Inspected and rated Outstanding

Care Quality Commission

NHS

University Hospitals Bristol

NHS Foundation Trust

University Hospitals Bristol NHS Foundation Trust

Annual Report and Accounts 2019/20

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

University Hospitals Bristol NHS Foundation Trust
Annual Report and Accounts 2019/20

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

Contents

1. Chairman's Statement

I've now spent two full years with the Trust and I continue to feel honoured to work closely with so many enthusiastic people, who are wholeheartedly dedicated to our patients and our community and, in recent months, shown how they are willing to put aside fears for their own health to help others battle the effects of Covid-19 infection

As Trust Chair, part of my role is to ensure we have a clear strategic direction and that we continue to innovate in order to improve healthcare. In 2019/20, we launched our new five year strategic plan: *Embracing Change, Proud to Care.* The strategy was developed over 14 months, in collaboration with staff, patients, their families and carers, governors, local people and partners.

Our vision for the next five years is to grow our specialist hospital services, working more closely with our partners to provide more joined-up local healthcare services. I've been hugely impressed with the way in which we continue to work with our counterparts across health and social care to further strengthen our relationships and work together more efficiently. This is essential to ensuring we continue to provide our communities with the best healthcare.

We also want to be recognised for our expertise in research and education, continuing with our Digital Hospital Programme to introduce new technologies to drive improvement in our hospitals and support our staff to use their own talent for innovation.

In May, we launched our new workforce diversity and inclusion strategy. This is at the heart of how we demonstrate our understanding of our staff and communities and it is something that the Board is monitoring closely. I am pleased that we have made some notable progress. Our reverse mentoring scheme has gathered pace and our commitments set out in the diversity and inclusion strategy are being scrutinised in the Trust's people committee. There is always more we can do and we need to remain accountable to our staff and patient forums in order to understand the needs of all of our staff and communities.

In August, the Care Quality Commission (CQC) rated the Trust 'Outstanding' for the second time in a row. This is testament to the hard work of all of our staff. The CQC recognised that staff across the Trust are committed to continuously improve the quality of our services. This innovation has been evident in our response to exceptional pressures on our system over the past few months in particular, and I'm proud of the way we continue to focus on improving the services we provide to our communities.

Since September, I have been Chair at Weston Area Health NHS Trust (WAHT), as well as at UH Bristol. I have been struck by the energy, enthusiasm and professionalism of staff in both trusts as they embrace the changes the merger has to offer. Significant planning for a successful merger took place across the year, to create a combined organisation of over 13,000 staff aiming to deliver exceptional local services for local people and specialist services across the South West and beyond. Following approval by the Secretary of State of Health and Care, we became University Hospitals Bristol and Weston NHS Foundation Trust on 1 April 2020.

The Council of Governors have played a vital role throughout the merger process in ensuring the views of our patients, staff, members and public were heard, and the final approvals demonstrate that these have been well considered in our plans.

Through the year, we have been actively engaged with the wider sustainability and transformation partnership that involves all health care providers, commissioners and the local authorities in the local area, to develop plans for greater integration of services for local people.

Together with the Trust Board and governors, I have been impressed by the tremendous efforts of our staff at this difficult time. The executive team continues to lead the response to the Coronavirus (Covid-19) pandemic, and I'd like to thank them and all of our colleagues who continue to work tirelessly to provide outstanding care to the communities we serve in the face of exceptional challenges.

Thank you.

Jeff Farrar QPM, OStJ
Chairman
June 2020

2. Chief Executive's Statement

Our mission as a Trust is to deliver exceptional care, teaching and research every day. 2019/20 has brought the unprecedented challenge of responding to the Coronavirus pandemic but our staff have continued to show their commitment to delivering excellent patient care even in the most difficult circumstances. I want to commend them for their resilience, their bravery and their professionalism at all times.

While impact of the pandemic has overshadowed much of what went before, it is important to register some fantastic achievements in the course of the year. I was absolutely delighted that the Trust was rated Outstanding by the CQC in August for the second time in a row. This clearly demonstrates that our staff are very special people, doing an exceptional job to provide the best possible care for those who need our services. I was thrilled that their hard work was recognised in this way.

We have also made great progress against the four priorities I set for senior leaders in the Trust at the start of the year. Caring for our 11,000 staff members, supporting their wellbeing and development and working to stamp out discrimination, bullying and harassment, was top of these priorities. Our staff are at the heart of the Trust and it is a fundamental principle that they should feel properly engaged and fairly supported.

I was therefore pleased that we saw the number of responses to the NHS Staff Survey rise significantly to 5,100 employees. I was even more pleased to see that our staff engagement score had increased for the sixth year running and that we performed better than the national average against the great majority of questions in the survey. However, our race equalities data indicated a range of disadvantages faced by staff from a black, Asian, or minority ethnic (BAME) background.

Ensuring we are an organisation that works equally for all staff, irrespective of race, gender, sexual orientation or disability, is a major commitment of the Trust Board. We launched our workforce diversity and inclusion strategy in May, confirming our commitment to inclusion in everything we do. In the following months, we implemented the NHS rainbow badge scheme as a way of demonstrating our commitment to provide an open, non-judgmental and inclusive environment for all, no matter how people define themselves. The Trust also hosted its second regional Black History Month event to celebrate the contribution of black and minority ethnic staff in the NHS.

The second of the leadership priorities I set for the year was to be the safest hospital trust with the best patient experience. Our national patient survey results confirmed that we generally provide among the best patient experience in England, in both adult and children's services. I never fail to be impressed with the way our staff look after those who need our services with care, compassion, dignity and respect. An in-year initiative building on these qualities was ReSPECT (Recommended Summary Plan for Emergency Care and Treatment). ReSPECT involves a conversation that helps to plan a person's clinical care in the event of a future emergency when they may be unable to make or express choices. Health and care organisations across the Bristol, North Somerset and South Gloucestershire (BNSSG) area, including UH Bristol, have implemented ReSPECT from 10 October 2019. I was also delighted that the PReCePt project, developed at St Michael's Hospital, won the 2019 Health Service Journal Patient Safety Award in the Maternity and Midwifery Services Initiative of the Year category.

My third leadership priority for the year was about working smarter, including planning effectively for the pressures that winter always brings. In the event, we had to adapt very quickly as the potential impact of the Coronavirus pandemic became apparent at the beginning of 2020. We rapidly increased capacity within our hospitals, set up efficient processes for the deployment of personal protective equipment, put in place training for staff, and established testing systems for staff and patients. Using digital technology, we were able to put many outpatient consultations online, while maintaining as much urgent surgery as possible. While the pandemic has put immense pressure on our hospitals and on the local health and care system, we have seen excellent joint working across Bristol, North Somerset and South Gloucestershire.

Aside from the pandemic, there were multiple examples of great innovation in the year, of which one example is the widespread introduction of secure, online 'tele-dermatology' to facilitate joint review between a patient's GP and one of our specialist dermatologists, removing the need for travel to hospital.

My final leadership priority was to make ourselves fit for the future. In May, we proudly launched our five year strategy – *Embracing Change, Proud to Care* – outlining our ambitious vision for the future. The strategy set out how we intend to build on our successes to date and respond to the significant challenges facing the Trust and the wider NHS over the next five years. We engaged extensively – with our staff, our patients, their families and carers, our governors, local people and our NHS and Local Authority partners about the role of the Trust as an anchor institution in the region.

Our plans encompassed our growing partnership with Weston Area Health NHS Trust, which involved me taking a dual Chief Executive role across Bristol and Weston from 1 September 2019 and culminated in a successful merger on 1 April 2020. The merger helped to bring stability to Weston General Hospital and created a new organisation with a greater purpose, which is seen as a beacon for outstanding education, research and innovation in care. When we merged we became University Hospitals Bristol and Weston NHS Foundation Trust – a sign of our determination to ensure that Weston General Hospital has a bright and certain future at the heart of its local community.

As the NHS is the biggest employer in Bristol and Weston, we recognise our responsibility to reduce our impact on the environment. In October 2019, UH Bristol and North Bristol NHS Trust jointly declared a climate emergency. Both Trusts set ambitious goals to become carbon neutral by 2030 and we launched a sustainability plan setting out the actions we will take to be more environmentally friendly.

Finally, I want to make special mention of the invaluable contribution made by our fantastic community of hospital volunteers, Trust governors and members, supporters of Above & Beyond and our other charities, and members of the public. Our staff have received tremendous support from our community during the pandemic and I can say on behalf of all of us that it makes a real difference.

With best wishes,

Robert Woolley
Chief Executive
June 2020

3. Performance Report

3.1 Overview

The Trust has had a very positive year in all domains, including operational delivery; ensuring the quality of its services; developing and investing in its workforce; working as part of the local and regional NHS systems, and delivering one of its key strategic ambitions to merge with Weston Area Health NHS Trust.

The main risks facing the Trust throughout the year related to: workforce capacity and capability; the availability of beds; meeting the increasing demands on the Trust and system; and investing in management and leadership skills.

An emerging risk in Q4 was the impact of the Coronavirus pandemic (Covid-19), and specifically ensuring that there was sufficient capacity to manage the expected surge in demand. The Trust worked with local, regional and national partners to free up internal capacity and to create new system capacity at the NHS Nightingale Hospital at the University of the West of England. A key part of the planning, preparation and response was to ensure that staff were kept safe with appropriate PPE and equipment, and where possible staff were able to work from home. At the time of writing the annual report, the full impact of the pandemic was not yet known, but the Trust was following guidance from the World Health Organisation, which included developing post-disaster recovery plans. Further reports will be available on the Trust website and through the meetings of the Board of Directors.

In terms of operational and service delivery, 2019/20 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. This was confirmed by the Care Quality Commission (CQC) who awarded the Trust an Outstanding rating for the second time.

The continued increase in demand and latterly Covid-19 has impacted on the Trust's ability to deliver the A&E 4 Hour Standard and Referral to Treatment Times (RTT) targets. The percentage of patients seen in four hours was 80.4%, and the percentage of patients who were treated within 18 weeks was 84.3%. Performance against the six-week diagnostic standard was also challenging and was 94.5%. The Trust has set up a Planned Care Steering Group, the purpose of which is to ensure the Trust delivers against the national RTT and diagnostic waiting times' standards – identifying areas of risk and overseeing the implementation of remedial actions to ensure performance gets back on track. The Trust continued to use the Clinical Utilisation Review (CUR) system to identify and track delays in the system to free up capacity and flow through the hospital.

The Trust maintained delivery of the Cancer 62-day GP standard for three of the four quarters with the impact of Covid-19 marginally lowering performance in Q4. The 2-week wait standards were met in all four quarters of the year. This places the Trust as one of the top cancer performers in the country and demonstrates the commitment to deliver high quality care to patients even though there has been exceptional demand.

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, and good performance against the number of C.Diff cases and rates of infection with C.Diff. Rates of pressure ulcers per 1000 bed days remained steady across the year.

Finally, the tireless dedication of our staff to continue to deliver high quality services during this very challenging year needs to be recognised. The latest annual staff survey, which was undertaken in 2019, shows that staff engagement continues to be high and above the average for its peer group. The survey does highlight that there is further work to be done to ensure that all staff members are treated fairly and equitably at the Trust. The People Committee will continue to focus on improvements on equality and inclusion during 2020/21 to ensure that the Workforce Race Equality data demonstrates tangible improvements.

Principal activities of the Trust

University Hospitals Bristol NHS Foundation Trust (the Trust) is a public benefit corporation authorised by NHS Improvement, the Independent Regulator of NHS Foundation Trusts on 1 June 2008.

We have more than 11,000 staff who deliver over 100 different clinical services across nine different sites, providing 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.

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.

For general provision, services are provided to the population of central and south Bristol and the north of North Somerset, around 350,000 patients. A comprehensive range of services, including all typical diagnostic, medical and surgical specialties, are 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, 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 2019/20 for an Applied Research Collaboration. 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 10 Non-executive Directors, three are female and seven are male.

Our mission, vision and values

The Trust completed a refresh of its strategy in May 2019 called 'Embracing Change, Proud to Care – our 2025 vision'. This reaffirmed the Trust's mission to 'improve the health of the people we serve by delivering exceptional care, teaching and research every day'.

The 2025 vision is to improve patient and population health by:

- Growing our specialist hospital services and our position as a leading provider in south west England and beyond
- Working more closely with our health and care partners to provide more joined up local healthcare services and support the improvement of the health and wellbeing of our communities
- Becoming a beacon for outstanding education and research and our culture of innovation.

The mission and vision is achieved through our Trust values:

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Our Strategic Priorities

Our key strategic priorities that will guide delivery of the vision are:

- **Our Patients:** we will excel in the 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 translated rapidly into exceptional clinical care, and embrace innovation.
- **Our Potential:** we will be at the leading edge of research and transformation that is translated rapidly into exceptional clinical care.
- **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, remaining responsive to the changing needs of our population and significant changes within both the national and local planning environment. Our strategy supports delivery of the objectives of the NHS Long Term Plan, and the vision of the Healthier Together system partnership*.*

Transforming Care

Our focus is 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.

2019/20 has been the final implementation year of our Here to Help Customer Care programme. The outputs of the programme include a set of principles for excellent customer service, designed collaboratively with staff, governors and patients. We also undertook a specific campaign called 'Take Phonership' to improve our telephone responsiveness, and introduced a new digital feedback system for service users so that we can support and respond to queries or concerns as they arise. The final element, an enhanced training course for front-of-house staff, will launch in summer 2020.

We have continued to focus on transforming outpatients services, launching a programme to redesign how outpatient care can be delivered and working collaboratively with our system partners to ensure the best options are designed for, and with, our patients. Key actions are underway to use technology to deliver non face-to-face appointments, to work with primary care to develop advice and guidance pathways for GPs, and to review pathways to make sure all appointments add value for patients. Our real-time outpatient approach focuses on completing next steps for patients on the day of their clinic appointment. Six additional specialties (four paediatric, adult rheumatology and maxillofacial surgery) have implemented the approach during 2019/20, which has led to patients receiving their clinic letters quicker, and blood tests and x-rays on the same day.

Our digital systems continue to be developed to support clinical teams deliver best care. The implementation of a digital Venous Thromboembolism (VTE) risk assessment has supported an improvement in our management and monitoring of patients at

risk of developing a hospital acquired VTE. The impact of Covid-19 on business operations has resulted in accelerating alternative means to support the delivery of excellent care to patients. The Digital Services team has implemented an upgraded WebEx platform to support multi-disciplinary team (MDT) and other Trust meetings; we have also supported the implementation of a video consultation system enabling patient to clinician appointments without the need to attend hospital.

- Pillar 2: Improving patient flow

The flow of patients through our hospitals is integral to ensuring that they receive excellent care.

Clinical teams have been supported to improve communication across the multidisciplinary team, using a new mobile real time communication system called CareFlow. Work has been undertaken to redesign handover processes, internal referrals to other clinical teams and task management, as well as reducing the volumes of paper being used on a daily basis. The programme includes undertaking this work for all our inpatient teams, and where appropriate including communication with external partners and organisations.

Since 2018, the Bristol Eye Hospital has undertaken a large programme of work to improve processes for patients referred for cataract surgery. To date, the programme has improved the information provided in referrals from community services/primary care, introduced non-invasive anaesthetic options, launched standard assessment guidelines and improved documentation to ensure all clinical information is available in one place. Funded by our Trust charity Above & Beyond, in 2020 pre-operative clinics will be transformed to allow the majority of patients to attend a one-stop clinic – reducing waiting times and the number of hospital visits before surgery.

To support collaborative working with our system partners, 2019/20 saw the start of a programme of work to implement Clinical Practice Groups (CPGs), based on the successful model developed by the Royal Free London NHS Foundation Trust. CPGs are clinically led forums which review patient pathways, using data to support the identification of variances in practice, patient/staff experience and outcomes. The overarching aim of CPGs is to reduce unwarranted variation in clinical practice, ensuring provision of care for patients is evidence based and delivered at the same standard across the system and in the most appropriate location for a patient. The merger between University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust will use the CPG model as one of the vehicles for clinical service integration, with the intention for clinical practice groups to be embedded in the future merged organisation structure to drive clinical changes at service level and to maintain and extend partnership working across the system.

- 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 to secure value for money for more than a decade has enabled us to invest in our hospital infrastructure and training our staff, which puts us in a good position to continue improving the care we provide into the future.

The Trust maintained a healthy financial position for the financial year ended 31 March 2020. We achieved an income and expenditure surplus of £12.890m before technical items, and prior year Provider Sustainability Funding (PSF) efficiency savings of £16.876m, a year end cash position of £129.840m and we have a strong balance sheet resulting in a ‘Use of Resources’ risk rating of one.

Savings programme governance is provided through the executive-led Cost Savings Delivery Board with Trust-wide workstreams acting as vehicles for delivery savings. Clinical Divisions have set up ‘Working Smarter Groups’ with the remit of improving efficiency and productivity. They are using the NHSEI Model Hospital and other benchmarking tools to identify opportunities to increase activity and, where possible, reduce costs.

The clinically driven ‘Getting It Right First Time’ (GIRFT) programme is being used to

improve patient outcomes and increase productivity and efficiency. This, along with the Trust's ongoing Clinical Utilisation Review (CUR), forms a significant element of the Trust's productivity savings.

At a Trustwide level, a monthly 'Working Smarter Forum' has been set up with the express purpose of "sharing knowledge, experience and best practice in the use of benchmarking tools".

UH Bristol has used the NHSEI Model Hospital benchmarking tool to compare delivery costs in gastrointestinal surgery with its peers, saving £60k. The Pharmacy Department used it to compare a wide range of drug costs against its peers, highlighting areas for attention and improvement. Estates and Facilities regularly use the Model Hospital and other benchmarking tools to identify areas for efficiency; and savings have been made in facilities costs over the past two years.

The Trust's Managed Inventory Solution (MIS) continues to be rolled out, with the Children's Hospital and Intensive Care Units going live over the next few months. This tool improves inventory management and will provide vital management information in the months ahead.

Following a successful trial in 2018/19, we expanded the offer of receiving appointment letters by email to the majority of our patients. Uptake by patients continues to increase each month. January 2020 saw the highest number of appointment letters sent by email (1,600), saving the cost of second class postage for each letter sent.

- Pillar 4: Renewing our hospitals

We continue to deliver our 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 2019/20, the Capital Team has successfully delivered a number of operational and divisional capital schemes, ranging from the redesign and rebranding of the hospital café outlet facilities to the full refurbishment of Linear Accelerator F and the Brachytherapy Suite within Bristol Haematology and Oncology Centre (BHOC).

Works have also been completed under the strategic capital programme to deliver the redevelopment of the Myrtle Road property, creating essential decant space for other proposed schemes within the strategic capital programme. Planning permissions have been secured for two further strategic schemes, namely extending the Bristol Heart Institute to create an additional Cardiac Catheterisation Lab and inpatient beds, with a second extension to construct a purpose built Cardiovascular Research Unit.

An extensive estate master planning exercise has also been undertaken regarding the future development of the estate, including the Marlborough Hill site. Work continues into 2020/21 to carry out additional scheme feasibility studies alongside the delivery of a range of approved schemes.

To improve the environment for our patients and staff, we have developed our Arts and Culture Programme. The programme was initially supported by our hospital charity, Above & Beyond up to October 2019, with an Arts and Culture Strategy approved by the Board in June 2019 allocating resource to ensure implementation. The Arts Programme Director's contract has been extended to May 2021, an Arts Programme Manager has been recruited and an administrative base is to be established in Dolphin House. Currently branded #UHBristolArts, the programme is becoming more visible internally, externally and in the rapidly growing Arts & Health sector. It is anticipated that following the merger of University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust, the Arts Programme will be rebranded with a visual identity and an appropriate internal and external communications plan.

In the last 12 months, art gallery hanging systems have been installed in the Bristol Royal Infirmary (BRI), South Bristol Community Hospital (SBCH) and St Michael's Hospital, which will facilitate the showing of works borrowed from cultural partners such as The Royal Photographic Society, Bristol Culture, and educational and community arts groups. 10 donated pianos have been installed. Following the second

'Audio Advent' programme in December 2019, the provision of live music as a gift to others is becoming commonplace year round.

Strategic partnerships with other NHS Trusts and with civic anchor institutions are contributing resource and building capacity. The Arts Programme Director is one of the founders of the National Performance Advisory Group (NPAG) for Arts Design and Heritage in Hospitals and hosted a meeting in October 2019, attended by representatives from 40 NHS Trusts who were addressed by key speakers from Arts Council England, the APPG on Creative Health, and international artist Luke Jerram. This NPAG shares best practice between Hospital Arts professionals, and has recently won support for fundraising training. Partnerships with educational institutions have added capacity for participatory work with patients and provided shared research and learning with staff. In the past year the programme has hosted student interns from the UWE MA in Curating, the Arts Therapies course at City of Bristol College and the School of Arts at Bristol University. Partnerships with schools and colleges are also being explored. Arrangements with national voluntary organisations such as The Reader are providing further resources for creative companionship for patients in SBCH and in 'care of the elderly' wards.

As capital and major refurbishment projects are commissioned, it is anticipated that the Arts and Culture programme will become more involved with architecture and the design of the aesthetic environment. The first of these is the new BRI Welcome Centre, incorporating the Gift of Life memorial artwork.

- 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, supporting their development, recognising them for their good work in continuously improving services for to deliver best care for our patients and public, and retaining their expertise within our services.

Our Transformation, Improvement and Innovation Strategy was launched in October 2019, which will deliver the following strategic objectives:

- Build and sustain the capability and capacity of staff across the Trust to deliver improvement and transformation of our services aligned to our Trust strategy
- Develop and spread our transformation, improvement and innovation culture throughout the Trust and build our regional and national reputation as an innovative organisation
- Work with our partners to maximise our capability and capacity to deliver transformation at pace and scale, share learning and improve the quality of care for our patients and population.

During 2019/20, the growth of the Quality Improvement (QI) Academy has continued with an additional 223 staff attending the QI Bronze programme which teaches the basic QI methods and tools. A further two cohorts of the QI Silver programme have taken place, providing training and support to deliver 30 improvement projects. The QI Gold programme was launched in September 2019, providing a nine month programme for six teams of staff in planning and delivering complex service change projects. We have also had 48 local improvement projects submitted through our QI Hub.

We relaunched our Bright Ideas competition in 2019, having received funding support from the Trust's charitable partner Above & Beyond and from the West of England Academic Health Science Network. Through our first cohort we were able to support eight innovative ideas from staff to improve aspects of patient care and wellbeing, and implement environmental sustainability ideas.

In 2019, the Trust's multi-disciplinary education strategy was launched with a vision of 'Developing exceptional people for exceptional careers'. The strategy sets out the priorities as:

- We will excel in the provision and procurement of high-quality education that creates a highly skilled, adaptable and competent workforce for safe, compassionate care

- We will become a beacon of outstanding education with a culture of organisational learning
- We will provide education that nurtures motivation and aspirational career development
- We will champion outstanding education and support of our trainees.

The education priorities are further guided through alignment with the principles of:

- Innovative and evidence-based education
- Welcoming, inspirational and supportive learning environments
- Inclusive education valuing the individual and the teams that work together
- Models of education enabling collaboration across the health and social care system.

Since the strategy launch a number of actions have been implemented, for example, a new governance structure for education; a successfully supported business case for further investment in the HR education team and structure, and building clearer career pathways. Education is a core component of enhancing our staff and trainees capability, aligned to the clinical priorities across the Trust and the health and social care system. Increasingly, education models such as apprenticeships and externally awarded contracts are being utilised to upskill or retrain our workforce to support new clinical models of care.

Following the unsatisfactory progress report from an OFSTED Monitoring Visit of the Trust's internal apprenticeship provision in 2018, a further monitoring visit took place in December 2019. This visit found that whilst the apprenticeship provision had stabilised enough to receive an overall 'Requires Improvement' rating, significant changes will continue to be required to achieve a good or outstanding rating in 2020. This matter will continue to be monitored by the Board and the People Committee.

- 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 even more essential for all health and social care partners to work in partnership to find solutions.

Throughout 2019/20, the Trust 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'. As a partnership, our focus has been on three priority areas in 2019/20: improving the delivery of urgent care, resolving workforce issues, and delivering financial sustainability for the whole system. Other key areas of progress made in 2019/2020 include:

- Approval of the outline business case for the development of neonatal intensive care services across the Bristol trusts
- Development of the stroke model of care across BNSSG, and building a strong stroke workforce
- Developing new models of care for frailty services across BNSSG, which will continue into 2020/21
- Development of the BNSSG long term strategy for delivering the national cancer strategy.

As part of the BNSSG collaborative, the Trust is heavily involved in the Workforce Transformation Steering Group that has a five-year workforce plan informed by the NHS Long Term Plan and local system requirements. The plan is focused on making the NHS the best place to work in, improving the leadership culture, releasing time for care, addressing urgent workforce shortfalls and optimising skills. The Learning Academy Group has developed an integrated steering group for education and training across the system to promote both efficiency and innovation.

Throughout 2019/20, we progressed detailed plans for the prospective merger of our Trust with Weston Area Health NHS Trust on 1 April 2020. Planning for the merger was a collaborative effort between the two

organisations, overseen by our joint Partnership Management Board.

Both organisations have a shared ambition to ensure Weston General Hospital remains at the heart of its community, delivering local services for local people. The merger provides the financial security of a larger trust, which will ensure Weston's high quality services can continue as well as providing opportunities to expand and improve.

Our newly merged Trust – University Hospitals Bristol and Weston NHS Foundation Trust – will bring together a combined workforce of over 13,000 staff, aiming to deliver exceptional local services for local people and specialist services across the South West and beyond. We will be stronger together, and merging brings many benefits to patients and staff. This is an exciting and unique opportunity to create a new organisation with a greater purpose, which is seen as a beacon for outstanding education, research and innovation.

Progress has been made in a number of non-clinical areas. The early merger of some teams in 2019/20 has aligned and developed their working practices, including the communications team and the estates and facilities directorate. It is planned that by October 2020 all corporate services will be merged.

In clinical areas, the detailed planning required for each clinical service commenced as part of the partnership arrangements pre-merger and will continue as a key part of the formal programme of post-merger integration. The clinical integration programme is supported by Clinical Integration Leads appointed to each of the six clinical divisions to progress the development of service models, integrate services and plan service transfers. The Clinical Integration programme supports the maturation of the Clinical Practice Groups model as an enabler for integrating clinical teams and reducing variation in patient pathways.

External partnerships have been further developed with local universities, further education colleges and the skills funding agency. A strategic group established with the University of Bristol has a number of mutual aims for future clinical and education objectives and has resulted in proposals for joint appointments and teaching offers. Further education colleges in Weston and Bristol have supported collaborative widening access opportunities for staff wishing to enter NHS careers and apprenticeship pathways tailored to NHS clinical careers. A West of England Institute of Technology has recently been approved by the Department of Education with a partnership across anchor organisations from NHS employers and education providers.

The Trust also continues to work in partnership with North Bristol NHS Trust and together the trusts have established a Clinical Sponsorship Board to bring clinical leadership together regularly to share learning and develop aligned strategic plans, ensuring that we work together to make best use of all our specialist skills and resources to achieve the best outcomes for our patients. The Clinical Practice Groups model is being progressed for a number of services across the STP, including Cardiology (with North Bristol NHS Trust), Adult Oncology and Respiratory Medicine.

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 the Trust's Financial Strategy is not delivered
- 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 staffing and the delivery of goods and services
- That the benefits of transformation, improvement and innovation are not realised.
- That the Trust fails to deliver its Sustainable Development Plan.
- That the Trust is unable to timely re-establish 'business as usual' following a major event (such as the Covid-19 Pandemic.

Going concern disclosure

The annual report and accounts have been prepared on a going concern basis.

The Trust acquired Weston Area Health Trust on 01 April 2020. Detailed financial assessments in respect of this transaction evidenced a sufficient level of working capital to support the going concern basis.

In light of the Covid-19 pandemic the Trust undertook a further detailed financial assessment considering the impact of changes to the financial regime for NHS Trusts and applying sensitivity analysis. This provided assurance that the Trust's cashflow was sufficient to support its services for the 12 months from the date of signing of these accounts. After considering both of the above and making appropriate enquiries the directors have a reasonable expectation that University Hospitals Bristol and Weston NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future.

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 23 May 2019 to achieve a surplus of £12.815m (before technical items) for the 2019/20 financial year. The plan was to deliver a £2.593m core control total surplus and receive £9.576m Provider Sustainability Funding and £0.646m of Marginal Rate Emergency Tariff (MRET) funding.

Provider Sustainability Funding (PSF) is earned by the Trust during the year if it delivers its control total. MRET funding is earned by the Trust by submitting a plan to deliver its core control total.

The Trust delivered a surplus of £12.890m (excluding technical items and prior year PSF), which is a major achievement considering the financial and operational pressures both locally and nationally. This included £9.576m of Provider Sustainability and £0.646m MRET Funding. Excluding the Provider Sustainability and MRET Funding, the surplus was £2.668m compared to the planned surplus of £2.593m. This was the 17th year in a row that the Trust delivered a surplus or breakeven position (excluding technical items).

The 2019/20 plan required savings of £16.876m 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 £14.373m, 85% of plan.

The Trust's statement of financial position remained strong with net current assets of £90.746m and a year-end cash and cash equivalent balance of £129.840m.

The Trust invested £35.740m 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. 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 NHSEI has about a provider and the level of regulatory intervention required. At the end of March 2020, the Trust had a risk rating of one.

Robert Woolley
Chief Executive
23 June 2020

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
- Reduce total wait list during 2019/20
- 99 per cent for six week diagnostic waiting times.

Performance against the 62 day cancer standard was achieved for six of the nine months April-December 2019 and was achieved for each of the three quarters overall.

Referral to Treatment performance achieved the NHSEI recovery trajectory at the end of April and May 2019 but has not achieved it since. The 92% standard has not been achieved. The total list size started the year below the March 2018 level of 29,207 (total list size was 28,763 as at end of April 2019) but has been above that level since, peaking at 35,350 at the end of February 2020.

A&E performance did not achieve the NHSEI improvement trajectory, which was 0.5% above the 2018/19 performance level for the corresponding month.

The six week wait for diagnostics has remained below the national standard of 99% and plans to recover by end of Q4 were submitted, but this was not achieved due to impact of Covid-19.

3.2.1 Referral to Treatment (RTT)

The national standard for Referral to Treatment (RTT) is 92%. This has not been achieved for the whole of 2019/20.

At the end of March 2020 the overall waiting list size for routine patients was at 32,832 with 7,134 patients over 18 weeks compared to March 2019 where the waiting list size was 28,481 and the over 18 week backlog position was 3,081.

The backlog growth in the main related to Dental, Ophthalmology and Paediatric Trauma and Orthopaedic (T&O). The Dental and Ophthalmology growth was a result of a number of staff vacancies and long term sickness. The Paediatric T&O growth occurred from patients referred into the Referral Assessment Service (RAS) and the lack of clinic capacity to book these patients in. Dental services accounted for around 38-40% of the 18 week backlog. During 2019 recovery plans were developed for all three areas. Dental Services was successful in reducing staff vacancies to allow additional weekend capacity to be delivered from December and additional recurrent capacity was being set-up in Outpatients. However, the Covid-19 pandemic prevented these solutions from continuing into 2020.

Two major impacts that also impeded recovery of the backlog during the year were the changes to the pension tax and the rates paid for waiting list initiatives. Both of these changes resulted in very poor uptake from staff to do extra sessions to support the recovery of the backlog positions.

The Trust's commitment to achieve zero 52 week breaches by September 2019 was not achieved. The Trust continues to report 52 week breaches with 31 reported at the end of March 2020. The 52 week wait position continues to deteriorate due to the impact of cancellations of routine patients during winter pressures and the lack of HDU/ITU and ward beds. This position is at high risk of deteriorating further due to routine cancellations to support the Covid-19 pandemic.

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 August 2019, and achieved 90.4 per cent for the year
- The Bristol Eye Hospital (BEH) achieved the 95 per cent standard in all 12 months, and achieved 97.8 per cent for the year
- The Bristol Royal Infirmary (BRI) did not achieve the 95 per cent standard in any month of 2019/20, and achieved 68.5 per cent for the year.

March 2020 saw a significant reduction in ED attendances due to the Covid-19 pandemic. April 2019 to February 2020 averaged 12,161 attendances per month. There were 9,168 in March 2020, which is a 25% reduction.

Excluding March 2020 and March 2019; overall A&E attendances between 2018/19 and 2019/20 were

- up 3.9 per cent across all three sites
- up 5.0 per cent at the BRI
- up 0.5 per cent at the BRHC
- up 7.2 per cent at the BRI.

The proportion of patients admitted to an inpatient bed as a result of their A&E attendance remained the same at 26 per cent (36 per cent at BRI and 24 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).

3.2.3 Cancer

The Trust achieved the 62 day GP referral to treatment standard in six out of 11 months in the period April 2019 to February 2020. This was in the context of continued national non-compliance with the standard. The main cause of non-compliance was the impact of cancellations and capacity restrictions due to emergency pressure within the Trust, especially over the winter months. The Trust has robust diagnostic pathways and expects to achieve the 28 day diagnostic standard when it is introduced.

The Trust met the first appointment standard for cancer in the majority of months but saw a short period of non-compliance in August and September 2019 following an unprecedented surge in dermatology demand (33% up on demand in the same period 2018/19). Even with additional capacity it was not possible to meet the standard for all patients, however delays were small and recovery rapid with compliance regained in October 2019 and sustained thereafter.

Compliance with the 31 day decision-to-treat standards was affected by two factors. In the first part of the year, specialised cleaning of the linear accelerators following a major fire caused delays to radiotherapy treatments. This cleaning was concluded and compliance with the subsequent radiotherapy standard regained in July and sustained thereafter. The second factor was the impact of cancellations and capacity restrictions during winter pressures as described above.

3.2.4 Diagnostic waiting times

The month end performance for diagnostic waiting times varied between 93.4% and 96.7% waiting under six weeks, averaging 95.4%. This was for each month end April 2019 to February 2020.

March 2020 saw deterioration in performance due to Covid-19 pandemic and the resulting slowdown in elective work. March 2020 finished at 84%.

The biggest backlogs as at March 2020 were:

- Adult Endoscopy (52% under six weeks)
- Magnetic Resonance Imaging, MRI (85% under six weeks)
- Non-obstetric Ultrasound (91% under six weeks)

Prior to March 2020, there were plans in place to deliver recovery by end of March 2020 in CT Cardiac and MRI through outsourcing options. These were on track as at the end of February 2020. There were In/outsourcing options in place in Q4 for Adult Endoscopy but recovery had not been achieved going into March 2020.

3.2.5 Outpatients

In response to the Long Term Plan, pathway redesign work has commenced to reduce the number of follow up appointments and increase the number of follow up appointments delivered non-face to face.

Non-face to face telephone clinics have been piloted in lung nodules and dental biopsy. Progress has been made with video conferencing services with a number of specialties expressing interest in developing 'attend anywhere' pilots. Advice and guidance continues to be progressed in the Trust with nine specialties using the service to triage referrals received from primary care. Plans are in progress to review the outpatient blended Tariff with the CCG and Healthier Together for 2020/21.

The outpatient services DNA rate has reduced further to 6.2% following the continued roll out of the text messaging reminder service to additional clinics. Currently the service is live in around 70% of clinics. Work has also been progressed on providing patients with more information about the clinic location they are booked to attend and the financial impacts of non-attendance. In support of cost effectiveness and allowing patients to receive information about their appointments in a method that they prefer, email appointment letters were launched in 2019/20. 1,000 letters a month are now sent to patients through email.

The CQC inspection in March 2019 identified the use of outpatient reception staff uniforms as an improvement to make staff more easily identifiable for patients. All patient-facing administration staff now wear a standard uniform. In addition, outpatient administration teams have been engaged in the delivery of standards of conduct and service delivery. This has demonstrated a reduction in complaints relating to telephones of 32% trust wide and 53% in the poorest performing departments.

Real Time Outpatients continues to make progress within the Trust. Valuable learning has been acquired through this project and it has become apparent that there is a broad requirement for the standardisation of service delivery across outpatients and further digitisation of information pathways. Plans are in progress to review and reprioritise the delivery of outpatient service projects linking a number of improvements to the Medway system and dictation software.

3.2.6 Important events since the end of the financial year

Although the Trust's response to the Covid-19 pandemic started before the end of the financial year, the majority of the impact has been felt in April and May 2020. In line with NHS England declaring Covid-19 as a 'level four incident, the Trust implemented a command and control structure to ensure that the safety of patients and staff was maintained through the response, and that enough hospital capacity was created to continue to provide care through the peak of the pandemic.

The Chief Executive led the response, and coordinated the strategic response through a Gold command meeting. This meeting was supported by a Silver command meeting, chaired by the Deputy Chief Executive and Chief Operating Officer, which managed and oversaw the tactical, day to day response. The Trust's approach was informed by guidance from the World Health Organisation and national guidance as this was communicated. The Board was updated on the Trust's response at its meetings each month, and through weekly briefings of Non-executive Directors.

A number of specific changes were implemented to support staff during this time, including a new Employee Assistance Programme, risk assessments for staff including those who were deemed to be more vulnerable, and a suite of resources to help staff manage their own wellbeing. Enhanced staff communications were also implemented, which included daily emails containing specific information about the Trust's response to Covid-19 to ensure that staff were informed as to changes in policy, process and availability of equipment, as well as weekly video briefings from the Chief Executive.

The risks associated with managing the response to the pandemic were handled through the Trust's existing risk management arrangements, and included the risks directly associated with Covid-19, as well as the medium and longer term risks associated with managing the impact of Covid-19, for example the postponing of elective care.

Table 1: Performance against national standards

National standard	Target	2017/18	2018/19	2019/20
A&E maximum wait of four hours	95%	86.5%	86.3%	80.6%
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	97.7%	95.6%	97.2%
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	52.2%	49.3%	50.2%
A&E Unplanned re-attendance within seven days	<5%	2.8%	3.3%	3.6%
A&E Left without being seen	<5%	1.9%	1.7%	1.6%
Cancer - Two week wait (urgent GP referral)	93%	94.3%	95.3%	93.4%
Cancer - 31 Day Diagnosis To Treatment (First treatment)	96%	95.8%	97.2%	95.8%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94%	92.0%	96.1%	92.5%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	98%	98.6%	98.4%	98.6%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	94%	96.3%	95.8%	94.6%
Cancer - 62 Day Referral To Treatment (Urgent GP Referral)	85%	81.7%	85.6%	85.5%
Cancer - 62 Day Referral To Treatment (Screenings)	90%	74.8%	66.7%	71.1%
Cancer - 62 Day Referral To Treatment (Upgrades)	85%	85.4%	83.7%	86.6%
18-week Referral to Treatment Time (RTT) incomplete pathways	92%	89.6%	89.0%	83.2%
Number of Last Minute Cancelled Operations	<0.8%	1.19%	1.31%	1.73%
Last Minute Cancelled Operations Re-admitted within 28 days	95%	94.2%	93.4%	92.9%
Six week diagnostic wait	99%	98.3%	96.7%	95.2%
Primary PCI - 90 Minutes Door To Balloon Time	90%	93.2%	92.5%	87.0%

3.3 Finance Review

3.3.1 Financial analysis

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

The Trust reported a surplus before technical items of £13.600m. This included Provider Sustainability Funding of £10.283m and Marginal Rate Emergency Tariff (MRET) funding of £0.646m. The Operational Plan was to achieve a surplus of £12.815m (before technical items), consisting of a £2.593m core surplus with receipt of £9.576m Provider Sustainability Funding and £0.646m Marginal Rate Emergency Tariff funding. The core surplus was exceeded by £0.075m and additional Provider Sustainability Funding of £0.710m was received.

The performance against the Operational Plan is shown below:

Table 2: Performance against 2019/20 plan:	Plan £m	Actual £m	Variance favourable/(adverse) £m
Operating income from patient care activities*	620.546	649.105	28.599
Other operating income - excluding PSF & MRET	92.222	100.312	8.090
Total operating income (excluding PSF & MRET)	712.768	749.417	36.649
Employee expenses*	(428.393)	(453.621)	(25.228)
Non pay expenses	(245.904)	(257.807)	(11.903)
Total operating expenses	(674.297)	(711.428)	(37.131)
(post plan requirement to include increased employer pension costs of £18.4m offset by income)*			
Depreciation	(23.939)	(24.223)	(0.284)
Interest receivable	0.527	0.842	0.315
Interest payable	(2.516)	(2.517)	(0.001)
Public dividend capital dividend	(9.950)	(9.423)	0.527
Total depreciation and financing costs	(35.878)	(35.321)	0.557
Net surplus/(deficit) before technical items excluding 2019/20 PSF	**2.593**	**2.668**	**0.075**
Provider Sustainability Transformation Funding:			
- Core	9.576	9.576	-
Marginal Rate of Emergency Tariff	0.646	0.646	-
Net surplus/(deficit) before technical items including 2019/20 PSF	**12.815**	**12.890**	**0.075**
Prior year post accounts PSF allocation	-	710	710
Technical Items:			
- Depreciation on donated assets	(1.590)	(1.639)	(0.049)

- Donations re assets	3.800	2.266	(1.534)
- Net impairments	(0.888)	(3.669)	(2.781)
Total technical items	1.322	(3.042)	(4.364)
Net surplus/(deficit) per annual accounts	**14.137**	**10.558**	**(3.579)**

The Trust delivered a surplus of £2.668m excluding PSF and technical items against a core control surplus of £2.593m.

Core Provider Sustainability Funding income is dependent on the Trust delivering its control total set by NHS Improvement. Given this was achieved the Trust earned all of the £9.576m funding available. The Trust received £0.646m of Marginal Rate of Emergency Tariff (MRET) funding given it agreed to a plan to meet its control total. The Trust achieved a surplus of £12.890m before technical accounting adjustments as defined by NHS Improvement.

Following the completion of the 2018/19 national NHS accounts, unallocated PSF for the year was distributed. The Trust received £0.710m of prior year post accounts PSF allocation.

There are a number of items classified as technical which are excluded by NHS Improvement 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.

Including the prior year post accounts PSF allocation and technical items the Trust reported a net surplus of £10.558m as reported in the annual accounts.

The Operational Plan was submitted in May 2019 and therefore does not reflect subsequent national changes during the year. Most notably the Trust received additional income to meet the national increase in employer pension contributions (£18.4m), to reimburse expenditure in responding to Covid-19 (£1.3m) and in respect of high cost drugs (£10.0m).

The reduced level of donations reflects the slippage in the capital programme.

Impairments are charged to operating expenditure from the revaluation of the Trust's land and buildings and when new or enhanced assets over £1m are brought into use. In 2019/20 the Valuation Office's desktop revaluation resulted in a net impairment of £1.559m and one asset over £1m was brought into use?, the refurbishment of Myrtle Road, which resulted in an impairment of £2.110m.

3.3.2 Savings

The Trust achieved £14.373m of savings against its plan of £16.876m. 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.

Table 3: Savings achieved during 2019/20:

	Plan	**Actual**	**Variance** Favourable /(adverse)
	£m	**£m**	**£m**
Allied Healthcare Professionals Productivity	0.025	0.025	-
Blood	0.133	0.133	-
Diagnostic Testing	0.181	-	(0.181)
Estates & Facilities	0.420	0.422	0.002
Healthcare Scientists Productivity	0.139	0.047	(0.092)
HR Pay and Productivity	0.058	0.078	0.020
Income, Fines and External	0.579	0.616	0.037
Medical Pay	0.286	0.288	0.002
Medicines	1.070	1.832	0.762
Non Pay	4.200	4.920	0.720
Nursing Pay	0.369	0.397	0.028
Other / Corporate	1.361	1.361	-
Productivity	5.619	3.761	(1.858)
Trust Services	0.490	0.493	0.003
Plans being developed	1.945	-	(1.945)
Total savings	**16.876**	**14.373**	**(2.503)**

3.3.3 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 2020 of £90.746m. This included year end cash and cash equivalents of £129.840m. This represents an increase in cash over the year of £29.985m. The table below shows the use of cash during the year.

Table 4: Use of cash 2019/20:

	£m	£m
Opening cash balance		**99.855**
Use of cash:		
Net cash flow from operating activities	72.052	
Capital expenditure	(35.129)	
Other net cash flows from investing activities	3.102	
Public Dividend Capital received	8.290	
Capital loan repayments to the DHSC	(5.834)	
Interest (on capital loan) payments to the DHSC	(2.343)	
Public Dividend Capital dividend payment	(9.578)	
Finance lease payments	(0.575)	
Increase in cash balance 2019/20		29.985
Closing cash balance		**129.840**

3.3.4 Capital

The Trust's planned capital expenditure for 2019/20 was £56.435m. In July 2019 NHS England and NHS Improvement (NHSEI) requested a national review of all capital programmes to identify schemes to be deferred into subsequent years to ensure national capital limits could be delivered. The Trust undertook a detailed exercise to identify and defer schemes into 2020/21 and notified NHSEI of a revised plan of £42.644m.

Capital funding is allocated to individual schemes in six areas which are monitored during the year. The Trust's capital programme is managed through the Trust's Capital Programme Steering Group. In 2019/20 the Trust spent £35.740m on capital schemes. The £6.904m underspend represents slippage which is carried forward to the 2020/21 capital programme. The table below provides a summary of the Trust's capital source and applications for 2019/20.

Table 5: Funding and expenditure on capital schemes:

Operational Plan 2019/20 £m		NHSEI review revised plan 2019/20 £m	Actual 2019/20 £m	Variance 2019/20 £m
	Source of Funding:			
8.600	Public Dividend Capital	8.600	8.290	(0.310)
-	Covid-19 funding *	-	0.251	0.251
3.800	Donations - cash	2.500	2.260	(0.240)
-	Donations - direct	-	0.006	0.006
23.939	Depreciation	25.529	25.862	0.333
-	Insurance claim	1.000	1.070	1.070
20.096	Cash balances	5.015	(1.999)	(8.014)
56.435	**Total funding**	**42.644**	**35.740**	**(6.904)**
	Expenditure:			

(16.627)	Strategic schemes	(11.202)	(8.580)	2.622
(12.628)	Medical equipment	(10.649)	(8.359)	2.290
(12.419)	Information technology	(8.990)	(8.444)	0.546
(3.124)	Estates replacement	(3.060)	(2.618)	0.442
(1.639)	Fire improvement	(1.275)	(0.800)	0.475
(9.998)	Operational capital	(7.468)	(6.939)	0.529
(56.435)	**Total expenditure**	**(42.644)**	**(35.740)**	**6.904**

** Covid-19 funding in relation to 2019/20 expenditure will be received in 2020/21*

3.3.5 Countering Fraud, Bribery and Corruption

The Board takes the prevention and reduction of fraud very seriously and has policies in place to minimise the risk of fraud, bribery and corruption and to promote 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 Local Counter Fraud, Bribery and Corruption policy and legislative background, is also available on the Trust's intranet, along with contact details of the LCFS and the NHS CFA.

3.3.6 NHS CFA Fraud and Corruption Reporting Line (FCRL)

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. All materials contain details of the FCRL.

3.3.7 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.

The Trust 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
- Register of Interests, Gifts and Hospitality 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.

Any suspicions of Fraud, Bribery or Corruption may be reported by contacting the Local Counter Fraud Specialist or the NHS CFA FCRL.

3.3.8 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 and continues to work closely with the cost recovery programme from NHSEI and other organisations involved in this field.

The Overseas Visitors Team provides a seven day a week eligibility checking service across the Trust. The team, which works in a non-discriminatory way, is responsible for establishing an individual's right to free NHS hospital treatment, the raising of invoices to directly chargeable visitors, the processing of European Health Insurance Card and other reciprocal healthcare agreements and for advising clinicians on their obligations to provide treatment or not under the regulations.

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

Robert Woolley
Chief Executive
23 June 2020

4. Sustainability Report

4.1 Overview

As an outstanding hospital trust we are meeting the needs of our communities today but we also have a duty to ensure we continue to deliver exceptional healthcare in a responsible way that embraces our role as an anchor organisation in Bristol. We aspire to be a leader in the field of sustainable healthcare using our influence to enable our staff, patients, suppliers and healthcare partners to achieve a sustainable and resilient health and care system for our region.

In January 2019, NHS England launched the NHS Long Term Plan which laid out the future direction of the NHS over the next 10 years. The plan commits the NHS to ambitious targets for carbon emission reduction, vehicle exhaust emission reduction and tackling the use of single use plastics within the NHS supply chain. Climate change has been declared as 'the greatest threat to global health' (Lancet, 2017) which will have serious implications for our health, wellbeing, livelihoods, and the structure of organised society. Failure to act quickly will heighten existing national health challenges, place further financial strain on the NHS, and worsen health inequalities within the UK and internationally.

In recognition of the urgency of the threat that climate breakdown poses to public health, University Hospitals Bristol NHS Foundation Trust was among the first NHS organisations in the UK to declare a climate emergency, demonstrating a clear and positive commitment to tackle climate change and the effects on the health of our population. To lead the way in healthcare in the city, we have set the ambitious goal to become carbon neutral by 2030. This is in partnership with North Bristol NHS Trust.

As one of the largest organisations in Bristol, we have a significant role to play to help protect the environment. We have developed a Sustainable Development Strategy which sets out how we intend to manage and reduce our environmental impact, improve efficiency and resilience and control the cost of delivering our services. Our specific goals are:

- Carbon neutral by 2030 – Benchmarked against our operating expenditure
- Contributing to all the UN Sustainable Development Goals – Benchmarked by achieving 70% rating in our Sustainable Development Assessment tool by 2025
- Cutting air pollution – Benchmarked by achieving excellent rating on the Clean Air Hospital framework by 2025
- Resource efficiency – zero waste to landfill by 2025 and reducing our consumption of energy and water.

We are committed to embedding sustainability across our own organisation, leading by example in our sector and improving the health and wellbeing of the communities we serve.

We collaborate with our healthcare partners and key stakeholders to ensure that our work is aligned to deliver a shared set of goals. We are committed to working in partnership to deliver Bristol's One City Plan[1] and the vision for a "fair, healthy and sustainable city".

4.2 Policies

We are reviewing our Sustainable Development policy to align it with our Sustainable Development Strategy and continue to embed sustainability in our process and procedures.

Table 6: Sustainability Policy Table

Area	Is sustainability considered?
Travel	Yes

[1] https://www.bristolonecity.com/about-the-one-city-plan/

Business Cases and annual business plans	Environmental impact is assessed
Procurement (environmental)	All our suppliers have been made aware of the Trust's declaration of a Climate Emergency and our 2030 target for carbon neutrality. 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	

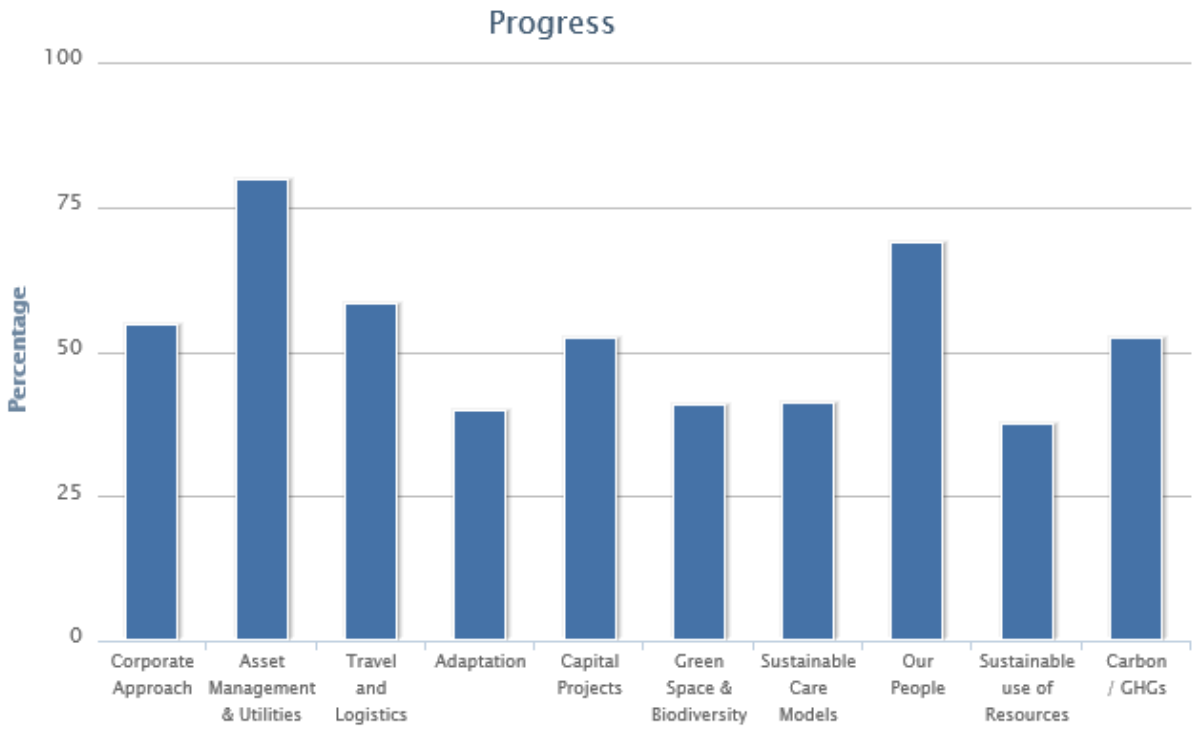
The Trust has established a Sustainable Development Board which will oversee our sustainability programme and ensure we deliver our Sustainable Development Strategy.

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 March 2020, scoring 53% (see table 8), improving on our October 2018 score of 44%. Plans to improve this further in 2020/2021 are included in the Sustainable Development Strategy.

Climate change brings new challenges to our business both in direct effects to the healthcare estate, but also to patient health. Examples in recent years include the effects of extreme temperatures and prolonged periods of cold, floods and droughts, which are expected to increase as a result of climate change. The Board has 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 climate change risk assessments and reviewed our Sustainable Development Strategy to take account of UK Climate Projections. This ensures the Trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Table 7: March 2020 Sustainable Development Assessment Tool Assessment Score 53%



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 Sustainable Development Assessment Tool 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 8: Performance on sustainability

	2015/16	2016/17	2017/18	2018/19	2019/20
Floor Space (m2)	206,310	195,044	195,044	195,044	195,044
No. of Staff	8,249	8,496	8,677	8,934	9,321

We have supported the Climate Change Act targets as follows:

4.3.1 Energy

The Trust has spent £4,778,945 on energy in 2019/20, which is a 2.3% decrease on energy spend in 2018/19. We have reduced our carbon emissions from energy use year on year. We have continued to purchase 100% renewable electricity under our supply contract.

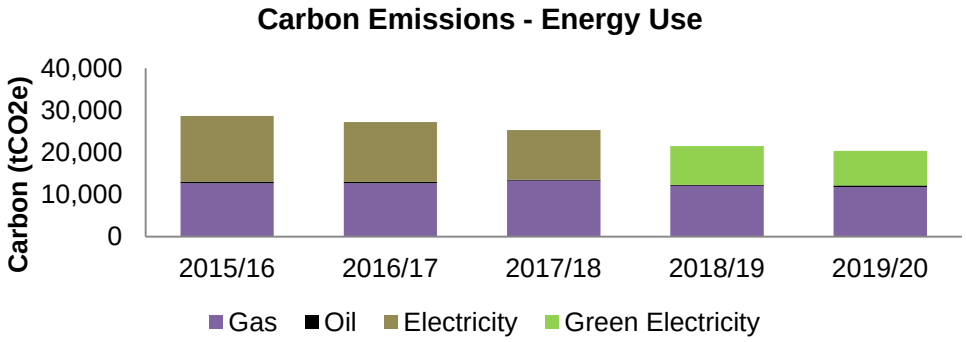


Table 9: Energy use and spend

Resource		2015/16	2016/17	2017/18	2018/19	2019/20
Gas	Use (kWh)	60,496,985	60,701,598	62,552,655	56,729,051	56,625,012
	tCO_2e	12,661	12,686	13,262	12,049	11,764
Oil	Use (kWh)	1,198,427	868,669	727,117	737,045	1,143,486
	tCO_2e	383	275	238	235	364
Coal	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Electricity	Use (kWh)	27,233,690	27,665,724	26,547,528	0	0
	tCO_2e	15,657	14,298	11,833	0	0
Green Electricity	Use (kWh)	52,520	55,804	42,964	26,223,729	26,189,963
	tCO_2e	0	0	0	9,238	8,263
Total Energy tCO_2e		28,701	27,259	25,332	21,522	20,392
Total Energy Spend		£ 4,289,488	£ 3,847,783	£ 4,148,595	£ 4,888,945	£ 4,778,457

Our carbon emissions from energy consumption have reduced by 1,131 tonnes (5.3%) in the past year. We have continued to implement energy saving projects through improving controls, lighting, insulation, heating and cooling.

We are replacing our existing 1MW Combined Heat and Power engine with a larger 3.36MW facility to efficiently generate more low carbon electricity and heat.

The Trust has completed installation of energy efficient LED lighting in the Education Centre, Trust Headquarters and in the corridors and stairwells of our hospitals. The Trust has approved funding for phase two to replace lighting across the organisation. This will reduce the cost of energy used by the lamps by 73% saving 2,944 tonnes of CO2 per year.

4.3.2 Travel

We can improve local air quality and improve the health of our community by promoting active travel (e.g. walking and cycling) – 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 10: Average travel levels

Category	Mode	2015/16	2016/17	2017/18	2018/19	2019/20
Patient and visitor travel	miles	28,992,086	30,005,436	30,856,225	32,023,650	31,947,447
	tCO_2e	10,484	10,844	10,994	11,410	11,823
Business travel and fleet	miles		762,008	136,688	144,000	140,092
	tCO_2e		275.40	50	53	52
Staff commute	miles	7,924,134	8,164,656	8,335,279	8,582,157	8,582,157
	tCO_2e	2,866	2,951	3073	3164	3315
Owned electric and PHEV	miles			15,048	14,024	2,875
	tCO_2e			1.71	2.83	0.48

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 are all now using the e-bikes at South Bristol Community Hospital to make home visits to stroke patients recently discharged from hospital. This means 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 are removing 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, reducing emissions from procuring and delivering new goods and providing 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).

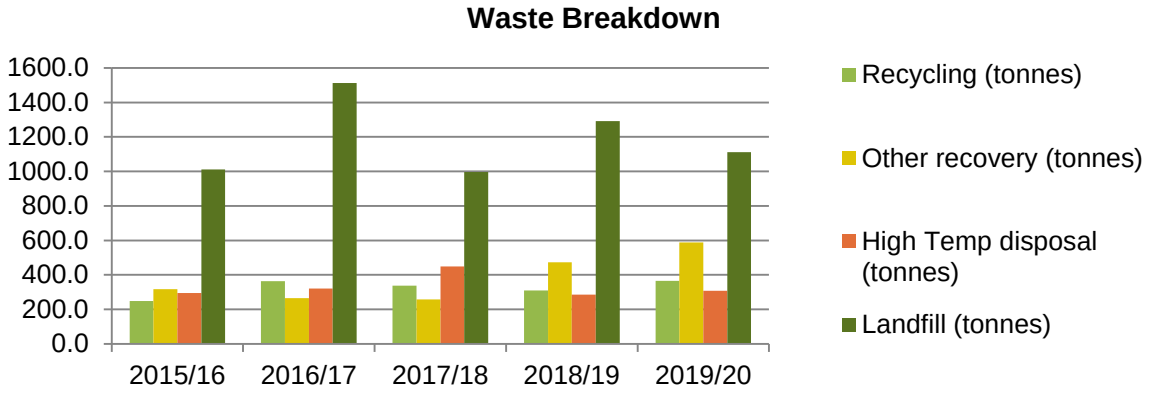
Table 11: Waste management

Waste		2015/16	2016/17	2017/18	2018/19	2019/20
Recycling	(tonnes)	249.00	363.00	336.68	309.64	364.89
	tCO_2e	4.98	7.62	7.33	6.74	7.79
Other recovery	(tonnes)	317.00	264.00	258.00	472.48	587.58
	tCO_2e	6.34	5.54	5.61	10.28	12.55
High Temp disposal	(tonnes)	294.00	320.00	448.00	285.91	307.17
	tCO_2e	64.39	70.40	98.56	62.90	67.58
Landfill	(tonnes)	1,012.00	1,512.00	996.41	1,292.66	1,111.00
	tCO_2e	247.35	468.72	343.25	445.31	381.22
Total Waste (tonnes)		1,872.00	2,459.00	2,039.09	2,360.69	2,370.64
% Recycled or Re-used		13%	15%	17%	13%	15%
Total Waste tCO_2e		323.06	552.29	454.75	524.95	469.14

4.3.4 Plastics in Theatres

We have reduced waste through the actions of our Children's Theatres team in the Bristol Royal Hospital for Children, who have introduced the RecoMed project[2] which diverts single-use, clinical, PVC, medical devices (such as oxygen masks and tubing) from our clinical waste streams, destined for landfill or incineration. Collection is free and saves the Trust disposal costs. The items are recycled into horticultural products such as tree ties. At the time of writing, the project has diverted a total of 257.16 kg and we are moving to roll out this approach across the rest of the Trust.

Theatre teams have also made the switch from disposable to washable surgical hats. In St Michael's Hospital this has already saved 25,000 hats, equating to £2,700 per year.



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 continuing to roll out a number of IT programmes to enable paperless working.

4.3.5 Water

With increased activity, we have increased our consumption of water in 2019/20. We have minimised this increase by repairing steam and condensate leaks in pipes across the precinct significantly reducing the demand for water at our boiler house.

Table 13: Consumption of water

Water		2015/16	2016/17	2017/18	2018/19	2019/20
Mains	m^3	234,553	250,457	233,033	223,504	226,912
	tCO_2e	230	246	227	218	221
Water & Sewage Spend		£485,126	£490,042	£461,650	£426,917	£455,879

4.4 Modelled Carbon Footprint

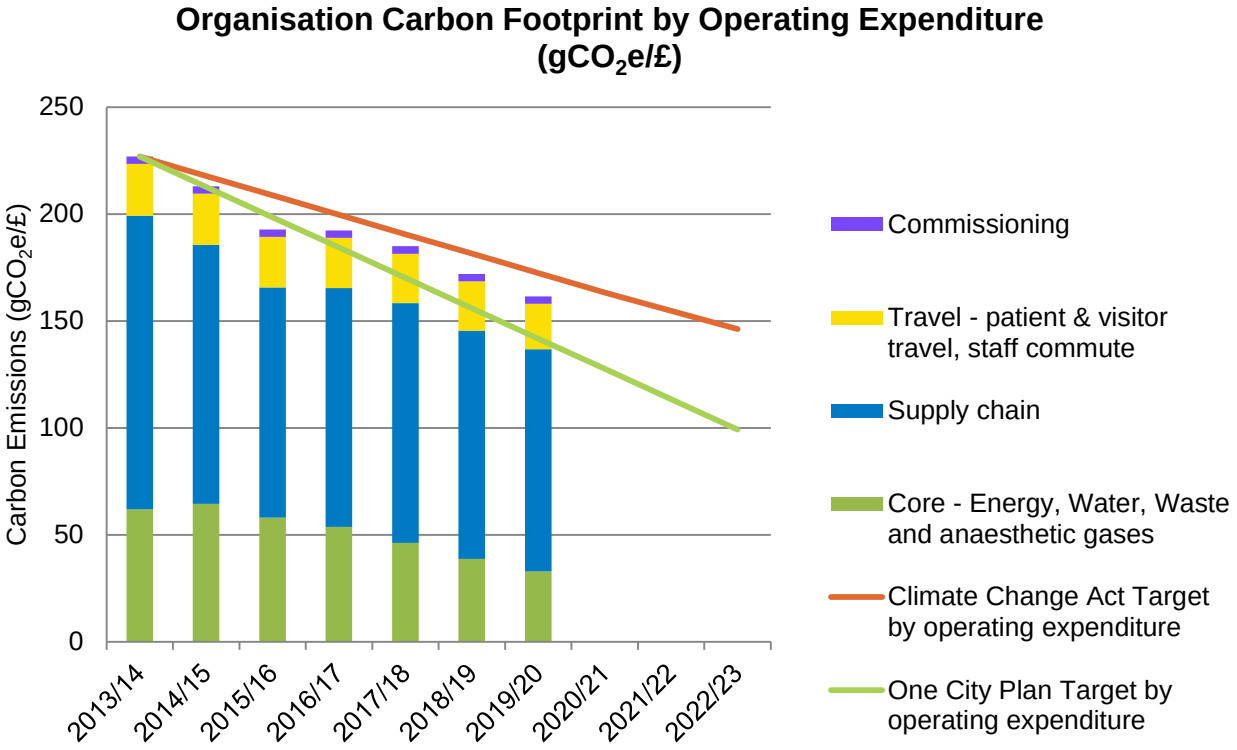
The information provided in the previous sections of this report uses the Estates Return Information Collection as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model, based on work performed by the Sustainable 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 114,893 tonnes of CO_2e for the Trust. Our carbon intensity is 161 grams of CO_2e emissions per pound of operating expenditure

[2] https://axiongroup.co.uk/services/specialist-collection-schemes/recomed/

($gCO_2e/£$) 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	20%
Supply Chain	64%
Commissioning	2%
Travel – Patient, Visitor and Staff commute	13%



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

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 include 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 Director of Corporate Governance.

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 Director of Corporate Governance maintains a register of interests, which is available to members of the public by contacting the Director of Corporate Governance, University Hospitals Bristol and Weston NHS Foundation Trust, Trust Headquarters, Marlborough Street, Bristol BS1 3NU. Email: Trust.Secretariat@uhbw.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 ASW Assurance, Counter Fraud and Consultancy Service.

Table 14: Board of Directors – Terms of Office

Board Member
Jeff Farrar, Chairman
Appointment 1 December 2017
End of first term 30 November 2020
David Armstrong, Non-executive Director
Appointment 28 November 2013
End of first term 27 November 2016
End of second term 27 November 2019
Re-appointed for a third term of three years ending on 26 November 2022
Sue Balcombe, Non-executive Director (Designate)
Appointment 1 June 2019
End of first term 31 March 2020
Madhu Bhabuta, Non-executive Director (Designate)
Appointment 3 July 2017
End of first term 2 July 2020
Julian Dennis, Non-executive Director and Senior Independent Director
Appointment 1 June 2014
End of first term 31 May 2017
1 June 2017 re-appointed for a second term of three years ending 30 May 2020
Bernard Galton, Non-executive Director
Appointment 1 July 2019
End of first term 30 June 2022
Jayne Mee, Non-executive Director
Appointment 1 June 2019
End of first term 31 May 2022
John Moore, Non-executive Director
Appointment 1 January 2011
End of first term 31 December 2013
End of second term 31 December 2016
End of third term 31 December 2019
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 ending 1 May 2021
Martin Sykes, Non-executive Director and Vice-Chair
Appointment 4 September 2017
End of first term 31 August 2020

Steven West, Non-executive Director Appointment 3 July 2017 End of first term 2 July 2020
Robert Woolley, Chief Executive Appointed 8 September 2010
Paula Clarke, Director of Strategy and Transformation Appointed 4 April 2016
Neil Kemsley, Director of Finance and Information Appointed 1 July 2019
Paul Mapson, Director of Finance and Information Appointed 1 June 2008 Retired 30 June 2019
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

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 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 Prompt Payments Code

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

Table 15: Performance against Prompt Payments Code:

	Year ended 31 March 2020	Year ended 31 March 2019
Total invoices paid within 60 days	154,413	154,956
Total invoices paid in the year	161,349	162,205
Percentage of invoices paid within 60 days	95.7%	95.5%

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

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

Table 16: Performance against Better Payment Practice Code:

	Year ended 31 March 2020			Year ended 31 March 2019		
	NHS contracts	Other invoices	Total	NHS contracts	Other invoices	Total
No. invoices paid within 30 days	3,334	129,204	132,538	3,127	136,721	139,848
No. invoices paid	5,546	155,803	161,349	4,810	157,395	162,205
Proportion paid within 30 days - number	60.1%	82.9%	82.1%	65.0%	86.9%	86.2%
Value of invoices paid within 30 days	£46.183m	£192.684m	£238.866m	£52.47m	£169.48m	£221.95m
Value of invoices paid	£69.687m	£238.967m	£308.654m	£74.12m	£200.65m	£274.76m
Proportion paid within 30 days - value	66.3%	80.6%	77.4%	70.8%	84.5%	80.8%

5.1.8 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, approving the appointment and removal of the Trust's External Auditor, and approving any application by the Trust to enter into a merger, acquisition, separation or dissolution.

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 strategic proposals; mergers and acquisitions, 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 six Council meetings in the year (including two extraordinary Council meetings), and the Annual Members' Meeting.

A particular area of focus this year was the role of the Council of Governors in relation to mergers and acquisitions, as the Trust proceeded with plans for a merger by acquisition of Weston Area Health NHS Trust on 1 April 2020. At their meetings, governors received updates and sought assurance relating to the merger. In January 2020, governors approved changes to the proposed Trust Constitution for the new combined Trust. In March 2020, governors voted unanimously to approve the transaction.

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.

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 Director of Corporate Governance at the address given in Appendix B of this report.

At the Council of Governors meeting in April 2019 governors approved the appointment of Mo Phillips as the lead governor for the year ahead.

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

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

Table 17: Membership and attendance at Council of Governors meetings 2019/20

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 2019 to 31 March 2020	**6**
Chair: Jeff Farrar	**C6 (6)**
Governors	
Hessam Amiri	2 (4)
Kathy Baxter	2 (6)
Pauline Beddoes	1 (2)
Michelle Bonfield	3 (4)
Graham Briscoe	2 (4)
John Chablo	6 (6)
Siobhan Coles	0 (3)
Andy Coles-Driver	0 (2)
Carole Dacombe	5 (6)
Aishah Farooq	2 (6)
Tom Frewin	5 (6)
Chrissie Gardner	3 (4)
Sophie Jenkins	5 (6)
Carole Johnson	0 (6)
Rashid Joomun	1 (2)
Florene Jordan	2 (2)
Barry Lane	6 (6)
Astrid Linthorst	3 (6)
Marty McAuley	0 (2)
Hannah McNiven	4 (4)
Sue Milestone	2 (6)
Sally Moyle	6 (6)
Debbi Norden	3 (4)
Graham Papworth	5 (6)
Penny Parsons	1 (6)
Mo Phillips	6 (6)
Ray Phipps	5 (6)
John Rose	5 (6)
Martin Rose	4 (4)
Marimo Rossiter	2 (3)
Jane Sansom	5 (6)
Jonathan Seymour-Williams	2 (2)
John Sibley	5 (6)
Tony Tanner	1 (2)
Malcolm Watson	5 (6)
Mary Whittington	3 (6)
Garry Williams	2 (6)
Non-executive Directors	
David Armstrong	5 (0)
Julian Dennis	5 (0)
Bernard Galton	4 (0)
Jayne Mee	3 (0)
John Moore	1 (0)
Anthony (Guy) Orpen	6 (0)
Martin Sykes	5 (0)
Steven West	3 (0)
Madhu Bhabuta (designate)	1 (0)
Sue Balcombe (designate)	4 (0)
Executive Directors	
Robert Woolley	5 (0)
Mark Smith	6 (0)
Paula Clarke	5 (0)
Matthew Joint	6 (0)
Paul Mapson	1 (0)
Carolyn Mills	1 (0)
Neil Kemsley	3 (0)
William Oldfield	3 (0)

5.1.9 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 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 two occasions. During the year, the Committee supported the re-appointment of Non-executive Director David Armstrong for a final three-year term of office subject to annual review and re-appointment. The Committee was also involved in the recruitment and appointment of two new Non-executive Directors (Bernard Galton and Jayne Mee) and a further candidate to join the board in a 'Designate' capacity for one year (Sue Balcombe). In January 2020, the Council of Governors approved the appointment of Sue Balcombe into a substantive Non-executive Director post with effect from 1 April 2020, following the departure of Non-executive Director John Moore on 31 December 2019.

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

5.1.10 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.

5.1.11 Governor elections

Governor elections are held every two years out of three. In 2019, 17 governor seats were up for election across seven constituencies, including public and staff members. In total, 28 people stood for election in May 2019; 14 governors were elected in five constituencies via a ballot and three governors in two constituencies were elected unopposed. All seats were filled.

The membership team worked with the Trust's Youth Involvement Group to support the appointment of two young governors, Aishah Farooq (reappointed) and Marimo Rossiter. They began a one year term of office on 1 September 2019.

Planning was undertaken in the latter half of the year to support governor elections scheduled for 2020, when there will be 10 seats up for election across five constituencies.

Table 18: Governors by constituency – 1 April 2019 to 31 March 2020

As at 31 March 2020, there were 29 governors in post (17 public, six staff and six appointed). A decision was taken in 2019 to change the composition of the Council of Governors by removing the patient constituency and two of the appointed governor posts. This resulted in a reduction in the number of governor seats from 35 to 29 from 1 June 2019.

Constituency	Name	Tenure	Elected or Appointed
Public Governors			
Public Bristol	Kathy Baxter	June 2019 to May 2022 June 2016 to May 2019	Elected
Public Bristol	John Chablo	June 2019 to May 2022 June 2017 to May 2019	Elected
Public Bristol	Carole Dacombe	June 2019 to May 2022 June 2016 to May 2019	Elected
Public Bristol	Tom Frewin	June 2019 to May 2022 June 2016 to May 2019	Elected
Public Bristol	Sue Milestone	June 2019 to May 2020	Elected
Public Bristol	Graham Papworth	June 2019 to May 2022 June 2017 to May 2019	Elected
Public Bristol	Maureen Phillips	June 2017 to May 2020	Elected
Public Bristol	Martin Rose	June 2019 to May 2022	Elected
Public Bristol	Mary Whittington	June 2017 to May 2020	Elected
Public North Somerset	Graham Briscoe	June 2019 to May 2020 June 2014 to May 2017	Elected
Public North Somerset	Penny Parsons	June 2017 to May 2020	Elected
Public North Somerset	John Rose	June 2017 to May 2020	Elected
Public South Gloucestershire	Pauline Beddoes	June 2016 to May 2019 June 2013 to May 2016 June 2010 to May 2013	Elected
Public South Gloucestershire	Ray Phipps	June 2019 to May 2022 June 2016 to May 2019 Mar 2015 to May 2016	Elected
Public South Gloucestershire	John Sibley	June 2019 to May 2022 June 2017 to May 2019	Elected
Public South Gloucestershire	Malcolm Watson	June 2019 to May 2022 June 2016 to May 2019	Elected
Public – Rest of England and Wales	Garry Williams	June 2019 to May 2022 June 2016 to May 2019 June 2010 to May 2013	Elected
Public – Rest of England and Wales	Hessam Amiri	June 2019 to May 2022	Elected

Public – Rest of England and Wales	Jonathan Seymour-Williams	June 2016 to May 2019	Elected
Patient Governors – stood down on 31 May 2019			
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	Kathy Baxter	June 2016 to May 2019	Elected
Carers of patients under 16 years	John Chablo	June 2017 to May 2019	Elected
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	Rashid Joomun	June 2016 to May 2019	Elected
Carers of patents 16 years and over	Sue Milestone	June 2013 to May 2016 June 2016 to May 2019	Elected
Carers of patients under 16 years	Graham Papworth	June 2017 to May 2019	Elected
Carers of patients 16 years and over	Garry Williams	June 2016 to May 2019 June 2010 to May 2013	Elected
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	Ray Phipps	June 2016 to May 2019 Mar 2015 to May 2016	Elected
Local Patient Governors who live in Bristol, North Somerset and South Gloucestershire	John Sibley	June 2017 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
Staff Governors			
Medical and Dental	Jane Sansom	June 2018 to May 2020	Elected
Non-clinical Staff	Chrissie Gardner	June 2019 to May 2020	Elected
Non-clinical Staff	Barry Lane	July 2018 to May 2020	Elected
Nursing and Midwifery	Florene Jordan	June 2010 to May 2019	Elected
Nursing and Midwifery	Hannah McNiven	June 2019 to May 2022	Elected
Nursing and Midwifery	Debbi Norden	June 2019 to May 2022	Elected
Other Clinical Healthcare Professional	Andy Coles-Driver	June 2016 to May 2019	Elected
Other Clinical Healthcare Professional	Michelle Bonfield	June 2019 to March 2020	Elected
Appointed Governors			
Bristol City Council	Carole Johnson	September 2016 to May 2020	Appointed
Joint Union Committee	Sophie Jenkins	June 2017 to May 2020	Appointed
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

Youth Involvement Group	Siobhan Coles	October 2017 to August 2018 September 2018 to August 2019	Appointed
Youth Involvement Group	Aishah Farooq	September 2019 to August 2020 September 2018 to August 2019	Appointed
Youth Involvement Group	Marimo Rossiter	September 2019 to August 2020	Appointed
South Western Ambulance Service NHS FT	Marty McAuley	June 2017 to May 2019 Post removed 31/5/19	Appointed
Avon and Wiltshire Mental Health Trust	Vacancy – post removed 31/5/19		Appointed

5.1.12 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.

Public membership is open to members of the public who are not eligible to become a member of the Trust's staff constituency and who are seven years of age and above. Public members receive a copy of the hospital magazine twice a year or a monthly e-newsletter with updates from around the hospitals (if they have provided an email address). 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.

In the year all Foundation Trust members (including staff), along with members of the public, were invited to hear about and share their views on a number of health and hospital related topics through a series of near monthly 'Health Matters' events.

Membership numbers have reduced in the year as a result of a continued proactive approach throughout the year in seeking updated contact information from members. However, collaborative work with the Trust's community outreach team has seen an increase in the number of new members joining the Trust in the year under the age of 22 years. Membership of the staff constituency is expected to increase by around 1,500 from 1 April 2020 with the merger with Weston Area Health NHS Trust. At 31 March 2020, public membership totalled 7,768 and staff membership 11,395.

Table 19: Members of the Foundation Trust

Public constituency	**2019/20**
At year start (April 1 2019)	8,066
New members	126
Members leaving	431
At year end (March 31 2020)	7,768
Staff constituency	**2019/20**
At year start (April 1 2019)	10,658
At year end (March 31 2020)	11,395

5.1.13 Membership strategy

In November 2019, the Council of Governors approved a new Membership strategy for 2020 to 2023, which set out how the Trust will carry out its duties in relation to maintaining and engaging its Foundation Trust membership. This was the culmination of discussions with governors over the previous 12 months. The direction of the new strategy is broadly in line with the Trust's previous membership strategy from 2015, though the vision and objectives were updated to align with the Trust's new five-year strategy. Three

core objectives now focus on awareness of membership, communication, and engagement with members, and include clear, realistic and measurable actions to for achievement. The key difference from the previous strategy is the aim to increase the proportion of public Foundation Trust members with an email address over the next three years. This will be achieved by asking members without an email address to reconfirm whether they wish to remain members, and a process for doing this in stages has been be agreed with governors as required by the Trust's Constitution.

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

Table 20: Analysis of current membership (merged public and patient constituencies)

Public constituency	Number of members	Eligible membership
Total (public members in Bristol, North Somerset and South Gloucestershire)	**7,054**	**969,439**
Age (years):		
0-16	166*	190,773
17-21	328	63,714
22+	6,376	714,952
Ethnicity:		
White	5,963	806,242
Mixed	110	21,138
Asian or Asian British	265	32,531
Black or Black British	203	28,584
Other	6	5,072
Socio-economic groupings:		
AB	1,988	101,139
C1	2,082	129,703
C2	1,400	82,759
DE	1,563	94,972
Gender analysis		
Male	2,916	481,667
Female	3,947	487,771

This analysis excludes public members with no date of birth, public members with no stated ethnicity and no stated gender, and public members living outside Bristol, North Somerset and South Gloucestershire.

**Members of The Trust must be at least seven years of age.*

Robert Woolley
Chief Executive
23 June 2020

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. Our pateints describe these 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 2019-2021

In 2019 we commenced a new three year patient safety improvement programme, building on the success of previous programmes.

The 2019-2021 programme includes further work on the 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 working towards our improvement goals under the national Maternity and Neonatal Health Safety Collaborative programme.

We also have a new 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.

Our current programme will be refreshed as we merge with Weston Area Health NHS Trust on 1 April 2020 to maximise learning and improvement opportunities across the new organisation. The Trust's Quality Improvement Academy will continue to support the capacity and capability of frontline staff to take forward the patient safety improvements locally and within our programme work streams.

5.2.2 Stakeholder relations

The Trust is currently not engaged in any formal consultation processes with the Local Authorities or Joint 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. In addition, we actively engage with the Bristol Deaf Health Partnership and Bristol Visual Impairment Partnership. These partnerships provide a single forum to foster dialogue; enabling us to work together to understand and improve the experience of Deaf, hard of hearing and visually impaired people across the health community in Bristol.

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.

We have undertaken widespread local and regional stakeholder communications relating to major Trust projects. During 2019-20 these included the merger with Weston Area Health

NHS Trust, the launch of our 2020-2025 vision – Embracing Change, Proud to Care, and the announcement of our latest Care Quality Commission (CQC) rating.

5.2.3 Research and Innovation

As part of the trust's triumvirate mission to provide exceptional healthcare, research and teaching every day, our leadership and involvement in research allows us to offer cutting edge services within clinical trials to our patients, and contribute to generating evidence to improve the care the NHS will provide in the future. During 2019/20, 7,629 of our patients and staff gave their time to take part in the research that we lead and host.

This year we saw our National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care renewed and relaunched as the Applied Research Collaboration West (ARC West), following a highly competitive process. The ARC and our NIHR Biomedical Research Centre (BRC) are centres for clinical, research and academic excellence, and partnerships which focus on translating early research into trial treatments, and clinical research findings into patient care. As part of a national NIHR infrastructure, our ARC and BRC are part of the system that helps our hospitals' services adapt and respond to NHS changes.

Our NIHR grants and infrastructure currently comprise the NIHR Bristol BRC, NIHR ARC West, 12 NIHR project or programme grants and one NIHR Fellowship. Our NIHR overall grant income continued to increase this year due to the BRC and ARC, despite a reduction in project and programme grants. We have renewed our focus on pump priming grants, and on increasing education and support for potential chief investigators – those who will go on to lead research – in order to increase our NIHR project and programme grants and the associated flexible funding we receive to support our research infrastructure. We are fortunate to have the support of funds from our local charity, Above & Beyond, with some large bequests for research into specific areas this year (breast and bowel cancer; brain and mental health; and eye research).

New grants starting in 2019 include:

- Umberto Benedetto: NIHR-EME: "Carbon Dioxide Insufflation and Brain Protection During Open Heart Surgery. A Randomized Controlled Trial. COTwo trial" £1.3 million
- Barney Reeves NIHR HTA: "Surgical interventions to treat severe pressure sores (SIPS)" £450K
- Jo Robson: NIHR RfPB: "Development and validation of a patient reported outcome measure for Giant Cell Arteritis" £150K
- Ela Chakkarapani NIHR RfPB: " 'CoolCuddle' study. Refinement and evaluation of safety of parents cuddling their baby with hypoxic-ischaemic encephalopathy (HIE) during cooling therapy" £150K

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.

Highlights of the last year include:

- Dr Michelle Bonfield successfully completed her NIHR Doctoral Fellowship: "The response of lower limb deep vein thrombosis to anticoagulation therapy: resolution, recurrence and post thrombotic syndrome"
- Professor John Sparrow completed his £2 million NIHR Programme Grant: "Cataract Surgery: Measuring and predicting patient level vision related health benefits and harms"; the patient reported outcome measures (PROMS) are likely to be adopted into standard care in the near future, with a dissemination event planned for 2020 to promote the findings to stakeholders.
- Charlotte Bradbury's NIHR RfPB trial: "A multicentre randomised trial of First Line treatment pathways for newly diagnosed Immune Thrombocytopenia: Standard steroid treatment versus combined steroid and mycophenolate (FLIGHT)" successfully met its recruitment target of 120 patients on time across a

challenging 43 sites. Follow up is due to complete in March 2020.

- Professor Ramanan's APTITUDE trial: "A phase II trial of Tocilizumab in anti-TNF refractory patients with JIA associated uveitis (funded by Arthritis Research UK/Versus Arthritis)" closed to follow up and the results have been accepted for publication in Lancet Rheumatology later this year.

We have maintained the size of our non-commercial portfolio and have participated actively as a partner organisation within the NIHR Local Clinical Research Network (LCRN), recruiting a challenging target number of participants into research studies which range from simple questionnaires and surveys to highly complex interventional trials in very rare conditions. This has been achieved through a huge effort by our research teams across the Trust, who have worked seamlessly with the R&I core team to set research up quickly and recruit the first participant within challenging timelines. Our research teams have been supported in this by our research matron, Nicola Manning, who joined the Trust this year. In particular we saw very high recruitment in paediatric immunology, infection and cardiovascular research. Research improves the care we provide and our aim is for research to be consistently embedded across all our clinical divisions. We are proud of our achievements, being placed in the top 15% of recruiting NHS trusts nationally.

We have maintained the number of new industry sponsored commercial studies opening to recruitment this year, and over the last three years our open commercial trials have increased by 47%. We continue to broaden our portfolio of commercial research, opening studies in new areas such as obesity, and increasing activity in areas such as dermatology, where we have had a lack of commercial studies in previous years. We have gained expertise in delivering trials involving Advanced Therapy Investigational Medicinal Products (ATIMPs), in particularly CAR-T cell therapy, where we have two trials in set-up and another in the pipeline.

All of this has enabled us to maintain our levels of commercial research income this year, and we have generated over £2 million in commercial research income, a proportion of which we have reinvested in our research teams by supporting new projects and providing maternity and sickness leave cover.

Overall, we have performed well against national benchmarks in terms of our set-up times and recruiting the required number of participants on time. We have recruited the first UK patient in eight commercial studies this year, one of which was the first patient globally in an ophthalmology study. This achievement warranted a letter from the NIHR CRN Chief Executive to congratulate the principal investigator and team.

Our commercial research manager continues to be actively involved in several national projects led by the NIHR CRN and NHS England around set-up and costing for commercial studies in the NHS, which enables us to have a voice nationally and also enhances our engagement with industry partners.

Going into 2020/21 we look towards new challenges and opportunities – in particular to working with new partners locally, and planning for the renewal of our NIHR Bristol BRC.

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 2019 to 31 March 2020.

5.3.1 Annual Statement on Remuneration

The purpose of the Remuneration, Nominations and Appointment 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 Chair and all Non-executive Directors were members of the Committee. The Committee is attended by the Chief Executive and Director of People in an advisory capacity when appropriate, and is supported by the Director of Corporate Governance to ensure it undertakes its duties in accordance with applicable regulation, policy and guidance.

The Committee met on five occasions in the reporting period to consider the annual review of Executive Directors' performance, the skills and knowledge mix of the Board of Directors, current remuneration levels, and the secondment of the Chief Executive to Weston Area Health NHS Trust as part of the Management Services Agreement. 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 and agreed an uplift to Director's salaries in line with the national guidance to reflect cost of living changes. The Committee considered the secondment of the Chief Executive to Weston Area Health NHS Trust to undertake a joint Chief Executive role as part of the Management Services Agreement. This was a step towards the merger with Weston Area Health NHS Trust which took place on 1 April 2020.

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 NHSEI. 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.

The Committee is also cognisant of its responsibilities in relation to addressing the gender pay gap and actively considered during the year how to ensure parity of pay of female and male Executive Directors. This is in line with the expectations of the UK Corporate Governance Code.

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

2019/20 and 2018/19. There were no taxable benefits, annual performance related bonuses or exit packages paid to any director in either year. This information has been subject to audit.

Table 21: Remuneration for the senior managers of the Trust 2019/20 (Audited)

Directors remuneration for 2019/20 (£'000)	Salary (bands of £5,000)	Taxable benefits (to nearest £100)	Annual performance related bonus (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chair:					
Jeffrey Farrar (note 1 & 5)	50-55	1700	n/a	n/a	55-60
Executive Directors:					
Robert Woolley, Chief Executive (note 2)	170-175	n/a	n/a	55-57.5	225-230
Mark Smith, Deputy Chief Executive and Chief Operating Officer	160-165	n/a	n/a	12.5-15	175-180
Paula Clarke, Director of Strategy and Transformation	140-145	n/a	n/a	30-32.5	170-175
Neil Kemsley, Director of Finance and Information from 1 July 2019 (note 3)	120-125	4,800	n/a	n/a	125-130
Paul Mapson, Director of Finance and Information until 30 June 2019 (note 4)	40-45	n/a	10-15	n/a	55-60
Carolyn Mills, Chief Nurse	145-150	n/a	n/a	15-17.5	160-165
Matthew Joint, Director of People	150-155	n/a	n/a	35-37.5	185-190
William Oldfield, Medical Director	210-215	n/a	n/a	32.5-35	240-250
Non-executive Directors					
David Armstrong (note 5)	15-20	800	n/a	n/a	15-20
Julian Dennis (note 5)	15-20	900	n/a	n/a	15-20
John Moore until 31 December 2019	10-15	n/a	n/a	n/a	10-15
Guy Orpen	10-15	n/a	n/a	n/a	10-15
Sue Balcombe from 1 June 2019 (note 5)	5-10	1200	n/a	n/a	5-10
Bernard Galton from 1 July 2019	10-15	n/a	n/a	n/a	10-15
Steven West	10-15	n/a	n/a	n/a	10-15
Martin Sykes (note 5)	15-20	3100	n/a	n/a	20-25
Madhu Bhabuta (note 6)	5-10	n/a	n/a	n/a	5-10
Jayne Mee from 1 June 2019	10-15	n/a	n/a	n/a	10-15

Note 1 – Jeffrey Farrar reflects amounts recharged to Weston Area Health NHS Trust as part of his role as Joint Chair

Note 2 - Robert Woolley reflects amounts recharged to Weston Area Health NHS Trust as part of his role as Joint Chief Executive

Note 3 - Neil Kemsley's taxable benefit relates to a lease car originally provided by the NHS Trust that previously employed him

Note 4 – Paul Mapson's performance-related bonus was made in recognition of full achievement of the Trust's 2018/19 financial plan and closure of the 2018/19 accounts, completion of the financial due diligence assessment of Weston Area

Health NHS Trust in preparation for the merger and comprehensive handover to his successor in the period January to June 2019

Note 5 – Taxable benefits relate to reimbursement of travel cost for home to base mileage

Note 6 – Madhu Bhabuta is a Designate Non-executive Director

Table 22: Remuneration for the senior managers of the Trust 2018/19 (Audited)

Directors remuneration for 2018/19 (£'000)	Salary (bands of £5,000)	Taxable benefits (to nearest £100)	Annual performance related bonus (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chair:					
Jeffrey Farrar (note 2)	50-55	1300	n/a	n/a	55-60
Executive Directors:					
Robert Woolley, Chief Executive	240-245	n/a	n/a	125-127.5	370-375
Mark Smith, Deputy Chief Executive and Chief Operating Officer	155-160	n/a	n/a	15-17.5	175-180
Paula Clarke, Director of Strategy and Transformation	135-140	n/a	n/a	42.5-45	180-185
Paul Mapson, Director of Finance and Information	155-160	n/a	n/a	n/a	155-160
Carolyn Mills, Chief Nurse	140-145	n/a	n/a	60-62.5	200-205
Matthew Joint, Director of People	150-155	n/a	n/a	32.5-35	180-185
William Oldfield, Medical Director from 1 Aug 2018	140-145	n/a	n/a	0	140-145
Mark Callaway, Medical Director until 31 July 2018 (note 1)	65-70	n/a	n/a	0	65-70
Non-executive Directors					
David Armstrong (note 2)	15-20	1600	n/a	n/a	15-20
Julian Dennis (note 2)	15-20	1600	n/a	n/a	15-20
John Moore	10-15	n/a	n/a	n/a	10-15
Guy Orpen	10-15	n/a	n/a	n/a	10-15
Alison Ryan from 3 September 2018	5-10	n/a	n/a	n/a	5-10
Jill Youds (note 2)	15-20	300	n/a	n/a	15-20
Steven West	10-15	n/a	n/a	n/a	10-15
Martin Sykes (note 2)	15-20	3900	n/a	n/a	20-25
Madhu Bhabuta (note 3)	5-10	n/a	n/a	n/a	5-10
Emma Woollett until 31 May 2018	0-5	n/a	n/a	n/a	0-5

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

Note 2 - Taxable benefits relate to reimbursement of travel cost for home to base mileage

Note 3 – Madhu Bhabuta is a Designate Non-executive Director

The value of pension benefits accrued in the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

NHS Pensions are still assessing the impact if the McCloud judgement in relation to changes to benefits in the NHS 2015 scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

There were no payments made for loss of office in either 2019/20 or 2018/19.

There were no payments to past senior managers in either 2019/20 or 2018/19.

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 2019/20 and 2018/19. As Non-executive directors do not receive pensionable remuneration, there are no entries in respect of any pensions. This information has been subject to audit.

Table 23: Pension benefits for the year ended 31 March 2020 (Audited)

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 2020	Lump sum at age 60 related to accrued pension at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2019	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 *(Note 1)*	5-7.5	15-17.5	75-80	230-235	N/A	1,768	N/A
Mark Smith	0-2.5	2.5-5	40-45	120-125	971	897	36
Paula Clarke	2.5-5	0	50-55	125-130	1,075	1,000	37
Neil Kemsley *(Note 2)*	-	-	-	-	-	-	-
Paul Mapson *(Note 2)*	-	-	-	-	-	-	-
Carolyn Mills	0-2.5	2.5-5	55-60	170-175	1,279	1,194	43
Matthew Joint	2.5-5	0	5-10	0	97	56	18
William Oldfield	2.5-5	0	55-60	75-80	945	873	38

Note 1 – left pension scheme in 2019/20 therefore no cash equivalent transfer value provided by NHS Pension Agency

Note 2– No pension benefits as not a member of an NHS Pension scheme

This table includes details for the directors who held office at any time in 2019/20.

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 24: Pension benefits for the year ended 31 March 2019 (Audited)

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 not a member of an NHS Pension scheme

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

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

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

Table 25: Future Policy Table

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

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

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

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

5.3.4 Fair pay multiple

The Trust is required to disclose the relationship between the remuneration of the highest-paid director and the median remuneration of the organisation's workforce. The banded remuneration of the Trust's highest paid director in 2019/20 was £210k - £215k (2018/19, £210k - £215k). This was 6.6 times (2018/19, 6.8 times) the median remuneration of the workforce, which was £32,442 (2018/19, £31,447). In 2019/20, no (2018/19, nil) employees received total remuneration in excess of the highest paid director. Remuneration ranged from £18,007 to £212,200, (2018/19, £17,460 to £210,827).

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

5.3.5 Remuneration of Non-Executive Directors

The remuneration of the Chair 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 Trust 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 Chair and Non-executive Directors.

Members of the Committee are appointed by the Council of Governors. The membership includes eight elected public governors, two elected staff governors and two appointed governors.

The Committee is chaired by the Chair 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, reappointment, suspension or removal of the Chair, by 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 Chair and Non-executive Directors, and, on a regular basis, monitor the performance of the Chair and Non-executive Directors.

In November 2019 the Committee reviewed the current remuneration of Non-executive Directors and recommended no changes to their current remuneration. At an extraordinary Council of Governors meeting in May 2019, governors discussed the Trust's current approach to the payment of expenses to Non-executive Directors and whether the Trust should continue to gross up expenses payments for Non-executive Directors, or make a change to process all expenses payments through payroll and deduct tax and National Insurance.

After due consideration the governors agreed that the current arrangements should continue.

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 Chair undertakes the performance review of the Chief Executive and Non-executive Directors. The Chair 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 Director of Corporate Governance. One Executive Director received performance-related remuneration and no Non-executive Director received performance-related remuneration 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 Director of Corporate Governance.

Table 26: Expenses paid to Governors and Directors

Year	Directors			Governors		
	No. in office	No. reimbursed	Amount (£)	No. in office	No. reimbursed	Amount (£)
2019/20	19	14	25,105	37	10	1,477
2018/19	18	13	25,811	35	10	2,892

**expenses are reimbursement of travel and subsistence costs incurred on Trust business*

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
23 June 2020

5.4 Staff Report

We recognise our workforce is our most valuable asset and have developed a clear People 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 27: Analysis of staff costs (Audited)

	2019/20			2018/19		
	Total £'000	Permanent £'000	Other £'000	Total £'000	Permanent £'000	Other £'000
Salaries and wages	351,388	322,871	28,517	332,064	305,927	26,137
Social security costs	32,237	30,858	1,379	30,019	28,760	1,259
Pension costs*	60,673	58,534	2,139	39,237	37,981	1,256
Apprenticeship levy	1,691	1,691	-	1,588	1,588	-
Termination benefits	45	45	-	182	182	-
Agency/contract staff	11,816	-	11,816	9,075	-	9,075
Total Gross Staff Costs	457,850	413,999	43,851	412,165	374,438	37,727
Income in respect of salary recharges netted off expenditure	(3,206)	(3,206)	-	(2,932)	(2,932)	-
Employee expenses capitalised	(977)	(964)	(13)	(681)	(562)	(119)
Net employee expenses	453,667	409,829	43,838	408,552	370,944	37,608

**employer's pension contribution increased by 6.3% from 1 April 2019.*

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 2019/20 and 2018/19 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.

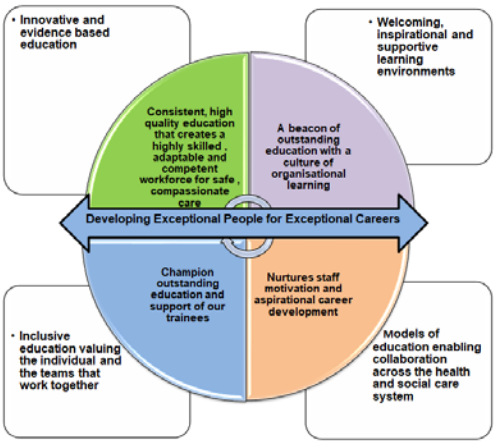
Table 28: Average staff numbers (whole time equivalents) (Audited)

Staff category	2019/20			2018/19		
	Total	Permanent	Other	Total	Permanent	Other
Medical and dental	1,305	1,217	88	1,235	1,153	82
Administration and estates	1,883	1,779	104	1,842	1,737	105
Healthcare assistant and other support	828	775	53	812	755	57
Nursing, midwifery & health visitors	3,569	3,151	418	3,401	3,027	374
Scientific, therapeutic and technical	1,286	1,240	46	1,243	1,202	41
Healthcare science staff	173	173	-	156	156	0
Total staff	9,044	8,335	709	8,689	8,030	659

5.4.3 Education, Learning and Development

In April 2019, the Trust approved the Education Strategy for 2020-2025 developed by the newly appointed Associate Director of Education, following extensive stakeholder engagement and external benchmarking. The strategy sets a vision of 'developing exceptional people for exceptional careers' through access to high quality, inspirational education which improves the care of patients. The Trust's strategic priorities for education are: to excel in the provision of high-quality education; to become a beacon of outstanding education within an organisational culture of learning; provide education that motivates and inspires careers; and to champion outstanding education and the support for trainees. The guiding principles for the education strategic intent are outlined in the model below:

Summary of the Education Strategy



The Trust's educational offer includes a diverse range of internal provision and externally procured programmes to develop a highly skilled, adaptable and competent workforce.

As a leading university teaching hospital the Trust has close relationships with local, national and global academic institutions. The Trust provides clinical placements to a large number of trainees, at undergraduate and postgraduate level within medical, dental, nursing, midwifery, allied health professions and healthcare science. In partnership with the local universities, University of Bristol and University of West England, staff access continuous professional development aligned to clinical service needs and workforce priorities. Clinical education is supported through a number of postgraduate 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. The Trust maintains an excellent working relationship and dialogue with Health Education England inclusive of the Severn Deanery.

In addition, the Trust provides broader skills development through its internal provision of customer service and leadership and management programmes

to all staff. In the past year the Trust has placed a particular focus upon developing customer services skills and will roll out a substantial delivery programme in 2020/21 for administration and clerical staff.

The Trust is supporting the leadership of the developing Healthier Together STP Learning Academy with an ambition for a system wide approach for education aligned to both workforce and people priorities. The apprenticeship provision has formed a core part of this activity and within 2019/20, 32 apprenticeship standards were procured for clinical and non-clinical career pathways and development ranging from level two to level seven provisions from local and national training providers. The provision has included supporting newly emerging roles and innovations such as trainees, nursing associates and developing a healthcare science apprenticeship. In partnership with the STP, the Trust is implementing a T-level strategy to meet the government's initial roll out in late 2020 and taking forward a skills pass porting project of statutory and mandatory training to enable enhanced staff and trainee mobility across all heathcare providers.

Building a sustainable and inclusive supply route is a core focus through local community engagement and by providing highly accessible training routes, e.g.community outreach activities, traineeships, work experience and school and college engagement activities. Through the Bristol Medical Simulation Centre, the Trust funds an outreach officer to engage with local schools and colleges using simulation activity at school events and large regionally organised recruitment events for years 12 and 13 students.

The Education Strategy places greater focus upon an integrated offer whilst promoting innovation and inspiring learning from induction and throughout an employee's career. The standard of delivery and teaching methodology are key drivers in the developing evidence based future provision, including a greater focus upon the use of technology and content of learning. Collectively these will all aim to place the Trust as a beacon of outstanding education with a learning organisation philosophy.

5.4.4 Diversity and Inclusion

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.

The Trust has set out its vision of being 'committed to inclusion in everything we do' in its Workforce Diversity and Inclusion Strategy, built on four overarching themes:

The Strategy was developed in partnership with the National Workforce Race Equality Standard team and over 70 stakeholders who attended a Diversity and Inclusion workshop in February 2019. By 2025 the Trust aims to:

- Be a Trust that continues to see an increase in staff engagement, with more staff feeling happy and content in their role
- Be recognised as an inclusive employer that develops our people at every opportunity, spotting talented staff no matter what their background
- Have leaders that role model our values and create an environment where staff feel safe to raise concerns and challenge where they see something that is not right
- Have an environment where innovation comes naturally – research shows that diversity helps teams to be more effective.

These ambitions will be delivered through the action plan underpinning the Strategy's objectives.

The Director of People is the nominated Executive lead for diversity and inclusion on the Board of Directors. Delegated responsibility for the delivery of the programme of work sits with Head of Organisational Development.

The Workforce Diversity Inclusion Group is chaired by the Head of Organisational Development, and is the Trust's key group in relation to delivering the Workforce Diversity and Inclusion Strategy 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.

Everyone 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.

A range of equalities information is published by the Trust on its public website, including 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), the Workforce Disability Equality Standard (WDES), Gender Pay Gap reporting and the NHS Equality Delivery System (EDS2). The WRES, the WDES and EDS2 are included in the Standard NHS Contract.

5.4.5 The Workforce Race Equality Standard (WRES)

The NHS Workforce Race Equality Standard (WRES) is designed to be a tool and an enabler of change. Through nine evidence-based measures, the WRES highlights any differences between the experience and treatment of white staff and BME staff in the NHS with a view to closing those gaps through the development and implementation of action plans focused upon continuous improvement over time. The Trust's actions to deliver this continuous improvement are aligned with the Workforce Diversity and Inclusion Strategy actions.

5.4.6 The Workforce Disability Equality Standard (WDES)

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the National Health Service (NHS). The WDES is a series of evidence-based Metrics that provides NHS organisations with comparative data between Disabled and non-disabled staff, giving a snapshot of the experiences of their Disabled staff in key areas. The information can be used to understand where key differences lie and provide the basis for the development of action plans, enabling organisations to track progress on a year by year basis. As with the WRES, actions to deliver improvement are aligned with the Workforce Diversity & Inclusion Strategy actions.

5.4.7 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.

5.4.8 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.

5.4.9 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. Trust-wide compliance has been at over 90 per cent since May 2018.

5.4.10 Diversity and Inclusion 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.

Integral to this work are the three Trust Staff Forums:

- The Black, Asian & Minority Ethnic (BAME) Workers Forum
- ABLE+ (the forum for staff with physical, sensory or mental impairments)
- The Lesbian, Gay, Bisexual & Transgender (LGBT) Forum.

The forums meet regularly to provide peer support and discuss issues relating to Trust policy and procedure. Their programmes of work are key to the delivery of the Trust's vision of being committed to inclusion in everything we do, including actions to support the WRES and WDES, as well as the introduction of the NHS Rainbow Badges Scheme to the Trust. Each Forum is represented on the Trust's Workforce Diversity & Inclusion Group.

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 the Workforce Disability Equality Standard.

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

- Equality, Diversity and Human Rights Policy: sets out the Trust's commitments to equality, diversity and human rights and its obligations under equalities legislation (Equality Act 2010) and the Human Rights Act 1998. It also describes the roles and responsibilities of individuals and groups in ensuring the Trust fulfils its commitments and obligations to develop and enhance a diverse and inclusive culture.
- 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.

5.4.11 Analysis of staff diversity profile

The Trust's annual statutory monitoring of workforce and patient data reflects information as at 31 March 2020. Some of the key workforce data is given in the tables below. This data applies to staff with a permanent employment contract with the Trust.

Table 29: Staff with permanent contract	**March 2020**	
Gender – All staff with a permanent employment contract	**Total**	**%**
Male	2281	22.8 %
Female	7725	77.2 %
TOTAL	10006	100%

Table 30: Directors by gender	**March 2020**	
Gender – Directors (Executive and non-Executive)	**Total**	**%**
Male	12	70.59%
Female	5	29.41%
TOTAL	17	100%

Table 31: Senior Managers by gender	**March 2020**	
Gender – Other Senior Managers *	**Total**	**%**
Male	5	33.33%
Female	10	66.67%
TOTAL	15	100%

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

Table 32: Ethnicity (staff with a permanent contract)

	March 2020	
Ethnicity	**Total**	**%**
A - White - British	7187	71.8%
B - White - Irish	130	1.3%
C - White - Any other White background	913	9.1%
D - Mixed - White & Black Caribbean	50	0.5%
E - Mixed - White & Black African	25	0.2%
F - Mixed - White & Asian	46	0.5%
G - Mixed - Any other mixed background	70	0.7%

	March 2020	
Ethnicity	**Total**	**%**
H - Asian or Asian British - Indian	354	3.5%
J - Asian or Asian British - Pakistani	45	0.4%
K - Asian or Asian British - Bangladeshi	9	0.1%
L - Asian or Asian British - Any other Asian background	147	1.5%
M - Black or Black British - Caribbean	170	1.7%
N - Black or Black British - African	259	2.6%
P - Black or Black British - Any other Black background	66	0.7%
R - Chinese	45	0.4%
S - Any Other Ethnic Group	191	1.9%
Z - Not Stated	299	3.0%
TOTAL	10006	100%

Table 33: Disability	**March 2020**	
Disability	**Total**	**%**
No	9349	93.4%
Not Declared	389	3.9%
Yes	268	2.7%
Total	10006	100%

Table 34: Age profile	**March 2020**	
Age profile	**Total**	**%**
16 – 20	126	1.3%
21 – 25	909	9.1%
26 – 30	1486	14.9%
31 – 35	1455	14.5%
36 – 40	1331	13.3%
41 - 45	1114	11.1%
46 – 50	1055	10.5%
51 – 55	1046	10.5%

Age profile	Total	%
56 – 60	880	8.8%
61 – 65	474	4.7%
66 – 70	99	1.0%
71 - 75	28	0.3%
76 - 80	2	0.0%
Total	10006	100%

Table 35: Religious belief	March 2020	
Religious belief	**Total**	**%**
Atheism	1640	16.39%
Buddhism	57	0.57%
Christianity	3703	37.01%
Hinduism	100	1.00%
Islam	205	2.05%
Jainism	3	0.03%
Judaism	10	0.10%
Sikhism	18	0.18%
Other	689	6.89%
I do not wish to disclose my religion/belief	3469	34.67%
Undefined	112	1.12%
Total	10006	100%

Table 36: Sexual orientation	March 2020	
Sexual orientation	**Total**	**%**
Bisexual	71	0.71%
Gay or Lesbian	151	1.51%
Heterosexual	7078	70.74%
Other sexual orientation not listed	2	0.02%
Not stated (person asked but declined to provide a response)	2560	25.58%
Undecided	34	0.34%

Undefined	110	1.10%
TOTAL	10006	100%

5.4.12 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 online support to staff and managers via its web portal, reducing the time to clear new staff for work, as well as 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.

The Trust has launched a holistic five year wellbeing framework bringing together the three key components of psychological, physical and healthy lifestyles. This further supports the work of the 250 Workplace Wellbeing Advocates who act as the nominated wellbeing advisor within their respective teams and ensure staff hear about wellbeing initiatives both corporately and locally.

The Trust continues to fulfil requirements of the NHS England Commissioning for Quality and Innovation (CQUIN) for Staff Health and Wellbeing. The focus for this year has been the delivery of the flu campaign which requires 80% frontline staff to be vaccinated, a target that the Trust has achieved.

5.4.13 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 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.

5.4.14 Sickness absence

Data in respect of the Trust's average sickness for 2019/20 can be found at: https://digital.nhs.uk/dataand-information/publications/statistical/nhs-sickness-absence-rates

5.4.15 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 2019/20 the Trust's identified and addressed. This includes physical and psychological hazards as well as the broader environmental risk assessments.

expenditure on consultancy was £0.435m (2018/19: £0.836m). This reflects the change in work in support of Healthy Weston.

5.4.16 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 2019/20 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. The Trust defines significant financial responsibility as being a member of a Divisional Board.

Table 37: All off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2020	-
Of which…	
No. that have existed for less than one year at time of reporting.	-
No. that have existed for between one and two years at time of reporting.	-
No. that have existed for between two and three years at time of reporting.	-

No. that have existed for between three and four years at time of reporting.	-
No. that have existed for four or more years at time of reporting.	-

Table 38: All new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, 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 2019 and 31 March 2020.	-
Of which:	
Number assessed as within the scope of IR35	-
Number assessed as not within the scope of IR35	-
Number engaged directly (via PSC contracted to the Trust) and are on the Trust's payroll	-
Number of engagements reassessed for consistency/assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	-

Table 39: Any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
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.	34

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

5.4.17 Exit packages

The table below shows the number and cost of staff exit packages (termination benefits) in 2019/20. 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 2018/19 are shown in brackets. This information has been subject to audit.

Table 40: Exit packages (Audited)

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	- (1)	5 (6)	5 (7)
£10,000 - £25,000	3 (2)	1 (2)	4 (4)
£25,001 - £50,000	- (1)	- (1)	- (2)
£50,000 - £75,000	-(-)	- (1)	- (1)
Total number of exit packages by type	**3 (4)**	**6 (10)**	**9 (14)**
Total cost (£'000)	45 (57)	34 (139)	79 (196)

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

Table 41: Analysis of non-compulsory departures (Audited)

	2019/20		2018/19	
	No.	£'000	No.	£'000
Voluntary redundancies including early retirement contractual costs			-	-
Mutually agreed resignation contractual costs (MARS)	-	-	2	96
Contractual payments in lieu of notice	6	34	7	28
Non-contractual payments requiring HMT approval	-	-	1	15
Total	6	34	10	139
Of which: Non contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

5.4.18 Engaging with staff

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 Staff 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.

5.4.19 NHS staff survey

The Trust continues to take an active part in the annual National Staff Survey for all staff and the results are utilised in developing local action plans to improve staff experience at work.

The 2019 National Staff Survey response rate was 55 per cent with over 5000 staff taking time to provide feedback on their experience at work. The 3 percent increase in the response rate, demonstrates an ever increasing number of staff taking the opportunity to take part in the survey. The average response rate for acute Trust is 47 percent.

Staff engagement with each other, the organisation, and our patients remains positive with an engagement score of 7.2. The staff engagement figure has remained positive for the positive for the past 6 years and remains above the average for acute Trust which is 7.0

The pride that staff have in organisation and their contribution is reflected in by the responses to recommending the organisation as a place to work and receive treatment which is demonstrated

in the results, with 74 percent of staff confirming that they would recommend University Hospitals Bristol NHS Trust as a place to work, and 85 percent saying they would recommend the Trust as a place to receive treatment. Wellbeing at work was a key focus this year for the Trust and the survey feedback shows support for this initiative. Understanding how effective our leadership role model positive behaviours is key to the delivery of well led patient care the feedback from the survey illustrates a positive increase in staff feeling that they feel encouraged and supported by their managers.

This is further demonstrated by the following 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
- Care of patients/service users is the organisations top priority

New to Staff Survey reporting this year as stated by the National Co-ordination Centre includes:

- Additional theme of `Team working' will be available, this uses questions such as `The team I work in has a shared set of objectives' and `the team I work in often meets to discuss the teams effectiveness'
- Both the Benchmark Reports and Summary Benchmark Reports will include data relating to the Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WDES)

The following table demonstrates the Trust's results in relation to the Survey 11 Indicators and comparative to the national Average for Acute Trust for the past four surveys:

Table 42: NSS 2019 11 Indicator Scores

	2019		**2018**		**2017**		**2016**	
11 Indicators	Trust	National Average for Acute Trusts	Trust	National Average for Acute Trusts	Trust	National Average for Acute Trusts	Trust	National Average for Acute Trusts
Equality Diversity and Inclusion	9.2	9.0	9.2	9.1	9.1	9.1	9.2	9.2
Health and well Being	6.1	5.9	6.0	5.9	6.1	6.0	6.2	6.1
Immediate Managers	6.9	6.8	6.8	6.7	6.7	6.7	6.7	6.7
Morale	6.4	6.1	6.3	6.1	N/A*	N/A*	N/A*	N/A*
Quality of Appraisal	5.6	5.6	5.5	5.4	5.3	5.3	5.2	5.3
Quality Of Care	7.4	7.5	7.3	7.4	7.3	7.5	7.4	7.6
Safe Environment Bullying and Harassment	8.2	7.9	8.2	7.9	8.1	8.0	8.1	8.0

Safe environment Violence	9.6	9.4	9.6	9.4	9.4	9.4	9.4	9.4
Safety Culture	6.9	6.7	6.8	6.6	6.7	6.6	6.6	6.6
Staff Engagement	7.2	7.0	7.2	7.0	7.1	7.0	7.1	7.0
Team Working	6.6	6.6	6.5	6.5	6.6	6.5	6.5	6.5

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

5.4.20 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 2019 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 key area of focus will be improving the quality of appraisal and the experience of our BAME staff as indicated by the WRES reported data and integrated into the aforementioned Workforce Diversity & Inclusion strategy.

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 continues to use 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.

5.4.21 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 and implementation of 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 (e.g. 7 day working and changes in shift patterns)
- Merger with Weston Area Health NHS Trust and the TUPE transfer of staff to the newly merged University Hospitals Bristol and Weston Foundation Trust.

5.4.22 Staff policies and actions applied during the financial year

Revisions of policies to support the new Agenda for Change pay framework have now taken place, this includes Supporting Performance, Appraisal and Linking Pay to Progression policies. All our policies are regularly reviewed to ensure that they meet with best practice standards and legislation, and with our corporate objectives.

5.4.23 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 and this is available via HR web with introduction of the 'supporting positive behaviours' framework which includes training for all staff being launched in March 2020.

5.4.24 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 43: Relevant union officials

Number of employees who were relevant union officials during 2019/20	Full-time equivalent employee number
41	8703

Table 44: Percentage of time spent on facility time

Percentage of time	No of employees
0%	-
1-50%	36
51%-99%	-
100%	5

Table 45: Percentage of pay bill spent on facility time

The total cost of facility time	£128,883
The total pay bill	£446,099,000
The percentage of the total pay bill spent on facility time	£0.029%

Table 46: Paid trade union activities

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

5.4.25 Freedom to Speak Up

The Trust is committed to an open and honest culture to ensure that everyone who works in the organisation feels safe and confident to speak up. We recognise the importance of enabling staff to speak up about any concerns at work to improve services for all patients and the working environment for staff. In most circumstances, concerns will be raised and resolved through the management structure of the Trust, however a number of other options are available to staff who do not feel able to raise

concerns in this way, including access to the Freedom to Speak Up Guardian (FTSUG). The Director of Corporate Governance is the Freedom to Speak Up Guardian who is supported by a network of more than 50 Freedom to Speak Up staff advocates from across the Trust.

During the year a Freedom to Speak Up Strategy was developed in consultation with staff, which was approved by the Board in May 2019. The three objectives of the strategy focus on raising awareness of and building confidence in the speaking up programme, and ensuring that our leadership programmes are informed by the feedback through the programme. In the year, the Freedom to Speak Up policy was amended to take in staff feedback and best practice from national case reviews.

The Guardian and advocates continue to ensure that they are visible across the Trust by attending key meetings and talking to staff groups to promote speaking up messages. There are regular communications about speaking up in the weekly newsletter to all staff (Newsbeat), including case studies on each of the advocates, and promotional materials advertising the contact details for the Guardian (a dedicated phone number and email address) are available across the Trust. For national Speak Up month in October 2019 a video was produced to help staff better understand what it means to raise a concern, which now forms part of corporate induction for all new starters; a Schwartz Round was held to discuss the emotional aspects of raising concerns; alongside drop in sessions and walk rounds.

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 2019/20 there were 55 referrals to the Freedom to Speak Up Guardian from all areas of the workforce (up from 32 in 2018/19), with the majority of concerns relating to attitudes and behaviours, similar to 2018/19.

Table 47: Number of concerns raised to the FTSUG in 2019/20

	Q1	Q2	Q3	Q4	Totals
Number of cases raised to the FTSUG	6	17	19	13	55
Cases relating to patient safety	0	1	2	1	4
Cases relating to attitudes and behaviours	2	10	11	7	30
Other cases	4	6	6	5	21

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 2019/20, with the exception of paragraph A.5.12. Governors of The Trust 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 Director of Corporate Governance.

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 14.

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

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

5.5.1 Board Performance

Boards of NHS Foundation Trusts have faced significant challenges, financial and operational, in 2019/20. 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 Trust has 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 48: Board and Sub-Committee Attendance 2019/20

The Board of Directors discharged its duties during 2019/20 in 11 private and 6 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 in brackets indicates that the individual was not a member and 'C' denotes the Chair of the Board or committee.

	Board of Directors	Remuneration & Nomination & Appointments Committee	Audit Committee	Quality & Outcomes Committee	People Committee	Finance Committee
No. of meetings	17	6	5	12	10	12
Chairman						
Jeff Farrar	17 (C)	5 (C)	2	10	7	9
Chief Executive						
Robert Woolley	17	(3)	(5)	(0)	(0)	11
Non-executive Directors						
David Armstrong	15	4	5 (C)	(6)	10	(7)
Sue Balcombe	13	5	(1)	9	2	(0)
Madhu Bhabuta	14	2	(0)	(1)	6	(1)
Julian Dennis	17	6	4	12 (C)	(1)	4
Bernard Galton	11	6	2	(0)	7 (C)	(0)
Jayne Mee	12	4	(0)	6	4	6
John Moore	10	3	(0)	(0)	4 (C)	2
Anthony (Guy) Orpen	17	6	(0)	(0)	(0)	(0)
Martin Sykes	15	5	4	(0)	5	11 (C)
Steven West	13	0	(0)	8	(0)	(0)
Executive Directors						
Paula Clarke	17	(0)	(1)	(0)	9	1
Matthew Joint	16	5	(0)	(1)	9	(0)
Neil Kemsley	12	(0)	(2)	(0)	(0)	10
Paul Mapson	5	(0)	(2)	(0)	(0)	3
Carolyn Mills	10	(0)	(1)	9	7	(0)
William Oldfield	17	(0)	(0)	9	8	(0)
Mark Smith	15	(0)	(0)	10	(0)	11

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 Chair 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 Director of Corporate Governance 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 Non-Executive members of the Audit Committee also serve as the Chairs of these committees. 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 is responsible for providing the Board with assurance on the adequacy of the Trust's Audit plans and performance against these, and the committee's review of accounting policies and the annual accounts.

During 2019/20, 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 PricewaterhouseCoopers LLP (PwC) as External Auditors in April 2017 for an initial three year term. The contract with PwC was extended for a further year in February 2020 following review by the Audit Committee and approval at the Council of Governors. 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 ASW Assurance 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:

- Releasing revised Terms of Reference, including a detailed analysis of the Audit Committee's Stakeholders and their respective requirements.
- Releasing a revised Annual Business Cycle, detailing the requirements for each Audit Committee meeting (as defined by the revised Terms of Reference) to ensure the Committee addresses all of its responsibilities in timely fashion. This is now referenced at each Audit Committee Meeting to ensure frequencies and timings are considered appropriate for the work of the Committee.
- Further 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.
- Development of the Quarterly Internal Audit Report to provide greater focus on overdue actions, to ensure that recommendations are described in terms of the benefits to the Trust and to simplify the presentation / scope of the content wherever this is appropriate.
- Assignment of all Strategic and Operational Risks to an appropriate

Committee of the Trust (or to the Board), wherever this is deemed appropriate to aid the Assurance of risk identification and the associated mitigation strategies and timescales.

- Further development of the Estates and Facilities Report. The Audit Committee has been asked by the Board to seek assurance about the arrangements for the governance of the Trust's estates functions, with a particular focus on fire safety.
- Maintaining 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.
- Oversight of the key audit matters in the External Auditor's audit report, namely: the risk of fraud in revenue and expenditure recognition; the valuation of property, plant and equipment; financial sustainability; and the impact of Covid-19.

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 Director of Corporate Governance or Head of Corporate Governance 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 2019/20, 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 established by the Board of Directors to support the Board in discharging its responsibilities in respect of people and workforce issues affecting the organisation.

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 Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

5.5.11 NHS Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

Following the acquisition of Weston Area Health NHS Trust on 1 April 2020 the Trust is currently in category 2, with support needs identified in operational performance.

This is the trust's position as at 23 June 2020. The current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

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 2019/20, 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 49: Performance against Use of Resources Rating 2019/20

Metric	Weighting	Metric performance	Metric rating
Liquidity	20%	40.7 days	1
Capital servicing capacity	20%	2.67 times	1
Income and expenditure margin	20%	1.7%	1
Variance in income and expenditure margin	20%	0.1%	2
Variance from agency ceiling	20%	0%	1
Overall URR rounded			1

5.5.13 2020/21 Financial Outlook

University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust submitted draft 2020/21 Operational Plans to NHS England and NHS Improvement (NHSEI) on the 5th March 2020 as separate legal entities pending the Secretary of State's approval for the merger. Following the approval of the merger with Weston Area Health NHS Trust (WAHT) with effect from 1st April 2020, a final Operational Plan for the newly merged Trust was due for submission to NHSEI on 29th April 2020. However, due to the Covid-19 outbreak, NHSEI suspended the requirement for the 2020/21 Operational Plan. The Trust considered and approved draft and final resource papers at the Finance Committee at the end of March and April respectively.

In response to Covid-19, NHSEI changed the financial regime for the first four months of 20120/21, suspending Payment by Results and the National Tariff. Block contract payments for patient care activities are in place with commissioners based on 2019/20 income values. Income from Local Authorities, Health Education England and NHS Provider Organisations are also through block payments. Any shortfall in these block payments is covered through monthly top up payments from NHSE/I. These top up payments include the reimbursement of additional costs associated with responding to the Covid-19 pandemic and shortfalls in income from other sources, offset by reductions in variable costs for reduced non-Covid related patient activity. Therefore, from 1st April until 31st July 2020 the Trust is expected to break even (excluding technical items). In completing the accounts for April 2020 the Trust required a very small true up payment, thereby confirming the reasonableness of the block funding plus top up.

From the 1st August 2020, there is an expectation that this funding arrangement will continue, although it is likely to evolve as the NHS is required to continue to respond to the Covid-19 Pandemic as well as delivering its usual non-Covid related activity.

The Trust has prepared a Covid-19 Financial Plan incorporating the guidance, notifications and requirements of NHS England and NHS Improvement (NHSEI) for the period 1st April 2020 to 31st July 2020. The plan shows the Trust breaking even during this period as required, with total income during this time of £286m. Forecast cash balances at the end of July 2020 are £142m. The Covid-19 Financial Plan represents the Trust's current operating conditions and the current financial regime issued by NHSEI which may be subject to further and significant change in due course. The Trust's financial plan will be developed to deliver its services in line with the funding available as the NHS moves into the second and subsequent phases of the response to Covid-19.

Robert Woolley
Chief Executive
23 June 2020

5.6 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, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts, and overseeing the use of public funds, 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 and disclose any material uncertainties over going concern.

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 them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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
23 June 2020

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 2020 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.

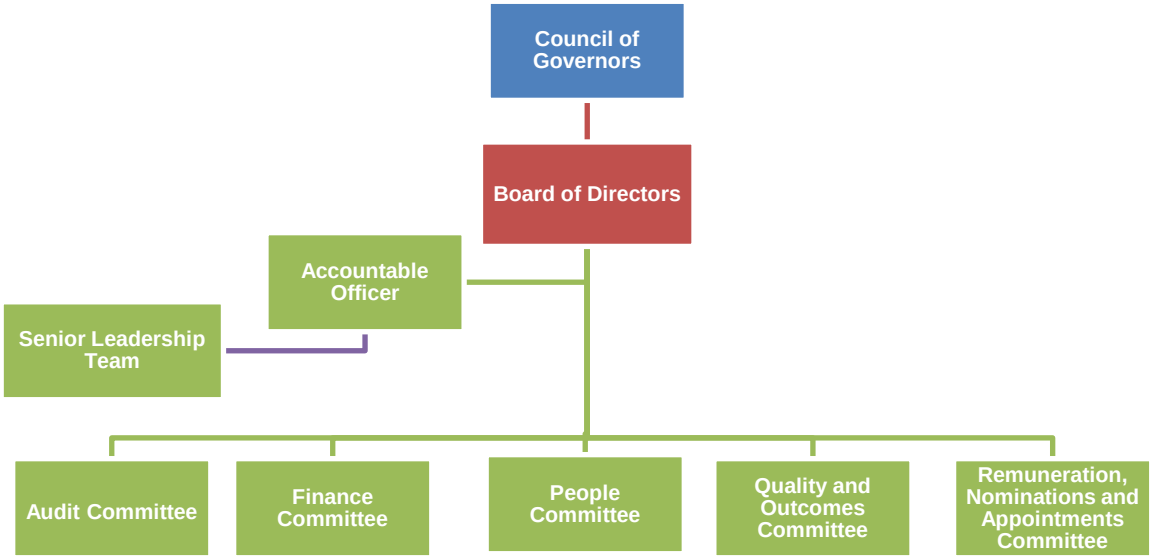
The Board committee structure is detailed earlier in the annual report and summarised below.

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 50: 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 Trust's 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 reviewed on an ongoing basis as opportunities for improvement are identified, and no less than once every three years, 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 risks are reviewed by one of the Board assurance committees.

At The Trust, 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 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 (ASW Assurance) 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.

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 2019/20 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.
- 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.

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 The Trust 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 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 Trust is fully compliant with the registration requirements of the Care Quality Commission and is currently rated as 'Outstanding'.

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve 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.

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

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

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its 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 Director of Finance and Information, 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 2019/20 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. Specific sessions have been arranged by NHS Digital and the National Cyber Security Centre for senior staff.
- 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.

- Confidential waste bins have been provided to all areas of the Trust to ensure paper records can be disposed of safely.
- 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. Significant work has been undertaken in creating and developing live monitoring dashboards for cyber security issues.
- 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 embedding the Information Asset Ownership model to ensure responsibility and accountability for all of our data is assigned and understood. This work has been essential in preparing the way for integration with Weston Area Health NHS Trust and we have been working closely with colleagues over there to ensure that all appropriate safeguards to data remain in place after the merger.

Four cases recorded in the Information Governance Incident Reporting Tool were reported to the Information Commissioner's Office in 2019/20. The details are provided in the following table.

Table 51: Incidents reported to the Information Commissioner's Office 2019/20

Date of Incident	Incident description	Number affected	How individuals were informed	Lessons Learned
July 2019	A clinician emailed a spreadsheet containing the information of 30,000 patients to their personal email account.	30,000	No risks to the rights and freedoms of the individuals, they were not informed.	Improved the secure transfer messages in annual Information Governance training. No further action recommended by the ICO.
July 2019	A system supplier had misconfigured their system which allowed patient records at a specific site to be viewed by clinicians at any site using the same system.	6,840	No risks to the rights and freedoms of the individuals, they were not informed.	The system supplier has improved their testing processes to prevent reoccurrence. No further action recommended by the ICO.
October 2019	Misfiled records were released to the family of a patient in response to a Subject Access Request.	2	Patient whose records were misfiled was contacted by a senior clinician.	A tertiary check for misfiled records was introduced before sending records. Electronic documentation configuration will be checked to ensure demographics populate correctly. No further action recommended by the ICO.
February 2020	Clinic outcome for a patient was sent to another patient incorrectly.	2	Patient informed by a senior clinician.	Improve training for staff involved in dictating and sending clinic outcome letters. No further action recommended by the ICO.

5.7.8 Data Quality and Governance

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. NHSEI issues 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. For 2019/2020, in view of the Covid-19 outbreak, foundation trusts are not required to produce Quality Reports, however there is still an expectation that Quality Accounts will be submitted, albeit to a delayed timescale.

The annual Quality Account provides 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 Account follows prescribed guidance from NHSEI; 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 annual Quality Account 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. Data included in the annual Quality Account is cross-referenced for accuracy with quality and performance data reported to the board during the previous year.

Our assurance that the Quality Account presents a balance view comes in part from the fact that the published document 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 perform a series of data quality checks prior to publication. The NHSEI's Intensive Support Team (IST) has reviewed our processes and is satisfied with our approach to reporting waiting times.

5.7.9 Significant Internal Control Issues

No significant internal control issues have been identified during the year.

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.

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 reviewed and updated its Board Development Plan for 2019/20 to cover the suggested topics. The Board Development plan was delivered through 2019/20 as planned. The Trust will undertake a further external review against the Well-led Framework in 2021/22 in line with the NHS Code of Governance.

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 that have responsibility for the development and maintenance of the internal control framework. I have drawn on the 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 2019/20 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 2019/20 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.

Robert Woolley
Chief Executive
23 June 2020

Appendix A – Biographies of Members of the Board of Directors

Jeff Farrar – Chairman

Prior to joining the Trust, Jeff 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 Remunerations Committee. He is a former 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 was appointed Chief Executive of University Hospitals Bristol NHS Foundation Trust in 2010, having served on the Trust Board since 2002. In 2019, the Trust became only the third general acute provider in England to be rated Outstanding twice by the Care Quality Commission in successive inspections. He also held the Chief Executive post at Weston Area Health NHS Trust from 2019, in anticipation of the merger of the two Trusts.

Before becoming Chief Executive, Robert was Director of Performance Management at United Bristol Healthcare Trust, and took the Strategy Director portfolio there in 2005, leading the creation of the 10 year plan which committed £200 million of strategic investment. He was project director for the Trust's successful application for Foundation status in 2008. Before moving to Bristol, he spent nine years at Barts Health NHS Trust in a range of planning and operational roles.

Robert is co-Executive Lead for Healthier Together, the Sustainability and Transformation Partnership for the Bristol, North Somerset and South Gloucestershire health and care system.

He holds an English degree from Lincoln College, Oxford, an MBA with distinction from the University of Bath and an honorary doctorate of laws from the University of the West of England (Bristol).

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 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 of 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.

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 has 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.

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. Prior to joining the Trust, 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 30 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 12 years' experience at Board level, including serving as the interim chief executive of Southern Health and Social Care Trust in 2015/16.

Paula has extensive experience in integrated care delivery, strategic planning, continuous improvement, partnership working and service transformation programmes.

Matthew Joint – Director of People

Matthew 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 for 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.

Neil Kemsley - Director of Finance and Information

Neil trained and qualified at The Trust before leaving in 1998 to progress his career through the finance ranks at University College London hospitals, Kings and then Portsmouth.

Neil has over 12 years' experience as a Board director working across the provider, commissioning and regulatory sectors of the NHS.

More recently he spent three-and-a-half years at University Hospitals Plymouth NHS Trust before returning to Bristol.

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, and retired from this position in July 2019. Paul served on the Finance Committee of the Board.

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. Martin is chair of the Finance Committee and vice chair of the Board.

Julian Dennis – Non-executive Director

A company director and public health scientist, Julian worked for the Public Health Laboratory Service at Porton Down before joining Thames Water. He was appointed a director of United Kingdom Water Industry Research Limited in 2003 before joining the board of Wessex Water as director of environment and science in 2004. He is also an adviser to The Quality and Environment committee of Welsh Water. Julian chairs the Quality and Outcomes Committee and is the Senior Independent Director (SID) on the Board.

Bernard Galton – Non-executive Director

Bernard has had a long and successful Civil Service career with 28 years in the Ministry of Defence, and 10 years in the Welsh Government. He retired in 2014 from his role as director general. With more than 20 years executive Board experience he has complemented this with non-executive directorships in the Royal National Mineral Hospital for Rheumatic Diseases Foundation Trust, Capita Property Services in Wales, and he is currently a non-executive director of the Board of Oxford Health NHS Foundation Trust. Whilst in the Welsh Government, Bernard led a large corporate services department spanning human resources, learning and development, information services, property, facilities, health and safety and security. He was head of profession for human resources and organisation development for all Public Service organisations in Wales, and also worked at the highest level in NHS Wales gaining an understanding of the key strategic issues facing health and social care services. He is a Chartered member of the Chartered Institute of Personnel and Development, and lives in Bath. Bernard is chair of the People Committee.

David Armstrong – Non-executive Director

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 Chartered Quality Institute and a Chartered Quality

Professional, and was a Chartered Engineer and Fellow of the Institute of Engineering and Technology from 2005-2019. David is chair of the Audit Committee.

Anthony (Guy) Orpen – Non-executive Director

Guy is the Deputy Vice-Chancellor, New Campus Development of the University of Bristol. 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 Bristol Green Capital Partnership CIC and a Board member of the Bristol Chamber of Commerce and Initiative.

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) of the University of Bristol.

Steven West – Non-executive Director

Steve took up the post of Vice-Chancellor and President of the University of the West of England Bristol in 2008. Steve trained as a podiatrist and podiatric surgeon in London and developed his research interests in lower limb biomechanics and the diabetic foot at King's College London. He worked as a clinician and clinical tutor in the NHS, university sector and undertook research and consultancy in industry and the retail healthcare sectors. He holds a number of national and international advisory appointments in higher education and in his clinical discipline, healthcare policy and practice. He is Non-executive Director for the Office for Students and chair of the UUK Mental Health in Higher Education Working Group. He is also a member of both the Education and the Diversity Honours Committees. He is chair of the West of England Local Enterprise Partnership (LEP) and chair of the West of England Academic Health Science Network (WEAHSN). Steve is a Deputy Lieutenant for the County of Gloucestershire and 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.

Jayne Mee – Non-executive Director

Jayne has spent more than 30 years in human resources and organisational development, working in executive roles with the Boots Company, Whitbread, Royal Mail, Punch Taverns and Barratt Developments. Until June 2015 she was director of people and organisation development at Imperial College Healthcare NHS Trust. Jayne runs executive coaching consultancy Calabash Ltd where she supports executives and organisations in culture change, engagement and transformation in a wide variety of private and public sector businesses. She is a Non-executive Director at London Ambulance Service NHS Trust, and a trustee at St John Ambulance and a Member of the Order of St John. Jayne is also HR counsel at private equity backed restaurant chain Prezzo. Jayne holds an MSc in human resource development from Nottingham Trent University, a certificate in coaching from Henley Management College and is a Fellow of the Institute of Personnel and Development.

Sue Balcombe – Non-executive Director

Sue is a registered nurse with more than 35 years' experience within the NHS and significant NHS board experience at an executive level. In 2005 she was Director of Nursing at Taunton Deane Primary Care Trust followed by Chief Nurse at Somerset Community Health. Following a merger and acquisition in 2015 she became Chief Nurse at Somerset Partnership NHS Foundation Trust bringing together community and mental health services within an integrated trust. Sue has extensive and varied clinical experience principally in urgent and emergency care and community care, assuming leadership roles in each. She brings significant experience in service integration and system redesign having played a clinical leadership role within Somerset STP prior to her retirement in 2018. Prior to joining the Board Sue was a Non-executive Director at Weston Area Health NHS Trust and a non-executive director (designate) at University Hospitals Bristol NHS Foundation Trust.

Madhu Bhabuta – Non-executive Director (Designate)

Madhu holds a 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 (CIO) 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 start-up she founded in 2018.

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. His third term of office ended on 31 December 2019 at which point he stood down as a Non-executive Director. 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.

Appendix B – Contact Details

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

Director of Corporate Governance
University Hospitals Bristol and Weston NHS Foundation Trust
Trust Headquarters
Marlborough Street
BRISTOL
BS1 3NU

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

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

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

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

Appendix C – Annual Accounts 2019/20

University Hospitals Bristol
NHS Foundation Trust

Accounts for the year ended 31 March 2020

Neil Kemsley
Director of Finance and Information

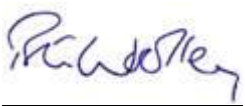
Finance Department
Trust Headquarters
Marlborough Street
PO Box 3214
BRISTOL BS1 9JR

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Accounts for the year ended 31 March 2020

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2020 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 23 June 2020

Statement of Comprehensive Income for the year ended 31 March 2020

	Note	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Income from patient care activities	3	649,105	591,126
Other operating income	4	113,510	127,407
Operating expenses	5-6	(740,895)	(677,307)
OPERATING SURPLUS/(DEFICIT)		**21,720**	**41,226**
Finance income	8.1	842	598
Finance expenses	8.2	(2,517)	(2,732)
Public dividend capital dividends payable		(9,423)	(8,917)
NET FINANCE COSTS		**(11,098)**	**(11,051)**
Other gains/(losses)		(64)	(107)
SURPLUS/(DEFICIT) FOR THE YEAR		**10,558**	**30,068**
OTHER COMPREHENSIVE INCOME/(EXPENDITURE)			
Will not be reclassified to income and expenditure			
Revaluations	10	10,424	15,699
TOTAL COMPREHENSIVE INCOME/(EXPENDITURE) FOR THE YEAR		**20,982**	**45,767**

ADJUSTED FINANCIAL PERFORMANCE		
Surplus / (deficit) for the year	*10,558*	*30,068*
Adjustment in respect of capital donations	*(627)*	*301*
Adjustment in respect of net impairments	*3,669*	*(515)*
Remove impact of prior year PSF, post accounts	*(710)*	*-*
Adjusted financial performance	***12,890***	***29,854***

The Trust's financial performance is reported to NHS England / 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 6-38 form part of these accounts

.

Statement of Financial Position as at 31 March 2020

	Note	31 March 2020	31 March 2019
		£000	£000
NON CURRENT ASSETS			
Intangible assets	9	14,099	14,976
Property, plant and equipment	10	401,180	383,734
Receivables	12.1	1,094	-
TOTAL NON CURRENT ASSETS		**416,373**	**398,710**
CURRENT ASSETS			
Inventories	11	11,724	11,406
Receivables	12.2	51,111	68,505
Other financial assets	13	104	104
Cash and cash equivalents	18	129,840	99,855
TOTAL CURRENT ASSETS		**192,779**	**179,870**
CURRENT LIABILITIES			
Trade and other payables	14	(88,282)	(83,225)
Borrowings	16.1	(6,839)	(6,859)
Provisions	17	(814)	(184)
Other liabilities	15	(6,098)	(5,311)
TOTAL CURRENT LIABILITIES		**(102,033)**	**(95,579)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**507,119**	**483,001**
NON CURRENT LIABILITIES			
Borrowings	16.2	(62,336)	(68,551)
Provisions	17	(1,273)	(212)
TOTAL NON CURRENT LIABILITIES		**(63,609)**	**(68,763)**
TOTAL ASSETS EMPLOYED		**443,510**	**414,238**
EQUITY			
Public dividend capital		216,046	207,756
Revaluation reserve		63,753	55,295
Other reserves		85	85
Income and expenditure reserve		163,626	151,102
TOTAL EQUITY		**443,510**	**414,238**

The accounts on pages 2 to 38 were approved by the Board on 23 June 2020 and signed on its behalf by:

Signed 

Robert Woolley, Chief Executive

Date: 23 June 2020

Statement of Changes in Equity for the year ended 31 March 2020

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 2019	207,756	55,295	85	151,102	414,238
Surplus/(deficit) for the year	-	-	-	10,558	10,558
Revaluations on property plant and equipment and intangible assets	-	10,424	-	-	10,424
Transfers between reserves	-	(1,966)	-	1,966	-
PDC Received	8,290	-	-	-	8,290
Equity at 31 March 2020	**216,046**	**63,753**	**85**	**163,626**	**443,510**

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 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**

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 and Social Care 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 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 2020

	Note	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus/(deficit) from continuing operations		21,720	41,226
OPERATING SURPLUS/(DEFICIT)		**21,720**	**41,226**
NON CASH INCOME AND EXPENDITURE			
Depreciation and amortisation	9-10	25,861	24,904
Net impairments	8.3	3,669	(515)
Income recognised in respect of capital donations		(2,266)	(1,279)
(Increase)/decrease in trade and other receivables	12	16,341	(18,150)
(Increase)/decrease in inventories	11	(318)	2,084
Increase/(decrease) in trade and other payables	14	4,566	15,293
Increase/(decrease) in other liabilities	15	787	(607)
Increase/(decrease) in provisions	17	1,691	(48)
Other movements in operating cash flows		1	(82)
NET CASH GENERATED FROM OPERATIONS		**72,052**	**62,826**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		842	579
Purchase of property, plant and equipment	10	(33,718)	(20,473)
Purchase of intangible assets	9	(1,411)	(1,931)
Receipt of cash donations to purchase capital assets		2,260	1,279
Sales of property plant and equipment		-	101
NET CASH USED IN INVESTING ACTIVITIES		**(32,027)**	**(20,445)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		8,290	4,106
Loans repaid to the Department of Health and Social Care		(5,834)	(5,834)
Capital element of finance lease rental payments		(357)	(333)
Interest paid		(2,343)	(2,557)
Interest element of finance leases		(218)	(246)
PDC dividend paid		(9,578)	(8,754)
NET CASH GENERATED/(USED) IN FINANCING ACTIVITIES		**(10,040)**	**(13,618)**
INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**29,985**	**28,763**
CASH AND CASH EQUIVALENTS AT START OF YEAR	18	**99,855**	**71,092**
CASH AND CASH EQUIVALENTS AT END OF YEAR	18	**129,840**	**99,855**

Notes to the Accounts

1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care 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 2019/20 issued by the Department of Health and Social Care. 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 DHSC 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.

The Trust acquired Weston Area Health Trust on 01 April 2020. Detailed financial assessments in respect of this transaction evidenced a sufficient level of working capital to support the going concern basis.

In light of the Covid-19 pandemic the Trust undertook a further detailed financial assessment considering the impact of changes to the financial regime for NHS Trusts and applying sensitivity analysis. This provided assurance that the Trust's cashflow was sufficient to support its services for the 12 months from the date of signing of these accounts.

After considering both of the above and making appropriate enquiries the directors have a reasonable expectation that University Hospitals Bristol and Weston 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

In the application of IFRS 15 a number of practical expedients offered in the Standard

have been employed. These are as follows;

- The Trust does 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 the Standard where the right to consideration corresponds directly with value of the performance completed to date.

Revenue from Contracts with customers

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. 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. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the Trust accrues

income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue

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 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 is based on the values notified by NHS England/Improvement This value is indicative and the final amount receivable by the Trust will be notified by NHS England/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 that 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.

Apprenticeship Levy

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

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 the end of the year is 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 is used to calculate the total number of hours owed to all staff in post at the end of the year. An average hourly cost is applied to each staff group to calculate the cost of annual leave owed. Due to Covid-19, the 2019/20 data to support the calculation was not received from all areas sampled. The Trust retained the same cost as the prior year.

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 the consideration payable. 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	9 years	48 years
Dwellings	16 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.

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 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash and bank balances are recorded at current values.

1.12 Financial Assets and Financial Liabilities

Financial assets and financial liabilities are recognised when the Trust becomes party to the contractual provision, or in the case of trade payable and receivables, when the goods or services have been received and delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

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 into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

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 other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1). HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trusts does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. For other 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.

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 -0.50% (0.29% 2019/20) in real terms. All general provisions are subject to separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

Expected cash outflows	Years	HMT real rate (%)	
		2019/20	2018/19
Short term	1-5	0.51	0.54
Medium term	6-10	0.55	1.13
Long term	10 or more	1.99	1.99

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 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but disclosed in note 21, 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 the Trust not been

bearing its 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 2019/20. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2021/22, 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*	Effective 1 April 2021 as adapted and interpreted by the FReM
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.

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the re-measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

The Trust has not adopted any new accounting standards, amendments or interpretations early.

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.

In March 2020 the Royal Institute of Chartered Surveyors (RICS), the body setting the standards for property valuations, issued guidance to valuers highlighting the uncertain impact of Covid-19 on markets which might cause a valuer to conclude there is a material uncertainty.

The Trust's valuers, the Valuation Office, opinion on the potential impact is that for specialised assets it is too early for Covid-19 related issues to impact on BCIS indices as adopted in the valuations and for non-specialised assets that at the date of valuation, on the information available, the impact falls within normal valuation tolerances.

The Valuer recommended that as further market evidence comes available the full extent of the Covid-19 impact will become clearer and that a future impairment review should be considered.

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, the Trust usually make an estimate for the accounts.

Normally the Trust's planned approach to this estimate for month 12 was to use forecast outturn at month 11 as an initial estimate, and then where month 12 interim activity data was available prior to closing the month 12 position this would be reviewed to assess whether changes were required. Where the assessment was deemed significant the estimates would be replaced with the actual data and the commissioners notified of the changes.

However, as a result of Covid-19 this approach could not be applied due to the significant changes to services and activity. As per the national guidance, the Trust worked with the host commissioners to reach an appropriate year end settlement and agreed month 11 forecast would be used as the fixed and final position.

e) Partially completed spells

This is an estimate of income due in relation to patients admitted before the year end, but not discharged.

Normally, the Trust's agreed method of calculating partially completed spells is to calculate 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.

However, for 2019/20, as a result of Covid-19, this approach could not be applied due to the significant changes to services and activity. The Trust agreed with host commissioners to use the 2018/19 partially completed spells estimate for 2019/20 as this would provide certainty and minimise the financial impact.

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.

Normally, the Trust's agreed method of calculating partially completed spells, as applied in 2018/19, is to calculate 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 the end of 29th February 2020 used as a proxy, for month 12 activity.
- Using the ante natal booking date, calculate how many days of the ante natal period are likely to occur after the end of 29th February 2020.
- Value these days as a proportion of the pathway tariff.

However, as a result of Covid-19 this approach could not be applied due to the significant changes to services and activity. The Trust agreed with host commissioners to use the 2018/19 antenatal pathway estimate for 2019/20 as this would provide certainty and minimise the financial impact.

g) Inventories

The Trust usually undertakes inventory counts at year end date to verify the existence and price the inventory balances held throughout the Trust.

Due to Covid-19 the Trust were unable to undertake inventory counts at 31 March 2020. The inventory value was established through

- System reports for inventories managed on a stock system; (WellSky in pharmacy and MIS in theatres)
- Assessment undertaken by the divisional finance team of inventory movement against activity
- For immaterial balances no movement from prior year.

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 affected by restating each element of equity (reserves) at the start of the prior year as if the accounting policy had always applied.

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 affected 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 2019/20 is shown below with comparator figures for 2018/19.

	Year Ended 31 March 2020 £000	Year Ended 31 March 2019 £000
Corporate income (excluding Provider Sustainability Funding (PSF))	658,757	624,974
Net Expenditure		
Diagnostic and Therapies	(60,864)	(57,031)
Medicine	(91,794)	(91,061)
Specialised Services	(119,827)	(114,230)
Surgery	(127,823)	(117,373)
Women's and Children's	(143,909)	(133,533)
Facilities and Estates	(41,292)	(40,191)
Trust Services	(32,886)	(29,308)
Corporate Services	(2,373)	(3,390)
Total net expenditure	(620,768)	(586,117)
Earnings before Interest, Tax, Depreciation & Amortisation	**37,989**	**38,857**
Financing costs	(35,321)	(34,375)
Net surplus before PSF and technical accounting adjustments	**2,668**	**4,482**
Provider Sustainability Funding	10,222	25,372
Net surplus before technical accounting adjustments reported to NHS Improvement	**12,890**	**29,854**
Prior Year PSF received in year	710	-
Technical accounting adjustments		
Donations received for Property Plant and Equipment	2,266	1,279
Depreciation on donated assets	(1,639)	(1,580)
Impairment charge when assets brought into use	(2,111)	-
Impairment (charge) / reversal from revaluation	(1,558)	515
Total Technical accounting adjustments	(2,332)	214
Surplus/(deficit) for year	**10,558**	**30,068**

3. Income from patient care activities

3.1 Income by nature

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Elective income	100,198	102,493
Non elective income	149,832	136,530
First outpatient income	34,835	34,954
Follow up outpatient income	47,475	46,686
Accident and emergency income	23,768	19,805
High cost drug income from commissioners	77,571	68,130
Other NHS clinical income *(see significant items below)*	184,064	165,642
Private patients	1,708	1,201
Agenda for Change pay award central funding *(Note 1)*	-	5,792
Additional Pension contribution central funding *(Note 2)*	18,415	-
Other clinical income	11,239	9,893
Total	**649,105**	**591,126**
Other NHS Clinical Income - Significant items include:		
Critical care bed days	56,680	44,716
'Payment by results' exclusions	24,405	22,861
Bone marrow transplants	9,788	7,574
Radiotherapy inpatient treatments	8,448	7,579
Diagnostic imaging	6,771	6,243
Direct access	5,483	6,046
Rehabilitation	5,984	5,805
Audiology, Cochlear implants, bone anchored aids	6,353	8,000
Contract penalties and rewards	3,086	8,460
Cystic fibrosis pathways	5,787	5,208
Maternity pathways	7,825	6,938
'Soft' facilities management and LIFTCO	3,419	3,031
Bowel Cancer & Bowel Scope Screening	3,695	3,452
Chemotherapy Delivery	4,035	4,296
Community Dental	1,823	1,332
Retrievals	2,892	2,762
Genetic testing *(Note 3)*	2,033	-
Operational Resilience and Capacity *(Note 4)*	-	1,266

Note 1
Funding for national pay awards is normally met through inflationary increases to contract income. In 2018/19 the Agenda for Change pay award was notified after contracts were agreed and was therefore funded separately.

Note 2
On 01 April 2019 the employer's pension contribution increased from 14.3% to 20.6%; the 6.3% increase was centrally funded in year.

Note 3
Genetic testing is a new block contract service for 2019/20.

Note 4
Operational resilience and capacity was removed in 2019/20 as part of the review of local prices.

3.2 Income by source

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
NHS England	328,301	282,518
Clinical Commissioning Groups	291,972	275,728
NHS Foundation Trusts	163	168
NHS Trusts	2,459	2,611
Local Authorities	8,119	8,352
Department of Health and Social Care (Agenda for Change pay award)	-	5,792
Non-NHS private patients	1,709	1,201
Non-NHS overseas patients	769	466
NHS Injury Scheme	731	877
Territorial Bodies	14,882	13,413
Total	**649,105**	**591,126**

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, £608.8m (2018/19: £570.2m) is from Commissioner Requested Services and £40.3m (2018/19: £20.9m) is from all other services

3.4 Income from overseas visitors

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Income recognised this year	769	466
Cash payments received (invoices raised in this and previous years)	312	382
Increase to credit losses of receivables (invoices raised in this and previous year)	236	189
Amounts written off (invoices raised in this and previous years)	199	809

4. Other operating income

4.1 Other operating income

From contracts with customers

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Research and development	18,298	17,745
Education and training	35,870	34,890
Non-patient care services to other bodies	12,337	14,208
Provider Sustainability Fund	10,932	25,372
Salary recharges	7,738	6,870
Other**	14,776	16,093
Total	**99,951**	**115,178**

Other non-contract operating income	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Research and development	8,592	8,285
Donated assets – property plant and equipment (income and physical asset)	2,266	1,279
Education and training – from apprenticeship fund	216	96
Charitable and other contributions to operating expenditure	910	938
Rental income from operating leases	1,575	1,631
Total	**13,559**	**12,229**
Total recognised operating Income	**113,510**	**127,407**

**Significant items include:

	£000	£000
Clinical excellence awards	3,022	2,987
Trading services - MEMO	1,028	978
Trading services – Pharmacy	1,386	1,313
Trading services - IT	321	437
Global Digital Exemplar income	1,000	1,000
Insurance income	1,060	1,560
Clinical testing	472	468
Catering	1,124	568
Staff accommodation rentals	188	211
Car park income	953	1,022
Staff contribution to employee benefit schemes	945	1,248
Property rentals	29	39

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 recognised in the period

	NHS Providers	Other DHSC group bodies	Non DHSC group bodies	Total
	2019/20	2019/20	2019/20	2019/20
	£000	£000	£000	£000
Revenue recognised previously included in liability balance	8	2,006	3,026	5,040
	2018/19	2018/19	2018/19	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

	NHS Providers	Other DHSC group bodies	Non DHSC group bodies	Total
Revenue from contracts entered into but expected to be recognised:	**31 March 2020** **£000**	**31 March 2020** **£000**	**31 March 2020** **£000**	**31 March 2020** **£000**
- within one year	5	2,179	3,914	6,098
- after one year but not later than five years	-	-	-	-
- after five years	-	-	-	-
Revenue from contracts entered into but expected to be recognised:	**31 March 2019** **£000**	**31 March 2019** **£000**	**31 March 2019** **£000**	**31 March 2019** **£000**
- 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 2020 £000	Year ended 31 March 2019 £000
Rental income – minimum lease receipts	1,575	1,631

4.5 Future minimum lease receipts due to the Trust

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
- no later than one year	1,495	1,556
- between one and five years	1,618	1,638
- after five years	1,020	1,057
Total	**4,133**	**4,251**

5. Operating expenses

5.1 Operating expenses by type

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Services from other bodies:		
- NHS & DHSC bodies	11,681	11,574
- non NHS & non DHSC bodies	1,906	1,413
Purchase of healthcare from non NHS bodies	4,732	3,538
Employee expenses excluding Board members	452,207	407,058
Employee expenses – Board members	1,460	1,494
Trust chair and non-executive directors	193	199
Supplies and services: clinical	69,188	68,917
Supplies and services: general	7,615	7,040
Drug costs	96,245	87,326
Establishment costs	9,472	9,458
Premises costs – business rates	3,170	3,104
Premises costs - other	12,276	12,174
Transport – business travel	1,313	1,067
Transport – other (including patient travel)	1,607	1,302
Depreciation on property plant and equipment	22,389	22,436
Amortisation on intangible assets	3,472	2,468
Net Impairments	3,669	(515)
Movement in contract credit loss allowance	(1,496)	(2,967)
Auditor's remuneration - statutory audit	84	66
Auditor's remuneration – other non-audit services	2	10
Internal audit	468	266
Clinical negligence	13,762	11,224
Research and development – other	7,410	7,315
Research and development – hosting payments	6,878	7,091
Rentals under operating leases	6,883	6,702
Other**	4,309	7,547
Total	**740,895**	**677,307**

**Significant items include:

	£000	£000
Consultancy	435	836
Education and training	2,643	2,682
External contractors' services	59	85
Childcare vouchers	947	1,226
Legal fees	544	355
Parking and security	539	532
Insurance	318	272

5.2 Other auditor remuneration and limitation of auditor's liability

The other non-audit service remuneration in note 5.1 relates to the audit of the Quality Accounts.

There is a limitation of liability of £1 million in respect of external audit services unless unable to be limited by law.

5.3 Operating lease expenses

	Year ended 31 March 2020	Year ended 31 March 2019
Minimum lease payments	**£000**	**£000**
Land	34	25
Buildings	5,848	5,613
Plant and machinery	1,001	1,064
Total	**6,883**	**6,702**

Future minimum lease payments due under operating leases	**£000**	**£000**
Before one year	1,588	1,708
Between one and five years	4,313	2,971
After five years	5,249	4,004
Total	**11,150**	**8,683**

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 2020	Year ended 31 March 2019
	£000	**£000**
Salaries and wages	351,388	332,064
Social security costs	32,237	30,019
Apprenticeship levy	1,691	1,588
Pension costs – employer contributions	42,258	39,237
Pension costs – employer contribution funded by NHSE	18,415	-
Termination benefits	45	182
Temporary staff - agency/contract staff	11,816	9,075
Gross employee expenses	**457,850**	**412,165**
Income in respect of salary recharges netted off	(3,206)	(2,932)
Employee expenses capitalised	(977)	(681)
Net employee expenses	**453,667**	**408,552**

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 and Social Care 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 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 to 20.6%, and the Scheme Regulations were amended accordingly.

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.

6.3 Early retirements due to ill health

During the year ended 31 March 2020 there were no early retirements from the Trust on the grounds of ill health (2018/19: 4 with estimated additional pension liabilities of these ill-health retirements of £0.164m). 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 £0.064m (2018/19: net loss of £0.107m) 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 2020 £000	Year ended 31 March 2019 £000
Interest on bank account and National Loan Fund Investments	842	598
Total	**842**	**598**

8.2 Finance expenses

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Loan interest on DHSC capital loans	2,299	2,490
Finance leases	218	242
Total	**2,517**	**2,732**

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 2020 £000	Year ended 31 March 2019 £000
Impairment of enhancements to existing assets	2,110	-
Changes in valuation	2,290	408
Reversal of impairments from change in valuation	(731)	(923)
Total	**3,669**	**(515)**

Property impairments occur when the carrying amounts are reviewed by the Valuation Office 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 2020 £000	Year ended 31 March 2019 £000
Impairment of enhancements to existing assets		
Myrtle Road	2,110	-
	2,110	**-**
Change in valuation		
Valuation Office's revaluation of land & buildings	1,559	(515)
Total	**3,669**	**(515)**

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 2019	23,324	1,421	24,745
Additions – purchased	1,230	787	2,017
Additions – donated	25	-	25
Reclassifications with PPE	560	-	560
Disposals	(256)	-	(256)
Cost at 31 March 2020	**24,883**	**2,208**	**27,091**
Accumulated amortisation at 1 April 2019	9,769	-	9,769
Charged during the year – purchased	3,444	-	3,444
Charged during the year – donated	28	-	28
Disposals	(249)	-	(249)
Accumulated amortisation at 31 March 2020	**12,992**	**-**	**12,992**
Net book value at 31 March 2020			
Purchased	11,790	2,208	13,998
Donated	101	-	101
Total net book value at 31 March 2020	**11,891**	**2,208**	**14,099**

	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**

10. Property, plant and equipment

The Valuation Office undertook a desktop exercise at the 31 March 2020 which valued the Trust's land and buildings on a depreciated replacement cost, Modern Equivalent Asset valuation (MEA). The last full valuation was undertaken at 31.03.19 (2019/20). The valuation resulted in a net increase at 31 March 2020 of £8.865m compared to the book values with £1.559m charged to the Statement of Comprehensive Income as a net impairment and £10.424m 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 Group Accounting Manuel (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

Covid-19 impact on valuations

On the 18 March 2020 the Royal Institute of Chartered Surveyors (RICS), the body setting the standards for property valuations, issued guidance to valuers highlighting the uncertain impact of Covid-19 on markets which might cause a valuer to conclude there is a material uncertainty.

On the 17 April 2020 the Trust's valuer, the Valuation Office, set out their opinion on the potential impact on the Trust's asset categories in a supplementary letter to the final desktop revaluation report. The Valuation Office's opinion on the potential impact on the Trust's relevant asset categories is that for specialised assets it is too early for Covid-19 related issues to impact on BCIS indices and adopted in the valuations and for non-specialised assets that at the date of valuation on the information available the impact falls within normal valuation tolerances.

The Valuer recommended that as further market evidence comes available the full extent of the Covid-19 impact will become clearer and that a future impairment review should be considered. The Trust will commit to review the need for and timing of a future impairment review in line with NHSE/I guidance and the Valuation Office's professional advice.

Notes to the Accounts

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2019	**25,900**	**303,796**	**2,405**	**10,214**	**91,140**	**780**	**20,560**	**1,012**	**455,807**
Additions – purchased	190	2,999	-	21,739	5,165	78	1,768	-	**31,939**
Additions – donated	-	18	-	223	1,518	-	-	-	**1,759**
Impairments	-	(2,110)	-	-	-	-	-	-	**(2,110)**
Reclassifications with intangibles	-	-	-	(560)	-	-	-	-	**(560)**
Reclassifications within PPE	-	10,764	-	(17,293)	4,113	-	2,416	-	**-**
Revaluations	155	(3,039)	45	-	-	-	-	-	**(2,839)**
Disposals	-	-	-	-	(8,701)	(51)	(267)	(321)	**(9,340)**
Cost or valuation at 31 March 2020	26,245	312,428	2,450	14,323	93,235	807	24,477	691	**474,656**
Accumulated depreciation at 1 April 2019	-	-	-	-	59,023	441	11,652	957	**72,073**
Charged during the year – purchased	-	10,969	120	-	6,234	69	3,361	26	**20,779**
Charged during the year – donated	-	615	-	-	953	8	34	-	**1,610**
Revaluations	-	(11,584)	(120)	-	-	-	-	-	**(11,704)**
Disposals	-	-	-	-	(8,644)	(50)	(267)	(321)	**(9,282)**
At 31 March 2020	-	-	-	-	57,566	468	14,780	662	**73,476**
Net book value at 31 March 2020									
Purchased	26,245	290,082	2,450	14,323	30,203	307	9,577	29	**373,216**
Donated	-	15,696	-	-	5,466	32	120	-	**21,314**
Finance leases	-	6,650	-	-	-	-	-	-	**6,650**
Total at 31 March 2020	**26,245**	**312,428**	**2,450**	**14,323**	**35,669**	**339**	**9,697**	**29**	**401,180**

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £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**

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 2020 £000	Year ended 31 March 2019 £000
Cost or valuation at 1 April	6,721	6,581
Additions	188	35
Revaluation	(188)	105
Reclassifications	-	-
Cost or valuation at 31 March	**6,721**	**6,721**
Accumulated depreciation at 1 April	70	67
Provided during the year	744	596
Revaluation	(743)	(593)
Accumulated depreciation at 31 March	**71**	**70**
Net book value at 31 March	**6,650**	**6,651**

10.2 Net book value of land building and dwellings

The net book value of land, buildings and dwellings comprises:

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Freehold	334,473	325,451
Long leasehold	6,650	6,650
Total	**341,123**	**332,101**

11. Inventories

The Trust usually undertakes inventory counts at the year-end date to verify the existence and to price the inventory balances held throughout the Trust. Due to the Covid-19 pandemic the Trust were unable to undertake inventory counts at 31 March 2020 and therefore the inventory value was established through;

- System reports for inventories controlled by a stock management system; (WellSky – pharmacy £4.4m, MIS – theatres £1.7m and materials management - £0.3m)
- Assessment undertaken by the divisional finance team of inventory movement against activity
- For immaterial balances no movement from prior year.

Year ended 31 March 2020	Drugs £000	Consumables £000	Energy £000	Totals £000
Carrying value at 1 April 2019	4,021	7,234	151	11,406
Additions	67,080	49,906	81	117,067
Consumed – recognised in expenses	(66,688)	(49,964)	(97)	(116,749)
Carrying value at 31 March 2020	**4,413**	**7,176**	**135**	**11,724**

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
Consumed – recognised in expenses	(58,385)	(50,283)	(29)	(108,697)
Carrying value at 31 March 2019	**4,021**	**7,234**	**151**	**11,406**

12. Receivables

12.1 Non-Current Contract and other receivables

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Clinical pension tax provision reimbursement funding from NHSE	1,094	-

12.2 Current Contract and other receivables

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
NHS contract receivables	27,025	31,198
Other contract receivables	10,078	7,387
VAT receivable	453	952
Allowance for credit losses	(5,435)	(6,976)
PDC Dividend receivable	41	-
Prepayments	3,852	2,336
Contract receivable not yet invoiced	14,432	33,608
Clinical pension tax provision reimbursement funding from NHSE	665	-
Total current:	**51,111**	**68,505**

12.3 Allowance for credit losses

	Year ended 31 March 2020 £000
Allowance as at 1 April 2019	**6,976**
Changes in existing allowances	(1,496)
Utilisation of allowances	(45)
Balance at end of year	**5,435**

	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**

13. Other financial assets

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £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 2020 £000	Year ended 31 March 2019 £000
Current amounts:		
NHS payables – revenue	14,930	18,267
Amounts due to related parties – revenue	6,092	5,585
Other payables – revenue	21,692	19,533
Capital payables	5,853	5,248
Tax and social security	9,282	8,544
PDC dividend payable	-	114
Accruals	30,433	25,934
Total	**88,282**	**83,225**

Non-current amounts:
There are no non-current trade and other payables in either year.

Outstanding pension contributions of £6.0m (2018/19: £5.6m) to the NHS Pension scheme and £0.1m (2018/19: £0.1m) for National Employment Savings trust (NEST) local pensions are included in amounts due to related parties. PAYE of £4.3m (2018/19: £3.9m) and £5.1m National Insurance (2018/19: £4.6m) are included in tax and social security.

15. Other liabilities

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Current liabilities:		
Deferred income – contract liability	6,098	5,311
Total	**6,098**	**5,311**

16. Borrowings

16.1 Current borrowings:

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Capital loans from Department of Health and Social Care	6,458	6,502
Finance lease obligations	381	357
Total	**6,839**	**6,859**

16.2 Non-current borrowings:

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Loans from Department of Health and Social Care	58,757	64,591
Finance lease obligations	3,579	3,960
Total	**62,336**	**68,551**

16.3 Borrowing rates and repayments

The Trust has three loans with the Department of Health and Social Care for the capital investment purposes

Amount borrowed	Interest Rate	Final repayment date
£20m	2.65%	June 2029
£70m	3.71%	June 2031
£5m	1.73%	March 2032

16.4 Finance lease obligations

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Payable:		
Before one year	575	575
Between one and five years	2,300	2,300
After five years	1,965	2,539
Sub-total	**4,840**	**5,414**
Less finance charges allocated to future years	(880)	(1,097)
Net lease liabilities	**3,960**	**4,317**

The finance lease arrangement relates to buildings comprising the Education Centre which will expire in September 2028.

16.5 Net finance lease obligations

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Payable:		
Before one year	381	357
Between one and five years	1,766	1,669
After five years	1,813	2,291
Net obligation	**3,960**	**4,317**

16.6 Reconciliation of liabilities arising from financing activities

	DHSC Loans £000	Finance Lease £000	Total £000
Carrying Value at 01 April 2019	71,093	4,317	75,410
Cash Movements			
Principal	(5,834)	(357)	(6,191)
Interest	(2,343)	(218)	(2,561)
Non Cash Movements			
Interest Charge arising in year	2,299	218	2,517
Carrying Value at 31 March 2020	**65,215**	**3,960**	**69,175**

	DHSC Loans £000	Finance Lease £000	Total £000
Carrying Value at 01 April 2018	76,994	4,654	81,648
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 2020	Clinician Pension tax reimbursement £000	Pension Injury Benefits £000	Legal Claims £000	Total £000
At 01 April 2019	-	244	152	396
Arising during the year	1,759	-	51	1,810
Utilised during the year	-	(33)	(11)	(44)
Reversed unused	-	-	(75)	(75)
At 31 March 2020	**1,759**	**211**	**117**	**2,087**

Timing of economic outflow	Clinician Pension tax reimbursement £000	Pension Injury Benefit £000	Legal Claims £000	Total £000
Before one year	665	32	117	814
Between one and five years	331	179	-	510
After five years	763	-	-	763
Total	**1,759**	**211**	**117**	**2,087**

There are no other provisions.

Year ended 31 March 2019	Pension Injury Benefits £000	Legal Claims £000	Total £000
At 01 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**

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. The clinical pension tax reimbursement represent the arrangements NHS England has established where certain clinicians who incur annual allowance tax charges as a result of their continued membership of any NHS pension scheme in 2019/20 will be able to look to the NHS Pension Scheme to pay those tax charges under the Scheme Pays arrangements and will receive additional payments in the future to compensate for any reduction in such payments.

17.2 Clinical negligence

NHS Resolution has included a £330.5m provision in its accounts (2018/19: £290.8m) in respect of clinical negligence liabilities of the Trust.

18. Cash and cash equivalents

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Cash with the government banking service	129,680	99,729
Commercial bank and cash in hand	160	126
Total cash and cash equivalents	**129,840**	**99,855**

19. Capital commitments

Commitments for University Hospitals Bristol NHS Foundation Trust under capital expenditure contracts at 31 March 2020 are £10.4m (2018/19: £4.3m - £2.2m Intangible assets and £2.1m Property Plant and Equipment); £3.5m for Intangibles assets and £6.9m for Property Plant and Equipment.

20. Post Statement of Financial Position events

The Trust acquired Weston Area Health Trust on the 01 April 2020 and from this date is known as University Hospitals Bristol and Weston NHS Foundation Trust.

The impact of Covid-19 was felt by all NHS organisations at the very end of the 2019/20 financial year, with significant impact continuing into 2020/21. DHSC has initiated changes to provide stability and support to the wider NHS through additional revenue and capital funding being provided in 2019/20 which will continue in 2020/21. Aligned to this, the NHS has temporarily suspended the Payment by Results mechanism and for an initial period covering 1 April to 30 July 2020, has introduced block contract payments from commissioners along with a central 'top-up' payment from NHSE/I. No post balance sheet adjustments have been made to the financial statements as a result of the impact of Covid-19.

21. Contingencies

The Trust has no contingent assets at 31 March 2020 (2018/19: £nil).

The Trust has no material contingent liabilities at 31 March 2020. 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.

Notes to the Accounts

All bodies within the scope of Whole of Government Accounting are related parties to the Trust. This includes the Department of Health and Social Care and its associated departments. Such bodies where income or expenditure, or outstanding balances as at 31 March, exceeded £500,000 are listed below.

Related parties arising from Trust Board members:

	31 March 2020 (£m)		31 March 2019 (£m)		2019/20 (£m)		2018/19 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
University of Bristol	0.23	3.68	0.33	2.45	1.95	8.74	1.98	8.30
University of the West of England	0.07	0.08	0.07	0.11	0.48	0.70	0.50	0.55
Sirona Care and Health CIC	-	0.01	-	0.07	0.54	0.09	0.51	0.04
West of England Academic Health Sciences Network	-	-	-	-	-	-	0.03	-
Cardiff University	-	-	0.01	-	-	-	0.01	0.45
Care Quality Commission	-	-	-	-	-	-	-	0.14
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 2020 (£m)		31 March 2019 (£m)		2019/20 (£m)		2018/19 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Avon and Wiltshire Mental Health Partnership NHS Trust	-	-	-	-	0.66	0.68	0.70	0.79
Bristol City Council	-	-	-	-	8.47	3.27	8.84	-
Community Health Partnerships	-	0.81	-	3.24	-	4.46	-	5.51
Department of Health and Social Care	-	0.98	-	-	22.74	-	28.28	-
Department for Work and Pensions	-	-	-	-	0.72	-	0.88	-
Gloucestershire Hospitals NHS FT	-	0.50	-	-	-	3.23	-	3.14
Great Western Hospitals NHS FT	-	-	-	-	-	0.59	-	0.61
Health Education England	1.42	-	-	-	37.07	-	34.31	-
HM Revenue and Customs	-	9.28	0.95	8.54	-	36.32	-	31.61
NHS Bath and North East Somerset CCG	-	-	-	-	9.64	-	9.11	-
NHS Blood and Transplant	-	0.62	-	0.67	-	6.35	-	5.29
NHS Bristol, North Somerset and South Gloucestershire CCG	2.36	2.69	6.52	2.05	257.51	1.11	245.54	-
NHS Devon CCG (18/19 data consolidation of merged bodies)	0.72	-	-	-	2.34	-	2.48	-
NHS England - Central Specialised Commissioning Hub	-	-	-	-	-	-	0.76	-
NHS England - Core	4.95	-	15.39	-	13.97	-	25.67	-
NHS England - South West	-	-	16.00	4.82	22.98	-	22.96	-
NHS England - South West Commissioning Hub	16.98	-	12.51	-	284.72	-	259.73	-
NHS England - Wessex Commissioning Hub	2.36	-	0.82	-	7.27	-	4.35	-
NHS Gloucestershire CCG	-	-	-	-	4.19	-	4.83	-
NHS Kernow CCG	-	-	-	-	0.84	-	1.45	-
NHS Pension Scheme	-	0.70	-	-	-	60.62	-	39.21
NHS Property Services	-	-	-	0.67	-	-	-	-
NHS Resolution	-	-	-	-	-	13.75	-	11.25
NHS Somerset CCG	-	-	-	-	9.69	-	8.89	-
NHS South Devon and Torbay CCG	-	-	-	-	-	-	0.65	-
NHS Swindon CCG	-	-	-	-	1.00	-	0.98	-
NHS Wiltshire CCG	-	-	-	-	3.58	-	3.98	-
North Bristol NHS Trust	4.23	9.36	2.62	6.72	5.43	13.28	5.39	13.68
Northern Health and Social Care Trust (N. Ireland)	-	-	-	-	0.57	-	0.69	-
Public Health England (PHE)	-	-	-	-	-	3.75	-	3.44
Plymouth Hospitals NHS Trust	-	-	-	-	-	0.68	-	0.57
Royal Devon and Exeter Foundation Trust	-	-	-	-	-	1.54	-	1.35
Royal United Hospital Bath NHS Foundation Trust	0.66	-	0.83	-	0.82	1.86	0.94	1.72
Taunton & Somerset NHS Foundation Trust	-	-	-	-	0.64	-	0.72	-
Torbay and S Devon NHS Foundation Trust	-	-	-	-	-	0.68	-	-
Welsh Assembly Government	-	-	-	-	-	-	10.10	-
Welsh Health Bodies – Aneurin Bevan Local Health Board	-	-	-	-	0.88	-	0.73	-
Welsh Health Bodies – Cwm Taf LHB	-	-	-	-	12.72	-	10.10	-
Weston Area Health NHS Trust	1.01	0.55	2.41	1.45	5.68	2.14	5.10	2.45

In addition the Trust pays HM Revenue and Customs tax and national insurance on behalf of employees; £72.2m in 2019/20 (£68.7m in 2018/19). The Trust also pays the NHS Pension Scheme for employees' contributions which totalled £28.6m in 2019/20 (£26.4m in 2018/19).

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 2019 (£m)		2019/20 (£m)		2018/19 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Above and Beyond	1.68	-	0.28	-	1.90	0.29	1.16	0.30
Grand Appeal	0.02	-	0.02	-	0.27	-	0.42	-

23. Private Finance Initiative (PFI) transactions

At 31 March 2020 the Trust has no PFI schemes (31 March 2019: none).

24. Financial Instruments

24.1 Financial risk management

IFRS 7, 'Financial Instruments: Disclosures', requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities.

The Trust's activities expose it to a variety of financial risks: market risk (including interest rate risk, and foreign exchange risk), credit risk and liquidity risk. Risk management is carried out by the Trust's Treasury Management Department under policies approved by Trust Board.

a) Market risk

i. Interest-rate risk
All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only elements of the Trust's assets that are subject to variable rate are short-term cash investments. The Trust is not, exposed to significant interest-rate risk. These rates are reviewed regularly to maximise the return on cash investment.

ii. Foreign currency risk
The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the year in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

The Trust has negligible foreign currency income and expenditure.

b) Credit risk
Credit risk arises from cash and cash equivalents and deposits with financial institutions, as well as outstanding receivables and committed transactions. The Trust operates primarily within the NHS market

and receives the majority of its income from other NHS organisations. This means that there is little risk that one party will fail to discharge its obligation with the other. However disputes can arise, around how amounts are calculated, particularly due to the complex nature of the Payment by Results regime. For financial institutions, only independently rated parties with a minimum rating (Moody) of P-1 and A1 for short-term and long-term respectively are accepted.

c) Liquidity risk
The Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. Therefore the Trust has little exposure to liquidity risk. Loans are serviced from planned surpluses.

24.2 Carrying Value of Financial assets by category

	31 March 2020 £000	31 March 2019 £000
Receivables with DHSC group bodies	40,320	62,800
Receivables with other bodies	7,539	2,417
Other financial assets	104	104
Cash and cash equivalents	129,840	99,855
Total	**177,803**	**165,176**

Receivables are held at amortised cost.

Maturity of financial assets

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Less than one year	176,709	165,176
In more than one years but not more than five years	331	-
In more than five years	763	-
Total	**177,803**	**165,176**

24.3 Carrying Value of Financial liabilities by category

	31 March 2020 £000	31 March 2019 £000
DHSC Loans	65,215	71,093
Obligation under Finance lease	3,960	4,317
Trade and other payables with DHSC group bodies	15,825	20,010
Trade and other payables with other bodies	63,175	54,557
Total	**148,175**	**149,977**

Financial liabilities are held at amortised cost.

Maturity of financial liabilities

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Less than one year	85,839	81,426
In more than one year but not more than two years	6,240	6,215
In more than two years but not more than five years	18,864	18,791
In more than five years	37,232	43,545
Total	**148,175**	**149,977**

24.4 Fair values

At 31 March 2020 and 31 March 2019 there was no material difference between the fair value and the carrying value of the Trust's financial assets and liabilities. The fair value of non current liabilities is not considered to be materially different as the majority of the Trust's non-current liabilities are borrowings from Department of Health and Social Care which are at 3.7%, as per the Financial Instruments discount rate.

25. Third party assets

At 31 March 2020 the Trust held £nil (31 March 2019: £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:

	2019/20		2018/19	
	No.	£000	No.	£000
Cash losses	55	34	7	15
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	452	331	615	920
Stores losses incl. damage to buildings	1	272	2	382
Ex gratia payments	51	8	52	8
Severance payments	-	-	1	15
Total	**559**	**645**	**677**	**1,340**

The amounts reported are prepared on an accruals basis and exclude provisions for future losses.

Appendix D – Independent Auditor’s Report to the Board of Governors

Independent auditors' report to the Council of Governors of University Hospitals Bristol NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, University Hospitals Bristol NHS Foundation Trust's (the "Trust") financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2020 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 2019/20.

We have audited the financial statements, included within the Annual Report and Accounts 2019/20 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2020; 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; the adjusted financial performance 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 2020 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 apart from two key audit matters that were new this year. Firstly, this relates to assessing the financial sustainability of the enlarged organisation that was formed when the Trust acquired Weston Area Health NHS Trust on 1 April 2020 to form University Hospitals Bristol and Weston NHS Foundation Trust. Secondly, this relates to the impact of COVID-19 on the Trust.

Our audit also involved forming a conclusion on the arrangements for securing economy, efficiency and effectiveness in the use of resources (the "3 Es"), in accordance with the Code of Audit Practice.

Overview

- Overall materiality: £15,250k (2019: £14,390k) which represents 2% of total revenue.
- Total revenue is made up of operating income from patient care activities and other operating income per the Statement of Comprehensive Income.
- 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
- Financial sustainability
- COVID-19 – Trust and arrangements for securing economy, efficiency and effectiveness in its use of resources

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 the conclusion on the arrangements for securing economy, efficiency, and effectiveness in the use of resources, 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 - Trust *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 Provider Sustainability 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 2020/21 and to recognise income incurred in respect of 2020/21 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"). For 2019/20, as a result of COVID-19, this approach could not be applied due to the significant changes to services and activity. The Trust agreed with host commissioners to use the March 2019 estimate for March 2020 as this would provide certainty and minimise the financial impact. 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: Income from patient activities* 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 traced them to cash payments where the amounts had been settled. We performed completeness testing on the Trust's interface between the patient record system and financial ledger. *Revenue: Other operating income* We tested a sample of income transactions and traced these to invoices, contracts, and correspondence from other bodies. Our work did not identify any transactions or contracts that were indicative of manipulation in the timing of the recognition of income *Intra-NHS agreement of transactions and balances* To assist in addressing completeness for commissioners income (including NHS England) , 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. We noted no material differences. *Expenditure* We selected a sample of payments made by the Trust and invoices received during the two months 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 have been appropriately accounted for in accordance with the Trust's accounting policies. We traced provisions to supporting documentation to assess whether the amounts recorded were complete. *Journals* We focused our work on income and expenditure journals that are the most susceptible to manipulation. These were non-standard journal transactions, including those that credit non-NHS and other operating income and debit balance sheet accounts (other than for example accounts receivable and cash); and those that credit expenditure and debit balance sheet accounts (other than for example accounts payable). We selected a sample of manual and automated journal transactions that had been recognised in either income or expenditure focussing on non-standard journals as highlighted above. 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 - Trust

Management's accounting policies, key judgements and use of experts relating to the valuation of the Trust's estate are disclosed in note 1 to the financial statements. The Trust is regularly required to revalue its estate in line with the Department of Health and Social Care Group Accounting Manual.

Property, plant and equipment ("PPE") represents the largest asset balance in the Trust's statement of financial position, with a value of £401,180k. 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, buildings and dwellings as at 31 March 2020 is £341,123k.

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; and
- 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.

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2017 and RICS UK National Supplement commonly known together as the Red Book, the valuer has declared a 'material valuation uncertainty' in the valuation report as a result of COVID-19.

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 confirmed that they were independent of the Trust.

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. The land is valued on its location and industrial land values.

We considered the assumptions and methodology 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 the Trust's estate's teams records 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 assets.

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.

We checked the disclosures made in the financial statements. The valuer has highlighted that it is too early to assess the impact of COVID-19 on the valuation. We read the disclosures included in the accounts on the material uncertainty in notes 1 and 10.

Financial sustainability – Arrangements for securing economy, efficiency and effectiveness in its use of resources

The Department of Health and Social Care Group Accounting Manual 2019/20 requires that the financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of an NHS Foundation Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

The Trust's current year surplus is £10,558k, which includes Provider Sustainability Funding after meeting its control total target.

On 1 April 2020, the Trust acquired Weston Area Health NHS Trust to form University Hospitals Bristol and Weston NHS Foundation Trust.

In considering the financial performance of the Trust and the appropriateness of the going concern assumption in the preparation of the financial statements, we obtained the transaction business case as well as the Trust's cash flow forecasts until the end of March 2021. Management have subsequently then updated these further in light of COVID-19.

We performed the following procedures:

- we examined the impact of cash flow sensitivities and assessed these against the Trust's ability to meet its liabilities as they fall due; and
- we sensitised the assumptions behind the Trust's financial forecasts by comparing them to historical performance.

The Trust's forecasts demonstrate that there is sufficient funding available to meet its liabilities as they fall due.

COVID-19 – Trust and arrangements for securing economy, efficiency and effectiveness in its use of resources

During the course of the audit, both management and the engagement team considered the impact that the ongoing COVID-19 pandemic has had on the activities, suppliers and wider economy of the Trust and its financial statements.

Management's assessment is that no significant impact on outturn as operations only significantly changed in scope for the last 3 weeks of the year. However, due to the significance of the pandemic, the financial statements have recognised the impact as a disclosure in its Annual Report and as a non-adjusting post balance sheet event in the financial statements.

As a result of this, we determined that the impact of COVID-19 should be a key audit matter.

We performed the following procedures to address the impact that COVID-19 has on the financial statements:

- we understood key expenditure controls the Trust has put in place with regards to COVID-19 and have evaluated these controls;
- looked at the items recognised as CVOID-19 costs to assess if the classification as being reimbursable was appropriate;
- held regular discussions with the deputy director of finance to understand the impact of the COVID-19 pandemic on the Trust;
- we obtained and assessed the Trust's cash flow forecasts, which management have applied sensitivities in light of COVID-19;
- we considered whether the Annual Report included sufficient disclosure related to COVID-19; and
- we considered if any adjustments to the carrying value of the Trust's assets and liabilities were required.

We concluded that management's assessment of the impact of COVID-19 on the financial statements and the arrangements for securing economy, efficiency and effectiveness in its use of resources is reasonable.

We determined that there were no further key audit matters relating to the Trust's arrangements for securing economy, efficiency, and effectiveness in the use of resources to communicate in our report.

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	£15,250k (2019: £14,390k)
How we determined it	2% of total revenue (2019: 2% of total revenue) Total revenue is made up of operating income from patient care activities and other operating income per the Statement of Comprehensive Income.
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 (2019: £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 where:

- 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 2019/20 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 2020 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

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 2019/20.

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 83, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20, 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.

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 2020. Key audit matters relating to this reporting requirement are set out in the Key audit matters table above, and identified as relating to the 3 Es conclusion.

We determined that there were no matters to report as a result of this requirement.

Other matters on which we report by exception

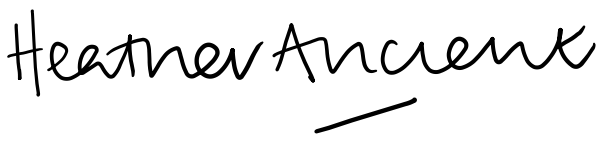
We are required to report to you if:

- the statement given by the directors on page 83, 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 78, 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 2019/20 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.



Heather Ancient (Senior Statutory Auditor)

for and on behalf of PricewaterhouseCoopers LLP

Chartered Accountants and Statutory Auditors

Bristol

Date: 24 June 2020.