement programmes is our three-year Maternity and Neonatal Collaborative Health Safety Improvement Programme which commenced in April 2017.

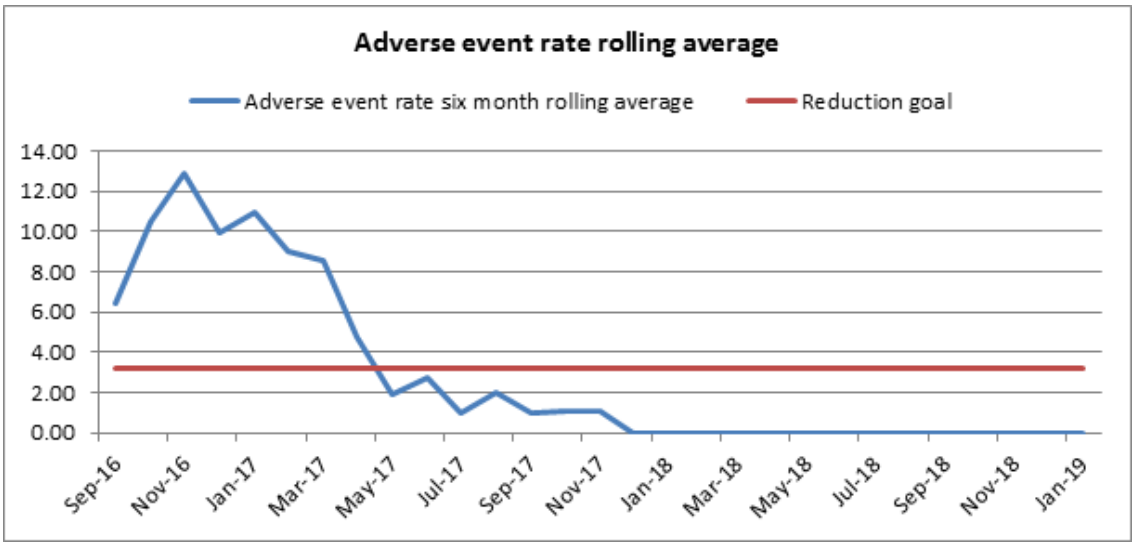
A summary of the key safety and quality achievements of our 2015-2018 Patient Safety Improvement Programme follows.

1. Overarching aims:

[8] Sign up to Safety was 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 did not achieve our mortality reduction improvement goal of best (lower) quartile for English Trusts for Summary Hospital Mortality Indicator with a SHMI of 101.7 in the 12 months to December 2018 against a lower quartile of 95.3. However, we achieved, exceeded and sustained our improvement goal for adverse event rate reduction to below 3.23 per 1,000 beddays with a rate of zero since July 2017.

Figure 1: Adverse event rate per 1,000 bed days rolling average



Source: Monthly Global Trigger Tool Audits

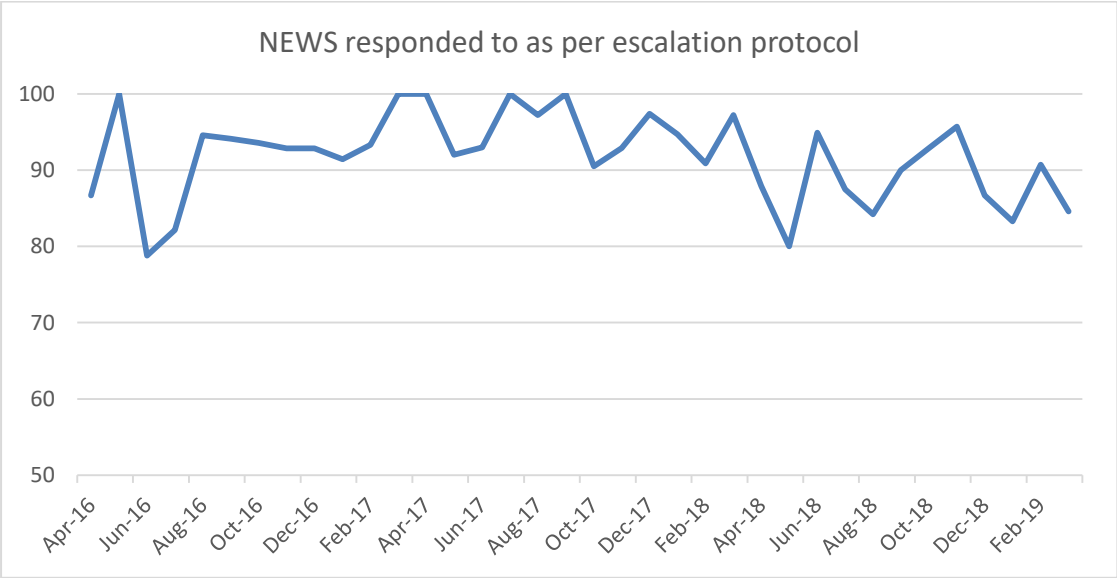
2. Improving the management of the deteriorating patient:

Assessment of a patient's physiological status, recognition of deterioration and obtaining a prompt response from a more senior healthcare professional continues to be one of the foundations of healthcare provision. Use of early warning scores calculated from measurement of physiological parameters is one of the tools used help detect underlying deterioration, even if a patient may appear relatively well.

Key achievements in 2018/19:

- While not in our original plan, the achievement of Global Digital Exemplar status for our Trust during meant that we could introduce an e-observations system. This allows patients' physiological parameters to be recorded electronically and automatically calculates an early warning score. A raised score triggers an electronic prompt for action by staff, including for the patient to be reviewed by a more senior clinician. This replaces the need for manual recording of observations on paper charts and removes the risk of miscalculation of an early warning score. We successfully completed implementation of an e-observations system in 2018/19 in adult inpatient ward areas.
- We also achieved the switch to the new National Early Warning Score (NEWS2) in October 2018, following publication of the improved NEWS2 tool by the Royal College of Physicians. NEWS2 standardises scoring adjustments for some patients with altered respiratory physiology and reduces the risk of over-oxygenation for these patients.
- We achieved and sustained our improvement goal of 95 per cent of patients having observations taken and early warning scores correctly added up. We also achieved our improvement goal of 95 per cent of deteriorating patients being escalated appropriately.

Figure 2: Early warning scores acted upon appropriately



Source: Monthly Safety Thermometer Audits

- We did not consistently achieve our 95 per cent improvement goal for the use of SBAR for escalating deteriorating patients, but in our 2019-2021 programme we plan to implement a system for automatic electronic escalation of deteriorating patients.
- In 2018/19, the Bristol Royal Hospital for Children undertook significant quality improvement projects improving the care of the deteriorating child, including developing new age-specific observation charts with integral Paediatric Early Warning Scores and instigated Rapid Review Calls for deteriorating children. Our new observation charts are being implemented in children's wards across the South West region to reduce risks of miscommunicating how poorly a child is when being transferred between hospitals.
- Maternity services continued to improve use of the Maternity and Obstetrics Early Warning Score and neonatal services started work to introduce the Newborn Early Track and Trigger Tool.

3. Improving the early recognition and treatment of patients with sepsis:

"Sepsis (also known as blood poisoning) is the immune system's overreaction to an infection or injury. Normally, our immune system fights infection – but sometimes, for reasons we don't yet understand, it attacks our body's own organs and tissues. If not treated immediately, sepsis can result in organ failure and death. Yet with early diagnosis, it can be treated with antibiotics."

UK Sepsis Trust

It is important to note that some patients with sepsis will die from organ failure despite early recognition and prompt, appropriate treatment. There is a close link between early recognition and general deterioration of patients and the early recognition and treatment of sepsis; indeed the latest evidence-based trigger for sepsis screening in adults is a raised NEWS score.

Key achievements in 2018/19:

- By the end of 2018/19, we achieved our 90 per cent improvement goals for sepsis screening, delivering antibiotics within an hour and 72 hour review of antibiotics. Screening inpatients with raised NEWS scores for sepsis has been improved by prompts from our e-observations system.

- Across the West of England Academic Health Science Network we reduced mortality in patients with suspicion of sepsis from around seven per cent to below six per cent.
- We also implemented sepsis screening and a sepsis pathway in our children's emergency department and maternity services, and we are developing inpatient sepsis pathways for children.

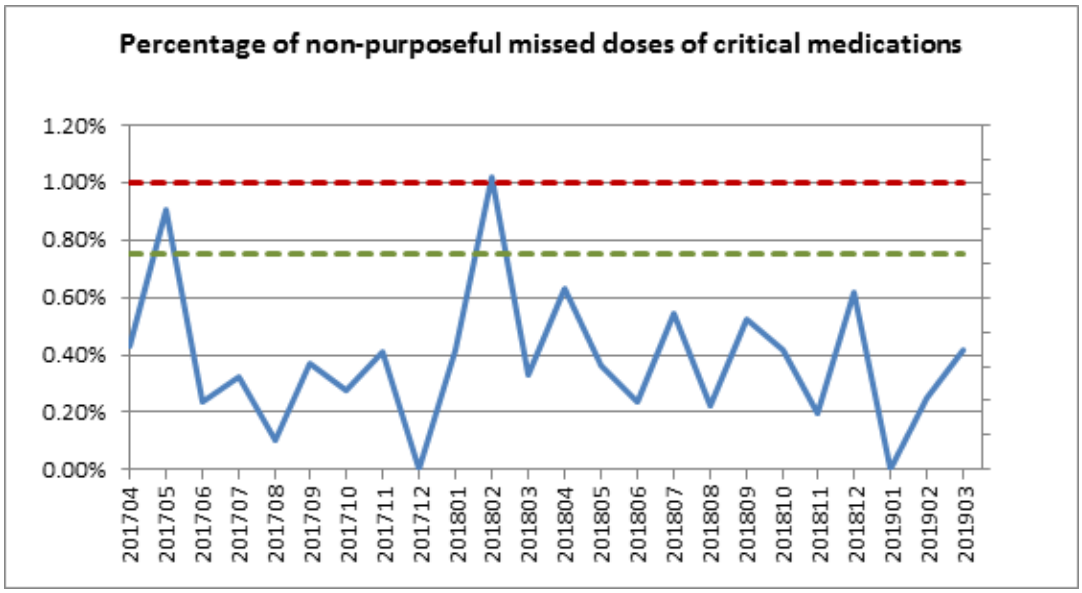
4. Improving medicines safety

Nationally, up to 600,000 (11 per cent) of non-elective hospital admissions are due to medicines and 20 per cent of people over 70 years old take five or more medicines. Locally, in our West of England Academic Health Science Network region, data suggests there are 10,938 admissions related to medicines (four per cent of total hospital bed capacity) with a projected annual cost of £20.6 million.

In 2018/19, we built on previous improvement work and put in place several measures to improve the quality of medicines information at handovers and transfers of care to allow accurate reconciliation of medicines at these transfers, for example:

- We introduced an electronic means of recording a patient's medication history and subsequent reconciliation with the patient's currently prescribed medication.
- We have developed a patient dashboard to allow the easy tracking of newly admitted patients who require their medication history to be checked and reconciled.
- We implemented an electronic system to refer patients with complex medicines to community pharmacies on discharge to help ensure they continued to take their medicines correctly and safely.
- We commenced implementation of an electronic prescribing and medicines administration system to standardise prescribing practice and implement safety checks.
- We achieved, exceeded and sustained our improvement goal of less than 0.75 per cent for reduction in non-purposeful omitted doses of critical medicines.

Figure 3



Red dotted line represents original CQUIN 2013/14 target; green line was the Trust's original stretch target
Source: Monthly UH Bristol pharmacy audit

5. Reducing peri-procedure Never Events:

- We further developed and strengthened our WHO checklists in theatres and interventional environments in response to national drivers and learning from incidents and sustained over 98 per cent improvement in their use.
- We implemented Local Safety Standards for Invasive Procedures in endoscopy and out of theatre settings such as wards, ITUs, Central Delivery Suite, and ambulatory care settings.
- Unfortunately we had a number of peri-procedure never events during the programme's lifetime therefore did not achieve our "days between" improvement goal of 365 days. Further details of never events which occurred in 2018/19 are provided in section 3.1.3.

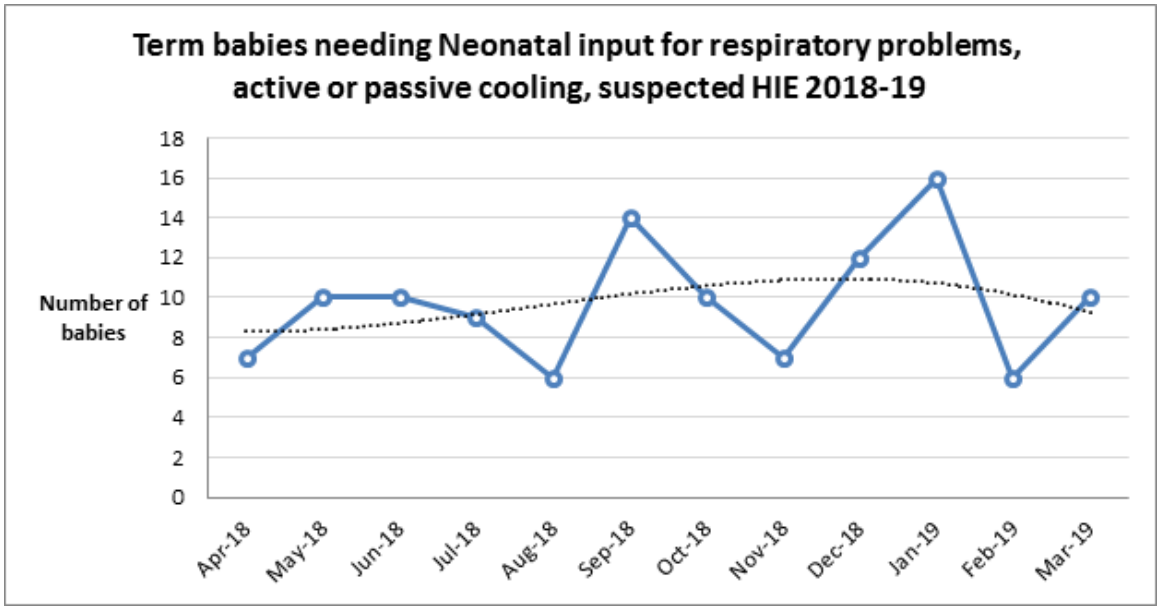
6. Leadership for improving safety

- We did not sustain our previously achieved improvement goal of conducting at least six executive director-led patient safety walk rounds per month; we completed an average of five walk rounds per month, and those areas which did not benefit from a walk round in 2018/19 have been prioritised for early 2019/20.
- We achieved our 80 per cent improvement goal of completing actions from walk rounds within two months.

7. Maternity and Neonatal Health Safety Collaborative programme

- We achieved a reduction in term admissions to Neonatal ICU.
- We achieved a reduction in the number of babies needing neonatal input for respiratory problems, active or passive cooling and suspected hypoxic ischaemic encephalopathy.
- We achieved an improvement in the measurement of Symphysis Fundal Height to monitor babies' growth during pregnancy and support early support and intervention.

Figure 4: Number of babies needing neonatal input for respiratory problems, active or passive cooling and suspected hypoxic ischaemic encephalopathy



Source: National neonatal database (Badger) monthly UH Bristol audit. As part of the ATAIN project (avoiding term admissions into neonatal units)

8. Developing our Safety Culture

- We held our annual "safety conversations" event as part of National Kitchen Table Week with front line staff in adults children's and maternity services as detailed in section 2.1.1.
- We also developed a system for "Learning from Excellence" as detailed in section 2.1.1.
- We sustained our upper quartile position in NHS Improvement's "acute teaching trust" peer group, indicating an open reporting culture where our staff feel able to report errors without fear of recrimination and understand the value of learning and making improvements from reported incidents.

3.1.1.2 Patient safety improvement programme 2019 to 2021

Our new patient safety improvement programme will commence in Quarter 1 of 2019/20. We set our patient safety priorities for 2019-2021 by gathering information from a number of sources in order to identify what our priorities should be the next three years. These sources included:

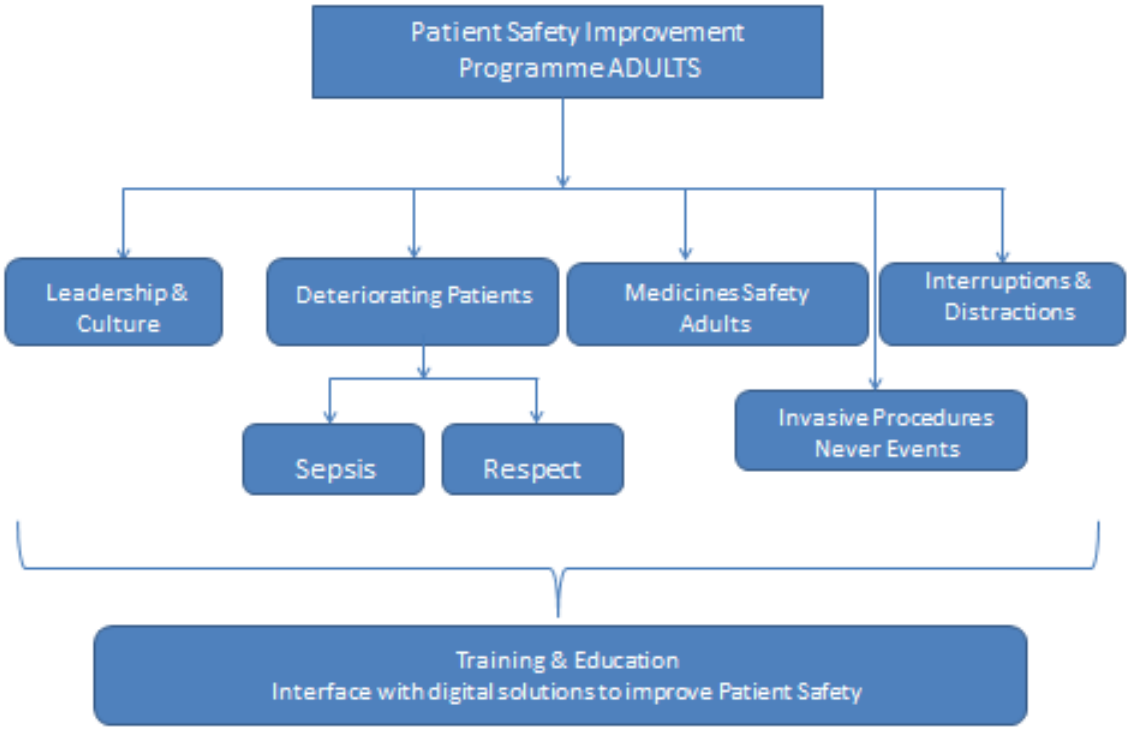
- A survey of staff on their top five patient safety concerns
- Analysis of reported incidents
- Analysis of serious incidents
- The Learning from Deaths process
- Claims data
- Priorities for joint working with the West of England of England Patient Safety Collaborative
- NHS Improvement national priorities
- Themes from safety conversations events which have taken place in our hospitals

We also conducted a thematic analysis of the information gathered and identified the following key themes on which to focus our improvement work for 2019 to 2021:

a) Medication safety
b) Deteriorating patient including sepsis and acute kidney injury
c) Maternity and neonatal care
d) Leadership and culture
e) Human factors elements of incidents/never events/distractions/interruptions
f) Communication particularly regarding handover and discharges and interface with IT systems

The resulting overall structure for our adults programme is shown in Figure 5 below:

Figure 5



3.1.2 Freedom to Speak Up

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistle-blowers). Ahead of such legislation, NHS trusts and NHS foundation trusts have been asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment.

The Trust has appointed a Freedom to Speak Up (FTSU) Guardian to whom all staff can raise concerns. To support the work of the Guardian, over 30 Speaking Up Advocates have been recruited to help raise awareness of speaking up and to provide more local support for concerns. To date, all individuals who have raised concerns have been supported personally by the Guardian and have received feedback following the investigations into their concerns. Overall feedback has been positive in relation to whether individuals would speak up again. The Guardian also works to ensure that individuals who raise concerns do not suffer detriment as a result of speaking up and, to date, no-one has identified that they have suffered detriment. In recognising that detriment may not occur immediately after speaking up or an investigation being completed, the Guardian has committed to following up with individuals approximately three months after providing feedback in cases where there is a risk of detriment, to check that nothing has arisen.

Where there are concerns relating to patient safety, these are immediately escalated to the Medical Director and Chief Nurse to investigate and take appropriate action.

However, the Guardian in only one mechanism through which staff can raise concerns. The Trust also has the following groups or processes which can assist staff:

- Bulling and harassment advisors
- Joint Union offices
- Occupational health
- Employee services
- Safeguarding team
- Patient Safety team

The key challenge is to ensure that staff are aware of the FTSU programme and the role of the Guardian. To support this:

- The Trust has used a FTSU message as a desktop background for all PCs;
- There are regular communications about Speaking Up in the weekly newsletter to all staff (Newsbeat), with case studies on each of the Advocates;
- Speaking Up is included in Trust induction for all new starters;
- There are posters and other materials around the Trust which describe what Speaking Up is; and
- The Guardian and Advocates attend meetings with staff groups to personal relay messages and ask questions about Speaking Up.

The Board and its People Committee receive a quarterly update on the FTSU programme which is delivered by the Guardian. Included in the updates are reviews to consider the learning from the National Guardian Office's case reviews of other Trusts, with learning identified for UH Bristol where appropriate.

3.1.3 Never Events

Despite the work we continue to do on preventing peri-procedure never events, there were five such Never Events reported in our Trust in 2018/19:

- Retained broken off tip of a central venous line guidewire (child) (August 2018)
- Alleged retained vaginal swab - occurring during care by a sub-contracted third party provider (November 2018)
- Wrong side nerve block for a hip procedure (December 2018)
- Wrong side laparoscopic testicular surgery (child) (December 2018)
- Left ovary removed during laparoscopic hysterectomy when the plan was to conserve both ovaries (March 19) – still under investigation.

At the time of writing, investigations have been completed for four of these cases, including one within the sub-contracted third party provider.

Examples of improvements we have made as a result of our investigations include:

- We have strengthened our Local Safety Standard for peripherally inserted central venous catheters to more explicitly check that the guidewire is complete on removal.
- The third party provider has identified action to strengthen leadership, to enhance and adhere to their swab counting policy, to review competencies and staff roles, and to ensure staff are clear about their role and responsibilities and are not acting outside the scope of their limitations.

- A number of investigations identified distractions and interruptions as contributory factors, so we have included a work stream in our 2019-2021 Patient Safety Programme to try to understand/quantify and reduce the frequency and impact of interruptions and distractions on clinical care.
- We will identify circumstances where additional "stop checks" on top of those required as part of the WHO safety checklist could occur in surgical procedures and implement accordingly.
- We have also included embedding the "stop before you block" check designed to prevent wrong site block in our invasive procedure Never Events work stream for 2019-2021 by engendering collective responsibility, ownership and empowerment. In addition, we will investigate options for using physical aids/barriers/prompts to prevent injection before the "Stop before you block" check.

During 2018/19, a contract performance notice was service by our commissioners regarding the number of Never Events which had occurred in 2017/18 into 2018/19. A remedial action plan was developed by the Trust and the majority of actions have been completed at the time of writing. Further information about learning from serious incidents and Never Events is provided in section 3.1.5.

3.1.4 Serious incidents

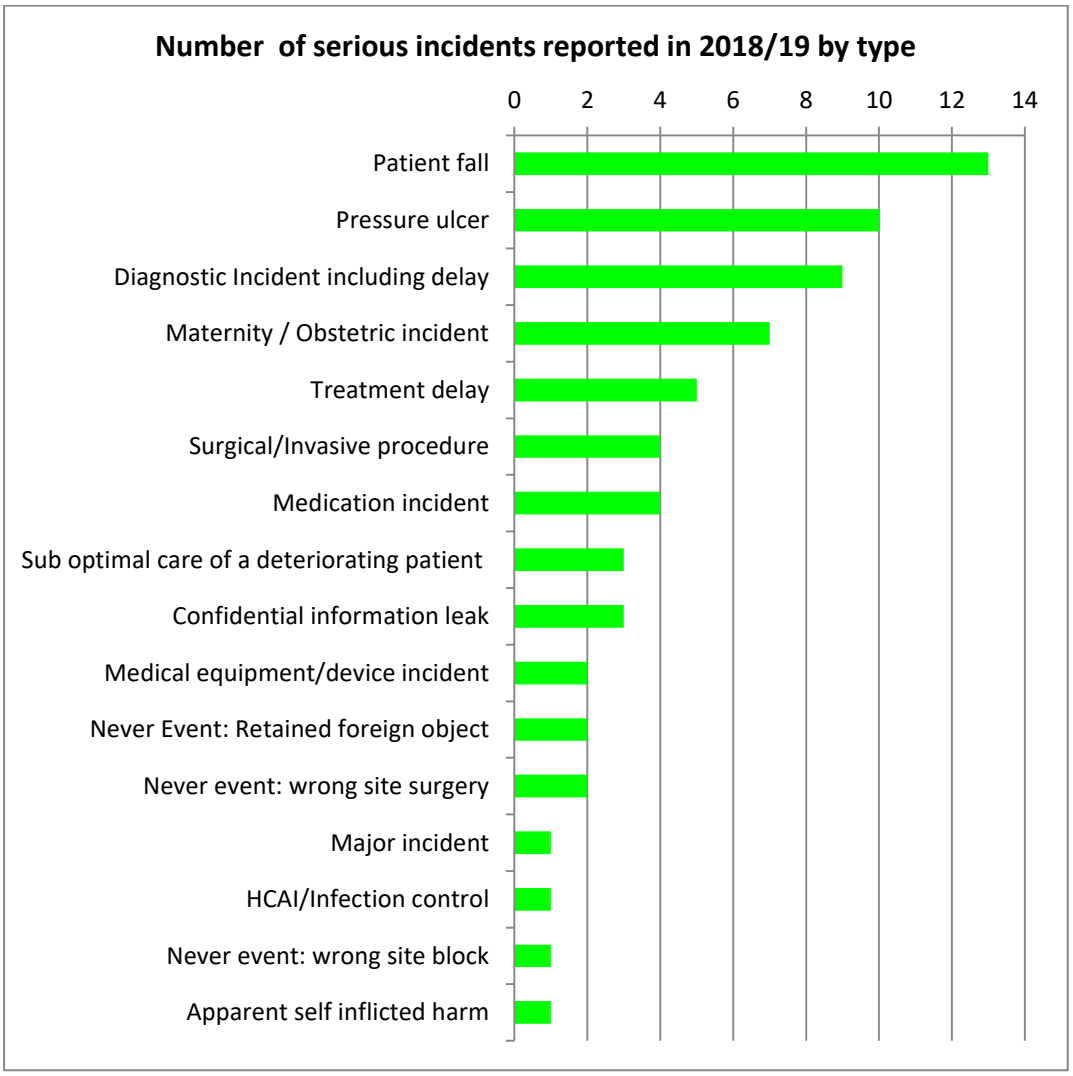
The purpose of identifying and investigating serious incidents, as with all incidents, is to understand what happened, learn and share lessons, and take action to reduce the risk of a recurrence. The decision that an event should be categorised as a serious incident is usually made by an executive director. Throughout 2018/19, 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 70, compared to 57 in 2017/18. Of the serious incidents reported, two were subsequently downgraded following investigation, two occurred in a service provided by a third party provider and 15 investigations were still under way at the time of writing (April 2019). A breakdown of the categories of the 68 confirmed serious incidents is provided in Figure 6 below.

Hospital acquired grade 3 pressure ulcers, patient falls resulting in major harm and diagnostic incidents remain the most frequently reported serious incidents, despite implementing actions to reduce their number. We have renewed our focus on reducing pressure ulcers, some of which have been unavoidable, including those relating to pressure caused by essential medical devices. Our investigations have also identified that, in some cases, all possible steps to prevent a patient falling were taken, however we have relaunched an education campaign to prompt staff to make and document a mental capacity assessment when patients request to be left alone for privacy and dignity reasons and to re-iterate their risk of falling whilst unattended. We have also implemented a new pathway for communicating incidental radiology findings following a multidisciplinary safety summit involving key staff members.

From April 2018, certain maternity incidents are being independently investigated by the Healthcare Safety Investigation Branch (HSIB) as part of the National Maternity Safety Strategy published by the Secretary of State for Health. This includes cases of intrapartum stillbirth, early neonatal deaths and some incidents where severe brain injury has been diagnosed in the first seven days of life which fit the HSIB criteria.

All serious incident investigations have robust action plans, which are implemented to reduce the risk of recurrence. The investigations for serious incidents and resulting action plans are reviewed in full by the Trust Quality and Outcomes Committee (a sub-committee of the Trust Board of Directors).

Figure 6



Source: UH Bristol Serious Incident Log

3.1.5 Learning from serious incidents and Never Events

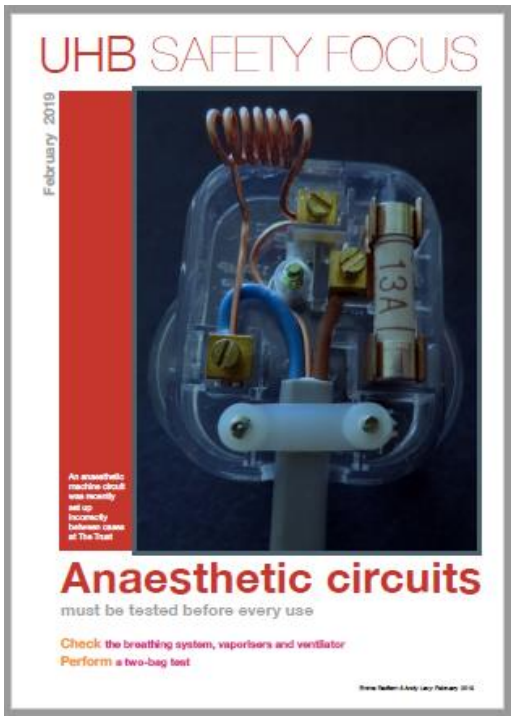
Internally, we have local and Trust-wide systems to learn from serious incidents and Never Events, including safety briefs, (Learning After Significant Event Recommendations (LASER) posters, governance and specialty meetings, clinical audit days, newsletters, and safety bulletins. We also incorporate learning from incidents into patient safety training sessions.

In line with our quality objective for 2018/19 to improve learning from serious incidents and Never Events, we introduced multidisciplinary safety summits.

We have held three successful summits in 2018/19. Topics included: prevention of invasive procedure never events (April 2018), conscious sedation, including use of midazolam (June 2018) and managing incidental radiology findings that require follow up (November 2018).

As a result, we have aligned policies for conducting the surgical count (a count of all countable items e.g. swabs, instruments and needles repeated at key points in all surgical procedures to prevent unintended retention of foreign objects) and have achieved organisation wide agreement on the role of the named supervising consultant in theatres for doctors in training. We are also working on a set of professional standards for the supervising consultant and are

undertaking a scoping exercise to improve the assessment competence of surgical trainees working with the Severn Deanery in Health Education England.



As well as completing actions in response to specific learning from the reported Never Event involving midazolam, our conscious sedation summit identified variation of requirements for competency assessment for conscious sedation among Royal Colleges, and therefore an opportunity to align practice with that considered the most comprehensive.

We have also strengthened our systems for communicating and acting on incidental radiology findings and developed a new standard operating procedure making this clear and explicit.

We have also developed and implemented a system called Greatix for staff to report 'learning from excellence'. This is currently working well in the Paediatric Intensive Care Unit, children's emergency department, adult intensive care unit and Heygroves Theatres. Advice from other organisations is to promote and encourage uptake and let it grow organically so that it becomes a locally owned and valued tool to support a positive culture of safer team working.

We have also used external opportunities to learn from other organisations. We have set up an informal network of anaesthetists nationally regarding Local Safety Standards for Invasive Procedures (LocSSIP) development and linked in with South West Patient Safety network in this regard.

We have strong links with medical Royal Colleges, including our Deputy Medical Director and Associate Medical Director for Patient Safety currently occupying key positions to influence improvement on a wider scale and bring back new initiatives into our organisation. We also have good links into Academic Health Science Networks and the Health Foundation's Q Community.

3.1.6 Duty of Candour

We continue to comply with the statutory and regulatory requirements for Duty of Candour as evidenced in each of our serious incident investigation reports. During 2018/19 we further developed electronic recording of Duty of Candour in our Datix system. This was to ensure a consistent record of evidence of compliance with Duty of Candour for all incidents that met the criteria of moderate or a higher level of harm, including those which were not designated serious incidents. After this change we sought further independent assurance that we had good compliance with Duty of Candour through an internal audit. The internal audit report concluded there was more comprehensive documentation of Duty of Candour processes for serious incidents and gave an overall satisfactory rating; recommendations were for divisions to undertake quarterly spot checks on Duty of Candour to provide more timely evidence of compliance and to ensure this is reported into their divisional boards and into corporate governance structures.

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 2018/19

The table below contains key quality metrics providing assurance to the Trust Board each month regarding the safety of the 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 2017/18" may vary slightly from the equivalent data in our 2017/18 Quality Report due to finalisation of provisional data.

Table 5

Quality measure	Data source	Actual 2017/18	Target 2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2018/19
Infection control and cleanliness monitoring								
Number of MRSA Bloodstream Cases	National Infection Control data (Public Health England)	4	0	3	1	1	1	6
Number of *Clostridium difficile* Cases	National Infection Control data (Public Health England)	35	<=44	8	12	9	5	34
Number of MSSA Cases	Trust Infection Control system (MESS)	25	<=25	12	6	7	5	30
Hand Hygiene Audit Compliance	Monthly audit	97.6%	>=95%	97.3%	97.6%	96.8%	96.5%	97.1%
Antibiotic prescribing Compliance	Monthly audit	86.4%	>=90%	82.5%	79.6%	77.6%	73.8%	79.4%
Cleanliness Monitoring - Overall Score	Monthly audit	96%	>=95%	95%	95%	95%	96%	95%
Cleanliness Monitoring - Very High Risk Areas	Monthly audit	98%	>=98%	97%	97%	98%	98%	97%
Cleanliness Monitoring - High Risk Areas	Monthly audit	96%	>=95%	96%	95%	96%	97%	96%
Patient safety incidents, serious incidents and Never Events								
Number of Serious Incidents Reported	Local serious incident log	57	No set target	17	20	18	15	70
Number of Confirmed Serious Incidents[1]	Local serious incident log	53	No set target	17	19	11		47
Serious Incidents Reported Within 48 Hours	Local serious incident log	100%	100%	100%	100%	94.4%	100%	98.6%
72 Hour Report Completed Within Timescale	Local serious incident log	94.7%	100%	100%	95%	83.3%	100%	94.3%
Serious Incident Investigations Completed Within Timescale	Local serious incident log	96.2%	100%	92.9%	100%	100%	93.3%	96.8%
Total Never Events	Local serious incident log	8	0	0	1	3	1	5
Number of Patient Safety Incidents Reported	Datix	15,656	No set target	4,184	4,615	4,399	3,071	16,269
Patient Safety Incidents Per 1000 Bed days	Datix/Medway	50.86	No set target	55.92	60.81	57.33	60.76	58.52
Number of Patient Safety Incidents - Severe Harm[2]	Datix	92	No set target	29	17	21	11	78
Falls								
Falls Per 1,000 Bed days	Datix/Medway	4.59	4.8	3.93	4.85	4.46	5.16	4.55
Total Number of Patient Falls Resulting in Harm	Datix	25	<=24	7	8	5	4	24
Pressure ulcers developed in the Trust								
Pressure Ulcers Per 1,000 Bed days	Datix/Medway	0.162	0.4	0.134	0.277	0.495	0.317	0.306
Pressure Ulcers - Grade 2	Datix	45	No set target	8	19	33	15	75
Pressure Ulcers - Grade 3 or 4	Datix	5	0	2	2	5	1	10

Venous Thromboembolism								
Adult Inpatients who Received a VTE Risk Assessment	Medway	98.4%	>=99%	98.3%	98.5%	98.2%	98.1%	98.3%
Percentage of Adult In-patients who Received Thrombo-prophylaxis	Monthly local pharmacy audit	95%	>95%	93.8%	92.9%	91.1%	90%	92.4%
Number of Hospital Associated VTEs	Monthly local pharmacy audit	50	No set target	10	13	10	7	40
Number of Potentially Avoidable Hospital Associated VTEs	Monthly local pharmacy audit	2	0	1	0	0	0	1
Nutrition								
Nutrition: 72 Hour Food Chart Review	Monthly local safety thermometer audit	92.1%	>=90%	92.1%	93.7%	93.1%	89.4%	92.2%
Fully and Accurately Completed Nutritional Screening within 24 Hours	Quarterly local dietetics audit	89.9%	>=90%	92.0%	90.4%	92.1%	88.9%	91.1%
WHO checklist								
WHO Surgical Checklist Compliance	Medway/Bluespier	99.7%	100%	99.7%	99.8%	99.8%	99.8%	99.8%
Medicines								
Medication Incidents Resulting in moderate or greater harm	Datix	0.55%	<0.5%	0.42%	0%	0.46%	0.77%	0.34%
Non-Purposeful Omitted Doses of the Listed Critical Medication	Monthly local pharmacy audit	0.4%	<1%	0.43%	0.4%	0.39%	0.13%	0.37%
Safety Thermometer								
Harm free care	Monthly local safety thermometer audit	97.9%	>=95.7%	97.3%	97.5%	97.4%	97.1%	97.4%
No new harms	Monthly local safety thermometer audit	98.8%	>=98.3%	98.6%	98.6%	98.3%	97.9%	98.3%
Deteriorating patient								
National Early Warning Scores (NEWS) Acted Upon	Monthly local safety thermometer audit	96%	>=95%	88.5%	86.7%	92.3%	86.3%	88.4%
Timely discharges								
Out of Hours Departures (20:00 to 07:00)	Medway PAS	8.7%	No set target	9.3%	9.7%	8.9%	7.2%	8.9%
Percentage of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	22.4%	>25%	21.5%	21.4%	21%	19.8%	21%
Number of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	11,138	No set target	2,672	2,730	2,813	1,649	9,864
Staffing levels								
Nurse staffing fill rate combined	National Unify return	98.9%	No set target	99.2%	98.2%	99.9%	100%	99.3%

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. In 2018/19, there were a number of positive results in these surveys for UH Bristol, including:

- In the 2017 National Inpatient Survey, patients gave UH Bristol the second highest overall experience rating nationally amongst non-specialist acute trusts.
- Our 2017 National Cancer Patient Experience Survey results showed an improvement for the third consecutive year – reflecting the positive effects of the comprehensive improvement plan that we have in place after disappointing results in the survey up to 2014.
- In the 2018 National Maternity Survey, we achieved a "better than national average" rating for the experience that women have during the labour and birth of their child.

Table 6 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 7 provides an indication of UH Bristol's performance relative to the national average.

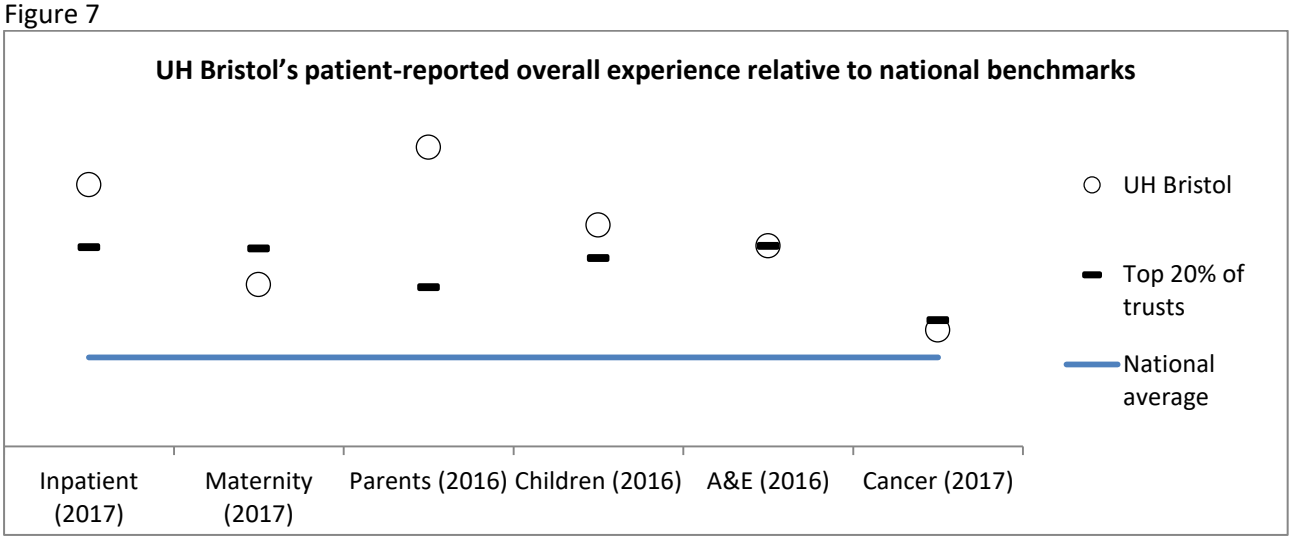
The survey results also provide us with important insights from patients about how we can continually improve our services. During 2018/19 we procured a new feedback and reporting system to allow patients, visitors and carers to provide us with feedback in real-time and raise issues or concerns. We have also carried out a range of improvement activities under the customer service corporate quality objective (see section 2.1.1) with the aim of providing a consistently excellent patient experience across our hospitals.

Table 6: Results of national patient surveys received by the Trust during 2018/19 (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
2017 National Cancer Survey	April-June 2017	8	40	0
2016 National Children's Survey	November to December 2016	20	43	0
2018 National Maternity Survey	February 2018	3	47	0
2017 National Inpatient Survey	July 2017	4	53	1

Source: Care Quality Commission Benchmark Report (www.nhssurveys.org)

Figure 7



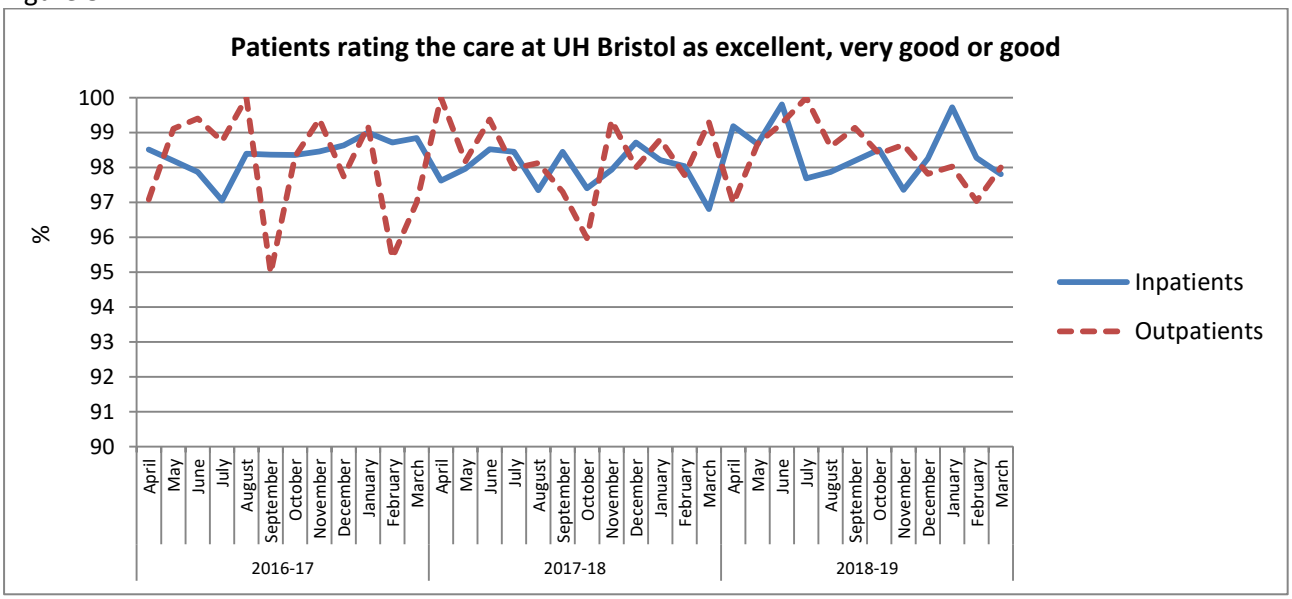
Source: UH Bristol Patient Experience and Involvement Team analysis of Care Quality Commission data

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 in our monthly postal surveys (Figure 7). Over the 2018/19 financial year, 98 per cent of inpatient and outpatient survey respondents rated the care they received at UH Bristol as excellent, very good, or good. Praise for our staff is by far the most frequent form of feedback that we receive.

Figure 8



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.

The following are highlights from this activity in 2018/19:

- In March 2019, "My Journey" was launched (see section 2.1.2 of this report)
- In partnership with Healthwatch, North Bristol NHS Trust, Bristol Community Health and voluntary sector partners we established the Bristol Deaf Health Partnership. The Partnership allows for a single voice to ensure that we, along with other healthcare providers, respond appropriately to the needs of the deaf community and those patients who are hard of hearing.
- In collaboration with the adult Ear, Nose and Throat team and the University of Bristol, patient focus groups were held to inform the design of a novel implantable artificial larynx. Patients who had undergone the removal of their larynx and the separation of the airway from the mouth, nose and oesophagus were invited to participate.
- An analysis of demographic data from the Trust's postal survey programme suggested that people from the Sikh community were giving slightly lower hospital satisfaction ratings than people from other faith groups. Whilst this difference was not statistically significant, the Trust's Patient Experience and Involvement Team engaged with the Bristol Sikh community to explore this finding. Overall, the feedback about UH Bristol was very positive and a number of suggestions and insights have been put forward by the community.
- The UH Bristol Carers' Strategy Steering Group was re-launched in October 2018. Participants from across the Trust were joined by an NHS England lead for Carers, representatives from the Carers Support Centre, UH Bristol Governors. The re-launch included a discussion about the national context in which this work is framed and re-affirmed both the content of our existing strategy and the commitment of staff to work together to deliver its ambition. Also see section 2.2.2 of this report.
- In January 2019, thirty Foundation 2 (F2) level doctors met with a group of six patients and parent carers to discuss the importance of the relational aspects of care. This is an annual conversation jointly run by the Patient Experience and Involvement team and Clinical Fellows working in the Trust's Medical Education team, and is part of the core training and development programme for F2 doctors. There is an emerging plan to extend the initiative into the paediatric care setting.
- In partnership with Macmillan Cancer Support, a patient and carer listening event was held as part of an evaluation of the Macmillan Treatment and Therapy Service. Patient and carer involvement in the evaluation was seen as a key element in determining the success of the Service which is hosted at UH Bristol and is part of the living with and beyond cancer initiative.
- And, in partnership with the Bristol Heart Institute, patient and carer focus groups were held to explore the social and psychological impact of less invasive heart procedures on patients and their families. This was part of a larger piece of work to inform how psychological services for patients can be developed in the future.
- Along with Healthwatch Bristol, the Trusts Patient and Public Involvement Team supported an event in collaboration with the Bristol Dental School, which reviewed the current student dentist curriculum. A key outcome of this work was that interpersonal-skills will be given a renewed emphasis in the curriculum alongside clinical skills.

3.2.4 Complaints received in 2018/9

In 2018/19, 1,879 complaints were reported to the Trust Board, compared with 1,817 in 2017/18[9]. 584 (31.1 per cent) of these complaints were investigated via the formal complaints process, with the remainder addressed through informal resolution.

A total of 85.1 per cent of formal complaints were responded to within the timescale agreed with the complainant: an improvement on the 83 per cent we reported last year. 83.5 per cent of informal complaints were responded to within the timescale agreed with the complainant – this has not been reported previously but has been included for the first time as the majority of the complaints we receive are now investigated via this informal route.

Of complaints responded to via the formal process between April and December 2018, 9 per cent resulted in a dissatisfied response. This compares favourably with the 11.2 per cent recorded for the equivalent period in 2017. Dissatisfaction with complaints responses is necessarily measured in arrears because we need to allow people time to respond; full year data will be published in our annual complaints report later in 2019.

In 2018/19, the Parliamentary and Health Service Ombudsman (PHSO) accepted 31 complaints from UH Bristol patients for investigation. At the time of writing, none of these cases have been upheld, whilst one case has been partly upheld. Summary information about cases referred to the PHSO is published by the Trust in its quarterly complaints reports.

Improvements to the complaints service in 2018/19 have included:

- Successful completion of two forms of complaints review panels. Firstly, we completed a series of panels where lay representatives retrospectively reviewed a range of complaints and shared points of learning with the lead divisions for those complaints. We also completed a series of monthly reviews of all dissatisfied complaints to determine whether or not – in our opinion – the Trust could have achieved a better outcome for all parties involved; again, we shared learning with the relevant divisions, and we will use the data from the reviews to set our board-reported target for 2019/20.
- Introduction of a new complaints survey, based on questions used by the Picker Institute.
- Delivery of complaints training to staff at all levels, Trust-wide. Sessions include 'Investigating and Responding to Complaints' and 'Handling Complaints with Confidence'. Attendance numbers have been high and feedback has been used to further improve the content and delivery of the training.

Looking ahead to 2019/20, our plans include:

- A renewed focus on achieving our 95 per cent target for timely complaints responses, including the introduction of a new Key Performance Indicator (KPI) in relation to the timely resolution of informal complaints.
- Introduction of an addition to the Datix complaints database to enable us to record the severity of complaints and use this information to inform reporting.
- A review of the Executive sign-off process for formal complaint letters in order to help improve the timeliness of responding to complaints by the deadline agreed with the complainant.
- A review of the Trust's application of NHS Regulations and PHSO guidance in respect of the '12 month rule' for investigating complaints and what exceptions should be applied, if any.

[9] Previously 1,874 in 2016/17, 1,941 in 2015/16 and 1,883 in 2014/15

The Trust will be publishing a detailed annual complaints report, including themes and trends, later in 2019.

3.2.5 Turning feedback and complaints into positive action: examples of improvements to patient care in 2017/18

Here are some examples of positive action taken in response to complaints and patient feedback:

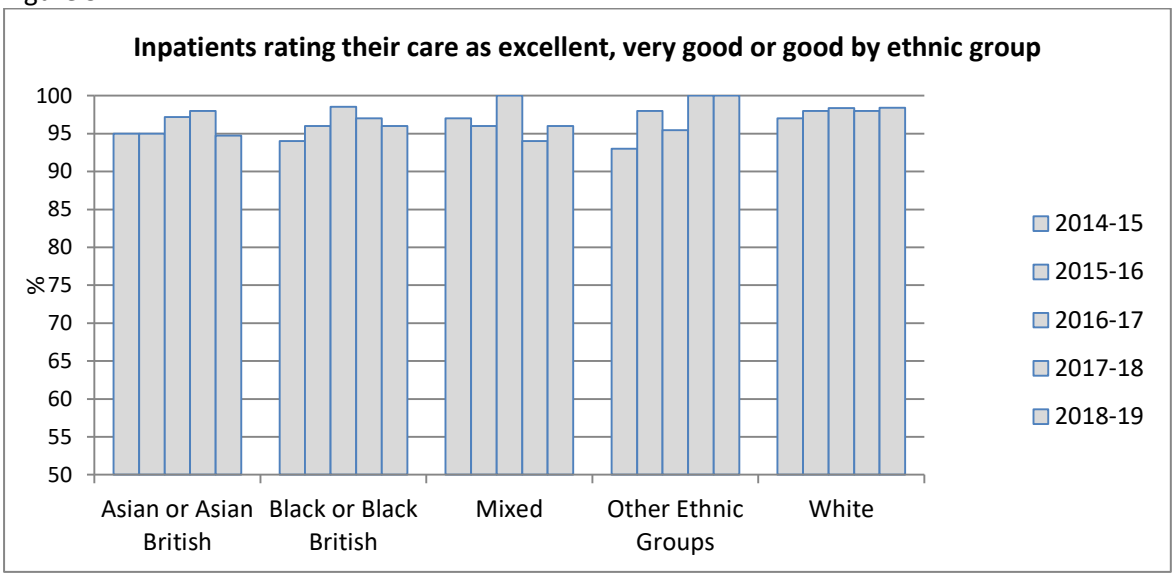
- In the Ultrasound Department, clerical staff have been reminded of the importance of following the correct protocol when following up a patient who has not attended their appointment.
- Cardiac Surgery Advanced Nurse Practitioners have been reminded to ensure medication is prescribed promptly on our electronic prescribing and medicines administration (EPMA) system in the event that a patient's surgery is postponed (patients may be required to temporarily stop taking certain medications prior to planned surgery).
- One of our Cardiology Consultants has updated guidelines for routinely performing stress echocardiograms before surgery.
- A training session has been delivered to staff in our Division of Surgery on the key factors to look for with regard to urine retention when looking after patients post-surgery.
- Plastic surgeons have been consulted and a local guideline developed for use in Children's Emergency Department in respect of the types of sutures to be used.
- Following an investigation into a complaint about a brain tumour being missed on an MRI scan by a radiologist, two neuro-radiologists will now always report on imaging in complex cases.
- Our Endocrinology team has developed a standard operating procedure for monitoring cortisol levels. Patients who need to have these levels monitored are now being managed at their GP practice and they receive full endocrine support during admissions to the Trust.
- To help respond to an increasing demand for capacity at the Bristol Haematology and Oncology Centre (BHOC), a dedicated room has been set aside for venepuncture, blood tests, line care and injections.
- A patient attended hospital and had an enema prior to a sigmoidoscopy, only to be told he could not have the procedure that day due to the medication he had been taking. As a result of this this complaint, the medicines policy has been recirculated to all nursing staff on the ward in question to remind staff about allergies and medication that can prevent a procedure taking place.
- In response to complaints about the main ENT (Ear Nose and Throat) reception area sometimes being closed when patients arrive for appointments, reception is now be covered during lunchtimes to ensure that patients can be booked in and directed to the correct waiting area.
- In response to survey data that suggested many patients didn't see information about how to give feedback or make a complaint during their hospital stay, we worked with a professional design agency to develop more effective messaging about these opportunities. The new posters that we developed have recently been introduced on our wards and departments. We have also starting installing touchscreen "feedback points" in our hospitals, for our service-users to give feedback and raise issues in real-time.
- The Trust ran an improvement programme focussed on reducing noise at night on our wards – which is a common theme in our patient feedback.
- We received patient feedback that boredom was a key issue for our long-stay patients at South Bristol Community Hospital. The hospital management team has recently been working with the Trust's Arts Director to explore how patients can remain engaged and

mentally active during their stay. New links are also being developed with a local college to attract more students into volunteering roles at the hospital.

3.2.6 Equality and diversity

Figure 9 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 9



Source: UH Bristol postal survey

In January 2018, the Trust established the Patient Inclusion and Diversity Group (PIDG). This group acts as the Trust's key group in relation to all equality and diversity issues affecting patients and service users. A divisional working group of PIDG exists to bring a practical focus to the work of PIDG.

The group meets quarterly and is charged with monitoring compliance against the NHS Accessible Information Standard. This year, for example, we re-designed the relevant pages of our external website to better signpost our patients, carers and visitors to the accessible information and communication support they can receive from our Trust; in response to public feedback, we also purchased a portable hearing loop for use at UH Bristol focus groups and engagement events).

PIDG also offers oversight and assurance in respect of the development and delivery of our translating and interpreting services. For example, this year we procured British Sign Language remote video interpreting software to help ensure that we can provide an interpreter for our patients and families, should they require it.

In 2018/19, the group has pursued a particular focus on reasonable adjustments for patients, and on understanding the experiences of the transgender community when accessing our services.

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 7 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2017/18" may vary slightly from the equivalent data in our 2017/18 Quality Report due to finalisation of provisional data.

Table 7

Quality measure	Data source	Actual 2017/18	Target 2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2018/19
Monthly patient surveys								
Patient Experience Tracker Score	Monthly postal survey	91.5	>=87	92	91	92	91	91
Kindness and Understanding	Monthly postal survey	95.5	>=90	96	96	96	97	96
Outpatient Tracker Score	Monthly postal survey	89	>=85	89	90	90	90	90
Friends and Family Test (coverage)								
Inpatient Coverage	Friends and Family Test	35%	>=30%	37.2%	33.5%	34.1%	36.1%	35.1%
ED Coverage	Friends and Family Test	17.30%	>=15%	17.6%	17.2%	15.1%	15.6%	16.4%
Maternity Coverage	Friends and Family Test	19%	>=15%	14.8%	15.6%	21.6%	21.6%	18.1%
Friends and Family Test (score)								
Inpatient Score	Friends and Family Test	97.7%	>=90%	97.3%	98.5%	98.5%	98.6%	98.2%
ED Score	Friends and Family Test	81%	>=70%	81.9%	82.9%	84.1%	80.7%	82.6%
Maternity Score	Friends and Family Test	96.9%	>=92%	96%	96.9%	97.6%	98.6%	97.3%
Patient complaints								
Number of Patient Complaints	Patient Support and Complaints Team	1,815	No set target	446	443	463	322	1,674
Complaints Responded To Within Trust Timeframe	Patient Support and Complaints Team	83%	>=95%	85.9%	86.1%	87.1%	82.9%	85.8%
Complaints Responded To Within Divisional Timeframe	Patient Support and Complaints Team	83.8%	No set target	82.2%	84.4%	87.6%	86.3%	85%
Percentage of Responses where Complainant is Dissatisfied	Patient Support and Complaints Team	10.68%	<5%	10.33%	8.89%	7.83%	-	9.02%

3.3 Clinical effectiveness

We will ensure that the 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

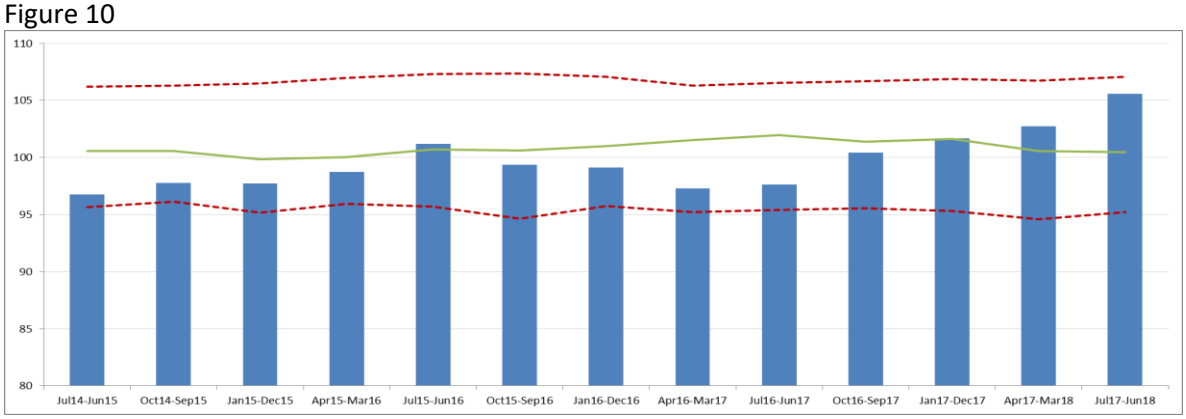
The Trust continues to monitor the number of patients who die in hospital and those who die within 30 days of discharge. This is done using the two main tools available to the NHS to compare mortality rates between different hospitals and trusts: Summary Hospital Mortality Indicator (SHMI) produced by NHS Digital (formally 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 10, 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 2017 to June 2018 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 2017 to September 2018[10]. In this period, the Trust had 1,833 deaths compared to 1,745 expected deaths; a SHMI score of 105.

Figure 10



Source: CHKS benchmarking

[10] Figure 8 is sourced from CHKS Limited and does not yet include data for the period October 2017 to September 2018

The latest HSMR data available at the time of writing is for the period January 2018 to December 2018. This shows 1,096 patient deaths at UH Bristol, compared to 1,057 expected deaths: an HSMR of 103.6

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 (local mortality review)

During the period of April 2018 to March 2019, 1325 of University Hospitals Bristol NHS Foundation Trust patients died. This comprised the following number of deaths that occurred in each quarter of that reporting period:

- 335 in the first quarter
- 228 in the second quarter
- 332 in the third quarter
- 370 in the fourth quarter.

By 31 March 2019, 366 case record reviews and nine investigations have been carried out in relation to 1,325 deaths. In nine cases, a death was subjected to both a case record review and a formal investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 60 in the first quarter
- 70 in the second quarter
- 107 in the third quarter
- 129 in the fourth quarter.

Any deaths identified as potentially avoidable are referred for a second review by the medical director team. No patient's deaths were during 2018/19 were judged as more likely than not to have been due to problems in the care provided to the patient.

These numbers have been calculated from the Trust's Mortality Review Database, now fully integrated into Medway PAS (from 1 September 2018).

The major themes identified from case note reviews during 2018/19 have been:

- The need for prompt initiation of end of an end of life care pathway
- The importance of timely review by senior clinical staff.

All consultants are now expected to undertake SCNR as part of the patient safety assessment of their supporting programme activities. Involvement of the entire adult consultant body means that, although important, this process will have a minimal impact on any single individual. This process started from the beginning of December 2018, and has meant that all outstanding reviews have now been allocated to a consultant for review.

The appropriate initiation of an end-of-life care pathway was agreed as a corporate quality objective for 2018/19. Progress against this can be found in section 2.1.1 of this report. The overarching identified themes are closely aligned to those found in other Trusts in the region. The Academic Health Science Network are supporting the roll of the ReSPeCT process across the health care system, this will improve the advanced care planning in the future.

3.3.3 Clinical standards for seven day hospital services

This year, providers of acute services have been asked to include a statement regarding progress in implementing the priority clinical standards for seven day hospital services in their Quality Reports.

The seven day hospital services (7DS) programme was developed to help providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. Ten 7DS clinical standards were originally developed by the NHS Services' seven days a week forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges. Four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

A board assurance model is in the process of replacing the previous bi-annual self-assessment survey, which had previously been used to measure progress against the four priority standards; through a combination of case note reviews and self-assessment.

In February 2019, the Trust declared non-compliance (i.e. standard met in <90 per cent of cases) with two of the four standards:

- Clinical Standard 2 – First consultant review within 14 hours
- Clinical Standard 8 – Ongoing consultant directed review.

Clinical standard two was met in 82 per cent of cases (78 per cent of patient admitted on a weekday and 94 per cent of patients admitted at the weekend). Clinical Standard 8 was met in 90 per cent of cases for those patient requiring a daily review (94 per cent if admitted on a weekday; 78 per cent if admitted on the weekend) and 73 per cent of cases where the patient required twice daily review (81 per cent if admitted on a weekday; 50 per cent if admitted on the weekend).

Both non-compliance issues relate to consultant provision and job planning. Funding has been identified to increase the number of consultants in acute medicine to support compliance however, to date, recruitment has been unsuccessful in spite of multiple attempts.

Further service development proposals to address the gaps in seven day coverage in other areas were discussed with commissioners through contract negotiations in 2017/18 and 2018/19, and are being reviewed during current negotiations for 2019/20. Commissioners indicated that the proposed investments were not affordable within the 2017/18 and 2018/19 planning rounds, and accepted that the Trust may not be able to meet all the standards until opportunities to improve compliance through service reconfiguration / commissioners re-prioritisation are assessed, despite the mitigation and service redesign being undertaken. We have agreed derogation of the standards in our contract with our commissioners due to the commissioner decision that plans to address these gaps in service are not affordable.

3.3.4 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 8 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2017/18" may vary slightly from the equivalent data in our 2017/18 Quality Report due to finalisation of provisional data.

Table 8

Quality measure	Data source	Actual 2017/18	Target 2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2018/19
Mortality								
Summary Hospital Mortality Indicator (SHMI)	NHS Digital	100.6	<100	105.6	105	-	-	105.3
Hospital Standardised Mortality Ratio (HSMR)	CHKS	106.4	No set target	107.8	104.8	97.2	-	103.2
Re-admissions								
Emergency Readmissions Percentage		3.62%	<3.26%	3.55%	3.43%	3.36%	2.85%	3.38%
Management of Sepsis								
Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	Casenote review	51.1%	>=90%	95.7%	100%	100%	-	99%
Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatients)	Casenote review	77.4%	>=90%	57.1%	100%	100%	-	75%
Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	Casenote review	93.3%	>=90%	100%	100%	100%	-	100%
Percentage of Patients Meeting Criteria Screened for Sepsis (Emergency)	Casenote review	83.4%	>=90%	89.3%	98%	96%	-	94.4%
Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Emergency)	Casenote review	85.5%	>=90%	81.1%	86.9%	86.7%	-	85.1%
Sepsis Patients Percentage with a 72 Hour Review (Emergency)	Casenote review	93.1%	>=90%	94.9%	98.8%	100%	-	97.7%
Fracture Neck of Femur								
Patients Treated Within 36 Hours	National Hip Fracture Database	64.20%	>=90%	64%	58.3%	59.1%	43.9%	57.9%
Patients Seeing Orthogeriatrician within 72 Hours	National Hip Fracture Database	61.60%	>=90%	97.3%	96.7%	97%	100%	97.5%
Patients Achieving Best Practice Tariff	National Hip Fracture Database	34.80%	>=90%	54.7%	55%	56.1%	41.5%	52.9%
Stroke Care								
Percentage Receiving Brain Imaging Within 1 Hour	Medway PAS & Radiology Information System	62.6%	>=80%	51.6%	44.8%	53.2%	51.1%	50.4%
Percentage Spending >90% Time On Stroke Unit	Medway PAS & Radiology Information System	85.8%	>=90%	82.8%	88.5%	83.1%	80%	84%

High Risk TIA Patients Starting Treatment Within 24 Hours	Medway PAS & Radiology Information System	54.6%	>=60%	46.5%	47.5%	63.3%	65.5%	54.2%
Dementia Care								
FAIR Question 1 - Case Finding Applied	Local data collection	89.3%	>=90%	83.6%	78%	84.7%	87.3%	83.2%
FAIR Question 2 - Appropriately Assessed	Local data collection	96.2%	>=90%	92.2%	94.9%	91.8%	96.9%	93.7%
FAIR Question 3 - Referred for Follow Up	Local data collection	92.9%	>=90%	50%	100%	100%	80%	90.5%
Percentage of Dementia Carers Feeling Supported	Local data collection	60%	No target set	100%	-	-	-	100%
Ward outliers								
Bed Days Spent Outlying.	Medway PAS	9,098	<9,029	2288	1735	1857	1261	7141

3.4 Performance against national priorities and access standards

3.4.1 Overview

NHS Improvement's single oversight framework (SOF) has four patient access metrics:

- Accident and Emergency (A&E) 4-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:

- 95per cent for A&E 4 hour waits
- 85 per cent for 62 day GP Cancer
- 92 per cent for RTT incomplete pathways
    - Additional requirement to maintain total wait list below March 2018 levels
- 99 per cent for six week diagnostic waiting times.

Provider Sustainability Fund (PSF) 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 the 62 day cancer standard was achieved for eight months in a row and also achieved for quarters two and three overall. Referral to treatment performance consistently achieved the NHSI recovery trajectory each month and the total wait list has remained below the March 2018 level of 29,207. A&E performance achieved the improvement trajectory in quarters one, two and three. The six week wait for diagnostics has remained below the national standard but plans are in place with a trajectory to return to achieving the standard in Quarter 2 of 2019/20.

Table 9: Performance against the agreed trajectories for the four key access standards in 2018/19 during each quarter

Access Key Performance Indicator		Quarter 1 2018/19			Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19		
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
A&E 4-hours Standard: 95%	Actual	83.96%	91.14%	92.84%	90.26%	90.07%	85.00%	89.16%	84.24%	83.05%	84.50%	81.05%	81.23%
	"Trust Footprint" (Year To Date)	92.05%			91.77%			90.84%			89.84%		
	Trajectory	90%	90%	90%	90.53%	91.26%	90.84%	90.06%	90.33%	87%	84%	87%	90%
	"Trust Footprint" Trajectory	90.0%			90.0%			90.0%			95.0%		
Cancer 62-day GP Standard: 85%	Actual (Monthly)	84.1%	82.4%	86.0%	85.7%	88.9%	87.4%	85.5%	87.9%	86.5%	85.1%	83.5%	82.9%
	Actual (Quarterly)	84.2%			87.3%			86.6%			83.8%		
	Trajectory (Monthly)	81%	83%	79%	83%	85%	85%	85%	85%	85%	85%	85%	85%
	Trajectory(Quarterly)	82.5%			85%			85%			85%		
Referral to Treatment Standard: 92%	Actual	88.2%	89.1%	88.6%	88.9%	88.7%	88.5%	89.6%	90.1%	89.3%	89.4%	89.1%	89.2%
	Trajectory	88%	88%	88.5%	88.5%	88.7%	88.5%	88.5%	88.0%	87.0%	86.0%	87.0%	87.0%
6-week wait diagnostic Standard: 99%	Actual	96.8%	97.6%	97.8%	97.9%	97.1%	98.1%	98.4%	96.9%	93.8%	93.3%	96.9%	95.5%
	Trajectory	97.9%	97.9%	97.9%	98.4%	99.0%	98.0%	98.0%	98.0%	98.0%	98.0%	99.0%	99.0%

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved (with Walk In Centre uplift for A&E 4 Hour standard).
RED rating = national standard not achieved, the STF trajectory not achieved

Note on A&E "Trust Footprint":
In agreement with NHS England and NHS Improvement, each Acute Trust was apportioned activity from Walk In Centres (WIC) and Minor Injury Units (MIU) in their region. This apportionment is carried out and published by NHS England as "Acute Trust Footprint" data. This data is being used to assess whether a Trust achieved the recovery trajectory for each quarter. The A&E "Trust Footprint" data above relates to Trust performance after WIC and MIU data has been added.

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 standard for Referral to Treatment (RTT) is 92 per cent. During the commissioning contract period for 2017/18 and 2018/19, we agreed with our local commissioners (CCG) a month-by-month trajectory for Trust compliance during 2018/19. This trajectory was delivered across twelve consecutive months from April 2018 to March 2019.

The number of patients on our waiting list is monitored and reported on a monthly basis to NHS Improvement and NHS England. At the end of each month in 2018/19, the total waiting list size was required to remain below the March 2018 level of 29,207, for eight months of the annual year the waiting list size was below this level and at year end of March 2019 final reported 28,481 and achieved the target set.

3.4.3 Accident & Emergency four-hour maximum wait

The Trust did not meet the national 95per cent standard for the number of patients discharged, admitted or transferred within four hours of arrival in our emergency departments. For the three emergency departments:

- Bristol Royal Hospital for Children (BRHC) achieved the 95 per cent standard in five months, and achieved 93.0 per cent for the year.
- Bristol Eye Hospital (BEH) achieved the 95 per cent standard in eleven months, and achieved 97.4 per cent for the year
- Bristol Royal Infirmary (BRI) did not achieve the 95 per cent standard in any month of 2018/19, and achieved 78.4 per cent for the year.

For the financial year 2018/19, PSF improvement trajectory in place with NHS Improvement. This combined Trust data with data from local walk-in centres to give an "acute trust footprint" performance figure. This data was published by NHS England and was then used by Trusts and NHS Improvement to assess whether a Trust had achieved the trajectory.

For UH Bristol, the trajectory required the organisation to achieve 90% performance, year-to-date, at the end of each quarter. The Trust achieved this trajectory in quarters one, two and three.

	Trust Level	Footprint Level
Quarter 1 (Apr-Jun)	89.3%	92.1%
Quarter 2 (Apr-Sep)	88.9%	91.8%
Quarter 3 (Apr-Dec)	87.7%	90.8%
Quarter 4 (Apr-Mar)	86.4%	89.8%

Overall, A&E attendance levels were up 6.5 per cent in 2018/19 compared to 2017/18; a 3.5 per cent increase at BRI, 11.2 per cent increase at BRHC and 7.0 per cent at BEH. However, the proportion of patients admitted to an inpatient bed as a result of their A&E attendance remained the same at 26 per cent (35 per cent at BRI and 23 per cent at BRHC). The proportion of patients arriving by ambulance remained steady at 26 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 the emergency departments. This figure rose from 6,215 in 2017/18 to 6,988 in 2018/19, which is a 12 per cent increase.

During this financial year, the Trust has supported Weston General Hospital's (WGH) A&E service; patients who would have attend WGH's A&E from 10pm each evening have been re-directed for care to UH Bristol and other local providers. Analysis of the 2018/19 data shows:

- 153 ED additional attendances at UH Bristol, on average, per month
- 88 ED admissions, on average, per month (58% conversion rate)

The number of Delayed Transfers of Care (DToC) patients reduced this year. In 2017/18, DToC patients averaged 32 at each month-end; 2018/19 averaged 25. Total bed days lost to DToC patients fell from 11,572 to 9,344.

3.4.4 Cancer

The Trust achieved the 62-day GP referral to treatment standard in eight months during the 2018/19 financial year (June 2018 to January 2019). This is the best performance since 2012, when changes to services left the Trust with a high proportion of complex cancer and treatment types. This achievement is in the context of non-compliance with the standard at national level. February and March saw an increase in delays at other providers impacting on the Trust's position, causing non-compliance in those months despite ongoing good internal performance of 92.8 per cent for quarter four.

In May 2018, a major fire in the Bristol Haematology and Oncology Centre (BHOC) caused some treatments to be delayed, and lower compliance with the standards in Quarter one. BHOC recovered impressively from this major incident, although specialist deep cleaning following the fire took place over winter and has affected our performance in Quarter four. The minimal impact of this unprecedented event and rapid recovery from it highlight the strong processes in-place within the Trust to manage cancer pathways and ensure patients are treated promptly whenever possible.

The 31-day standard for first and subsequent cancer treatments were met in Quarters two, three and four. The two-week-wait standard for first appointment after GP suspected cancer

referral was met in every quarter of the year. The Trust is preparing to submit data from April 2019 for the new standard of 28 days from referral to diagnosis or ruling out of cancer; this standard will be measured from April 2020.

The main cause of 'breaches' of the 62-day standard remains late referrals from other providers, which usually accounts for around half of all breaches of this standard and resulted in a downturn in performance in quarter 4, which the Trust is predicting will recover in quarter 1 of 2019/20. Around 30 per cent of breaches are due to cases being clinically complex or are due to patient choice, whilst approximately 20 per cent are due to operational pressures and capacity issues within the organisation; these breaches are spread across specialties and causes with no single theme accounting for breaches that are within the control of the Trust.

New national rules for allocating the performance accountability between providers were expected in October 2018, but have been delayed until April 2019. These rules should benefit the Trust's performance by more fairly reflecting the amount of a patient's pathway each provider involved was accountable for.

3.4.5 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 have been waiting under six weeks. Month-end performance varied from 93.3 per cent to 98.4 per cent across 2018/19 and the average month-end performance was 96.7 per cent.

As at end of March 2019, neurophysiology, audiology, dual-energy X ray absorptiometry (DEXA) scans and sleep studies are currently achieving the 99 per cent standard, with MRI slightly below at 98.9 per cent. Endoscopy services (gastroscopy, flexi sigmoidoscopy and colonoscopy) are at 95 per cent.

A reduction in staffing capacity through vacancies and staff absence prevented achievement of the standard for endoscopy services, non-obstetric ultrasound and echocardiographies. These services are using additional capacity through waiting list initiative sessions whilst staffing levels are restored. The services expect the standard to be achieved by quarter two 2019/20. Computed tomography (CT) services are not achieving the standard due to cardiac CT experiencing a 30% per cent growth in referrals (October-January 2018/19 compared with April-September 2018). A new CT scanner is planned for end of quarter two.

The Trust has submitted a recovery trajectory to NHS Improvement showing compliance with the 99 per cent standard by end of September 2019.

3.4.6 Outpatients

The Trust has an active programme of transformation within outpatients; this is overseen by the outpatient steering group which is sponsored by the deputy chief executive and chief operating officer.

During 2018/19, a significant validation programme was undertaken to improve patient pathways and reduce delays and to instil, on a monthly basis, active and responsive validation of all patient pathways beyond a six-month time period.

On 1 October 2018, NHS England changed the standard contract to mandate that all GP referrals must be received via e-referral service (e-RS) into consultant-led first outpatient appointments,

or the Trust will not be paid for the appointment. All GP referrals to first outpatient appointments are now being received via e-RS. This enables patients to choose where and when they would like to be seen. Consultant-led first outpatient appointments accounted for £30million income to the Trust in 2018/19.

The Trust has been exploring ways to improve the outpatient experience for patients - focusing on "doing today's work, today". A real-time outpatient project was launched on 12 October 2018, which is focused on making sure that everything is done on the day of a patient's appointment where possible, rather than notes and letters being typed up in the following days. The objective is to turn clinic letters around on the day, booking follow-up appointments or diagnostics (if within six weeks) in person at reception following clinic, and performing blood tests and plain film X rays on the day.

In 2018/19, a patient journey training video was designed, which gives new staff an insight into all the steps in the patient journey from referral to treatment and then discharge. This will form part of the induction package for all new administrative staff and may be rolled out to newly-qualified clinical staff.

Table 10: Performance against national standards

National standard	Target	2016/17	2017/18	2018/19
A&E maximum wait of 4 hours	95%	85.0%	86.5%	86.3% Ⓐ
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	97.4%	97.7%	95.6%
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	52.6%	52.2%	49.3%
A&E Unplanned re-attendance within 7 days	<5%	2.6%	2.8%	3.3%
A&E Left without being seen	<5%	2.2%	1.9%	1.7%
Cancer - 2 Week wait (urgent GP referral)	93%	94.8%	94.3%	95.3%
Cancer - 31 Day Diagnosis To Treatment (First treatment)	96%	96.7%	95.8%	97.2%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94%	94.4%	92.0%	96.1%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	98%	98.7%	98.6%	98.4%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	94%	96.6%	96.3%	95.8%
Cancer - 62 Day Referral To Treatment (Urgent GP Referral)	85%	79.3%	81.7%	85.6% Ⓐ
Cancer - 62 Day Referral To Treatment (Screenings)	90%	69.4%	74.8%	66.7%
Cancer - 62 Day Referral To Treatment (Upgrades)	85%	87.9%	85.4%	83.7%
18-week Referral to treatment time (RTT) incomplete pathways	92%	91.7%	89.6%	89.0%
Number of Last Minute Cancelled Operations	<0.8%	0.98%	1.19%	1.31%
Last Minute Cancelled Operations Re-admitted within 28 days	95%	90.8%	94.2%	93.4%
6-week diagnostic wait	99%	97.8%	98.3%	96.7%
Primary PCI - 90 Minutes Door To Balloon Time	90%	91.7%	93.2%	92.5%

Ⓐ data subjected to external audit scrutiny as part of the process of producing this report

Appendix A – Feedback about our Quality Report

a) Statement from the Council of Governors of the University Hospitals Bristol NHS Foundation Trust

This Quality Report is an annual NHS requirement for University Hospitals Bristol NHS Foundation Trust (UH Bristol) to present the public with an account of their quality and performance in providing NHS acute hospital services during the past year. In this section we, the Council of Governors, are requested to provide our opinion on whether this Quality Report provides a fair representation of their achievements.

The report clearly identifies both the Trust's successes and areas of weaker performance. Importantly, the Trust has continued to demonstrate evidence of appropriate response in reaction to public and patient concerns. The report also identifies learning from experience and taking appropriate action in investigating all serious incidents.

The Trust has performed well over the last year, even though they have the same national issues to deal with as all other NHS acute hospitals throughout the UK. These issues include budgetary constraints, staff shortages and increasing demand. There also was the fire at Bristol Haematology and Oncology Centre in May 2018, which, thanks to all staff involved, was restored to provide a quality service to patients within a very short time.

Governor involvement throughout the past year

During the year, the Governors have seen the effort that the Trust Board puts into finding out what is working and not working across the nine hospitals that make up the Trust. As elected Governors of UH Bristol, it is our duty to continuously monitor the Trust's performance on your behalf. The governors review the Trust's quality and performance at Quality Focus Group meetings held every two months, chaired by a Governor and attended by the Medical Director or the Chief Nurse, Governors, and the Non-Executive Director Chair of the Trust's Quality and Outcomes Committee. At this meeting, Governors ask questions about the quality reports and receive presentations on quality issues from other senior Trust staff. This Focus Group reports back to the full Council of Governors.

Governors also attend the Trust Board meetings held in public every two months at the Trust Headquarters in central Bristol, which any members of the public are also welcome to attend. The various reports discussed at these meetings can be obtained by the public from the Trust website before the meeting, and remain available afterwards.

The Governors question the Non-Executive Directors by meeting with them regularly and raising specific topics so that they can be examined in greater depth. Governors' questions have been answered well by the Trust, in an open and team-working atmosphere.

Governors also have the facility to raise formal questions in writing to the Board via what is referred to as "The Governors Log". During the past year, Governors have raised 20 formal questions via the Governors Log. The questions and the Trust's formal written answers are available to the public within the papers on the website associated with the public Board meetings.

The activities outlined above, along with our quarterly governor development seminars, have equipped the governors with the tools to raise questions and offer challenges about many of the quality and performance issues referred to in this Quality Report.

Priorities for Improvement

The Governors recognise that there are many activities taking place within the Trust every day, and that staff do their best to make improvements all the time. Each year, the Trust sets out a

number of specific areas for improvement to focus on. For the 2018/19 year, the Trust set eight objectives within its Priorities for Improvement. This Quality Report records that it succeeded in six of these, made some improvement in one additional area, and found that one was based on an incorrect assumption that improvement was needed. The Governors are aware of the efforts that Trust staff put into these objectives and are pleased to be able to recognise their successes.

Eight highly relevant new objectives have been set for the coming year, and your Governors will be taking a close interest in their progress.

Review of Trust Services

In Section 3.0 of this Quality Report, the Trust details its performance under three principal headings: Patient Safety, Patient Experience and Clinical Effectiveness. These are the areas uppermost in the public mind when judging a provider of healthcare services. This section expresses in a clear way the importance the Trust places upon these areas. The Governors can confirm that these subjects are under constant review by the Trust and recognise the improvements described.

Areas of special interest to the Council of Governors during the past year

Staffing

The Governors have welcomed the creation by the Trust of a specific Board subcommittee called "the People Committee". This was formed with the intention of increasing the Trust's focus on staff retention and staff satisfaction. The Trust wishes to become "the employer of choice" within the NHS in order to attract staff to Bristol and to retain them. It is recognised that, during the current shortage of staff at all levels within the NHS, this is the best way to achieve the numbers of staff required to operate a quality service.

The Governors are specifically interested in the Trust's actions to promote equality and diversity and eliminate bullying. We are monitoring the effectiveness of the provision of a "Freedom to Speak up Guardian" and the supporting network of advocates. This provides a protected route, available to all staff, through which they can express concerns without fear of repercussions.

There is also a Guardian of Safe Working Hours, specifically to oversee the hours worked by junior doctors. The Governors have been made aware that the Trust is looking into the various shift planning processes in use across the Trust with the intention of ensuring that best practice is adopted universally.

Adoption of IT solutions

The Governors welcome the Trust's introduction of electronic prescribing, in which all prescriptions made by Trust qualified staff can only be made using the Trust computer systems. This has reduced errors and delays experienced with the previous paper system and improved efficiency and control.

The Governors support the Trust's efforts in continually exploring the use of IT across all Trust activities where implementation might allow more time to be spent in caring for patients.

Improvement in Telephone communications

The Governors welcome the Trust's approach to improving telephone communication with the public. It has been a source of complaints and it would appear that results have been good.

Fractured Neck of Femur and Stroke Care

Disappointingly, the performance of the Trust in relation to the Best Practice Tariff for Fractured Neck of Femur continues to cause significant concern. The Tariff sets out strict timetables for early review by specialist consultants and for speedy surgery, and these have been difficult to achieve, partly for staffing reasons. The situation is under close scrutiny at the Quality and Outcomes Committee and the Governors' Quality Focus Group. Stroke Care is similarly a long-standing area needing improvement. Governors have regularly raised questions about the action plans relating to these and will continue to challenge the Trust if progress is not achieved.

Diagnostic Waits

Performance against the 6 week standard for diagnostic waits has fallen short of the NHS target for the last three years. The Trust has identified the cause as the shortage of skilled staff needed associated with the complex diagnostic equipment. The Governors appreciate the Trust's willingness to discuss this and other similar matters openly and to hear of the actions being taken to improve matters.

Timely Discharge

The discharge of patients at a time when it is most beneficial to the patient has been under constant review. Ideally, the time spent by a patient in a bed at the Trust is minimised, consistent with successful treatment and the avoidance of physical de-conditioning of the patient caused by inactivity. The Trust, working with other healthcare providers and community services has improved the discharge process to get patients home more quickly. Further improvements are to be made as there have been a few cases when patients have been discharged late in the day or at night.

"Timely Discharge" is defined as being discharged between the hours of 7:00am and 12:00 noon. The majority of in-patients (70%) are discharged between noon and 8:00pm. "Out of Hours discharge" is between 20:00hrs and 7:00am and is to be avoided. The reasons for discharge late at night are various. Some are due to the organisation of a satisfactory destination, and some are due to the patient's own arrangements or choice. The Governors will be reviewing future discharge activity in an attempt to reduce the numbers of patients discharged out of hours.

Trust Participation in the Transformation of Healthcare Provision in our Region

The Trust has taken an active part in working with the Bristol, North Somerset, and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) in their task of re-organising the provision of health and social care in our region. This process has been named "Healthier Together", and has the aim of improving the provision of healthcare in our region while working within budgetary constraints. It brings together 13 local health and care organisations to consult with the public and to collaborate in the implementation of new practices.

The Trust has kept the Governors informed regarding intentions and progress with these partners. The Governors endorse the Trust's commitment to wider healthcare planning including the development of closer working relationships with North Bristol NHS Trust and Weston Area Health NHS Trust. Progress is expected to continue for at least another 12 months.

Overall Governors Assessment of the 2018/19 Quality Report

The Governors consider that this Quality Report accurately represents the performance of the Trust over the past year and that this performance has been good, with the Trust recognising that there are always areas where performance can be improved.

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 2018/2019 quality priorities is very positive. We agreed that the document evidences a culture of learning from the trust managers and staff. Healthwatch Bristol and Healthwatch South Gloucestershire believe the trust's eight quality objectives for the coming year are addressing identified need.

Healthwatch Bristol and Healthwatch South Gloucestershire made the following comments and recommendations about UH Bristol's Quality Report 2018/2019. The document suggests that quality improvement had been good, with six of the eight priorities for 2018/19 being RAG rated green. For example:

- Complaints about telephone communications fell by 63% in the thirteen poorest performing departments.
- The score for staff who would recommend the trust as a place to work improved in 2017. Healthwatch would like to see the figures for staff who use the 'Happy app' to identify how the relaunch is going.
- Healthwatch welcomes the slight improvements in BAME staff experience and look forward to seeing the more detailed analysis. Healthwatch are still concerned that 24% of staff have experienced harassment and bullying or abuse from colleagues.
- The trust has made significant improvement in performance for the 62 day GP referral to cancer treatment with just a small dip to 80% in the final quarter of 2018/19 despite the effort put in by all the staff.
- Healthwatch welcome the 'My Journey' programme and will be pleased to see the development in 2019/20.
- Healthwatch applaud the trust for their open and honest approach to recording the serious incidents and never events and the learning from these issues.
- Healthwatch understands the constraints and looks forward to hearing more about the early recognition of the dying patient, that has an amber rating at present.
- Healthwatch would like to hear more feedback from the 'Patient Experience at Heart' workshops held in January 2019 with regard to improving patients' experience of maternity services.
- Healthwatch are pleased that the improvement of safe prescribing and the use of insulin has been recognised as a problem and note the difficulties in reporting on this.

Healthwatch Bristol and Healthwatch South Gloucestershire noted the eight quality objectives the trust has set for 2019/20:

- Healthwatch look forward to hearing more about the improvements in patient safety using digital technology, as the year progresses.
- Healthwatch note the five never events that occurred during 2018/19 and welcome the learning from these including the implementation of multidisciplinary safety summits.
- Healthwatch welcome the objective to support the needs of young carers across the trust and wonder how the trust will be measuring the benefits to young carers.
- The 'Happy app' is a great way to measure real time staff experience, Healthwatch are interested in how managers can support staff who have anonymously contributed?
- Improving physical access is paramount and Healthwatch hope to hear more when funding is in place to take this forward. Healthwatch would like to see recognition from

the trust that not all patients and public are web users or have English as their first language when improving the physical access information.

- The implementation of the Medical Examiner system is welcomed by Healthwatch; it is reassuring that this objective is being implemented.
- Healthwatch are disappointed that the originally proposed objective for improving outpatients communication through use of SMS text messaging about appointments could not be included this year.
- The development of training for Trust lay representatives is welcomed by Healthwatch, who would like to be reassured that lay representatives are recruited to represent the nine protected characteristics.

Statements of assurance from the board

Healthwatch applaud the Trust's participation in a range of clinical audits and national confidential enquiries and note the eight national clinical audits reviewed in 2018/19.

The trust has great track record of participation in clinical research and Healthwatch are pleased to see the trust working with researchers to submit applications for funding to continue research.

Healthwatch asks whether the twelve CQUIN targets are in priority order, noting that improving staff health and wellbeing is number two on the list.

Of the mandatory indicators, Healthwatch would appreciate seeing updated comparative figures for Emergency readmissions, but note that this is still the latest published data available.

It was disappointing to read that the trust did not meet the mortality reduction improvement goal and Healthwatch ask how this could be rectified?

In improving the management of the deteriorating patient, both physiological status recognition and staff understanding of the patient's mental health including dementia and learning disability should be to be taken into account.

In sepsis screening, Healthwatch were pleased to see the 90% improvement goals and wonder what is the national average? Is the trust above average on this achievement?

Healthwatch welcomes the 'Freedom to Speak Up' and asks whether advocates have been recruited from both staff and lay representatives?

The rise from fifty seven serious incidents in 2017/18 to seventy in 2018/19 is disappointing, Healthwatch are aware of the learning that the trust takes from these incidents.

Healthwatch are pleased to see a clear chart tabling infection control monitoring, against previous years recordings and note the six cases of MRSA when the target was to have no cases.

Healthwatch applaud the trust for the ongoing commitment to patient and public involvement through a range of engagement activities.

It is always useful to see Equality and Diversity within the Quality Report. Healthwatch would be happy to assist the trust with their Equality Delivery System 2. It is important to provide translation for the BME community and for staff to have cultural understanding of patients and family situations.

Meeting the four hour wait in Accident and Emergency is a difficult challenge and Healthwatch know the staff work hard to meet the target; we would like to see some improvement on the figures for Bristol Royal Infirmary for 2019/20.

It would also be useful to have an appendix with a glossary of terms for the lay person reading the Quality Account.

Healthwatch Bristol Healthwatch South Gloucestershire

c) Statement from Healthwatch North Somerset

Introduction

This comprehensive Quality Report (also known as the Quality Account) is robust and covers progress against eight quality objectives identified by the Trust as areas for improvement, outlines quality objectives in the current year, and, gives an overview of service reviews undertaken in 2018/9.

The Quality Report has been reviewed by Healthwatch North Somerset (HWNS). Our review is informed by feedback received by Healthwatch North Somerset on local services and is reported within the context of the Trust's *Quality Strategy 2016-20* and *Embracing Change, Proud to Care, our 2025 Strategy.*

It is clear from the draft Quality Report that a learning culture is evident within the Trust and that it is listening to people's experiences to inform its practice.

Quality Objectives 2018/19

1. Customer Service Mindset
HWNS recognises that opting for the development of a toolkit on customer services rather than working to achieve a recognised standard is a less intensive option. We recommend that this is evaluated from the outset and reported on next year. It is good to see that patient's experience of telephoning into the organisation has improved significantly. This is mirrored by HWNS received intelligence which shows that in the past we have received complaints but none in recent months.

2. Staff reported ratings for engagement and satisfaction
HWNS recognises that an engaged workforce reflects well on the patient experience. We are interested in the relaunch of the Happy App for staff and in the results being generated by this real-time mechanism. HWNS welcomes its inclusion as a Quality Objective for 2019/20.

3. Compliance with 62-day referral indicator for cancer
HNWS is happy to see improvements against this standard.

4. Mystery Shopping Programme
The My Journey programme has been rolled out successfully. HWNS is keen to see the end project report once completed. We recommend that Face2Face volunteers are involved in discussions about the implementation of a more detailed mystery shopping programme.

5. Improved learning from Never Events and serious incidents
HWNS welcomes the commitment to this and has received no reports to the contrary.

6. Improve early recognition of the dying patient
HWNS welcomes continued improvements planned for this area of practice.

7. Improve patient experience of maternity services
HWNS welcomes the Trust's aim to become the best again in the national Maternity Patient's Survey, and its continued involvement in BNSSG-wide developments and improvements in this key area.

8. Improve the safe prescribing and use of insulin
HWNS has received no intelligence from the public in this area. We recognise that is not applicable to rate this using self-assessed RAG criteria. We welcome the actions taken by the Trust in 2018/19 to strengthen patient safety and reduce the likelihood of omitted insulin doses in the future.

Quality Objectives 2019/20
We note the quality objectives for 2019-20 and commend the fact that five of them are directly related to the patient experience. We are particularly interested in the support for young carers as we recognise this to be a 'hidden population'. HWNS has also identified digital innovation and inclusion as a current priority work area and would be happy to support the Trust in assessing patient experiences of new developments. HWNS will ensure our staff and volunteers are familiar with the current objectives and will continue to monitor public intelligence.

Patient Experience
HWNS notes that extensive work is being undertaken to understand and improve the patient experience. We welcome the in-house UH Bristol Patient Experience programme and its positive results particularly in relation to staff. Of note, is the important contribution made, in achieving positive results, by the *Face2Face* team and the Patient Involvement Network.

Overview
The Quality Report 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.

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 13th May and Members were satisfied with the contents of the University Hospitals Bristol (UH Bristol) NHS Foundation Trust Quality Report.

Members welcomed UH Bristol's innovative approach to its 'Here to Help' customer service programme and welcomes the rollout of the electronic feedback points throughout the Trust sites. The 'Here to Help' demonstrated that UH Bristol are committed to taking a person centred approach to their service development.

The People Commission thanked UH Bristol for the open and transparent relationship with scrutiny.

e) Statement from South Gloucestershire Health Scrutiny Committee

South Gloucestershire Council is holding local elections this year and as such we are now in Purdah. The Health Scrutiny Committee will therefore be unable to comment this year.

f) Statement from North Somerset Health Overview and Scrutiny Panel (QA Sub Committee) Response to United Hospitals Bristol Trust QA

Thank you for submitting a PowerPoint presentation outlining UH Bristol's Quality Account to North Somerset Council's Health Overview & Scrutiny Panel Quality Accounts Sub-Committee. Unfortunately a number of issues beyond our control have come together this year such that providing a formal response has not been possible. Due in part to the close proximity of Local Elections at the time, the sub-committee was inquorate on the day of its meeting to review Quality Accounts. The Panel will be reviewing its approach to the annual Quality Accounts and I am aware that Members recognise the need to rationalise the process going forward.

g) Statement from Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Account 2018/19 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 2018/19. 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 the achievements against the eight quality objectives for 2018/19, six were fully achieved and one partially achieved. The CCG noted that for objective 1 the rating was classed as not applicable as the baseline data was found to be flawed. However, the CCG recognises that reported insulin-related incidents will not only be missed doses and it would have been useful to have explanation of the planned actions taken to strengthen patient safety and their results that are mentioned in the explanation of the RAG rating.

The CCG acknowledges and congratulates the Trust for the improved and sustained performance against the 62-day standard for first treatment after referral that is above the national average for the standard.

We do however, share concern over the diagnostics standard and how this may then impact on other standards including cancer standards. The CCG are committed to continue working with the Trust to improve this position through work with all providers to ensure all the available capacity for diagnostics is maximised to support performance.

The CCG welcomes learning from serious incidents and Never Events, noting the significant amount of work undertaken to address the nine Never Events that had occurred in 2017/18. Whilst the CCG notes no further Never Events in the areas that gave rise to concerns, it is disheartening that a further 5 Never Events were reported in 2018/19. The CCG supports the inclusion of this objective as an area for further work in 2019/20.

The CCG supports the chosen areas for quality improvement for 2019/20, particularly enabling improvements to digital technology with a focus on antibiotic stewardship, management of intravenous cannulas, NEWS and VTE, however we would like further narrative on how this will be used and how the Trust will ensure that an arm's length review does not replace patient reviews and prescriber education. We would also question why the objective to improve early recognition of the dying patient is not being taken forward.

Similarly to 2017/18, BNSSG CCG commends the excellent quality improvement work relating to the patient safety improvement programme of work, and UH Bristol's continued partnership working with the West of England Academic Health Science Network's (AHSN) Patient Safety Collaborative is also noteworthy.

Within the quality account UH Bristol has demonstrated continued good progress in improving patient experience, noting continued achievement of the national target for both sample size and response rate for the Friends and Family Test and the early identification and management of sepsis.

In reviewing the data in relation to pressure ulcers the CCG notes a deterioration across all three metrics in comparison to 2017/18; pressure ulcers per thousand bed days and pressure injuries grade 3 and 4 and the CCG would have liked to have seen some narrative in this respect.
The metrics relating to the management of neck of femur fractures continues to be a challenge for the Trust in terms of treatment within 36 hours and achieving the best practice tariff. The CCG recognises that this may require a system approach and again would like to see the improvement plan described. We note the significant improvement in patients receiving an Ortho-geriatrician review within 72 hours.

The Trust achieved compliance with the C. difficile target, however, as noted in the previous year's statement by BNSSG CCG we 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 2019/20 as current activity has exceeded both the national threshold and the Trust outcome figure for the previous year. MSSA cases have also exceeded the 2018/19 target. During 2018/19 the national E. coli ambition reduction target has been a challenge to achieve and again the CCG would have welcomed some narrative around this to include the introduction of the Urinary Catheter Passport during 2019/20.

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 bacteraemia.
- 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 2019/20 to deliver those improvements.

Jan Baptiste Grant
Interim Director of Nursing & Quality

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.

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Detailed descriptor

PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

Data definition

All cancer two-month urgent referral to treatment wait.

Numerator

Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).

Denominator

Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).

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).

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 2018/19 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 2018 to May 2019
    - papers relating to Quality reported to the board over the period April 2018 to May 2019
    - feedback from commissioners received 14/5/2019
    - feedback from governors received 2/5/2019
    - feedback from local Healthwatch organisations received 2/5/2019 and 16/5/2019
    - feedback from (Bristol) Overview and Scrutiny Committee received 17/5/2019
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009[11]
    - the 2017 national patient survey published 13/6/2018[12]
    - the 2018 national staff survey published 29/3/19
    - the Head of Internal Audit's annual opinion over the trust's control environment dated 24 May 2018

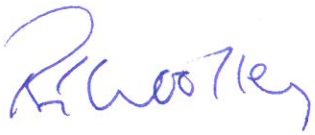
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance 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.

[11] This report is due to be received by the board later in 2019
[12] The 2018 survey results have not yet been published

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Jeff Farrar
Chairman
24 May 2019



Robert Woolley
Chief executive
24 May 2019

Appendix D – Independent Auditors' Limited Assurance Report to the Council of Governors

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 2019 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 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*
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	Page 67 of the Quality Report
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Page 67 of the Quality Report

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 NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the 'Detailed requirements for quality reports 2018/19' issued by NHSI. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Report listed above.

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 2018/19';
- 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 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19'; 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 consistent with the following documents:

- Board minutes for the financial year, April 2018 and up to 24 May 2019 ("the period");
- Papers relating to quality reported to the Board over the period;
- Feedback from the Commissioners dated 14 May 2019;
- Feedback from Governors dated 2 May 2019;
- Feedback from local Healthwatch organisations dated 2 May 2019 and 16 May 2019;
- Feedback from the (Bristol) Overview and Scrutiny Committee dated 17 May 2019;

- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 8 May 2018;
- The 2017 national patient survey dated 13 June 2018;
- The 2018 national staff survey dated 29 March 2019; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 24 May 2019.

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 complied with 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) 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 2019, 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 2018/19';
- 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 criteria set out in the FT ARM and 'Detailed requirements for quality reports 2018/19'.

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.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2019:

- 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 2018/19';
- The Quality Report is not consistent in all material respects with the documents specified above; 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 2018/19'.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Bristol
24 May 2019

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 2018/19

University Hospitals Bristol
NHS Foundation Trust

Accounts for the year ended 31 March 2019

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 2019

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2019 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

Date 24 May 2019

Statement of Comprehensive Income for the year ended 31 March 2019

	Note	Year ended 31 March 2019	Year ended 31 March 2018 £000
Income from patient care activities	3	591,126	570,203
Other operating income	4	127,407	113,939
Operating expenses	5-6	(677,307)	(654,255)
OPERATING SURPLUS/(DEFICIT)		**41,226**	**29,887**
Finance income	8.1	598	189
Finance expenses	8.2	(2,732)	(2,954)
Public dividend capital dividends payable		(8,917)	(8,601)
NET FINANCE COSTS		**(11,051)**	**(11,366)**
Other gains/(losses)		(107)	(16)
SURPLUS/(DEFICIT) FOR THE YEAR		**30,068**	**18,505**
OTHER COMPREHENSIVE INCOME/(EXPENDITURE)			
Revaluations	10	15,699	6,143
TOTAL COMPREHENSIVE INCOME/(EXPENDITURE) FOR THE YEAR		**45,767**	**24,648**
ADJUSTED FINANCIAL PERFORMANCE			
Surplus / (deficit) for the year		30,068	18,505
Adjustment in respect of capital donations		301	366
Adjustment in respect of net impairments		(515)	1,032
Adjusted financial performance		**29,854**	**19,903**

The Trust's financial performance is reported to NHS Improvement using the surplus/(deficit) per the Statement of Comprehensive Income adjusted for technical accounting items. Donations in respect of assets, depreciation on donated assets and net impairments are excluded in the Trust's reported financial performance. Further details are provided in note 2 to the accounts.

The notes on pages 6-39 form part of these accounts

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Statement of Financial Position as at 31 March 2019

	Note	31 March 2019	31 March 2018
		£000	£000
NON CURRENT ASSETS			
Intangible assets	9	14,976	12,124
Property, plant and equipment	10	383,734	369,821
Receivables	12	-	1,050
TOTAL NON CURRENT ASSETS		**398,710**	**382,995**
CURRENT ASSETS			
Inventories	11	11,406	13,490
Receivables	12	68,505	49,354
Other financial assets	13	104	104
Cash and cash equivalents	18	99,855	71,092
TOTAL CURRENT ASSETS		**179,870**	**134,040**
CURRENT LIABILITIES			
Trade and other payables	14	(83,225)	(65,394)
Borrowings	16.1	(6,859)	(6,170)
Provisions	17	(184)	(199)
Other liabilities	15	(5,311)	(5,918)
TOTAL CURRENT LIABILITIES		**(95,579)**	**(77,681)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**483,001**	**439,354**
NON CURRENT LIABILITIES			
Borrowings	16.2	(68,551)	(74,744)
Provisions	17	(212)	(245)
TOTAL NON CURRENT LIABILITIES		**(68,763)**	**(74,989)**
TOTAL ASSETS EMPLOYED		**414,238**	**364,365**
EQUITY			
Public dividend capital		207,756	203,650
Revaluation reserve		55,295	41,211
Other reserves		85	85
Income and expenditure reserve		151,102	119,419
TOTAL EQUITY		**414,238**	**364,365**

The accounts on pages 2 to 39 were approved by the Board on 24 May 2019 and signed on its behalf by:

Signed .....

Date: 24 May 2019

Robert Woolley, Chief Executive

Statement of Changes in Equity for the year ended 31 March 2019

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 2018	203,650	41,211	85	119,419	364,365
Surplus/(deficit) for the year	-	-	-	30,068	30,068
Revaluations on property plant and equipment and intangible assets	-	15,699	-	-	15,699
Transfers between reserves	-	(1,615)	-	1,615	-
PDC Received	4,106	-	-	-	4,106
Equity at 31 March 2019	**207,756**	**55,295**	**85**	**151,102**	**414,238**

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 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**

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 2019

	Note	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus/(deficit) from continuing operations		41,226	29,887
OPERATING SURPLUS/(DEFICIT)		**41,226**	**29,887**
NON CASH INCOME AND EXPENDITURE			
Depreciation and amortisation	9-10	24,904	23,788
Net impairments	8.3	(515)	1,032
Income recognised in respect of capital donations		(1,279)	(1,204)
(Increase)/decrease in trade and other receivables	12	(18,150)	(13,663)
(Increase)/decrease in inventories	11	2,084	(1,305)
Increase/(decrease) in trade and other payables	14	15,293	3,318
Increase/(decrease) in other liabilities	15	(607)	1,342
Increase/(decrease) in provisions	17	(48)	157
Other movements in operating cash flows		(82)	(3,389)
NET CASH GENERATED FROM OPERATIONS		**62,826**	**39,963**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		579	192
Purchase of property, plant and equipment	10	(20,473)	(20,180)
Purchase of intangible assets	9	(1,931)	(5,554)
Receipt of cash donations to purchase capital assets		1,279	1,204
Sales of property plant and equipment		101	18
NET CASH USED IN INVESTING ACTIVITIES		**(20,445)**	**(24,320)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		4,106	7,428
Loans repaid to the Department of Health		(5,834)	(5,834)
Capital element of finance lease rental payments		(333)	(328)
Interest paid		(2,557)	(2,741)
Interest element of finance leases		(246)	(268)
PDC dividend paid		(8,754)	(8,249)
NET CASH GENERATED/(USED) IN FINANCING ACTIVITIES		**(13,618)**	**(9,992)**
INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**28,763**	**5,651**
CASH AND CASH EQUIVALENTS AT START OF YEAR	18	**71,092**	**65,441**
CASH AND CASH EQUIVALENTS AT END OF YEAR	18	**99,855**	**71,092**

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 2018/19 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. After making enquiries, the directors have a reasonable expectation that University Hospitals Bristol NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future.

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 Operating Segments

Income and expenditure are analysed in the Operating Segments note (Note 2) and are reported in line with management information used within the Trust.

1.4 Income

Revenue from Contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- As per paragraph 121 of the Standard the Trust will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a

performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS Contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific performance obligation which is to be satisfied in the following financial year, that income is deferred.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

Provider Sustainability Funding (PSF)

Income recognised in the accounts relating to the Provider Sustainability 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.

NHS Injury cost recovery scheme

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 has completed the NHS2 form and confirmed there are no discrepancies with the treatment. 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 in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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.

1.5 Expenditure on employee benefits

Employee benefits - short term

Salaries, wages and employment-related costs, including payments arising from the apprenticeship levy, 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.

An assessment of annual leave owing to staff at 31st March 2019 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 2019. 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. The schemes 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.

1.6 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. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 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 and assets under construction are not depreciated. Freehold land is considered to have an infinite life, 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	14 years	49 years
Dwellings	18 years	26 years
Plant and machinery (incl. medical equipment)	1 year	20 years
Transport equipment	1 year	7 years
Information technology	1 year	7 years
Furniture and fittings	1 year	9 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. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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.

1.8 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	9 years

Purchased computer software licences are amortised over the shorter of the term of the licence and their estimated economic lives.

1.9 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 and Social Care 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.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.10 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.

1.11 Financial Assets and Financial Liabilities

Financial assets and financial liabilities are recognised when the Trust becomes party to the contractual provision and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

Financial assets and financial liabilities are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial assets at amortised cost

Financial assets and financial liabilities measured at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset or financial liability to the gross carrying amount of the financial asset or amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Expected losses are charged to operating expenditure within the Statement of

Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.13 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

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.14 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 (%)	
		2018/19	2017/18
Short term	1-5	0.54	-2.42
Medium term	6-10	1.13	-1.85
Long term	10 or more	1.99	-1.56

Clinical negligence costs

The NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution which, in return, settles all clinical negligence claims. The contribution is charged to the Statement of Comprehensive Income. Although the NHS Resolution 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 NHS Resolution 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 Resolution 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.

1.15 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) are 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.

1.16 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance which represents the Department of Health and Social Care'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 Provider Sustainability 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 and Social Care 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.

1.17 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.

1.18 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.

1.19 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 26 is compiled directly from the losses and

compensations register which reports on a cash basis with the exception of provisions for future losses.

1.20 Accounting standards that have been issued but not yet been adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2018-19. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020-21, and the government implementation date of IFRS17 still subject to HM Treasury consideration.

Standards and Interpretations	Financial year for which the change first applies
IFRS 16 *Leases*	Application required for accounting periods beginning on or after 1 January 2020, but not yet adopted by the FReM: early adoption is not therefore permitted.
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 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 leases standard IFRS 16 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 2020/21 detailed work has not yet been undertaken to quantify the impact. There will be no significant impact from the other standards.

1.21 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 49 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.

For 2018/19 the Building Cost Information Service (BCIS) publications for Quarter 1 2019, adopted for 31st March 2019 valuations, had a marked variation in the BCIS location factors applicable to the South West region of England compared to the 31st March 2018 asset valuations. The District Valuer's professional expertise was this reflected a short term

fluctuation, reducing the impact of the published indices through adopting a smoothing approach to the location factor, providing greater consistency in the valuations of the Trust's specialised assets.

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 reviewing actual contract monitoring data from month 7 onwards for estimating the final months of the year.

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 is 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 17/18 and 18/19 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 2019 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 2019.
- Value these days as a proportion of the pathway tariff.

1.22 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 2018/19 is shown below with comparator figures for 2017/18.

	Year Ended 31 March 2019 £000	Year Ended 31 March 2018 £000
Corporate income (excluding Provider Sustainability Funding (PSF))	624,974	593,021
Net Expenditure		
Diagnostic and Therapies	(57,031)	(51,336)
Medicine	(91,061)	(83,389)
Specialised Services	(114,230)	(111,431)
Surgery	(117,373)	(114,269)
Women's and Children's	(133,533)	(129,490)
Facilities and Estates	(40,191)	(37,049)
Trust Services	(29,308)	(27,802)
Corporate Services	(3,390)	(3,728)
Total net expenditure	(586,117)	(558,494)
Earnings before Interest, Tax, Depreciation & Amortisation	**38,857**	**34,527**
Financing costs	(34,375)	(33,584)
Net surplus before PSF and technical accounting adjustments	**4,482**	**943**
Provider Sustainability Funding	25,372	18,960
Net surplus before technical accounting adjustments reported to NHS Improvement	**29,854**	**19,903**
Technical accounting adjustments		
Donations received for Property Plant and Equipment	1,279	1,204
Depreciation on donated assets	(1,580)	(1,570)
Impairment charge when assets brought into use	-	(1,281)
Impairment reversal / (charge) from revaluation	515	249
Total Technical accounting adjustments	214	(1,398)
Surplus/(deficit) for year	**30,068**	**18,505**

3. Income from patient care activities

3.1 Income by nature

	Year ended 31 March 2019 £000	Year ended 31 March 2018 (Restated *) £000
Elective income * *(Note 1)*	102,493	98,047
Non elective income	136,530	129,546
First outpatient income	34,954	33,653
Follow up outpatient income	46,686	44,069
Accident and emergency income	19,805	18,271
High cost drug income from commissioners	68,130	68,060
Other NHS clinical income *(see significant items below)* **(Note 1)*	165,642	166,413
Private patients	1,201	1,701
Agenda for Change pay award central funding *(Note 2)*	5,792	-
Other clinical income	9,893	10,443
Total	**591,126**	**570,203**
Other NHS Clinical Income - Significant items include:		
Critical care bed days	44,716	45,379
'Payment by results' exclusions	22,861	20,590
Bone marrow transplants	7,574	8,708
Radiotherapy inpatient treatments	7,579	7,591
Diagnostic imaging	6,243	5,983
Direct access	6,046	6,069
Rehabilitation	5,805	5,647
Audiology, Cochlear implants, bone anchored aids	8,000	7,339
Contract penalties and rewards	8,460	10,785
Cystic fibrosis pathways	5,208	5,148
Maternity pathways	6,938	7,314
'Soft' facilities management and LIFTCO	3,031	3,034
Bowel Cancer & Bowel Scope Screening	3,452	2,868
Chemotherapy Delivery	4,296	3,650
Community Dental	1,332	1,330
Retrievals	2,762	2,787
Winter Pressure funding	-	1,863
Operational Resilience and Capacity	1,266	-

***Restated**

There is no change in total income. The restatements are within headings, as noted below.

Note 1

In 2017/18 Regular Day Attenders were included within Other NHS Clinical Income and disclosed separately within significant items. In 2018/19, in line with NHS data dictionary definitions, the income is now disclosed within Elective Income.

Note 2

The agenda for change pay award came into effect from 01 April 2018 and was centrally funded.

3.2 Income by source

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
NHS England	282,518	279,004
Clinical Commissioning Groups	275,728	265,339
NHS Foundation Trusts	168	270
NHS Trusts	2,611	2,328
Local Authorities	8,352	8,566
Department of Health and Social Care (Agenda for change pay award)	5,792	-
NHS – Other	-	67
Non-NHS private patients	1,201	1,701
Non-NHS overseas patients	466	406
NHS Injury Scheme	877	777
Territorial Bodies	13,413	11,745
Total	**591,126**	**570,203**

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, £570.2m (2017/18: £550.5m) is from Commissioner Requested Services and £20.9m (2017/18: £19.7m) is from all other services

3.4 Income from overseas visitors

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Income recognised this year	466	406
Cash payments received (invoices raised in this and previous years)	382	212
Increase to credit losses of receivables (invoices raised in this and previous year)	189	194
Amounts written off (invoices raised in this and previous years)	809	93

4. Other operating income

4.1 Other operating income

From contracts with customers

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Research and development	17,745	16,746
Education and training	34,890	35,184
Non-patient care services to other bodies	14,208	14,106
Provider Sustainability Fund	25,372	18,960
Salary recharges	6,870	4,986
Other**	16,093	12,646
Total	**115,178**	**102,628**

Other non-contract operating income	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Research and development	8,285	7,557
Donated assets – property plant and equipment (income and physical asset)	1,279	1,204
Education and training – from apprenticeship fund	96	32
Charitable and other contributions to operating expenditure	938	945
Rental income from operating leases	1,631	1,573
Total	**12,229**	**11,311**
Total recognised operating Income	**127,407**	**113,939**

**Significant items include:

	£000	£000
Clinical excellence awards	2,987	3,103
Trading services - MEMO	978	928
Trading services – Pharmacy	1,313	1,157
Trading services - IT	437	403
Clinical testing	468	432
Catering	568	386
Staff accommodation rentals	211	172
Car park income	1,022	988
Staff contribution to employee benefit schemes	1,248	1,410
Property rentals	39	137

The Trust's trading services income is matched with costs in Operating Expenditure; trading services are revenue neutral.

4.2 Additional Information on contract revenue (IFRS15) recognised in the period

	Revenue recognised from NHS Providers 2018/19	Revenue recognised from other DHSC group bodies 2018/19	Revenue recognised from non DHSC group bodies 2018/19	Total 2018/19
	£000	£000	£000	£000
Revenue recognised previously included in liability balance	-	1,846	2,339	4,185

4.3 Transaction price allocated to remaining performance obligations

	Revenue expended from NHS Providers 31 March 2019	Revenue expected from other DHSC group bodies 31 March 2019	Revenue expected from non DHSC group bodies 31 March 2019	Total 31 March 2019
	£000	£000	£000	£000
Revenue from contracts entered into but expected to be recognised:				
- Within one year	8	2,020	3,283	5,311
- After one year but not later than five years	-	-	-	-
- After five years	-	-	-	-

4.4 Operating lease income

	Year ended 31 March 2019	Year ended 31 March 2018
	£000	£000
Rental income – minimum lease receipts	1,631	1,573

4.5 Future minimum lease receipts due to the Trust

	Year ended 31 March 2019	Year ended 31 March 2018
	£000	£000
- no later than one year	1,556	1,501
- between one and five years	1,638	1,757
- after five years	1,057	1,767
Total	**4,251**	**5,025**

5. Operating expenses

5.1 Operating expenses by type

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Services from other bodies:		
- NHS & DHSC bodies	11,574	11,301
- non NHS & non DHSC bodies	1,413	1,593
Purchase of healthcare from non NHS bodies	3,538	4,279
Employee expenses excluding Board members	407,058	383,607
Employee expenses – Board members	1,494	1,362
Trust chair and non-executive directors	199	197
Supplies and services: clinical	68,917	66,234
Supplies and services: general	7,040	7,132
Drug costs	87,326	85,971
Establishment costs	9,458	8,443
Premises costs – business rates	3,104	2,995
Premises costs - other	12,174	11,923
Transport – business travel	1,067	928
Transport – other (including patient travel)	1,302	1,317
Depreciation on property plant and equipment	22,436	21,931
Amortisation on intangible assets	2,468	1,857
Net Impairments	(515)	1,032
Movement in contract credit loss allowance	(2,967)	5,476
Auditor's remuneration - statutory audit	66	61
Auditor's remuneration – other non-audit services	10	10
Internal audit	266	263
Clinical negligence	11,224	8,771
Research and development – hosting payments	7,315	7,459
Research and development – other	7,091	6,665
Rentals under operating leases	6,702	6,616
Other**	7,547	6,832
Total	**677,307**	**654,255**
**Significant items include:		
Consultancy	836	373
Inventories written down	-	26
Education and training	2,682	2,375
External contractors' services	85	82
Childcare vouchers	1,226	1,261
Legal fees	355	163
Parking and security	532	451
Insurance	272	280

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 2019	Year ended 31 March 2018
Minimum lease payments	**£000**	**£000**
Land	25	34
Buildings	5,613	5,308
Plant and machinery	1,064	1,274
Total	**6,702**	**6,616**

Future minimum lease payments due under operating leases	**£000**	**£000**
Before one year	1,708	1,782
Between one and five years	2,971	3,783
After five years	4,004	5,084
Total	**8,683**	**10,649**

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. The Trust continues to occupy and pay expenses while ongoing arrangements and future lease costs and payments are being re-negotiated and these costs are reflected in the minimum lease payments however there are no costs recognised in future minimum payments.

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 2019	Year ended 31 March 2018
	£000	**£000**
Salaries and wages	332,064	313,385
Social security costs	30,019	28,595
Apprenticeship levy	1,588	1,505
Pension costs	39,237	36,851
Termination benefits	182	80
Temporary staff - agency/contract staff	9,075	8,863
Gross employee expenses	**412,165**	**389,279**
Income in respect of salary recharges netted off	(2,932)	(2,730)
Employee expenses capitalised	(681)	(1,580)
Net employee expenses	**408,552**	**384,969**

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 for Health 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme 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 recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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 2019 there were 4 (2017/18: 6) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill-health retirements will be £0.164m (2017/18: £0.349m). 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 £0.107m (2017/18: net loss of £0.016m) 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 2019 £000	Year ended 31 March 2018 £000
Interest on bank account and National Loan Fund Investments	598	189
Total	**598**	**189**

8.2 Finance expenses

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Loan interest on DHSC capital loans	2,490	2,686
Finance leases	242	268
Total	**2,732**	**2,954**

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 charged to operating surplus resulting from:	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Impairment of enhancements to existing assets	-	1,281
Changes in valuation	408	1,669
Reversal of impairments from change in valuation	(923)	(1,918)
TOTAL	**(515)**	**1,032**

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 2019 £000	Year ended 31 March 2018 £000
Impairment of enhancements to existing assets		
Queen's Building	-	1,281
	-	**1,281**
Change in valuation		
District Valuer's revaluation of land & buildings	**(515)**	**(249)**
Total	**(515)**	**1,032**

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 2018	19,204	314	19,518
Additions – purchased	1,082	1,721	2,803
Reclassifications with PPE	2,517	-	2,517
Reclassifications within intangibles	614	(614)	-
Disposals	(93)	-	(93)
Cost at 31 March 2019	23,324	1,421	24,745
Accumulated amortisation at 1 April 2018	7,394	-	7,394
Charged during the year – purchased	2,442	-	2,442
Charged during the year – donated	26	-	26
Disposals	(93)	-	(93)
Accumulated amortisation at 31 March 2019	9,769	-	9,769
Net book value at 31 March 2019			
Purchased	13,451	1,421	14,872
Donated	104	-	104
Total net book value at 31 March 2019	**13,555**	**1,421**	**14,976**

	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	11,680	314	11,994
Donated	130	-	130
Total net book value at 31 March 2018	**11,810**	**314**	**12,124**

10. Property, plant and equipment

The District Valuer undertook a full revaluation at the 31 March 2019 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 2019 of £16.214m compared to the book values with £0.515m charged to the Statement of Comprehensive Income as a net reversal of impairments and £15.699m charged to the revaluation reserve in the Statement of Financial Position.

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 (DHSC 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 DHSC 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.
- 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

The Building Cost Information Service (BCIS) publications relevant to Quarter 1 2019, adopted for 31st March 2019 valuations, had a marked variation in the BCIS location factors applicable to the South West region of England compared to the 31st March 2018 asset valuations. The District Valuer's professional expertise was this reflected a short term fluctuation, reducing the impact of the published indices through adopting a smoothing approach to the location factor, providing greater consistency in the valuations of the Trust's specialised assets.

The impact of the smoothing approach was £14.913m; valuation increase without smoothing £31.127m compared to valuation used for 2018/19 of £16.214m.

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 2018	24,448	291,836	2,579	4,629	96,130	909	22,631	1,012	**444,174**
Additions – purchased	-	1,500	1	16,022	3,487	70	582	-	**21,662**
Additions – donated	-	156	-	518	524	-	-	-	**1,198**
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications with intangibles	-	-	-	(2,517)	-	-	-	-	**(2,517)**
Reclassifications within PPE	569	5,851	3	(8,438)	274	-	1,741	-	**-**
Revaluations	883	4,453	(178)	-	-	-	-	-	**5,158**
Disposals	-	-	-	-	(9,275)	(199)	(4,394)	-	**(13,868)**
Cost or valuation at 31 March 2019	25,900	303,796	2,405	10,214	91,140	780	20,560	1,012	**455,807**
Accumulated depreciation at 1 April 2018	-	-	-	-	60,465	550	12,432	906	**74,353**
Charged during the year – purchased	-	10,328	133	-	6,720	81	3,568	51	**20,881**
Charged during the year – donated		595	-	-	916	8	36	-	**1,555**
Revaluations	-	(10,923)	(133)	-	-	-	-	-	**(11,056)**
Disposals	-	-	-	-	(9,078)	(198)	(4,384)	-	**(13,660)**
At 31 March 2019	-	-	-	-	59,023	441	11,652	957	**72,073**
Net book value at 31 March 2019									
Purchased	25,900	280,353	2,405	10,214	27,209	299	8,754	55	**355,189**
Donated	-	16,793	-	-	4,908	40	154	-	**21,895**
Finance leases	-	6,650	-	-	-	-	-	-	**6,650**
Total at 31 March 2019	**25,900**	**303,796**	**2,405**	**10,214**	**32,117**	**339**	**8,908**	**55**	**383,734**

	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**

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 2019 £000	Year ended 31March 2018 £000
Cost or valuation at 1 April	6,581	6,581
Additions	35	232
Revaluation	105	(232)
Reclassifications	-	-
Cost or valuation at 31 March	**6,721**	**6,581**
Accumulated depreciation at 1 April	67	53
Provided during the year	596	561
Revaluation	(593)	(547)
Accumulated depreciation at 31 March	**70**	**67**
Net book value at 31 March	**6,650**	**6,514**

10.2 Net book value of land building and dwellings

The net book value of land, buildings and dwellings comprises:

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Freehold	325,451	312,353
Long leasehold	6,650	6,510
TOTAL	**332,101**	**318,863**

11. Inventories

Year ended 31 March 2019	**Drugs £000**	**Consumables £000**	**Energy £000**	**Totals £000**
Carrying value at 1 April 2018	3,778	9,578	134	13,490
Additions	58,628	47,939	46	106,613
Write down of inventory recognised as expense	-	-	-	-
Consumed – recognised in expenses	(58,385)	(50,283)	(29)	(108,697)
Carrying value at 31 March 2019	4,021	7,234	151	11,406

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

12. Receivables

12.1 Contract and other receivables

	Year ended 31 March 2019 £000	* Year ended 31 March 2018 £000
Current:		
NHS contract receivables *	31,198	30,186
Other contract receivables *	7,387	8,351
VAT receivable	952	1,121
Allowance for credit losses	(6,976)	(10,111)
PDC Dividend receivable	-	49
Prepayments	2,336	2,947
Contract receivable not yet invoiced *	33,608	16,811
Total current:	**68,505**	**49,354**
Non current:		
Other receivable	-	1,050

* Following the application of IFRS15 from 01 April 2018 the Trust's entitlement to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis of trade receivable and accrued income. IFRS15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

The non-current receivable in 2017/18 related to deferred element from the sale of the Old Building which was received ahead of plan in 2018/19.

12.2 Allowance for credit losses

	Year ended 31 March 2019 £000
Allowance as at 1 April 2018	**10,111**
Changes in existing allowances	(2,967)
Utilisation of allowances	(168)
Balance at end of year	**6,976**

	Year ended 31 March 2018 £000
Allowance as at 1 April 2017	**4,718**
Movement in provision	5,476
Utilised in year	(83)
Balance at end of year	**10,111**

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS7 prior to IFRS9 adoption. As a result it differs in format to the current period disclosure.

13. Other financial assets

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Other 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 2019 £000	Year ended 31 March 2018 £000
Current amounts:		
NHS payables – revenue	18,267	10,861
Amounts due to related parties – revenue	5,585	5,250
Other payables – revenue	19,533	16,357
Capital payables	5,248	2,090
Tax and social security	8,544	7,863
PDC dividend payable	114	-
Accruals *	25,934	22,973
TOTAL	**83,225**	**65,394**

* Following the adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 16.1. IFRS 9 is applied without restatement therefore comparatives have not been restated

Non-current amounts:
There are no non-current trade and other payables in either year.

Outstanding pension contributions of £5.578m (2017/18: £5.247m) to the NHS Pension scheme and £0.007m (2017/18: £0.003m) for National Employment Savings trust (NEST) local pensions are included in amounts due to related parties. PAYE of £3.947m (2017/18: £3.601m) and £4.597m National Insurance (2017/18: £4.261m) are included in tax and social security.

15. Other liabilities

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Current liabilities:		
Deferred income – contract liability	5,311	5,918
Total	**5,311**	**5,918**

16. Borrowings

16.1 Current borrowings:

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Capital loans from Department of Health and Social Care *	6,502	5,834
Finance lease obligations	357	336
Total	**6,859**	**6,170**

* Following the application of IFRS 9 from 01 April 2018 the carrying value of capital loans includes both the principle of £5.834m and the interest accrual £0.668m. IFRS 9 is applied without restatement therefore the comparative has not been restated and therefore represents just the principle value.

16.2 Non-current borrowings:

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Loans from Department of Health and Social Care	64,591	70,426
Finance lease obligations	3,960	4,318
Total	**68,551**	**74,744**

16.3 Finance lease obligations

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Payable:		
Before one year	575	578
Between one and five years	2,300	2,300
After five years	2,539	3,115
Sub-total	**5,414**	**5,993**
Less finance charges allocated to future years	(1,097)	(1,339)
Net lease liabilities	**4,317**	**4,654**

The finance lease arrangement relates to buildings comprising the Education Centre which will expire in September 2028.

16.4 Net finance lease obligations

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Payable:		
Before one year	357	336
Between one and five years	1,669	1,573
After five years	2,291	2,745
Net obligation	**4,317**	**4,654**

16.5 Finance lease commitments

There are no finance lease commitments at 31 March 2019 (31 March 2018 £nil.)

16.6 Reconciliation of liabilities arising from financing activities – 2018/19

	DHSC Loans	Finance Lease	Total
	£000	£000	£000
Carrying Value at 01 April 2018	76,260	4,654	80,914
Impact of IFRS 9	734	-	734
Cash Movements			
Principal	(5,834)	(333)	(6,167)
Interest	(2,557)	(246)	(2,803)
Non Cash Movements			
Interest Charge arising in year	2,490	242	2,732
Carrying Value at 31 March 2019	**71,093**	**4,317**	**75,410**

17. Provisions

17.1 Provision for liabilities:

Year ended 31 March 2018	Pension Injury Benefits	Legal Claims	Total
	£000	£000	£000
At 1 April 2018	276	168	444
Arising during the year	-	122	122
Utilised during the year	(32)	(25)	(57)
Reversed unused	-	(113)	(113)
At 31 March 2019	**244**	**152**	**396**

Timing of economic outflow	Pension Injury Benefit	Legal Claims	Total
	£000	£000	£000
Before one year	32	152	184
Between one and five years	212	-	212
After five years	-	-	-
Total	**244**	**152**	**396**

Year ended 31 March 2017	Pension Injury Benefits	Legal Claims	Total
	£000	£000	£000
At 1 April 2017	127	160	287
Arising during the year	180	113	293
Utilised during the year	(31)	(32)	(63)
Reversed unused		(73)	(73)
At 31 March 2018	**276**	**168**	**444**

Pension injury benefits are in respect of staff injury allowances payable to the NHS Business Services Authority (Pensions Division). Legal claims represent liabilities to third parties for 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 £290.833m provision in its accounts (2017/18: £242.475m) in respect of clinical negligence liabilities of the Trust.

18. Cash and cash equivalents

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Cash with the government banking service	99,729	70,900
Commercial bank and cash in hand	126	192
Total cash and cash equivalents	**99,855**	**71,092**

19. Capital commitments

Commitments under capital expenditure contracts at 31 March 2019 are £4.3m (2017/18: £4.8m Intangible assets); £2.2m for Intangibles assets and £2.1m for Property Plant and Equipment.

20. Post-Statement of Financial Position (SoFP) events

There are no post-Statement of Financial Position events.

21. Contingencies

The Trust has no contingent assets at 31 March 2019 (2017/18: £nil).

The Trust has no material contingent liabilities at 31 March 2019. The Trust has contingent liabilities in relation to new claims that may arise from past events under the NHS Resolution "Liability to Third Parties" and "Property Expenses" schemes however 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.

Notes to the Accounts

Related parties arising from Trust Board members:

	31 March 2019 (£m)		31 March 2018 (£m)		2018/19 (£m)		2017/18 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
University of Bristol	0.33	2.45	-	2.25	1.98	8.30	1.89	9.58
University of the West of England	0.07	0.11	-	0.07	0.50	0.55	0.40	0.46
West of England Academic Health Sciences Network	-	-	-	-	0.03	-	0.02	0.01
Cardiff University	0.01	-	-	-	0.01	0.45	-	-
Care Quality Commission	-	-	-	-	-	0.14	-	0.33
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 2019 (£m)		31 March 2018 (£m)		2018/19 (£m)		2017/18 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Avon and Wiltshire Mental Health Partnership NHS Trust	-	-	-	-	0.70	0.79	0.83	0.95
Bristol City Council	-	-	0.90	-	8.84	-	9.13	-
Community Health Partnerships	-	3.24	-	-	-	5.51	-	4.94
Department of Health	-	-	-	-	28.28	-	21.68	-
Gloucestershire Hospitals NHS FT	-	-	-	0.54	-	3.14	-	3.05
Great Western Hospitals NHS FT	-	-	-	-	-	0.61	-	0.63
Health Education England	-	-	0.56	-	34.31	-	35.07	-
HM Revenue and Customs	0.95	8.54	1.12	7.86	-	31.61	-	30.10
NHS Bath and North East Somerset CCG	-	-	-	-	9.11	-	8.61	-
NHS Blood and Transplant	-	0.67	-	0.74	-	5.29	-	5.79
NHS Bristol, North Somerset and South Gloucestershire CCG	6.52	2.05	4.89	1.94	245.54	-	191.86	-
NHS England - Central Specialised Commissioning Hub	-	-	-	-	0.76	-	-	-
NHS England - Core	15.39	-	12.30	-	25.67	-	22.35	-
NHS England - South West (North)	12.63	-	-	-	19.12	-	-	-
NHS England - South West (South)	3.37	4.82	-	-	3.84	-	-	-
NHS England - South West Commissioning Hub	12.51	-	13.87	-	259.73	-	254.73	-
NHS England - Wessex Commissioning Hub	0.82	-	-	-	4.35	-	-	-
NHS Gloucestershire CCG	-	-	-	-	4.83	-	-	-
NHS Kernow CCG	-	-	-	-	1.45	-	-	-
NHS Northern, Eastern, Western Devon CCG	-	-	-	-	1.83	-	1.65	-
NHS Pension Scheme	-	-	-	5.26	-	39.21	-	36.84
NHS Property Services	-	0.67	-	1.04	-	-	-	0.67
NHS Resolution	-	-	-	-	-	11.25	-	8.77
NHS Somerset CCG	-	-	-	-	8.89	-	8.32	-
NHS South Devon and Torbay CCG	-	-	-	-	0.65	-	0.70	-
NHS Swindon CCG	-	-	-	-	0.98	-	0.79	-
NHS Wiltshire CCG	-	-	-	-	3.98	-	3.70	-
North Bristol NHS Trust	2.62	6.72	3.47	6.45	5.39	13.68	5.64	13.46
Northern Health and Social Care Trust (N. Ireland)	-	-	-	-	0.69	-	0.97	-
Public Health England (PHE)	-	-	-	-	-	3.44	-	3.19
Plymouth Hospitals NHS Trust	-	-	-	-	-	0.57	-	0.77
Royal Devon and Exeter Foundation Trust	-	-	-	-	-	1.35	-	1.27
Royal United Hospital Bath NHS Foundation Trust	0.83	-	0.56	-	0.94	1.72	0.99	1.67
Taunton & Somerset NHS Foundation Trust	-	-	-	-	0.72	-	0.73	-
Welsh Assembly Government	-	-	-	-	10.10	-	8.91	-
Welsh Health Bodies – Aneurin Bevan Local Health Board	-	-	-	-	0.73	-	0.67	-
Weston Area Health NHS Trust	2.41	1.45	1.52	0.84	5.10	2.45	3.73	2.32

In addition the Trust pays HM Revenue and Customs tax and national insurance on behalf of employee; £68.706m in 2018/19 (£65.166m in 2017/18). The Trust also pays the NHS Pension Scheme for employees' contributions which totaled £26.424m in 2018/19 (£24.930m in 2017/18).

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.

Both charities are independently managed by boards of trustees and are not consolidated within the Trust's accounts. The transactions are as follows:

	31 March 2019 (£m)		31 March 2018 (£m)		2018/19 (£m)		2017/18 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Above and Beyond	0.28	-	0.40	-	1.16	0.30	1.77	0.31
Grand Appeal	0.02	-	0.08	-	0.42	-	0.24	-

23. Private Finance Initiative (PFI) transactions

At 31 March 2019 the Trust has no PFI schemes (2018: 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

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Under IFRS 9 **31 March 2019** **£000**	Under IAS 39 **31 March 2018** **£000**
Receivables with DHSC group bodies	62,800	38,652
Receivables with other bodies	2,417	7,637
Other financial assets	104	104
Cash and cash equivalents	99,855	71,092
Total	**165,176**	**117,485**

Receivables are held at amortised cost.

At 31 March 2019 all financial assets were due within one year.

24.3 Carrying Value of Financial liabilities by category

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Under IFRS 9 **31 March 2019** **£000**	Under IAS 39 **31 March 2018** **£000**
DHSC Loans	71,093	76,260
Obligation under Finance lease	4,317	4,654
Trade and other payables with DHSC group bodies	20,010	12,894
Trade and other payables with other bodies	54,557	44,634
Total	**149,977**	**138,442**

Financial liabilities are held at amortised cost.

Maturity of financial liabilities

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Less than one year	81,426	63,698
In more than one year but not more than two years	6,215	6,191
In more than two years but not more than five years	18,791	18,719
In more than five years	43,545	49,834
Total	**149,977**	**138,442**

24.4 Fair values

At 31 March 2019 and 31 March 2018 there was no significant difference between the fair value and the carrying value of the Trust's financial assets and liabilities.

25. Third party assets

At 31 March 2019 the Trust held £nil (2018: £nil) cash and cash equivalents relating to third parties.

26. Losses and special payments

Losses and special payments were made during the year as follows:

	2018/19		2017/18	
	No.	£000	No.	£000
Cash losses	7	15	13	13
Fruitless payments	-	-	1	10
Bad debts and claims abandoned *	615	920	45	97
Stores losses inc. damage to buildings **	2	382	3	139
Ex gratia payments	52	8	45	6
Severance payments	1	15	3	13
Total	**677**	**1,340**	**110**	**278**

* The Trust reviewed all debts relating to overseas visitor income resulting in a significant increase in the write off of bad debts.

** The stores losses include £0.173m losses from the fire at Bristol Haematology and Oncology Centre in May 2018

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 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;
- confirm 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; 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 2019

Appendix E – Independent Auditor’s Report to the Council 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 (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 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 2018/19.

We have audited the financial statements, included within the Annual Report and Accounts 2018/19 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2019; 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 2019 was planned and executed having regard to the fact that the Trust'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 key audit matters was largely unchanged.

Overview

- Overall materiality: £14.39m (2018: 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.
- Risk of 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.

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*
Risk of 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 because there is pressure on NHS bodies to meet or to exceed the financial targets set for them by regulators. In particular, there is additional 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 income and expenditure to defer costs to 2019/20 and to recognise income incurred in respect of 2019/20 in these financial statements. *Revenue* 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 value of the year end 'true up' is subject to judgement by the directors as actual validated activity levels which form the basis of income are not available for March ("month 12") at the time of preparation of the accounts and the completion of the audit. A further 'true up' occurs later in the year when actual month 12 activity figures are known and validated. The Trust's next largest sources of income include research and development income and education and training income. These balances include multi-year contracts, where income is recognised in line with delivery of the contract or once performance criteria are satisfied. Due to 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.	*Revenue* 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 developed an independent estimate of the month 12 income and compared this to the directors' estimate. We compared the directors' estimates in prior years with the actual figures for month 12 in those prior years to determine whether the directors' estimates were consistent with actual results. The levels of payment adjustment for the final 'true up' historically have been immaterial and accounted for in the following year's financial statements, which provides additional comfort over the accuracy of management's estimation process. On the basis of this work, we are satisfied that the estimate is not materially misstated. 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. We also read the terms and conditions for a sample of research and development and education and training contracts and agreed the value of income recognised in the year under these contracts. 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. *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 financial statements was appropriate. Our work did not identify any issues. Our work did not identify any transactions that were indicative of fraud in the recognition of income or expenditure, in particular to overstate income or understate expenditure.

Valuation of property, plant and equipment

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's 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 £383.734m. 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 2019 is £332.101m.

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. 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 structure of the Trust, the accounting processes and controls, and the environment in which the Trust operates.

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	£14.39m (2018: £13.7m)
How we determined it	2% of total revenue (2018: 2% of total 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 (2018: £300,000) 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 2018/19 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.

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 2019 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

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 and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

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 38, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19, 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.

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.

Our audit did not consider any impact that the United Kingdom's withdrawal from the European Union may have on the Trust as the terms of withdrawal are not clear, and it is difficult to evaluate all of the potential implications on the Trust's activities, patients, suppliers and the wider economy.

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

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 2019.

We determined that there were no key audit matters or other matters to report as a result of this requirement.

Other matters on which we report by exception

We are required to report to you if:

- the statement given by the directors on page 79, 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 patients, regulators, and other stakeholders 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 82, 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 2018/19 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
24 May 2019