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University Hospitals Bristol and Weston NHS Foundation Trust

Annual Report and Accounts 2020/21

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

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

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1. Joint Chief Executive and Trust Chair statement

The year 2020-21 has been unprecedented and one that has affected us all, as the world responded to Covid-19. The global pandemic has changed all of our lives and forced us to adapt at home, at work, and in the way we interact with friends, family and colleagues. Face masks, social distancing and video calls have all become a new way of life. As we write this, restrictions are starting to ease and the vaccination programme is well under way and it remains to be seen what the long-term impact of the pandemic will be.

For our staff at the Trust, together with the wider NHS, the focus has been on our response to the pandemic and we are immensely proud of the way all of our staff have risen to the monumental challenge and continued to provide high quality care to our patients and adapted to ensure the safety of our patients and staff at our hospitals. In line with national guidance we reconfigured our wards, introduced enhanced PPE (personal protective equipment), moved to video and telephone consultations for routine appointments where appropriate and where a physical examination is not needed, and also needed to restrict visiting.

We can't overestimate the significant impact the pandemic has had on our ability to deliver services. This has included the need to reschedule or postpone planned appointments, such as surgery, and we don't under-estimate the impact this has had on patients and their relatives. A priority for 2021-22 will be to work through the backlog of patients who are waiting, as quickly and safely as possible. We would like to thank our patients and their relatives for their understanding and support.

We would also like to thank our staff for their response. Covid-19 has caused anxiety for us all and the way staff have continued to come to our hospitals and care for patients, despite any anxieties they may have had about the virus, is testament to their dedication to wanting to provide the best care possible for our patients.

Innovation is a major part of the way we work and we are proud that our teams have been involved in a number of major innovations as part of the Covid-19 response, not least research that has led to a vaccine. We were part of the University of Oxford's vaccination trial recruiting almost 700 participants who helped to ensure it was ready and safe to be used. This has continued throughout the year with UHBW being involved in recruiting and delivering other trials, whilst the Trust was also the lead sponsoring organisation for a trial looking at the safety and immune responses when giving the Covid-19 and flu vaccination at the same time. This trial is still underway at the time of writing and will be pivotal to our understanding for delivering booster jabs for both Covid-19 and the flu as we approach winter. Our Trust also hosted vaccination hubs and we're delighted to say that we delivered over 31,500 vaccinations between December 2020 and April 2021 at our hubs to keep frontline NHS and social care staff protected from the virus.

Whilst Covid-19 has dominated the headlines and been the major focus for the NHS, it is not all that has happened during the past 12 months – not least we became a new and bigger organisation. At the very start of the year Weston Area Health NHS Trust and University Hospitals Bristol NHS Foundation Trust merged to become University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). When the merger was agreed none of us could have imagined that the merger date would fall just weeks into a global pandemic.

Uniting the Trusts increases our diversity, capacity and resilience, and provides a unique opportunity to bring together the things that make the Weston and Bristol hospitals great places to work and receive care and the merger will make an even better and stronger organisation for the future. One of the Trust Board's priorities is to build a really strong, united future as a single Trust; a future in which we can continue to recover from a year of relentless challenge and grow together. Whilst Covid-19 unfortunately impacted on our integration timescales, we are committed to picking up the pace on that work and are at the start of the process to develop a shared set of Values with our staff that will define who we are in this future: what we stand for, what matters to us and the way we do things as a Trust. Whether you are a patient at our hospitals in Bristol or Weston, we're committed to ensuring you continue to receive high quality and safe care.

Recognising the efforts of our staff is incredibly important to us and we would like to highlight some of the many awards and accolades our colleagues were nominated for or won during the year. Two of our staff won South West NHS Parliamentary Awards; Joshua Bell, a nursing assistant at Weston General Hospital, won the 'NHS Rising Star Award'; and the 'Excellence in Urgent and Emergency Care Award' went to Retrieve. This is the new South West Adult Critical Care Transfer Service which is one of the first of its kind in the country, is hosted by our Trust and is funded by NHS England and Improvement South West.

Our rheumatology team won the Best Practice Award from the British Society for Rheumatology in partnership with Versus Arthritis; these celebrate innovative projects that make a difference to the lives of rheumatology patients. The project was also specifically recognised for its Outstanding Patient Involvement. The project involved developing a set of courses to support osteoporosis patients to avoid hip and spinal fractures, with practical exercises to help them manage their condition.

Four members of staff were also recognised in the Queen's honours during the year. In October, Dr Rebecca Hoskins, a consultant nurse, received her MBE for services to emergency nursing, and Dr Andrew McIndoe, a consultant anaesthetist, received his MBE in recognition of his services to medical simulation, electronic learning and assessment. In December, Dr Phil Cowburn, a consultant in emergency medicine, was awarded an MBE for services to pre-hospital care, particularly during the response to Covid-19 and Ema Swingwood, a respiratory physiotherapist, was honoured with an OBE for services to physiotherapy.

We would also like to mention one of our porters Ali Abdi, who was photographed by acclaimed photographer Rankin. His photograph was showcased on local bus stops, roadside billboards as well as iconic pedestrian areas, including the world-famous Piccadilly Lights in central London, to mark the 72nd anniversary of the NHS.

Finally, we want to thank everyone for your support during the pandemic – members of the public, our amazing community of hospital volunteers, Trust Governors and members, and supporters of Above & Beyond, the Grand Appeal and other charities. The support for our staff has been fantastic and continues to have a positive impact.

With best wishes,

Robert Woolley
Chief Executive

Jayne Mee
Interim Trust Chair

2 Performance Report

2.1 Overview

The year has been dominated by the need to respond to the Covid-19 pandemic and the effects this has had on the ability of the Trust to deliver its services. The need to prioritise capacity to care for patients who have tested positive for Covid-19, whilst maintaining access to patients requiring emergency care, has meant an impact on the waiting time for patients in the majority of specialties who require non-urgent or elective care. This includes longer waits for outpatient appointments, diagnostic tests and treatment.

In relation to the key operational performance metrics, the Trust was unable to achieve the A&E 4 Hour Standard and Referral to Treatment Times (RTT) targets. The percentage of patients seen in four hours was 80.1%, and the percentage of patients who were treated within 18 weeks was 61.7%. Performance against the six-week diagnostic standard was also challenging and was 62.3%.

The Trust performance against the Cancer standards was also impacted significantly by the pandemic with the majority of standards not achieved during the year due to capacity, patient choice and medical deferrals.

To respond to the pandemic the Trust made changes to its estate to ensure that beds were distanced, and that patients were cohorted depending upon their infection status, with green, amber and blue pathways created to minimise the impact of cross infection. Revised policies and procedures were implemented to keep staff and patients safe, including changes to Personal Protective Equipment (PPE), visiting policies and staffing ratios.

The Trust implemented a command and control structure to ensure a rapid response to the changing situation in the hospitals, and the local, regional and national context. This structure included a Silver command meeting chaired by the Deputy Chief Executive and Chief Operating Officer, and a Gold command chaired by the Chief Executive. These meetings were convened to consider urgent decisions and to consider how best to implement new guidance as this was issued by the NHS and the government.

As part of the response, the Trust has invested in and implemented new technology to improve accessibility of services for patients. This includes expanding the Attend Anywhere platform for outpatient appointments, so that some patients could still be seen by clinicians albeit virtually. The Trust also invested in its wellbeing offer for staff to ensure they were supported through the pandemic. This included an enhanced employee assistance programme, additional psychological wellbeing support, and access to a range of other support applications.

In addition to the Trust responding to the pandemic, the Trust merged with Weston Area Health NHS Trust on 1 April 2020. The previous Trust became a standalone division within the governance of the Trust, with a triumvirate leadership of a Clinical Chair, Head of Nursing and a Divisional Director. Work progressed through the year to align the systems and processes across the Trust and to implement the integration plan agreed as part of the merger. The plan spanned multiple years and will continue beyond 2020/21. The pandemic did delay the planned work to align the values and behaviours of the two organisations and ensure cultural alignment. This work commenced in April 2021 and is anticipated to take six months. In respect of Clinical and corporate service integration, all but two corporate services are fully integrated and a number of clinical services including maternity and paediatrics are now operating as single services. It is planned that all clinical services will be integrated by the end of 2021/22.

The main risks facing the Trust throughout the year, beyond responding to the Covid-19 pandemic related to: workforce capacity and capability; the availability of beds; and investing in management and leadership skills.

The Trust was inspected by the CQC during the year, with a focused inspection of the Emergency Department at the Bristol Royal Infirmary in February 2021, with the report published on 17 March 2021. There was no change to the Trust's rating for this service (requires improvement) and an

action plan has been developed and is being implemented to address the recommendations from the report.

The CQC also undertook a focussed inspection of medical wards at Weston General Hospital on 11th March 2021, looking at the safe, effective and well-led quality domains. The CQC's inspection report was published on 12th May. The report included 15 action points relating to a number of issues, including staffing, supervision, incident reporting and leadership. An action plan has been developed to address these points, with monthly engagement meetings being held with the CQC. The Trust Board will also be updated on a monthly basis.

A triggered visit by Health Education England (HEE) to the Department of Medicine at Weston General Hospital in January 2021 identified a number of concerns about the educational and clinical supervision of medical trainees, which the Trust has sought to address with variable success, given a long-standing shortage of substantive senior medical personnel in the department. In March 2021, HEE advised that the April rotation of Foundation Year 1 Doctors into Medicine placements at Weston would not proceed, meaning that 10 trainees were re-assigned within the Trust, while mitigating steps were taken at Weston to ensure the continuity of patient services. The Trust continues to work closely with HEE on improvements which will allow it to provide high quality medical education and training in the Department of Medicine at Weston General Hospital on a sustainable basis.

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 uniquely challenging year needs to be recognised. We are hugely proud of how our staff responded to the challenges the pandemic brought, with shining examples of dedication and patient focus throughout the year. Even with the difficulties of Covid-19, the latest annual staff survey, which was undertaken in 2020, shows that staff engagement continues to be high and above the average for its peer group.

2.1.1 Principal activities of the Trust

University Hospitals Bristol and Weston 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 13,000 staff who deliver over 100 different clinical services across ten different sites, providing care to the people of Bristol, North Somerset 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 £950m.

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 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 city centre campus and from Weston General Hospital in Weston-Super-Mare, 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.

2.1.2 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.

Our Trust mission, vision and strategic objectives were tested in autumn 2020 in the context of, and learning from, the Covid-19 pandemic and it was reaffirmed through Trust Board in October 2020 that the commitment to our mission and vision remains unchanged.

The mission and vision is achieved through our Trust values:

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

2.1.3 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.

Our priorities and strategic objectives, outlined in our strategic plan; *Embracing Change, Proud to Care*: *Our 2025 Vision* were reviewed in autumn 2020 and it was confirmed that our strategic priorities remain relevant in the context of our changed planning and operating environment. As a result of this review, the following Strategic Objectives were added as an addendum to our strategic document through Trust Board in September 2020.

- Engage with partners to develop a system wide capacity and demand model that maximises delivery of the right care in the right place, first time
- Work within the Healthier Together Integrated Care System to apply the learning from transformational changes rapidly implemented in response to the pandemic, agreeing and implementing system and organisational solutions that maximise impact for our populations.
- Develop and implement an adult Bristol critical care strategy with North Bristol Trust that builds resilience and enables further development of Bristol as the lead tertiary centre for specialist service delivery in the South West.
- Sustain the long term requirements for staff wellbeing and health and safety, including ways of working and technological solutions to enable all staff, clinical and non-clinical to perform their roles to the best of their ability.
- Maximise our role as an anchor institution in supporting economic recovery through local employment and volunteering
- Work with system partners to improve equity of access to our services for all patients, including actively understanding and addressing the impact of any service change.

We remain 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 and vision of our local and regional partners and our commitment to our developing Healthier Together Integrated Care System.

2.1.4 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.

Unsurprisingly the 2020/21 Transforming Care priorities have been impacted by thCovid-19 pandemic. The following summary of work undertaken includes improvement initiatives, implemented to support the organisation in our response to the pandemic.

- **Pillar 1: Leading in partnership**

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

Vaccination programme

In December 2020 UHBW began supporting the BNSSG Covid 19 Mass Vaccination Programme. The Hospital hubs at the BRI and Weston General Hospital sites were established to provide the frontline health and social care staff across BNSSG with the opportunity to book a vaccination.

In order to prepare, plan and set up the vaccination hubs at the Bristol BRI and Weston WGH sites, a multidisciplinary team was rapidly established by the Executive Senior Responsible Officer (SRO). Daily meetings commenced to establish the vaccination hubs for their go live on Monday, 28th December 2020. It should be recognised that this team has been instrumental in setting up and establishing the UHBW vaccination programme at pace and they are applauded for this extraordinary effort.

The success and rate at which the hubs stepped up supported the BNSSG system in meeting the national target to vaccinate the Joint Committee on Vaccination and Immunisation (JCVI) cohorts 1-4 by 15th February 2021.

The Hospital Hubs programme of work ended in April 2021 having successfully administered all of the second doses to the frontline health and social care across BNSSG.

Although the main volume of work for the hospital hubs concluded in April 2021 UHBW will continue to lead in:

- Vaccination for patients with a new diagnosis requiring immunosuppressive therapy or existing patients starting a new course of immunosuppressive therapy.
- Vaccination for long term paediatric inpatients aged 12-15 years old that meet the JCVI criteria and will miss vaccine appointments as they are unlikely to have been discharged.

Acute provider collaboration

UHBW continues to work in partnership with North Bristol NHS Trust, utilising our joint Clinical Sponsorship Board to bring clinical leadership together in order 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 patients. The Trust also works closely with other health service partners as part of the Integrated Care System for Bristol, North Somerset and South Gloucestershire.

The Trusts have jointly commissioned the Acute Services Review (ASR), a clinically-led programme of collaboration focusing on:

- Specialist and tertiary provision - collaborating in our approach to define a ‘Bristol offer’ across our varied specialist portfolios;

- How we organise, manage and govern ourselves, and use our available capacity to best effect;
- How we address constraints and barriers to delivering change.

The ASR is initially focused on a series of priority areas of collaboration including stroke, Neonatal Intensive Care, Adult Critical Care, Cancer, Diagnostics and Genomics.

UHBW has worked closely with the Bristol, North Somerset and South Gloucestershire (BNSSG) Stroke Reconfiguration Programme to develop the pre-consultation business case (PCBC) outlining proposals for the future state of Stroke services across BNSSG. The vision is to improve the delivery of stroke care to our population to reduce mortality and to improve outcomes following a stroke. Two options are proposed for public consultation for the configuration of hyperacute, acute and sub-acute stroke care.

The PCBC was reviewed and supported by the Joint Health Oversight and Scrutiny Committee (JHOSC) in March. Further review and approval by NHSE/I and the System Board completed in May with the 12 week public consultation is planned to begin in June 2021. UHBW is working with system partners to develop communications and materials for the public consultation.

Adopt and Adapt delivery
In July 2020 the Adopt and Adapt initiatives were commenced in the South West. A range of improvement projects have been completed or commenced within the radiology departments across our Weston and Bristol sites. These included:

- A pan system MRI service utilising a research MRI facility in Filton to image musculoskeletal and neurological MRI scans for patients who would normally attend Southmead, Weston or the BRI. This was a joint project with North Bristol NHS Trust (NBT) and has been commended as a positive example of collaborative working. Staff and equipment of the Biobank Research facility were utilised and along with NBT colleagues the staff have been trained to undertake the scans and extend their MRI experience. Our patients attend a green site and we have increased our MRI capacity by 88 scans per week for Bristol radiology and 44 scans per week for Weston Radiology. The service has been running since the start of December 2020 and will continue until November 2021.
- The Trust was fortunate to receive government funding for a new CT scanner at South Bristol Community Hospital (SBCH), this will allow patients to attend the community hospital for their CT scans and will help to provide some of the capacity we have lost due to the impact of Covid-19 in our existing CT scanner suites, due to infection prevention and control requirements and social distancing in waiting areas. We anticipate the scanner will run 7 days per week and expect our first patients in late Quarter1 of 2021/22.
- Radiographers are on the national occupational shortage list. As part of the regional Adopt and Adapt initiative, we have been able to benefit from a recruitment programme which took place in November 2020, where 150 overseas radiographers were interviewed and offered jobs in the South West. Weston radiology have already received three overseas recruits, and Bristol radiology anticipate the arrival of seven more overseas recruits who will be arriving in the UK between 12th April and the end of May.

Weston and Bristol integration
Work has continued to bring the staff and services together across University Hospitals Bristol and Weston NHS Foundation Trust following the merger of the two organisations on the 1st April 2020.

The first phase of bringing together clinical services across Bristol and Weston is almost complete and has been led by services leads working together across sites. Adult Therapies, Laboratory Services and Sexual Health completed integration on 2nd November, with UHBW paediatrics and

audiology services integrating from April 2021. The second phase of service integrations is underway, with the aim of completion in the spring/summer of 2022.

Whilst services continue to be delivered from Weston as they are now, bringing the organisation of clinical services together across the Trust brings a number of benefits such as offering more resilience and cross cover, the sharing of best practice and the removal of barriers to delivering a wider range of clinical services to the patients of Weston. As an example of the benefits to be secured, Adult Therapies have identified that service integration will improve workforce sharing and cross-site rotations to cover vacancies or gaps, better cross sites data review and audit to improve service quality and delivery, enabled by a common patient care system (Medway).

From 1st April 2020, interim arrangements have been in place to ensure that corporate services across Bristol and Weston had single leadership arrangements. Through the course of the year, work has continued to formally bring together corporate services across the Trust to form single teams to reduce duplication, improve organisational resilience, share best practice and ensure that there is a common approach across the organisation. Out of a total of 21 areas, over 90% of services have completed this process on target by April 2021, with the remaining two services expected to complete in summer 2021.

To ensure that UHBW will continue to be a diverse and inclusive place to work that attracts, develops and retains exceptional people, with the help of an external specialist partner, we are building and developing shared vision and values across our Bristol and Weston sites.

Whilst more quality and service related benefits will flow from bringing together clinical and corporate services in the longer term, initial benefits of operating as a single organisation since April 2020 include:

Critical mass
Weston Area Health Trust was the smallest non-specialist acute Trust nationally. The opportunity to operate as part of a larger organisation is starting to allow services to be planned and developed across a much larger template, and offer stronger support to underpin services at Weston Hospital. This has been particularly beneficial in managing the impact of Covid-19 providing the opportunity to transfer patients across our hospitals to comply with infection prevention and control requirements. An additional CT scanner has also been brought into operation at WGH, supported by the radiography teams working together and enabling patients requiring planned scans to have more timely access than would have been possible, under two separate Trusts. Weston General Hospital has also benefitted from access to remote working and remote consultation technologies, with the successful introduction of on-line outpatient consultations across Bristol and Weston. The roll out of remote working applications and laptops to keep staff safe whilst home working, with the ability to access to the Trusts extensive on-line training and information resource, has also been enabled with the support of a larger scale digital team.

Recruitment and retention
Making improvements to the recruitment and retention of medical, nursing/allied health professionals and administrative posts at Weston General Hospital, is a key part of our plans to address the long standing and systemic workforce issues at Weston General Hospital. We know this will take time and resources which is why a five year programme of support has been put in place with specific recruitment activity in Weston General Hospital, enabled through the integration recruitment taskforce.

Clinical alignment, reduction in service variation and risks
Before the merger, both Trusts were already collaborating to develop new models of care designed to reduce variation in the delivery of services and to help drive up quality, reduce risk and improve productivity. A good example of this is Critical Care, where services are being re-shaped in line

with the Healthy Weston model. The future model of Critical Care for people at Weston General Hospital is based upon closer working with the Bristol Royal Infirmary (BRI) and patients seamlessly accessing specialist clinical services as part of their treatment plan. This is enabled through a number of changes and innovations including a dedicated transfer service between Weston and Bristol (ambulance with consultant led transfer team), in addition to the new regional 'Retrieve' service, hosted by the Trust. Furthermore, work is in an advanced stage, to roll out a single ITU clinical system, providing a digital link to the Bristol Royal Infirmary to provide joint oversight and central monitoring of patient care. Additional ITU beds at the BRI have now been brought on stream, which will enable the vision for Healthy Weston and critical care to be realised.

Staff training and education will be enhanced
Enhanced training and development programmes for new and existing staff have been rolled out, with new roles now featuring more cross-site working for both Bristol and Weston based staff. This is helping the process of 'cross-fertilisation' of good practice throughout the Trust and it is anticipated that this will continue for the long-term. The Trust continues to build a number of strategic partnerships with education providers in the region, including the University of Bristol, University of the West of England (UWE), City of Bristol College and Weston College. Through increased development of local partnerships, the Trust is seeking to position itself as an 'anchor institution' in North Somerset with a reputation for providing great training and education to the benefit of existing staff and prospective employees. The aim is to ultimately support improvements at Weston General Hospital with recruitment and retention as well enabling the support and development of new healthcare roles.

Corporate synergies and digital capability
The Trust is continuing its development of a revised single estates strategy for the expanded Trust 'footprint' the objective will be to provide an estate that will enable the configuration of services that will allow greatest access to patients and the maximum capacity for the Trust to develop key services in the most appropriate locations. Introduction of standard working practices and elimination of process duplication across the Trust's corporate services are areas of particular focus. Integration of IM&T systems in corporate services will facilitate this. Successful implementation of the Medway PAS system in Weston General Hospital means that the whole Trust operates using this same system, which is an important first step in establishing a baseline to further develop digital innovation going forward.

The Healthy Weston Decision Making business Case (DMBC) was signed off in 2019 with key changes across four priority areas for Weston General Hospital: Urgent and Emergency Care, Paediatrics, Emergency Surgery and Critical Care. Work to progress these plans has been undertaken at Weston General Hospital over the last 12 months, however, due to the Covid-19 pandemic the timetable in some areas has been delayed.

- **Pillar 2: 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.

In response to the Long Term Plan, UHBW has created a redesign of outpatients programme to support the development of services in line with the national vision and incorporating learning from the real time outpatients programme. This plan has been developed in conjunction with the Healthier Together Strategy which has involved patients and taken their views in to the design process. Work has commenced to undertake self-assessment with each division to create strategies that support a tailored change programme for specialities.

Two key elements of the Redesign of Outpatients programme were accelerated during the Trust's response to the first wave of the Covid-19 pandemic. To support referral management, working with BNSSG system partners, the Advice and Guidance service for primary care was rapidly expanded from 9 to 54 services. The purpose of Advice and Guidance is to enable primary care clinicians to access specialist expertise to support patient care and prevent patients having to attend hospital. Throughout 2020/21 over 18,000 advice and guidance requests have been received and responded to by Trust teams. Work continues with system partners to sustain the Advice and Guidance services and evaluate the impact on outpatient referrals to our hospitals.

The other accelerated element was the rapid roll out of the Attend Anywhere system, to enable clinicians to undertake video outpatient appointments, instead of patients attending our hospitals. A rapid roll out enabled 93 clinical services to have the ability to provide a video clinic when required. Over 25,000 video appointments have been undertaken during 2020/21. Patient feedback surveys have been central to the development of the new service, with over 9,000 patients providing information about their experience of virtual consultations. These views have supported the development of evidence for the effectiveness of video consultations in clinical practice and allowed reflection on future developments to reduce health care inequalities in patients accessing care in virtual settings. Along with telephone appointments this has achieved the national target of 33% by 2024 outlined by the long term plan. Work will be undertaken to ensure this is sustained.

A community phlebotomy hub was successfully piloted in South Bristol Community Hospital (SBCH), supported and staffed by our community partner Sirona. Patient feedback from the delivery of this model has informed the development of a BNSSG primary care community phlebotomy model with the view of supporting patients to access care as close to home as possible. Plans are in progress to review the proposed model and longer term sustainability of the service.

- **Pillar 3: Improving patient flow**

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

An Emergency Department (ED) Redirection and Streaming project was established to reduce the number of patient visits to our emergency departments and minimise overcrowding. The project aim was to provide alternative pathways for urgent and emergency patients to receive the most appropriate level of urgent care, with the NHS 111 service as the 'first line of defence'. This complex and challenging issue required collaboration with system partners, and necessitated a culture change to move away from the idea of ED as the default option.

Initiatives have been developed with patient safety and experience in mind, whilst also considering the needs of some of our vulnerable population to ensure that we are not disadvantaging them through redirection.

Within the BRI and Weston EDs, we have implemented a number of pre-hospital and ED redirection pathways for patients who could be managed in another setting. This includes a service that triages GP medical referrals, a GP at the front door pilot, redirection to GP, redirection to Urgent Treatment Centres and Minor Injury Units, redirection to urgent eye and dental services and introducing new same day emergency care service (SDEC) services within the Trust. Early results have shown a 7% increase in redirection of patients to alternative urgent or primary care. We will continue to evaluate effectiveness and develop these services in 2021/22.

One of our key challenges during the pandemic was how we could safely manage a predicted surge of patients with coronavirus, but limit the impact on other patients who urgently needed inpatient care. As numbers continued to rise, NHS England issued an extraordinary national contract to collaborate with private providers to increase hospital capacity. UHBW worked especially closely with an independent care provider to devise an operating model that would ensure patients were treated effectively in the right facility. A team of staff from UHBW and Spire

Bristol Hospital swiftly developed a model that defined everything from clinical criteria for transfers to Spire Bristol Hospital, to how we could extend our IT networks and devices to request tests, review results and keep consistent records in our existing systems. We planned rotas, trained Spire nursing staff in new specialty areas, and arranged for the correct equipment to be on site. Spire Bristol Hospital faced a dramatic shift from working in small teams, to liaising with ten different specialties across five clinical divisions. A task of this magnitude would usually take many months of planning. Yet, in just three weeks, the first patients received elective procedures at Spire Bristol Hospital. By the end of the contract, the operating model had delivered over 15,500 elective imaging and surgical procedures. This accounted for 87% of all UHBW/private sector collaboration to reduce the impact of Covid-19 on waiting lists, maximise inpatient capacity and keep patients safe.

Making accurate predictions about demand for our services, and planning the capacity to meet it, is a familiar challenge for any NHS Trust. A project to develop a more sophisticated modelling approach using new software called Simul8 was undertaken, to simulate the impact of changes in demand on resource availability. At UHBW, traditional methods of modelling relied heavily on averages, yet this approach doesn't cater well to fluctuations. Simul8 uses variance in demand (such as arrival patterns) and available resources (such as inpatient beds) to simulate how often and by how much we could exceed capacity. This information will be considered in future resource planning.

We developed a starter model that identifies predicted use of resource for different work types: unplanned or elective demand for intensive care, assessment unit or ward beds, and what happens when we prioritise emergencies over planned admissions. The learning from this model can be taken to develop new bespoke models. It has been added to the suite of tools available for analysts to support Trust clinical divisions with annual business planning and to facilitate local service improvements. A newly-formed Demand and Capacity Group will manage how Simul8 is used to support different projects across the Trust in 2021/22.

- **Pillar 4: Delivering best value**

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

Although a challenging year, savings programme governance continues to be 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 NHS Model Health System (formerly Model Hospital) and other benchmarking tools to identify opportunities to increase activity and, where possible, reduce costs. It should be noted that cost savings were significantly reduced in 2020/21, with the Trust only achieving 46% of its target. As with most NHS Trusts, productivity and efficiency opportunities were limited due to the impact of the Covid-19 pandemic.

At a Trustwide level, the 'Working Smarter Forum', an umbrella term used to describe the many productivity and efficiency programmes the Trust has in place, continues to operate. The Forum meets monthly, attended by divisional operational managers, finance managers and information managers working to identify, develop, deliver and monitor productivity and efficiency.

The Managed Inventory Solution (MIS) has been rolled out across the Trust. This tool greatly improves inventory management and will provide vital management information through interactive dashboards.

An approach the Trust adopted in order to restart and refresh our savings programme post Covid-19 was to draw on the experience of leading English NHS Trusts in order to identify areas of potential efficiency and productivity that we might adopt. UHBW has been working with Leeds

Teaching Hospitals NHS Trust, Newcastle Upon Tyne Hospitals NHS Foundation Trust, Salford Royal NHS Foundation Trust, St. Georges University Hospitals NHS Foundation Trust, Western Sussex NHS Foundation Trust and Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust to this end.

- **Pillar 5: 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.

We have made significant steps with the implementation of the Trust's sustainable development strategy. The appointment of staff to develop the sustainability team has enabled the establishment of a Sustainable Development Board and setting up workstreams for delivery.

The clean air work stream has reviewed the car parking policy and implementation and communication plans which support active travel have been approved and aligned to clean air zone implementation.

A £17.6m grant has been awarded for a heat decarbonisation project which will build on the past year's installation of a larger combined heat and power engine and district heating pipes to fully de-steam the site making a big impact on our carbon emissions.

We are embedding sustainability into our business cases and procurement processes. The EcoQuip+ project is bringing in an innovative procurement approach to reducing single use plastics in our operating theatres and sustainable waste management. For further detail on the sustainability programme please see the sustainability report.

- **Pillar 6: 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 to deliver best care for our patients and public, and retaining their expertise within our services.

Our Transformation, Improvement and Innovation strategy

The vision of the Trust's Transformation, Improvement and Innovation strategy is:

"To empower staff to improve patient and population health through improving, transforming and innovating our services."

This is achieved by developing the culture and capability for delivery of transformation, improvement and innovation, within the Trust and with our partners.

We have continued to develop our Quality Improvement (QI) Academy in 2020/21 despite the disruption to staff training resulting from the Covid-19 pandemic. To enable some training to continue we adapted our QI Bronze and Silver courses for online delivery via WebEx. QI Bronze training was paused for seven months and therefore the number of staff trained is lower than planned, with 97 staff undertaking the training. One cohort of QI Silver was delivered, which saw seven projects being delivered. The first cohort of the QI Gold programme was completed in September 2020, providing a nine month programme for six teams of Trust staff in planning and delivering complex service change projects. Out of the six QI Gold projects, four were significantly altered or affected by Covid. The QI Hub, which supports staff to undertake local improvement projects, remained open all year and received 42 entries.

We have held two Bright Ideas competitions for staff in 2020/21, having received funding support from the Trust's charitable partner Above & Beyond and from the West of England Academic

Health Science Network. Through the competition we are able to support innovative ideas from staff to improve aspects of patient care and wellbeing, and implement environmental sustainability ideas. The spring 2020 competition was delayed from April 2020 until October 2020 when three winners were selected from eight finalists. The autumn 2020 competition asked staff for their Bright Ideas specifically around Covid-19, and three winners were chosen in November 2020 from seven finalists. Unfortunately, due to the clinical and operational demands arising from the pandemic, all Bright Ideas have had to be paused at some point in the year, though at the time of writing, many projects are restarting.

We are continuing to develop strong working relationships with the University of Bristol. We have developed a Quality Improvement in Healthcare module for the Post Graduate certificate in Healthcare Improvement and the MSc in Healthcare Management, which will commence in the 2021/22 academic year. We are also working collaboratively with the Centre for Innovation and Entrepreneurship (CfIE) to develop a number of student placements at UHBW, and have submitted a proposal for a placement third year undergraduate medical students to undertake an innovation project in clinical handover using quality improvement and human-centred design techniques.

In other successes, we were selected to share our experience of creating a QI programme at the Institute for Healthcare Improvement international conference in December 2020. In March 2021, our previous Clinical Lead for Transformation, Anne Frampton, was a finalist at the HSJ awards as recognition of her leadership in the conception and development of the QI programme over the last four years.

2.1.5 Key risks to delivering our objectives

The Board receives reports on the risks on a quarterly basis, it scrutinises the controls and assurances in place and the actions being taken to minimise risk and as a number of enabling strategies whose focus is on the delivery of key objectives designed to mitigate specific strategic risk and delivery of benefits to the Organisation.

The assessment of the Trusts strategic risks have remained static apart from the assessment of the potential impact on Trust operations if it is unable to recruit sufficient numbers of substantive staff, particularly in certain specialties, which has increased in response to known national shortages of suitably qualified and experienced staff.

The Covid-19 pandemic has negatively impacted on the delivery timescales of action plans in relation to the mitigation of strategic risks as it has been necessary in many cases to re-direct resources to assist with the operational response. The Covid pandemic has also led to a number of changes at a national and regional level that may further impact on the commissioning of services and the financial regime and funding envelopes.
A summary of the risks to our strategic plans are outlined below:

- That the Trust fails to achieve the objectives of its financial strategic plan
- That the Trust is unable to recruit sufficient numbers of substantive staff
- That Trusts IM&T Systems fail to deliver the required levels of efficiencies
- That services are not commissioned at levels of forecasted demand
- That the Trust is unable to invest in modernising the Trust estate
- That the STP fails to deliver a system strategy
- That the Trust has insufficient leadership capacity
- That the Trust is unable to retain members of the substantive workforce
- That Research and Innovation is not adequately supported
- That the benefits of transformation, improvement and innovation are not realised
- That the Trust fails to make a positive impact on combatting climate change.

2.1.6 Going concern disclosure

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS Foundation Trust will continue in operational existence for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Alongside the Trust's 2021/22 financial plan, further forecasting has been undertaken in relation to the Trust's cash position for the period from 1st April 2021 through to 30th June 2022. The cashflow forecast predicts significant cash balances throughout the period with a projected minimum cash balance of c£125m as at 30th June 2022. In addition, downside forecasting has been undertaken, which considered a number of factors, for example, inflationary pressures and a failure to deliver the NHSEI savings requirement, to stress test the cashflow forecast. The downside forecast continues to predict significant cash balances throughout the period. The project minimum cash balance is £103m as at 30th June 2022. After consideration of the cashflow forecasts, the directors have adopted the going concern basis.

2.1.7 Overview of financial performance

The NHS financial regime for 2020/21 changed significantly in response to the Covid-19 pandemic. In the first half of the financial year, the Trust received fixed block income payments, prospective top up payments and a retrospective true up payment mechanism to ensure delivery of a break-even net income and expenditure position. The arrangement also simplified financial arrangements and provided cash certainty under the national lock-down arrangements.

The financial regime for the second half of the financial year moved to a fixed financial income envelope based on prior year financial performance. In accordance with NHS England and Improvement's (NHSEI) requirements, the Trust submitted a 2020/21 financial plan for the second half of the financial year on 22nd October 2020. The Trust's financial plan was a net income and expenditure deficit of £13.465m (excluding technical items).

The Trust reported a net surplus of £0.343m (excluding technical accounting adjustments as stated in note 2 of the financial statements). This is a fantastic achievement given the extremely difficult and challenging operating environment all of our staff worked within. The 2020/21 financial year was the 18th year in a row that the Trust delivered a net surplus or breakeven income and expenditure position (excluding technical items).

The Trust achieved savings of £8.500m against a plan of £18.575m. Understandably, the Covid-19 pandemic significantly reduced the Trust's ability to make savings during the course of 2020/21.

The Trust's statement of financial position remained strong with net current assets of £69.996m and a year-end cash and cash equivalent balance of £170.078m.

Despite the disruption caused by the Covid-19 pandemic, the Trust invested £68.470m on capital expenditure covering the Trust's estate, purchasing medical equipment and investing in information technology.
In accordance with NHSEI requirements, the Trust will be submitting a break-even 2021/22 financial plan covering the first six months of the financial year in late May 2021.

Robert Woolley
Chief Executive
9th June 2021

2.2 Performance Summary

The NHS Oversight Framework outlines the approach taken by NHS England and NHS Improvement to oversee organisational performance and identify where organisations may need support. The framework describes the measures that are used to assess performance. There are several waiting time standard measures relevant to organisations providing hospital services, including:

- Percentage of patients admitted, transferred, or discharged from A&E within four hours
- People with urgent GP referral having first definitive treatment for cancer within 62 days of referral
- Patients waiting 18 weeks or less from referral to hospital treatment
- Patients waiting six weeks or less for a diagnostic test

The national standards are:

- 95% of patients should be admitted, transferred, or discharged from A&E within four hours
- 85% of people referred by their GP should have their first definitive treatment for cancer within 62 days of referral
- 92% of patients should wait 18 weeks or less from referral to hospital treatment
- 99% of patients should wait six weeks or less for a diagnostic test

2.2.1 Referral to Treatment (RTT)

The national standard for Referral to Treatment (RTT) is 92%. This has not been achieved for the whole of 2020/21.

At the end of March 2020 the overall waiting list size for routine patients was at 39,703 with 8,289 patients waiting over 18 weeks compared to March 2021 where the waiting list size was 46,3538 and the over 18 week backlog position was 17,817.

The backlog growth in the main related to the Covid pandemic with step-down of capacity to support the pressures in the hospital relating to admitted Covid patients. This was further exacerbated with winter pressures and the added pressures relating to periods of the year where critical incidents and decompression activities resulted in the temporary closure of theatres and the step-down of all patients requiring routine treatment, whether as an in-patient admission or an outpatient attendance

Across the Trust all services have seen backlog increases and patients waiting longer for an appointment or treatment. The largest areas of growth have been seen in Dental services, Ophthalmology, Cardiac, Trauma and Orthopaedic (T&O) in both adult and paediatric areas. The Dental and Ophthalmology growth was a result of step-down of theatres from four to one in the Bristol Eye Hospital and the suspension of dental treatments due to the guidance received during the pandemic relating to the use of air-flow equipment. Furthermore, staff have been re-deployed to support ward and other pressured areas within the Trust during the pandemic. The T&O growth has occurred from patients referred into the Referral Assessment Service (RAS) and the lack of clinic capacity to book an appointment slot for these routine patients. Overall the waiting list as a whole has increased by 6,835, with 3,457 of those over 18 weeks relating to Weston General Hospital patients, who are now included in the overall UHBW position following integration.

With the Covid pandemic, the winter pressures and step down of many of the lower priority routine patients, the focus for the Trust is to continue with the national clinical prioritisation programme and to identify capacity to treat those patients who have been clinically prioritised as P2 - require treatment within one month. However, recovery of RTT performance is expected to be difficult given the volume of more urgent patients, especially those on cancer pathways, that require the majority of the capacity that is available.

The Trust's commitment to achieve zero 52 week breaches has not been achieved and in March 2020, the Trust reported 31 patients who have waited for 52 weeks or more for treatment. This compares to 4,424 patients in March 2021 who have waited more than 52 weeks.

The NHS Constitution states that patients are entitled to start first definitive treatment within 18 weeks. However, given the current backlogs and priority within all services to treat patients who are more clinically urgent such as cancer patients and emergency admissions, ensuring equality of access within routine services is likely to be extremely challenging over the coming months. Every effort is continuing to be made with partners in the BNSSG health care system to maximise capacity, including within Independent sector providers, where patients will be transferred if capacity is available and a transfer is deemed safe and clinically appropriate to do so.

2.2.2 Accident & Emergency four hour maximum wait and 12 hour trolley waits

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. Annual performance for all sites combined was 80.1%. For the four emergency departments (EDs):

- The Bristol Royal Hospital for Children (BRHC) ED achieved the 95 per cent standard in one month during 2020, and achieved 92.32% for the year
- The Bristol Eye Hospital (BEH) ED achieved the 95 per cent standard in *all 12* months, and achieved 98.57% for the year
- The Bristol Royal Infirmary (BRI) ED did not achieve the 95 per cent standard in any month of 2020/21, and achieved 70.17% for the year
- The Weston General Hospital ED did not achieve the 95 per cent standard in any month of 2020/21, and achieved 77.49% for the year.

March 2020 saw a significant reduction in ED attendances due to the Covid-19 pandemic and activity remained suppressed throughout the year. April 2020 to March 2021 averaged 11,672 attendances per month, a decrease of 4,425 from the average of the previous year.

Overall A&E attendances between 2019/20 and 2020/21 were

- 27% down across all four sites
- 18% down at the BRI
- 36% down at the BRHC
- 27% down at the BEH
- 33% down at Weston

Although A&E attendances were suppressed, challenges to flow were experienced throughout the year due to Emergency Department and inpatient ward reconfiguration to stream patients during the Covid pandemic, which significantly affected bed capacity, productivity and ambulance handover performance. The Trust recorded 1,440 twelve hour trolley wait breaches (against a national standard of zero) which was an increase of 619 from the previous year. 459 were at the BRI and 981 were in Weston.

2.2.3 Cancer

The Covid pandemic has affected the Trust's delivery of cancer standards in terms of compliance throughout the year, however the Trust has maintained services despite the challenging circumstances, with patient safety at the forefront of delivery. Every cancer patient treated outside the 62 or 31 day standards is assessed for potential harm as a result of their additional waiting time, with only one patient during the year identified with potential harm as a result of the extra time waited. The Trust's cancer performance has been reported in an integrated way (across its Bristol and Weston sites) since the point of merger in April 2020.

The Trust achieved the 62 day GP referral to treatment standard in one out of 12 months in the period. During the early part of the year (the first wave of Covid) the main impacts were from high numbers of patients choosing to delay investigations/treatments and from the closure of the elective endoscopy service in line with national infection control guidance. In the latter part of the year (impacted by the second wave of Covid), the impact was greater on surgical diagnostics and

treatments due to the high number of patients admitted during this period. Despite the challenges during this period, the Trust has continued to treat the majority of patients within 62 days of a GP suspected cancer referral, with the percentage treated in this timescale remaining above 70% in every month.

The Trust achieved the two week wait standard for first appointment following GP suspected cancer referral in two months out of twelve. This standard was heavily impacted by the suspension of the endoscopy service (endoscopy being a common first appointment type following cancer referral) and by patients choosing to delay their appointments. Endoscopy capacity has continued to be a limiting factor throughout the year particularly when the need for pre-procedure isolation periods for patients are considered. There was a marked deterioration in performance against the standard in September and October due to a surge in Dermatology demand which exceeded capacity, with options to increase capacity limited by the necessary Covid precautions. The surge in demand was a combination of the usual seasonal increase over summer, combined with patients who had chosen to defer appointments becoming more willing to attend as Covid rates had reduced, and with patients assessed via the telephone due to the pandemic needing further appointments for face to face assessment. The service resolved these issues and this resulted in a significant improvement in compliance from November which was sustained for the remainder of the year.

The 31 day decision to treatment standards have performed better overall than the earlier pathway standards. The 31 day first definitive treatment standard was achieved in in 4 out of 12 months. This reflects the Trust's success in maintaining cancer treatments almost as normal between the first and second waves despite the ongoing restrictions associated with the pandemic. The subsequent oncology standards have retained compliance for every month of the year. The subsequent surgery standard was not compliant in any month during the year due to the impact of the pandemic on surgical capacity (including bed capacity for patients post-operatively), in the context of a standard with a low denominator where small numbers of breaches are sufficient to cause non-compliance.

The introduction of monitoring against the 28 day faster diagnosis standard was deferred nationally to the 2021-22 financial year. The Trust has continued to collect and validate data for the standard and remains ready for its formal introduction. The Trust is already compliant with the national threshold of 75%.

Ensuring equality of access is a priority for the Sustainability and Transformation Partnership's cancer working group going into the next financial year. There is limited data at present to fully assess cancer standard attainment across different patient groups and the BNSSG healthcare system is working to obtain this and identify any areas for improvement. This work has started with lung cancer, due to the national drop in referrals and diagnoses during the pandemic, which has been far greater in lung than other cancer types. A specific working group is in place to investigate and implement recommendations for improvement. This can then be used as a model for similar work on other cancer types. The Trust has always acted on an *ad hoc* basis to address any apparent issues with equality of access to cancer care that have arisen, for example, in the previous financial year where improvement plans were designed with the commissioners for prisoners' health. The Trust now has contacts in place who can rapidly resolve any issues with arranging attendance by people in prison who require cancer investigations or treatment.

2.2.4 Diagnostic waiting times

The NHS constitutional standard for 99% of patients waiting for a diagnostic test within 6 weeks was not met at any point during the year. Month end performance for diagnostic waiting times varied between 41.3% at the start of the Covid pandemic and recovered to a maximum of 67.49% in July 2020, but ended the year with 65.2% waiting under 6 weeks for a diagnostic test. Annual performance was 62.3%.

April and May 2020 saw a marked deterioration in performance. This was affected by a change in behaviours where patients opted to delay appointments during the first wave of the pandemic, in

addition to restrictions on routine referrals, periodic closures of services such as diagnostic endoscopy and lower productivity due to the introduction of Infection Prevention and Control standards in diagnostic imaging, physiology and endoscopy.

The diagnostic tests where performance has been most adversely affected by backlogs as at the end of March 2021 were:

- Adult endoscopy (31.16% under six weeks)
- Echocardiography (60.13% under six weeks)
- Dexa scans (37.25% under six weeks)

Diagnostic activity recovered well in the second half of the year and is operating close to normal levels in areas such as CT, adult MRI and endoscopy, although backlogs remain in areas such as CT Cardiac, endoscopy and adult ultrasound. Recovery has been supported by outsourced activity to the Independent Sector and a partnership with North Bristol NHS Trust and UK Biobank to increase adult MRI capacity. Waiting lists have also been validated and data cleansed to ensure patients are correctly on new and planned surveillance waiting lists respectively. An extension of the principles introduced via the national elective waiting list clinical validation and prioritisation exercise is also being implemented by the end of August 2021.

2.2.5 Outpatients

In response to the Long Term Plan, UHBW has created an outpatients redesign programme to support the development of services in line with the national vision and incorporating learning from the real time outpatients programme. This plan has been developed in conjunction with the BNSSG Healthier Together Programme which has involved patients in co-designing the future strategy. Work has commenced to undertake a self-assessment with each Division in UHBW to create strategies that support a tailored change programme for specialities holding outpatients.

During the Covid response non-face to face activity has been rapidly scaled up. 30% of outpatient consultations are now undertaken either by the phone or using the video consultation platform Attend Anywhere. This achieves the national target of 30% by 2024 outlined within the long term plan. There are now over 1,905 clinical users of the Attend Anywhere system, delivering over 28,124 virtual consultations this year. Patient feedback surveys have been central to the development of the new service and over 9,000 patients have responded about their experience of virtual consultations. These views have supported the development of evidence for the effectiveness of video consultations in clinical practice and allowed reflection on future developments to reduce health care inequalities in patients accessing care in virtual settings.

To support referral management during the Covid response, Advice and Guidance has been progressed from the nine pilot specialities in 19/20 to 54 specialities in 20/21. Over 21,725 advice and guidance responses have been provided. Plans are in progress to review the sustainability of this rapid redesign of outpatient delivery with the CCG and Healthier Together Programme for 2021/22.

Work has been progressed with our community providers to develop new outpatient models of care. A community phlebotomy hub has been successfully piloted in South Bristol Community Hospital, supported and staffed by our community partner Sirona Health and Care. Patient feedback from the delivery of this model has informed the development of a BNSSG primary care community phlebotomy model with the view of supporting patients to access care as close to home as possible. Plans are in progress to review the proposed model and longer term sustainability of the service.

To support patients attending outpatient departments for face to face care changes were required to support social distancing. New processes were developed and risk assessments were undertaken. Patient communications have been reviewed to provide patients with information on how to access care during the pandemic. Work has been undertaken to develop a number of new

appointment letters, text message reminders and patient leaflets. DNA rates have risen in 20/21 and are largely attributed to the patient's concerns of accessing care during the pandemic. The Trust is in the process of reviewing non-attendance to understand the patient's reasons for not attending further.

At the peak of Covid hospital cases, outpatient activity was cancelled to support the urgent care and patient flow pathways. Outpatient clinical activity was clinically reviewed and reprioritised, with only essential outpatient activity undertaken. As a result, the Trust now has large follow up and new outpatient patient back log. Plans are being developed to advance the use of waiting list validation and patient initiated follow up to reduce waiting list backlogs.

2.2.6 Important events since the end of the financial year

The Covid-19 pandemic continues to have an impact on our capacity because of the need to maintain social distancing in ward and outpatient areas. This has meant that the Trust has reduced some of its bed capacity and has limited the numbers of patients that can be safely managed within outpatient waiting areas. There also continues to be an impact on our workforce related to changes to the model of care offered to our patients as part of the Trust's response to the pandemic.

The loss of capacity has resulted in a lower level of activity being delivered compared to pre-pandemic levels. The level of day case, elective inpatient, diagnostic, and outpatient activity that is being delivered continues to be monitored.

To oversee the restoration of activity to pre-pandemic levels, the Trust established the Restoration Oversight Group in April 2021.

In May 2021, our local healthcare system was successful in its bid to participate in the NHS elective accelerator initiative. This accelerator initiative is an opportunity for systems to rapidly develop plans to increase activity levels above pre-pandemic levels to reduce the care backlogs that have formed because of the Covid-19 pandemic. The intention of this initiative is threefold: to reduce waiting times, to learn from the experience of other accelerator systems, and to increase activity levels whilst safeguarding the wellbeing of our patients and workforce.

The Board will continue to maintain oversight on the risks associated with the pandemic through its integrated performance report, focused assurance reporting through the Quality and Outcomes Committee and through its risk management processes.

Table 1: Performance against national standards

Note that 2020/21 includes Weston data, previous years are Bristol only

National standard	Target	2018/19	2019/20	2020/21
A&E maximum wait of four hours	95%	86.3%	80.6%	80.1%
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	95.6%	97.2%	81.1%
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	49.3%	50.2%	68.0%
A&E Unplanned re-attendance within seven days	<5%	3.3%	3.6%	4.5%
A&E Left without being seen	<5%	1.7%	1.6%	1.0%
Cancer - Two week wait (urgent GP referral)	93%	95.3%	93.4%	81.9%
Cancer - 31 Day Diagnosis To Treatment (First treatment)	96%	97.2%	95.8%	95.1%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94%	96.1%	92.5%	84.1%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	98%	98.4%	98.6%	99.4%
Cancer - 62 Day Referral To Treatment (Urgent GP Referral)	85%	85.6%	85.5%	78.7%
Cancer - 62 Day Referral To Treatment (Screenings)	90%	66.7%	71.1%	57.1%
Cancer - 62 Day Referral To Treatment (Upgrades)	85%	83.7%	86.6%	86.7%
18-week Referral to Treatment Time (RTT) incomplete pathways	92%	89.0%	83.2%	60.1%
Number of Last Minute Cancelled Operations	<0.8%	1.31%	1.73%	1.15%
Last Minute Cancelled Operations Re-admitted within 28 days	95%	93.4%	92.9%	83.4%
Six week diagnostic wait	99%	96.7%	95.2%	62.3%

2.3 Finance Review

2.3.1 Financial analysis

The Trust reported a net surplus of £0.343m, excluding technical accounting adjustments as set out in note 2 of the financial statements. There are a number of items classified as technical which are excluded by NHSEI when considering the Trust's financial performance. As in previous years, technical items comprise depreciation on donated assets, donated income in respect of assets, impairments and reversal of impairments. For 2020/21 it also included the transfer by absorption of the accumulated surplus from Weston Area Health NHS Trust, received upon acquisition. The £13.807m improvement against the plan was primarily due to additional income of £9.286m from NHSEI and lower than planned expenditure on winter operating costs.

Including technical items and as per the annual accounts, the Trust reported a net surplus of £17.771m. This position includes £16.583m in relation to assets acquired from the former Weston Area Health NHS Trust on the 1st April 2020.

The financial plan for 2020/21 submitted by the Trust to NHSEI in October 2020 comprised two halves; the actual costs of the first six months of the year and the forecast plan for the second half of the year. There were a number of national changes mandated in March 2021 which, given they were not reflected in the forecast for the second half of the year, caused significant variances when comparing out-turn to plan. Most notably the Trust was required to account for additional spend of £22.938m in respect of increased national employer pension contributions with corresponding additional income and additional income of £13.691m to reimburse costs relating to the Covid-19 pandemic.

The Trust's income and expenditure performance for the year is shown in the table below:

Table 2: Performance against 2020/21 plan:

	Plan £m	Actual £m	Variance favourable/(adverse) £m
Operating income from patient care activities	785.507	816.949	31.442
Other operating income	115.384	136.729	21.345
Total operating income	900.891	953.678	52.787
Employee expenses	(560.813)	(595.771)	(34.958)
Non pay expenses	(339.380)	(345.523)	(6.143)
Total operating expenses	(900.193)	(941.294)	(41.101)
Interest receivable	0.001	-	(0.001)
Interest payable	(2.368)	(2.284)	0.084
Public dividend capital dividend	(11.757)	(9.683)	2.074
Other Gains and Losses	(0.038)	(0.074)	(0.036)
Total net non-operating costs	(14.162)	(12.041)	2.121
Trust financial (deficit)/surplus before technical items	**(13.464)**	**0.343**	**13.807**
Technical Items:			

- Depreciation on donated assets	(1.590)	(1.639)	(0.049)
- Donations re assets	3.800	2.266	(1.534)
- DHSC donated consumables (net effect)		2.848	2.848
- Net impairments		(1.587)	(1.587)
- Transfer by absorption		16.583	16.583
Total technical items	(1.607)	17.428	19.035
Net (deficit)/surplus per annual accounts	**(15.071)**	**17.771**	**19.035**

2.3.2 Savings

The Trust achieved financial improvement savings of £8.500m against a plan of £18.575m. The Covid-19 pandemic significantly reduced the Trust's ability to make productivity and efficiency savings. However, the Trust continued to develop work streams that focussed on transactional efficiencies such as obtaining best value through purchasing, controlling spend and use of technology. The Trust also sought to maximise synergies arising through the Weston merger and reducing length of stay and other key efficiency metrics wherever possible.

Table 3: Savings achieved during 2020/21:

	Plan	**Actual**	**Variance** favourable/(adverse)
	£m	**£m**	**£m**
Allied Healthcare Professionals	0.062	0.049	(0.012)
Diagnostic Testing	0.207	0.052	(0.155)
Estates & Facilities	0.619	0.619	-
Healthcare Scientists Productivity	0.198	0.129	(0.069)
HR Pay and Productivity	0.028	0.028	-
Income, Fines and External	0.615	0.159	(0.456)
Medical Pay & Productivity	0.348	0.268	(0.080)
Medicines	0.535	0.584	0.049
Non Pay	4.063	3.490	(0.573)
Nursing Pay & Productivity	0.364	0.364	-
Productivity	2.252	0.485	(1.767)
Trust Services	0.447	0.489	0.042
Weston Merger	2.700	1.785	(0.915)
Plans to be developed from Pipeline	6.138	-	(6.138)
Total	**18.575**	**8.500**	**(10.075)**

2.3.3 Statement of financial position

The Trust's cash balance as at 31st March 2021 stands at £169.644m, an increase of £40.238m from last year. How the Trust used its cash during the year is shown in the table below:

Table 4: Use of cash 2020/21:

	£m	£m
Opening cash balance		**129.840**
Transfer from Weston		4.393
Use of cash:		
Net cash flow from operating activities	99.098	
Capital expenditure	(67.047)	

Other net cash flows from investing activities	1.582	
Public Dividend Capital received	79.506	
Capital loan repayments to the DHSC	(63.416)	
Interest (on capital loan) payments to the DHSC	(2.323)	
Public Dividend Capital dividend payment	(11.426)	
Finance lease payments	(0.563)	
Increase in cash balance 2020/21		35.411
Closing cash balance		**169.644**

The Trust maintained a strong statement of financial position (balance sheet) throughout the year with net current assets at 31st March 2021 of £69.996m.

2.3.4 Capital

The Trust approved a gross capital programme for 2020/21 to invest £97.5m; an ambitious plan reflecting the Trust's priorities to continue to invest in its estate, infrastructure and equipment for the benefit of patients and staff.

In April 2020 a new approach to capital funding was introduced by NHS England and NHS Improvement (NHSEI), allocating a capital envelope for each Sustainability Transformation Partnership (STP or system). This envelope set a limit on the capital expenditure within a system requiring the partners to work together to prioritise spending. For 2020/21 the BNSSG STP was allocated a capital envelope of £76.889m with the Trust's share being £53.161m.

In addition to the STP envelope the Trust received capital allocations from Department of Health and Social Care (DHSC) via Public Dividend Capital funding. The total approved funding for the year was £24.587m and included funding of £5.807m for Urgent and Emergency Care, £4.995m for Covid response, £3.558m for Critical Infrastructure, and £3.058m for critical beds.

The Trust's final NHSEI approved capital plan for 2020/21 was £78.5m, including £0.763m for donations and grants.

	£m
System envelope	53.161
DHSC approved funding	24.587
Donations and Grants	0.763
Total	**78.511**

The new capital regime, with the limit on capital expenditure, meant that not all of the Trust's approved capital schemes could be prioritised for delivery within the year. Schemes which were not approved in the final NHSEI plan have been carried forward to 2021/22.

Performance against this plan is shown in Table 5 below.

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 2020/21 the Trust invested £68.470m on capital schemes. This included the following significant investments:

- Purchase of St James Court £12.551m
- Completion of Combined Heat & Power project £10.430m
- Various items of Medical Equipment £12.576m
- Strategic Projects – BHOC & Cardiac/GICU £6.480m

Table 5: Funding and expenditure on capital schemes:

Approved Plan £m	Subjective Heading	NHSEI Plan £m	Actual Spend £m	Variance to NHSEI Plan £m
	Sources of Funding			
24.587	PDC	24.587	21.467	(3.120)
1.323	Donations - Cash	0.521	0.521	0.000
0.242	Salix Grant	0.242	1.063	0.821
31.494	Depreciation	30.374	30.374	0.000
71.524	Cash balances	22.787	15.045	(7.742)
129.170	**Total Funding**	**78.511**	**68.470**	**(10.041)**
	Application/Expenditure			
40.377	Strategic Schemes	20.599	31.542	10.943
24.194	Medical Equipment	13.355	12.576	(0.779)
28.742	Operational Capital	16.422	11.598	(4.824)
3.451	Fire Improvement Programme	1.269	0.758	(0.511)
13.982	Information Technology	8.509	6.771	(1.738)
14.000	Estates Replacement	13.959	3.205	(10.754)
4.424	Weston	4.398	2.020	(2.378)
129.170	**Gross Expenditure**	**78.511**	**68.470**	**(10.041)**

2.3.5 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.

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.

2.3.6 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.

2.3.7 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.
- A corporate offence of failing to prevent bribery

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

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.

2.3.8 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.

Robert Woolley
Chief Executive
9th June 2021

3 Sustainability Report

3.1 Overview

As a Trust rated as outstanding by the Care Quality Commission, 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 and Weston. 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 October 2020 the NHS adopted a multiyear plan to become the world's first carbon net zero national health system. The commitment comes amid growing evidence of the health impacts of climate change and air pollution, and aims to save thousands of lives and hospitalisations across the country. Air pollution is linked to killer conditions like heart disease, stroke and lung cancer, and academics have linked high pollution days with hundreds of extra out-of-hospital cardiac arrests and hospital admissions for stroke and asthma.

2020/21 has been dominated by Covid-19 and is the most pressing health emergency facing us. But undoubtedly climate change poses the most profound long-term threat to the health of the nation. It is not enough for the NHS to treat the problems caused by air pollution and climate change – from asthma to heart attacks and strokes – we need to play our part in tackling them at source. The NHS has already made significant progress decarbonising our care, but as the largest employer in Britain, responsible for around 4% of the nation's carbon emissions, if this country is to succeed in its overarching climate goals the NHS has to be a major part of the solution.

In recognition of the urgency of the threat that climate breakdown poses to public health, University Hospitals Bristol and Weston 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.

As one of the largest organisations in Bristol and Weston, we have a significant role to play to help protect the environment. We have begun to implement our Sustainable Development Strategy (NHS Green Plan) which sets out how we will 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. Following the merger with Weston we are applying the strategy Trust wide. We have made progress in the past year with the bringing together of energy, waste, transport, staff and recruiting to build a Sustainability Team responsible for delivery.

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".

3.2 Policies

The Sustainable Development Strategy acts as the Trust's Green Plan which addresses issues such as carbon emissions and net zero, air pollution, and adaptation. It also considers our direct impacts and potential as well as our influence on their supply chain and local communities. The strategy forms a key part of sustainable healthcare delivery to ensure our services are fit for purpose today and for the future.

Table 6: Sustainability Policy Table

Area	Is sustainability considered?
Travel	Yes the travel policy has been updated to incorporate sustainability objectives and contribute to the Trust's target of becoming a clean air hospital
Business Cases and annual business plans	Sustainability impact is assessed for business cases over £1M. Sustainability impact assessment will be brought into business planning
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 integrate sustainability into decision making at all stages of our procurement process.
Procurement (social impact)	
Suppliers' impact	

The Trust has established a Sustainable Development Board which oversees our sustainability programme and ensures we deliver our Sustainable Development Strategy. Work streams have been established to implement the actions for delivery.

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 6), plans to improve this further are included in the Sustainable Development Strategy. The tool is currently being reviewed by NHSEI and we will next apply it when the revised version is released, which is expected in summer 2021.

The NHSE/I Greener NHS team are updating the Green Plan guidance and tools they provide to more closely align with the NHS' Net Zero and Environmental sustainability priorities. This includes revising the Sustainable Development Assessment Tool (SDAT) which has been withdrawn from use whilst this is taking place. We will update our assessment when the revised tool is issued following the Greener NHS review.

We are reviewing our Sustainable Development Policy and will align it with the new guidance and update our Sustainable Development Strategy (Green Plan), so we continue to embed sustainability in our processes and procedures.

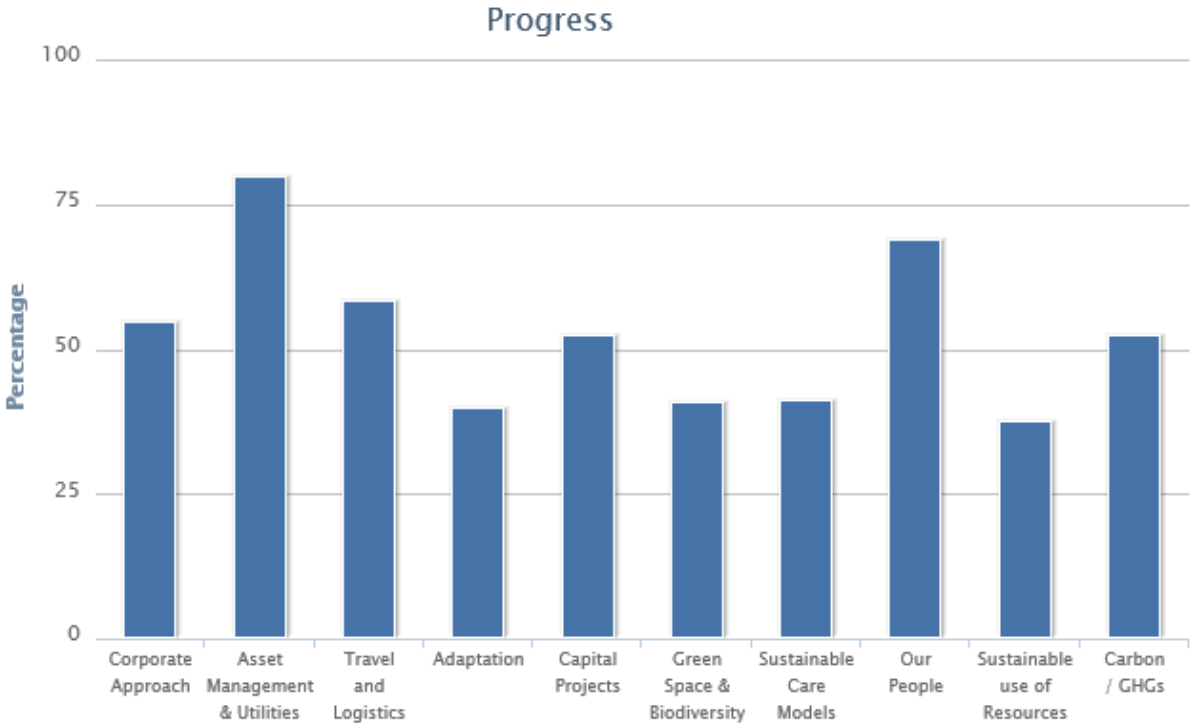
Climate change brings new challenges to our business both in direct effects to the healthcare estate, but also to patient health. Examples in recent years include the effects of extreme temperatures and prolonged periods of cold, floods and droughts, which are expected to increase as a result of climate 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

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

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.

3.3 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 the organisation has changed over time. The table also shows the changes following the merger with Weston from 2020/21. We will look to re-baseline the historical data to account for the merger.

Table 8: Organisational change

	2016/17	2017/18	2018/19	2019/20	2020/21 incl. Weston
Floor Space (m2)	195,044	195,044	195,044	195,044	227,565
No. of Staff	8,496	8,677	8,934	9,321	11,131

We have supported the Climate Change Act targets as follows:

3.3.1 Energy

We have reduced our carbon emissions from total energy use year on year. We have continued to purchase 100% green Renewable Energy Guarantees of Origin (REGO) electricity under our supply contract since 2018/19. With the addition of Weston data for the 2020/21 year, LPG has been introduced as it is used to heat their dental building.

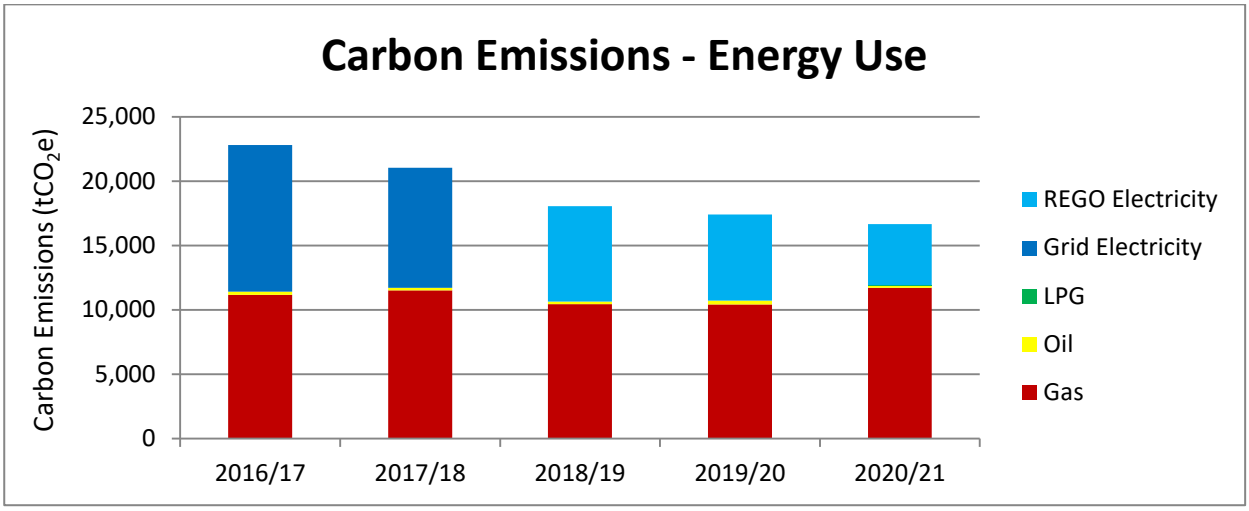


Table 9: Energy use

Resource		2016/17	2017/18	2018/19	2019/20	2020/21 incl. Weston
Gas	Use (kWh)	60,701,598	62,552,655	56,729,051	56,625,012	63,745,857
	tCO_2e	11,169	11,520	10,438	10,411	11,721
Oil	Use (kWh)	868,669	727,117	737,045	1,143,486	675,780
	tCO_2e	233	195	198	306	181
LPG	Use (kWh)	0	0	0	0	10,542
	tCO_2e	0	0	0	0	2

Grid Electricity	Use (kWh)	27,665,724	26,547,528	0	0	0
	tCO_2e	14,298	11,833	0	0	0
Grid REGO Electricity	Use (kWh)	55,804	42,964	26,223,729	26,189,963	20,366,737
	tCO_2e	0	0	7,413	6,684	4,748
Total Energy tCO_2e		22,801	21,048	18,049	17,401	16,652

Our carbon emissions from energy consumption have reduced by 749 tonnes (4.3%) in the past year. This has been primarily driven by the wider decarbonisation of the national grid, reducing the emissions from our electricity consumption. This has been so effective that it has offset the increase in gas use associated with our two new Combined Heat and Power (CHP) engines.

We have replaced our existing 1 megawatt (MW) CHP engine with a larger 3.36MW CHP and district heating facility in phase 1 of a project which will enable the Trust to efficiently generate more electricity and heat; further reducing the electricity we import from the grid.

The Trust has been awarded £17.6 million of Public Sector Decarbonisation Scheme (PSDS) funding to complete the second phase of this project, which has now begun. This will see the CHP system linked to the rest of Bristol's city centre buildings, enabling us to fully de-steam the site. The second phase is due to be completed by the end of 2021, and will result in moderate decreases in natural gas emissions.

The PSDS funding supports decarbonisation projects at Weston, including upgrades to the heat distribution system and building management system. Solar photovoltaic panels, air source heat pumps and LED lighting replacements will also go ahead. These projects will significantly help the Trust meet its ambitious goal to become carbon neutral by 2030.

3.3.2 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. We have seen a huge drop in air pollution during the first Covid lock down and a large number of staff taking up walking or cycling to work. The challenge will be to support staff to maintain these changes going forward. We have also seen many staff working from home and will seek to maintain the benefits that flexible working arrangements have shown.

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. We have made improvements to the Trust cycle centres increasing capacity and improving security. 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	2016/17	2017/18	2018/19	2019/20	2020/21 incl. Weston
Patient and visitor travel	miles	30,005,436	30,592,210	35,990,587	35,711,130	32,179,499
	tCO_2e	10,844	10,994	11,410	11,823	8,876
Business travel and fleet	miles	762,008	136,688	144,000	140,092	139,296
	tCO_2e	275	50	53	52	51
Staff commute	miles	8,164,656	8,335,279	8,582,157	8,957,481	10,606,557
	tCO_2e	2,252	2,299	2,367	2,471	2,926

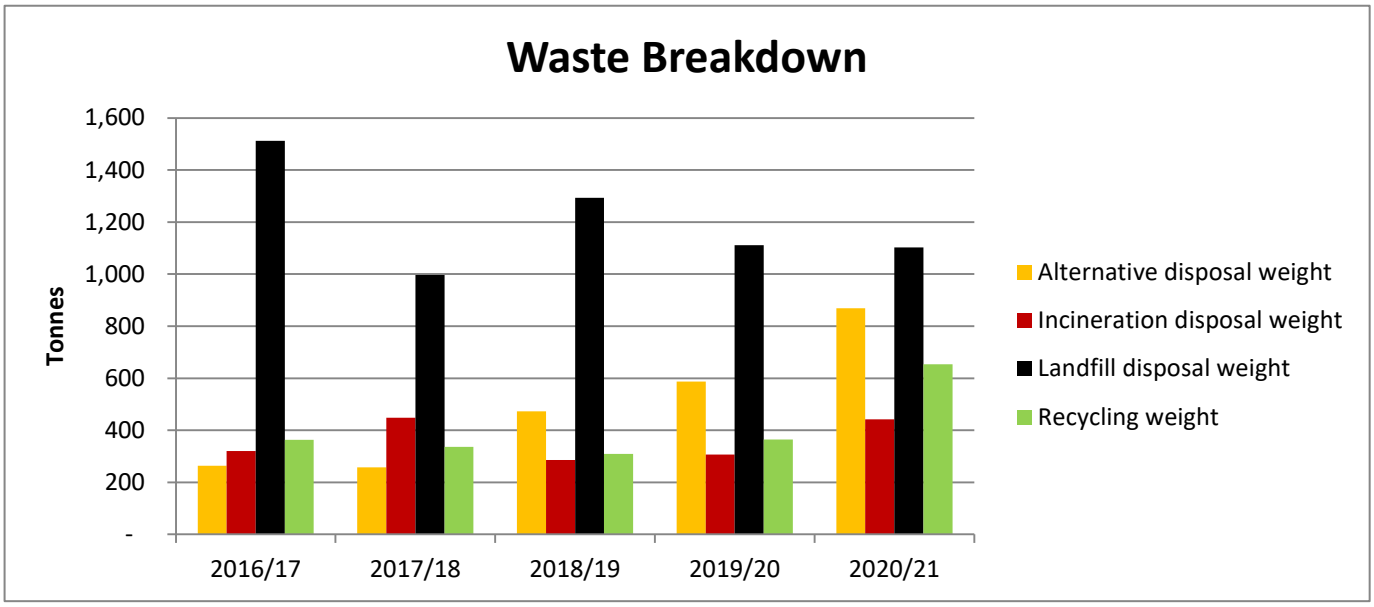
3.3.3 Waste

Overall, waste has increased in 2020/21 due to higher levels of activity. We have seen increases due to Covid related waste which has been a significant impact as well as backlogs of clearance due to national issues with processing capacity. 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, making recycling the first choice, 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 partnering with local organisations (such as Collecteco).

Table 11: Waste management

Waste		2016/17	2017/18	2018/19	2019/20	2020/21 incl. Weston
Recycling	(tonnes)	363	337	310	365	653
	tCO_2e	8	7	7	8	14
Other Recovery	(tonnes)	264	258	472	588	869
	tCO_2e	6	5	10	13	19
High Temp Disposal	(tonnes)	320	448	286	307	441
	tCO_2e	7	10	6	7	9
Landfill	(tonnes)	1,512	996	1,293	1,111	1,102
	tCO_2e	693	457	592	509	505
Total Waste (tonnes)		2,459	2,039	2,361	2,371	3065
% Recycled or Re-used		15%	17%	13%	15%	21%
Total Waste tCO_2e		713	479	615	536	547



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.

3.3.4 Water

Increased activity and the inclusion of Weston data has increased our consumption of water in 2020/21.

Table 12: Consumption of water

Water		2016/17	2017/18	2018/19	2019/20	2020/21 incl. Weston
Mains Use	m^3	250,457	233,033	223,504	226,912	272,470
	tCO_2e	86	80	77	78	94
Waste Treatment	m^3	225,411	207,952	199,529	202,218	245,223
	tCO_2e	160	147	141	143	174

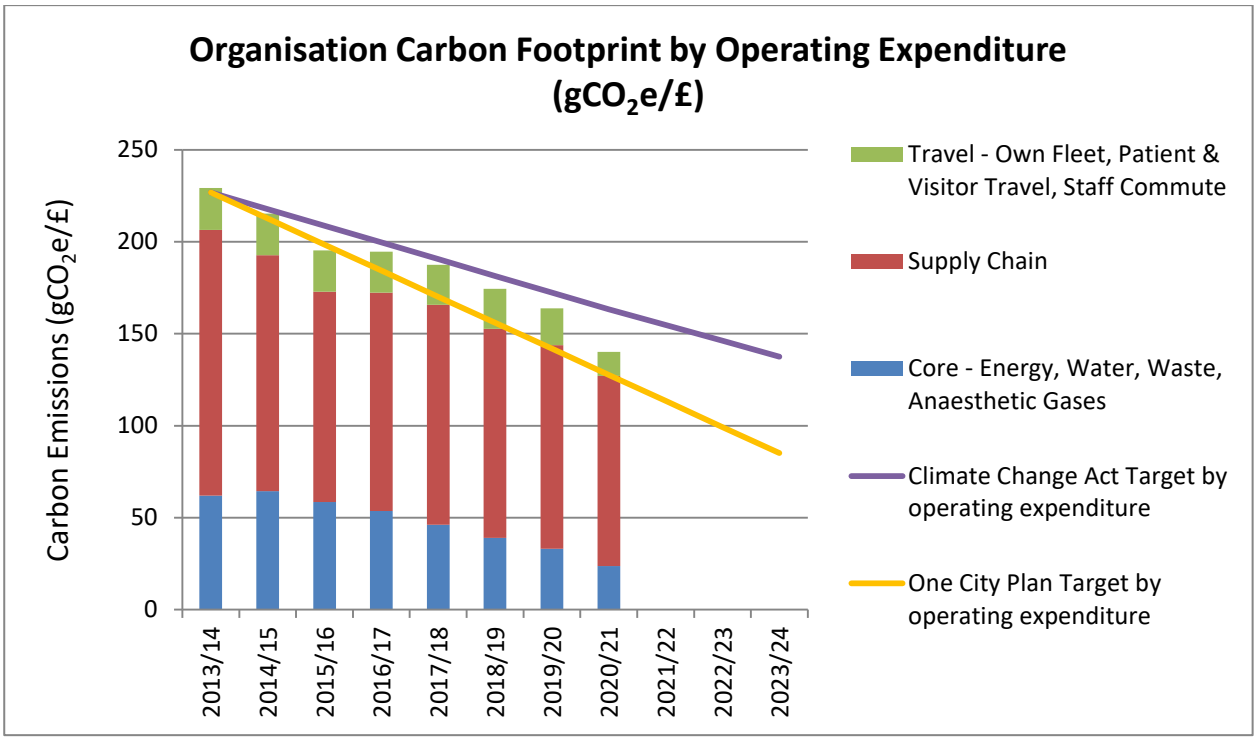
3.4 Modelled Carbon Footprint

This model indicates an estimated total carbon footprint of 127,799 tonnes of CO_2e for the Trust. Our carbon intensity is 140 grams of CO_2e emissions per pound of operating expenditure (gCO_2e/£), below the average emissions for acute services nationally, which is 200 grams per pound of operating expenditure.

With 74% of the Trust's carbon footprint being attributed to our supply chain we are working with Bristol and Weston Purchasing Consortium and are involved with a number of projects (Healthcare Without Harm, EcoQuip+) to reduce these procurement impacts.

Table 13: Total carbon footprint

Carbon Footprint Category	% CO_2e
Core – Energy, Water, Waste, Anaesthetic Gases	17 %
Supply Chain	74%
Travel - Own Fleet, Patient & Visitor Travel, Staff Commute	9%



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.

4 Accountability Report

4.1 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.

4.1.1 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

4.1.2 Political donations

The Trust made no political donations during 2020/21.

4.1.3 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 End of second term 30 November 2023
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 Appointment 1 April 2020 End of first term 31 March 2023
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 End of second term 30 May 2020 Re-appointed for a third term of three years ending on 30 May 2023
Bernard Galton, Non-executive Director Appointment 1 July 2019 End of first term 30 June 2022
Kam Govind, Associate Non-executive Director Appointment 1 April 2020 End of first term 31 March 2021
Jayne Mee, Non-executive Director Appointment 1 June 2019 End of first term 31 May 2022
Jane Norman, Non-executive Director Appointment 1 March 2021 End of first term 29 February 2024
Anthony (Guy) Orpen, Non-executive Director Appointment 2 May 2012 End of first term 1 May 2015

End of second term 1 May 2018 End of third term 31 December 2020
Martin Sykes, Non-executive Director and Vice-Chair Appointment 4 September 2017 End of first term 31 August 2020 End of second term 31 August 2023
Steven West, Non-executive Director Appointment 3 July 2017 End of first term 2 July 2020 End of second term 2 July 2023
Robert Woolley, Chief Executive Appointed 8 September 2010
Paula Clarke, Director of Strategy and Transformation Appointed 4 April 2016
Deirdre Fowler, Chief Nurse Appointed as Interim Chief Nurse 18 January 2021 Appointed as Chief Nurse 29 April 2021
Matthew Joint, Director of People Appointed 1 November 2017
Neil Kemsley, Director of Finance and Information Appointed 1 July 2019
William Oldfield, Medical Director Appointed 1 August 2018
Mark Smith, Deputy Chief Executive and Chief Operating Officer Appointed 13 February 2017
Carolyn Mills, Chief Nurse Appointed 6th January 2014 End of term 31st January 2021

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

4.1.4 Statement on compliance with cost allocation and charging guidance

The Trust ensures that it sets any charges to recover full costs in line with the guidance issued by HM Treasury.

4.1.5 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.

4.1.6 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 objectives 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 2020, we published our new four year quality strategy (2021-25), which structures our quality improvement work around four core quality themes:

1. To make quality the first priority for every member of staff – the 'why' that's behind everything we do.
2. To reduce unwanted variation in the quality and safety of services through an unswerving focus on continuous evidence-informed improvement.
3. To work closely with patients, families and other healthcare partners to improve healthcare experience and co-design better joined up care.
4. To be recognised by our patients, staff and regulators for delivering consistently outstanding patient care.

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 six clinical divisions and Trust Services corporate division with monthly and quarterly Divisional Reviews conducted with the Executive team, although these reviews were impacted by the Covid-19 pandemic in 2020/21. 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.

4.1.7 Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. Financial processes ensure all invoices are properly authorised before being paid. The complexity of services provided to the Trust 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 Trust's performance against this standard is shown in the table below:

Table 15: Performance against Better Payment Practice Code:

	Year ended 31 March 2021			Year ended 31 March 2020		
	NHS Payables	Non NHS Payables	Total	NHS Payables	Non NHS Payables	Total
No. invoices paid within 30 days	2,698	131,924	134,622	3,334	129,204	132,538
No. invoices paid	5,370	162,321	167,691	5,546	155,803	161,349
Percentage paid within 30 days - number	50.2%	81.3%	80.3%	60.1%	82.9%	82.1%
Value of invoices paid within 30 days	£46.614m	£251.306m	£297.920m	£46.183m	£192.684m	£238.866m
Value of invoices paid	£79.592m	£327.424m	£407.016m	£69.687m	£238.967m	£308.654m
Percentage paid within 30 days – value	58.6%	76.8%	£73.2%	66.3%	80.6%	77.4%

The reduction in performance reflects the challenges of operating within the pandemic, through the remote working of administrative staff, the difficulty in obtaining authorisation to pay from operational staff and the increased time taken to engage with and resolve queries with other organisations. In addition the significant changes to the intra-NHS funding regime through the year impacted on the performance with regard to NHS payables.

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 a paid to cover debt recovery cost under this legislation.

4.1.8 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 roles and responsibilities of the Council are set out in a separate document. 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 governors' meetings.

Communications and consultations between the Council and the Board include the Trust's annual Quality Report; strategic proposals; mergers and acquisitions, significant transactions, 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 of Governors at the Annual Members' Meeting.

The Council has developed a good working relationship with the Chair and Directors, and through the forums of Governor Focus Groups (dealing with matters of constitution and membership engagement; strategy and planning; and quality and performance monitoring), development seminars and informal Governor-NED Engagement Sessions, governors are provided with information and resources to enable them to engage in a challenging and constructive dialogue with the Non-Executive Directors.

Council of Governors Meetings

The four formal meetings of the Council of Governors are scheduled to follow some of 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. All governor and membership activities formally report into the Council meetings. 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. Governors use these meetings to publicly seek assurance on matters of public and staff interest.

There were 5 formal Council of Governors meetings in the year (including one extraordinary meeting). Due to the Covid-19 pandemic, all were held virtually by videoconference and were livestreamed via YouTube for public viewing. Two key areas of focus for governors this year concerned the Trust's handling of the pandemic (with a strong emphasis on staff safety and wellbeing as well as on patient care) and the way that the Trust was approaching its integration and cultural change aspirations following the merger between University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust. These are also the formal decision-making meetings for governors. Among the decisions taken in 2020/21 were the following:

- To re-appoint the Chair, Jeff Farrar, and Non-Executive Directors Guy Orpen, Julian Dennis, Martin Sykes, Steve West, and David Armstrong.
- To appoint Jane Norman as Non-Executive Director for a three-year term of office from 1 March 2021.
- To increase remuneration for the Trust Chair from £55,000pa to £60,000pa, to reflect the change of size of the Trust post-merger and to bring UHBW into line with the NHSE/I median rate for Trusts with an equivalent income. Also to increase Non-Executive Director remuneration by £1,000pa to £14,000pa to bring UHBW into line with its peer Trusts.
- To approve Chair Jeff Farrar's temporary departure from the Trust for six months from 1 April-30 September 2021 (to take up a temporary role as Chair of the Healthier Together Integrated Care System), and to appoint Non-Executive Director Jayne Mee as Interim Chair of the Trust for six months in his place.
- To appoint KPMG as the Trust's External Auditors for a period of three years from June 2021.

- To approve the Capital Business case for the purchase of an office block in central Bristol.

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.

Table 16: Membership and attendance at Council of Governors meetings 2020/21

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 2020 to 31 March 2021	**5**
Chair: Jeff Farrar	**C5 (5)**
Governors	
Hessam Amiri	3 (5)
Kathy Baxter	0 (1)
Ashley Blom	4 (4)
Graham Briscoe	5 (5)
John Chablo	5 (5)
Carole Dacombe	5 (5)
Aishah Farooq	2 (5)
Tom Frewin	4 (5)
Chrissie Gardner	4 (5)
Sophie Fernandes (nee Jenkins)	2 (5)
Carole Johnson	0 (1)
Barry Lane	0 (2)
Astrid Linthorst	1 (1)
Hannah McNiven	4 (5)
Sue Milestone	4 (5)
Sally Moyle	4 (5)
Hannah Nicoll	3 (3)
Debbi Norden	2 (5)
Graham Papworth	2 (5)
Penny Parsons	0 (5)
Mo Phillips	5 (5)
Ray Phipps	5 (5)
John Rose	5 (5)
Martin Rose	4 (5)
Marimo Rossiter	1 (2)
Jane Sansom	3 (5)
John Sibley	5 (5)
Malcolm Watson	2 (5)
Mary Whittington	2 (5)
Garry Williams	0 (5)
Non-executive Directors	
David Armstrong	5 (0)
Sue Balcombe	4 (0)
Julian Dennis	5 (0)
Bernard Galton	4 (0)
Kam Govind (Associate)	4 (0)
Jayne Mee	5 (0)
Jane Norman	1 (0)
Anthony (Guy) Orpen	2 (0)
Martin Sykes	5 (0)
Steven West	1 (0)

Executive Directors	
Robert Woolley	5 (0)
Deirdre Fowler	2 (0)
Mark Smith	4 (0)
Paula Clarke	0 (0)
Matthew Joint	3 (0)
Carolyn Mills	2 (0)
Neil Kemsley	5 (0)
William Oldfield	2 (0)

4.1.9 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 UHBW 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. The Committee is chaired by the Chair of the Trust and has 12 governor members.

The Committee met via videoconference on two occasions (May and November 2021), and in between meetings it conducted business via email. The Committee's work included reviewing activity records and annual performance appraisal reports for each of the Non-executive Directors and making recommendations on re-appointment decisions for the Chair and Non-Executive Directors. The Committee also reviewed Chair and Non-Executive Director remuneration, and recommended an increase in both, taking into account benchmarking information from similar-sized Trusts and national guidance. Committee members were involved in all aspects of the recruitment process and appointment of a new Non-Executive Director (November 2020-January 2021) and the recruitment of a new Interim Chair (February-March 2021), including reviewing applications and sitting on the interview panel. In the year the Committee conducted a self-review and review of its terms of reference.

4.1.10 Performance and development of the Council of Governors

Development of the Council of Governors has been shaped by the Covid-19 pandemic which necessitated a shift in the Trust's priorities as well as the need to adopt new ways of working. This has meant establishing effective online governor meetings and ensuring that governors are able to participate.

Maintaining information flow has been important in this period (particularly with relation to how our hospitals and staff were coping with the pandemic) and in supporting interaction between governors and the Chair, the Board, and within the governor group. The Council of Governors rose to the challenge and has not only been able to carry out all of their necessary formal statutory duties in the year but has also provided a considerable amount of constructive challenge, questions and feedback on the impact of the pandemic on the Trust and many other areas of the Trust's work. A lot of this work was carried out through online meetings of the three governor groups: the Quality Focus Group, Governors' Strategy Group and Constitution Focus Group.
In terms of formal training, two Governor Development Seminar afternoons took place. These form an important part of the programme of development for governors, and the programme provides governors with training on their statutory duties (such as the appointment of the External Auditor) and talks on the effect of the pandemic on the patients and staff at our hospitals by looking at the impact of Covid on Trust performance, and on the Trust's People Strategy, Digital Strategy, Sustainable Development Strategy and Education Strategy.

The Lead Governor for 2020-21 was Mo Phillips, Public Governor.

4.1.11 Governor elections

Governor elections are held every two years out of three. Governor elections were due to open for nominations on 1 April 2020 on the formation of UHBW; however these were postponed for

12 months due to the impact of Covid-19 on the Trust and its activity. This was in line with the measures outlined for local government elections in the Coronavirus Act 2020.

The membership team worked with the Trust's Youth Involvement Group to support the appointment of two young governors, Aishah Farooq (reappointed) and Hannah Nicoll. They began a one year term of office in September 2020.

Planning was undertaken in the latter half of the year to support the governor elections postponed from 2020 now taking place in spring 2021, with 11 seats up for election across five constituencies.

Table 17: Governors by constituency – 1 April 2020 to 31 March 2021

There are 29 governor seats in total. As at 31 March 2021, there were 25 governors in post (16 public, four staff and five appointed) and four vacancies.

Constituency	Name	Tenure	Elected or Appointed
Public Governors			
Public Bristol	Kathy Baxter	June 2019 to July 2020 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 2017 to May 2020 (extended to May 2021) June 2016 to May 2019 June 2013 to May 2016	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 (extended to May 2021)	Elected
Public Bristol	Martin Rose	June 2019 to May 2022	Elected
Public Bristol	Mary Whittington	June 2017 to May 2020 (extended to May 2021)	Elected
Public North Somerset	Graham Briscoe	June 2019 to May 2020 (extended to May 2021) June 2014 to May 2017	Elected
Public North Somerset	Penny Parsons	June 2017 to May 2020 (extended to May 2021)	Elected
Public North Somerset	John Rose	June 2017 to May 2020 (extended to May 2021)	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
Staff Governors			
Medical and Dental	Jane Sansom	June 2018 to May 2020 (extended to May 2021)	Elected
Non-clinical Staff	Chrissie Gardner	June 2019 to May 2020 (extended to May 2021)	Elected
Non-clinical Staff	Barry Lane	July 2018 to Oct 2021	Elected
Nursing and Midwifery	Hannah McNiven	June 2019 to May 2022	Elected
Nursing and Midwifery	Debbi Norden	June 2019 to May 2022	Elected
Appointed Governors			
Bristol City Council	Carole Johnson	September 2016 to May 2020	Appointed
Joint Union Committee	Sophie Jenkins	June 2020 to May 2023 June 2017 to May 2020	Appointed
University of Bristol	Astrid Linthorst	June 2017 to May 2020	Appointed
University of Bristol	Ashley Blom	June 2020 to May 2023	Appointed
University of the West of England	Sally Moyle	June 2020 to May 2023 June 2017 to May 2020	Appointed
Youth Involvement Group	Aishah Farooq	September 2020 to August 2021 September 2019 to August 2020 September 2018 to August 2019	Appointed
Youth Involvement Group	Marimo Rossiter	September 2019 to August 2020	Appointed
Youth Involvement Group	Hannah Nicoll	September 2020 to August 2021	Appointed

4.1.12 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). The Trust has two membership constituencies as follows:

- A public constituency with four constituency classes: Bristol; North Somerset; South Gloucestershire; and Rest of England and Wales
- A staff constituency with four constituency classes: medical and dental; nursing and midwifery; other clinical healthcare professionals; and non-clinical staff.

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.

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. Membership is free to

join and people can become members by completing a short application form, which is available on the Trust website or in printed form around our hospitals. Public members receive news from our hospitals, invitations to come to events or have their say on our services, and can stand for election as governors and vote for governors to represent them. Members of the Trust can contact the elected governors who represent them by emailing FoundationTrust@uhbw.nhs.uk. This information is available on the Membership page of the Trust website: https://www.uhbw.nhs.uk/p/working-with-us/become-a-member-of-our-trust and is publicised in all communications to members.

Changes as a result of the merger

Of the two Trusts that merged to form UHBW on 1 April 2020, only University Hospitals Bristol NHS Foundation Trust was a Foundation Trust. The membership and Council of Governors of University Hospitals Bristol NHS Foundation Trust therefore remained in place in the combined Trust post-merger, with the only change being that Weston Area Health NHS Trust staff became Foundation Trust members on 1 April 2020 and were now represented by the Trust's staff governors. Consideration had been given by the Council of Governors as to whether changes were required to the structure of the Trust's public membership on merger, but it was decided that this was not necessary as UH Bristol already had a sizeable North Somerset public membership which was representative of the local population and which was represented by three governors.

Information about the composition of Trust membership is below.

Table 18: Members of the Foundation Trust

Public constituency	**2020/21**
At year start (1 April 2020)	7,757
New members	74
Members leaving	1,373
At year end (31 March 2021)	6,458
Staff constituency	2020/21
At year start (1 April 2020)	13,486
At year end (31 March2021)	14,200

4.1.13 Membership Strategy

Membership Engagement: Despite the pandemic, the Trust continued to implement many of the objectives of its 2020-23 Membership Strategy and to engage with its members as appropriate. Members for whom the Trust had an email address continued to receive regular monthly email newsletters with key messages about the pandemic and other Trust news as well as involvement opportunities from around the Trust and our partners in the wider health system. These were introduced by a different governor each month to enable governors to engage with their constituents. Members who the Trust can only contact by post (just over half of the public membership) received a letter from the Trust Chair in August and March in lieu of the Trust's 'Voices' magazine, production of which had halted this year due to the pandemic. Restrictions on face-to-face events this year reduced the number of membership involvement opportunities in this period, but members were invited to the Annual Members' Meeting in September and an event for carers to highlight support during the pandemic in October, both of which were held online. More members than usual contacted the membership team and the governors this year to ask questions, raise issues and give feedback on our services. Young Members continued to be engaged with the help of the Trust's Youth Involvement Group, with one of our Youth Involvement Group governors, Aishah Farooq, representing young people at a national level on the NHS Youth Forum. Staff governors engaged with their constituents through regular articles in staff newsletters. Awareness-raising of membership and of the governor role increased in February-March 2021 in the run-up to

the 2021 governor elections, including a greater social media presence and additional promotion to Weston staff.

Reducing Membership Numbers

Membership numbers have reduced in the year as a result of a proactive approach to updating membership records, as set out in the Trust's 2020-23 Membership Strategy. The strategy recognised that for some members who joined over a decade ago, membership may no longer be relevant. The Trust therefore committed to writing to a proportion of members every year over three years to ask them to reconfirm whether they wish to remain members, with the intention of removing from membership those who do not respond. In August 2020, the Trust wrote to a tranche of 1,000 members who joined in 2007 who were asked to positively reconfirm whether they wished to remain as members of the Trust. They were informed that if they did not wish to remain members, they did not need to contact us and their details would be removed from the Trust's register of members after 3 months. Around 30 members contacted the Trust to request continuation of their membership and the remainder were removed from the Trust's register of members in November 2020.

Table 19: Analysis of current membership

Public constituency	Number of members	Eligible membership
Total (public members in Bristol, North Somerset and South Gloucestershire)	**5,705**	**977,100**
Age (years):		
0-16	89*	190,825
17-21	313	64,189
22+	5,154	722,086
Ethnicity:		
White	4,732	806,242
Mixed	101	21,138
Asian or Asian British	241	32,531
Black or Black British	170	28,584
Socio-economic groupings:		
AB	1,620	100,766
C1	1,686	129,184
C2	1,125	82,379
DE	1,249	94,941
Gender analysis		
Male	2,310	485,625
Female	3,201	491,475

This analysis excludes public members living outside Bristol, North Somerset and South Gloucestershire, and (as appropriate) public members with no date of birth, no stated ethnicity or no stated gender. *Members of UHBW must be at least seven years of age.

4.2 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 remains focused on responding to national requirements and delivering our commitment to address aspects of care that matter most to our patients. Our patients 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.

4.2.1 Our Patient Safety Improvement Programme 2019-2021

Our original three year patient safety improvement programme was paused in 2019/20 as staff who support the programme were necessarily deployed to focus on patient care and other support activities during the Covid-19 pandemic. However, the focus of patient safety improvement work within UHBW switched to agile national initiatives such as 'Covid oximetry at Home'.

4.2.2 Stakeholder relations

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 2020/21 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.

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.

4.2.3 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 2020/21, 8388 patients, staff and volunteers gave their time to take part in the research that we lead and host.

This year saw Bristol Health Partners accredited as the Bristol Health Partners National Institute for Health Research Academic Health Science Centre (BHP NIHR AHSC), one of just eight designated in April 2020. Our academic and clinical strengths, demonstrated by the AHSC designation, alongside our role as host for the NIHR Applied Research Collaborative West (ARC West) and NIHR Biomedical Research Centre (Bristol NIHR BRC), have positioned us to respond strongly to the challenge of the Covid-19 pandemic, underpinning 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, 14 NIHR project or programme grants and 3 NIHR Fellowships. Our NIHR overall grant income remained at last year's level. Our focus on pump priming grants and submissions to NIHR funding streams, with the local and regional support of the NIHR Research Design Service has continued, despite the challenge of the Covid-19 pandemic. New grants starting during the reporting period include:

- Andrew Dick NIHR-HTA: Adalimumab vs placebo as add-on to Standard Therapy for autoimmune Uveitis: Tolerability, Effectiveness and cost-effectiveness. The ASTUTE pragmatic randomised controlled trial.
- Chris Bourdeaux: SMARTT Critical Care Pathways - (Safe, Machine Assisted, Real Time Transfer) An artificial intelligence based decision support tool to enable safer and more timely critical care transfer.

We have worked with researchers to submit 18 grant applications for NIHR funding, more than in any recent year, and whilst not all will be successful, this is a measure of the Trust's engagement with research and dedication of researchers to continue applying despite challenging clinical workloads.

Highlights of the last year include:

Andrew Dick's "ASTUTE" HTA mentioned above started work on the grant; this has been a hugely complex undertaking involving a home delivery healthcare company in a research trial for the first time; logistically and financially challenging to set up and included collaboration between the University of Bristol and several Trust departments - finance, procurement; pharmacy and R&I, as well as the regional specialised commissioners.

The ComFluCOV trial that looks at safety of giving Covid and Flu vaccines at the same time was submitted in a very short time in March, and again a recognition of the willingness of all Trust departments and University colleagues to work together on this urgent public health study commissioned by JCVI.

Chris Bourdeaux's SMARTT NIHR grant referred to above was submitted in April last year, at the height of the 1st wave of the pandemic. It is a testament to the dedication of Chris, an ITU consultant, and his team that they were able to do this under such enormous clinical pressures.

In response to the Covid-19 pandemic we suspended much of our research portfolio at the beginning of the reporting year as clinical services were paused, and then prioritised restarting studies which directly impacted significantly on the clinical conditions of our patients. At the end of the financial year we had restarted 45% of our portfolio, and 30% of recruiting studies had restarted and recruited.

Whilst the volume of our regular portfolio has reduced, our medical and nursing workforce has supported a new portfolio of research that is focussing on tackling the challenge of Covid-19. A Covid-19 clinical research leadership group was formed to triage and set up the Urgent Public Health studies that we considered were the most appropriate for the Trust. One of our biggest contributions to developing treatments for Covid-19 has been in recruiting over 400 patients to the RECOVERY trial in Bristol and Weston across the newly merged Trust. In addition, UHBW was the 7th highest recruiter to the REMAP-CAP study and recruited close to 500 staff into the Siren study which has provided Public Health England with crucial information regarding protection against re-infection of Covid-19. This research, along with other UPH studies, remains a priority alongside reopening our regular portfolio.

We were one of five centres to take part in COV-001, an early phase trial sponsored by the University of Oxford to look at the safety and effectiveness of ChAdOx1 nCoV-19 vaccine (now licensed and being administered as the AstraZeneca vaccine) and fully recruited to the trial within timelines, moving onto COV-002 immediately afterwards. We are now part of the COV-006 trial of the vaccine in under 18-year olds. We were able to deliver these trials initially by using a cross-Trust approach to staffing, with significant support from the local NIHR Clinical Research Network

(NIHR CRN West of England) and our regional partners. We subsequently appointed a dedicated vaccine and testing research team which is located in our newly established Clinical Research Facility and have participated in a 'first in man' trial of a novel Covid-19 vaccine, as well as additional phase 3 vaccine trials. The team is also running the AvonCAP study, which is a Pan-Pandemic Acute Lower Respiratory Tract Disease Surveillance Study and was highlighted by the Secretary of State for Health during a recent televised government Covid-19 briefing. The end of the financial year has seen us planning and sponsoring a trial to look at the tolerability and effectiveness of administering licensed Covid-19 vaccines at the same time as the Influenza vaccine, to generate data to inform the Winter 2021 flu programme.

Whilst the suspension of much of our commercial portfolio has reduced our usual activity, the funding associated with the Covid-19 research, both vaccine and therapeutic, has allowed us to maintain and increase our workforce to respond to the challenge.

Overall, we have performed well against national benchmarks in terms of our set-up times. The Clinical Research Network High Level Objectives have been suspended for this year, but despite this, recruitment levels overall have remained high, reaching 8388 at the end of the financial year.

There have been several notable achievements relating to industry led commercial trials over the last year. UHBW was selected as the lead UK site for the Phase 1 trial of Valneva's Covid-19 vaccine and recruited and vaccinated the first 15 participants anywhere in the world, as well as a further 41 participants to the trial. Our commitment and success in delivering this and other Covid-19 vaccine trials, have been recognised by the UK Vaccine Task Force in several letters of thanks. The Haematology Team in Bristol Haematology and Oncology Centre (BHOC) Clinical Trials Unit recently recruited the first patient in the UK to receive novel CAR-T therapy treatment for Multiple Myeloma as part of a commercial clinical trial. Over the last year, UHBW's Commercial Research Manager has been part of the NIHR CRN's group of National Vaccine Study Costing Leads, reviewing costings for Covid-19 vaccine trials on behalf of the NHS in England, which has helped to enhance UHBW's reputation as one of the key sites for vaccine research in the UK.

Going into 2021/22 our new challenges and opportunities will be to support the Covid-19 portfolio of research whilst reopening our standard portfolio in the challenging world where capacity is limited by the societal requirements for distancing in the clinical environment.

4.3 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 2020 to 31 March 2021.

4.3.1 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 was attended by the Chief Executive and Director of People in an advisory capacity when appropriate, and supported by the Director of Corporate Governance to ensure it undertook its duties in accordance with applicable regulation, policy and guidance.

The Committee met on six occasions in the reporting period to consider the annual review of Executive Directors' performance, the skills and knowledge mix of the Board of Directors, current remuneration levels, and the secondment of the Chief Nurse to the NHS Nightingale Hospital in Bristol and the Director of Strategy and Transformation to NHS England and Improvement. The Committee reviewed and approved the Trust's Fit and Proper Persons Policy, and received updates on compliance with the policy.

4.3.2 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 and to recognise the increased complexity following the merger with Weston Area Health NHS Trust.

4.3.3 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. In doing so, the Committee approved an additional uplift for two female Executive Directors to bring their remuneration in line with the male Executive Directors.

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 2020/21 and 2019/20. There were no exit packages paid to any director in either year. This information has been subject to audit.

Table 20: Remuneration for the senior managers of the Trust 2020/21 (Audited)

Directors remuneration for 2020/21 (£'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	55-60	n/a	n/a	n/a	55-60
Executive Directors:					
Robert Woolley, Chief Executive	235-240	n/a	n/a	n/a	235-240
Mark Smith, Deputy Chief Executive and Chief Operating Officer	175-180	n/a	n/a	65-67.5	245-250
Paula Clarke, Director of Strategy and Transformation	155-160	n/a	n/a	112.5-115	265-270
Neil Kemsley, Director of Finance and Information(note 1,2)	165-170	6200	n/a	n/a	170-175
Carolyn Mills, Chief Nurse until 31st January 2021	130-135	n/a	n/a	17.5-20	150-155
Deirdre Fowler, Chief Nurse from 1st February 2021	30-35	n/a	n/a	25-27.5	60-65

Matthew Joint, Director of People	160-165	n/a	n/a	37.5-40	200-205
William Oldfield, Medical Director	240-245	n/a	n/a	95-100	335-340
Non-executive Directors					
David Armstrong	15-20	n/a	n/a	n/a	15-20
Julian Dennis	15-20	n/a	n/a	n/a	15-20
Jane Norman from 1st March 2021	0-5	n/a	n/a	n/a	0-5
Guy Orpen until 31st January 2021	10-15	n/a	n/a	n/a	10-15
Sue Balcombe	10-15	n/a	n/a	n/a	10-15
Bernard Galton	15-20	n/a	n/a	n/a	15-20
Steven West	10-15	n/a	n/a	n/a	10-15
Martin Sykes (note 3)	15-20	200	n/a	n/a	15-20
Madhu Bhabuta until 2nd July 2020	0-5	n/a	n/a	n/a	0-5
Jayne Mee	10-15	n/a	n/a	n/a	10-15

Note 1 – No NHS Pension benefits have been disclosed as they are no longer a contributing member of the scheme.
Note 2 - Neil Kemsley's taxable benefit relates to a lease car.
Note 3 – Taxable benefits relate to reimbursement of travel cost for home to base mileage.

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

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 1st July 2019 (note 3)	120-125	4,800	n/a	n/a	125-130
Paul Mapson, Director of Finance and Information until 30th 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 31st 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 1st June 2019 (note 5)	5-10	1200	n/a	n/a	5-10
Bernard Galton from 1st 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 1st June 2019	10-15	n/a	n/a	n/a	10-15

Note 1 – Jeffrey Farrar reflects amounts recharged to Weston Area Health Trust as part of his role as Joint Chair.
Note 2 - Robert Woolley reflects amounts recharged to Weston Area Health Trust as part of his role as Joint Chief Executive. Robert Woolley's salary across both organisations was £235-240k, his pension related benefit was £75-77.5k, and his total remuneration was £310-315k.

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 Trust in preparation for 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.

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 of 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 2020/21 or 2019/20. (Audited)

There were no payments to past senior managers in either 2020/21 or 2019/20. (Audited)

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 2020/21 and 2019/20. 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 22: Pension benefits for the year ended 31 March 2021 (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 2021	Lump sum at age 60 related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 31 March 2021	Cash Equivalent Transfer Value at 1 April 2020	Real Increase in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Robert Woolley *(note 1)*	-	-	-	-	-	-	-	-
Mark Smith	2.5-5	10-12.5	45-50	135-140	1,098	971	96	0
Paula Clarke	5-7.5	7.5-10	60-65	135-140	1,219	1,075	116	0
Neil Kemsley *(note 1)*	-	-	-	-	-	-	-	-
Deirdre Fowler	0-2.5	0-5	45-50	140-145	1,036	834	31	0
Carolyn Mills	0-2.5	5-7.5	60-65	180-185	1,360	1,279	47	0
Matthew Joint	2.5-5	0	10-15	0	142	97	22	0
William Oldfield	5-7.5	5-7.5	60-65	85-90	1,064	945	92	0

Note 1 – No NHS Pension benefits have been disclosed as they are no longer a contributing member of the scheme.

This table includes details for the directors who held office at any time in 2020/21.

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 23: Pension benefits for the year ended 31 March 2020

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 1 April 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.

Table 24: 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 consistent 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 £150,000, 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.

4.3.4 Fair pay multiple (Audited)

The Trust is required to disclose the relationship between the remuneration of the highest-paid director in the organisation and the median remuneration of the organisation's workforce. The remuneration report shows that the highest paid director's remuneration fell into the £240,000 to £245,000 band (2019/20 £210,000 to £215,000). The midpoint of this band was 7.5 times (2019/20, 6.6 times) the median remuneration of the workforce, which was £32,139 (2019/20, £32,422). Remuneration ranged from £18,005 to £238,567 (2019/20, £18,007 to £212,200).

In 2020/21, no (2019/20, nil) employees received total remuneration in excess of the highest paid director.

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.

4.3.5 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.

4.3.6 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.

4.3.7 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 25: Expenses paid to Governors and Directors

Year	Directors			Governors		
	No. in office	No. reimbursed	Amount (£'00)	No. in office	No. reimbursed	Amount (£'00)
2020/21	19	8	35	30	3	2
2019/20	19	14	251	37	10	15

**expenses are reimbursement of travel and subsistence costs incurred on Trust business. The reduction in 2020/21 reflected the restrictions arising from the Covid-19 pandemic.*

4.3.8 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.

4.3.9 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
9th June 2021

4.4 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.

4.4.1 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 26: Analysis of staff costs

	2020/21			2019/20		
	Total	Permanent	Other	Total	Permanent	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	461,805	422,789	39,016	351,388	322,871	28,517
Social security costs	41,054	38,917	2,137	32,237	30,858	1,379
Pension costs*	75,392	72,642	2,750	60,673	58,534	2,139
Apprenticeship levy	2,130	2,190	-	1,691	1,691	-
Termination benefits	320	320	-	45	45	-
Agency/contract staff	20,310	-	20,310	11,816	-	11,816
Total Gross Staff Costs	601,011	536,798	64,213	457,850	413,999	43,851
Income in respect of salary recharges netted off expenditure	(3,456)	(3,456)	-	(3,206)	(3,206)	-
Employee expenses capitalised	(1,784)	(1,742)	(42)	(977)	(964)	(13)
Net employee expenses	595,771	531,600	64,171	453,667	409,829	43,838

4.4.2 Analysis of average whole time equivalent staff numbers

An analysis of the average whole time equivalent staff numbers employed by the Trust for 2020/21 and 2019/20 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 27: Average staff numbers (whole time equivalents)

Staff category	2020/21			2019/20		
	Total	Permanent	Other	Total	Permanent	Other
Medical and dental	1,664	1,553	111	1,305	1,217	88
Administration and estates	2,220	2,107	113	1,883	1,779	104
Healthcare assistant and other support	1,036	934	102	828	775	53

Nursing, midwifery & health visitors	4,548	3,970	578	3,569	3,151	418
Scientific, therapeutic and technical	1,466	1,409	57	1,286	1,240	46
Healthcare science staff	197	197	-	173	173	-
Total staff	11,131	10,170	961	9,044	8,335	709

4.4.3 Education, Learning and Development

The Trust wide education strategy was approved in 2019 with a vision of '*developing exceptional people for exceptional careers'* and the ambition for the Trust to become a beacon of outstanding education. 2020/2021 has seen the ongoing implementation of the strategy reflective of the core priority areas.

In order to support the strategy, and further the integration for Bristol and Weston based education teams, an education consultation of the Trust service structures were completed in December 2020. The new structure offers an integrated Trust education team with new capacity and capability to support the increasing profile of education.

The Trust's educational offer includes a diverse range of internal and external provision with the aim to develop and retain our people. 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. The Trust provides educational teaching and clinical placements for undergraduate medical students on behalf of the University of Bristol where students are based at both the South Bristol Academy and North Somerset Academy where the curriculum is overseen by Academy Deans and an education faculty employing dynamic, and inclusive methods of teaching.

Clinical placement expansion projects have been initiated during the past year that aim to seek new methods of both increasing capacity along with ensuring high quality learning environments. This work is seeking enhanced use of technology and models of clinical supervision. During the pandemic the education teams enabled national initiatives to be fully realised through under graduate students being offered paid student placements as a way to provide additional workforce supply. This work entailed close partnership working with universities such as UWE, Bristol and Health Education England. Students have reported positively on the support that was provided.

Clinical education aligned to workforce priorities is supported through a number of work streams. National funding for continuing professional development for nurses, midwives and Allied Health Professionals was made available during 2020/21 that was able to make a positive impact in the investment of education across all of the clinical divisions. The funding has been able to secure additional post registration education aligned to workforce priorities. As a result, a number of practice educator facilitator roles have been secured; roles able to work in clinical areas providing educational support and work based models of teaching. The roles complement the large network of existing multi-disciplinary clinical educator roles in adult and paediatric services that ensure subject expertise directly informs the skills development for safe and high quality patient care. In addition the simulation service provide a multi-disciplinary point of care programme tailored to the need of the clinical areas and informed through patient safety and local/national policy. During 2020/21 the simulation team were awarded accreditation with the Association for Simulated Practice in Health Care signalling a high level of assurance in relation to their ascribed standards. Postgraduate Medical Education is responsible for the governance and quality of training provided to all doctors in training in partnership with Health Education England. The team consists of a

Director of Medical Education and an administrative team alongside a broad base of educational faculty including educational and clinical supervisors.

In order to support decision making, the library and knowledge management services undertake a number of activities from outreach work to literature searches. The services support staff and trainees ensuring the right knowledge and evidence at the right time and in the right place for enabling high quality decision making. There is a physical library space at both the Weston and Bristol sites with access to a wide range of digital and physical resources.

The Trust continues to respond to government initiatives supporting young people into employment through the apprenticeship and traineeship programmes. The Trust provides a broad range of apprenticeship programmes working in close partnership with local colleges and universities. The apprenticeship pathways aim to recruit an inclusive and talented workforce from our local communities whilst providing career development pathways for existing staff. The range of apprenticeships moves from level 2 through to master's qualifications where staff are able to learn whilst in the workplace. During 2020 there was additional resource made available for literacy and numeracy functional skills for all staff groups thereby facilitating both skills attainment and opportunities for career progression. Going forward the education strategy will continue to maximise the many opportunities from apprenticeships aligned to both workforce and staff priorities. As part of the education strategy the Trust has a work experience programme linking with local schools and colleges. This activity promotes engagement with local communities and actively supports the widening participation agenda.
The Trust is part of actively leading the ICS BNSSG Learning Academy aimed at promoting integrated models of education to develop the skills for our current and future workforce ambitions. The priorities include pass porting of training records, collaborative school and college engagement, implementation of a system wide response to T-levels and the development of careers pathways and commissioning of education to support new roles. This activity has also developed system wide leadership development opportunities to support staff to work across organisational boundaries and engender innovation.

Partnerships with the University of Bristol and UWE, Bristol ensure the education and training of our workforce reflects local, regional, national and international priorities. Working collaboratively, training programmes promote multi-disciplinary models of education and many members of the Trust are involved in the delivery of both under graduate and post graduate education. The Trust also has strong connections with the local region for skills development through the West of England Combined Authority working with further education institutions such as Weston College and the City of Bristol College.

During 2020/21 education adapted to support the service response to the pandemic. This response involved rapidly mobilising upskilling programmes, introducing virtual learning, inducting military staff, online inductions, increased clinical and healthcare support worker inductions and diversification of training. In result, new skills have been attained such as digital and developing flexible training programmes. These changes will have a long standing legacy in the ways in which education is provided to our workforce.

4.4.4 Diversity and Inclusion

The Trust is committed to inclusion in everything we do because everyone has a right to be treated with dignity and respect. 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. To achieve this, the Trust launched an ambitious five-year workforce equality, diversity and inclusion strategy with an annual action plan built on four overarching themes with ten objectives.

By 2025 the Trust aims to:

- Be a Trust that continues to see an increase in staff engagement
- Be recognised as an inclusive employer that develops our people at every opportunity, spotting talent in every area of our diverse workforce
- 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 an annual action plan underpinning the strategy's objectives. To achieve this, the Trust has established robust equality, diversity and inclusion governance and reporting pathways. The Director of People is the nominated executive lead for equality, diversity and inclusion on the Trust Board with delegated responsibility for the delivery of the programme of work sitting with the Head of Organisational Development. The workforce equality, diversity and inclusion steering group is the Trust's key group delivering on the Trust equality, diversity and inclusion strategic objectives and compliance assurance with legislative and regulatory requirements relating to equality, diversity and inclusion. The Head of Organisational Development chairs the steering group and progress against the strategic objectives is monitored through the Trust's People Committee, which is chaired by a Trust Non-Executive Director.

A range of equality, diversity and inclusion information is published by the Trust on its public website, including demographic information in relation to its workforce and patients and measures to improve equality, diversity and inclusion across all protected characteristics.

The published information includes annual progress reports and action plans on Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES), Gender Pay Gap and the NHS Equality Delivery System (EDS2). The WRES, WDES and EDS2 are included in the Standard NHS Contract.

4.4.5 The Workforce Race Equality Standard (WRES)

The NHS Workforce Race Equality Standard (WRES) is designed to ensure employees from Black, Asian, and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Through nine evidence-based measures, the WRES highlights any differences between the experience and treatment of white staff and BAME 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 WRES action plan is integrated into the Trust's yearly equality, diversity and inclusion action plan and the Trust's yearly WRES report is available on its website.

4.4.6 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 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. This information is 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. The WDES action plan is integrated into the Trust's yearly equality, diversity and inclusion action plan and the Trust's yearly WDES report is available on its website.

4.4.7 The NHS Equality Delivery System (EDS2)

EDS2, with its four goals and 18 outcomes, is a toolkit that helps NHS organisations identify best practice and potential areas for improvement in relation to the experience of staff and patients from all protected groups. The Trust has completed the work required for the self-assessment of the four goals and 18 outcomes. Identified areas of improvement are incorporated into the Trust's yearly equality, diversity and inclusion action plan and through patient experience and involvement group for the patient outcomes.

4.4.8 Gender Pay Gap Reporting

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 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. The Trust's yearly gender pay gap report is available on its website and has been reported on the Government's gender pay gap reporting portal as required. Comparison data can be found at:
https://gender-pay-gap.service.gov.uk/

4.4.9 Training and the Equality Act

The Trust's equality, diversity and 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 refreshed 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 with the training remains consistently good.

4.4.10 Diversity and Inclusion in the Workplace

The Trust is committed to equality of opportunity for our staff across all protected groups through inclusive leadership and cultural transformation, positive action and practical support, accountability and assurance, monitoring progressive and benchmarking. Integral to this work are the three Trust staff networks:

- ABLE+ staff network supports staff and volunteers with physical, sensory or mental impairments to raise awareness of reasonable adjustment solutions to issues encountered at work.
- BAME staff network supports staff from Black, Asian and minority ethnic groups and other backgrounds.
- LGBT+ staff network supports lesbian, gay, bi-sexual and trans staff.

The staff networks meet regularly to provide peer support and discuss issues relating to Trust policy and procedure. Each staff network is represented on the Trust's workforce equality, diversity and inclusion steering group. Their programmes of work are key to the delivery of the Trust's vision of being committed to inclusion in everything we do, this includes:

- Contributing to the development and implementation of the Trust 2020/25 equality, diversity and inclusion strategy
- Playing an active part in celebrating the valuable contribution of our diverse staff
- Contributing to the WRES, WDES and LGBT reporting pathways and action plans
- Helping to support the programme of work to change organisational culture to be more inclusive

The Trust's HR Policies further underpin our commitment to equality, diversity and inclusion including:

- Equality, diversity and human rights policy: This sets out the Trust's commitments to equality, diversity, inclusion and human rights and its obligations under the 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: This 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: This 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 mental health and wellbeing.

4.4.11 Analysis of staff diversity profile

The Trust's annual statutory monitoring of workforce and patient data reflects information as at 31 March 2021. 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 28: Staff with permanent contract	**March 2021**	
Gender – All staff with a substantive employment contract	**Total**	**%**
Male	2,765	22.9%
Female	9,289	77.1%
GRAND TOTAL	12,054	100.0%

Table 29: Directors by gender	**March 2021**	
Gender – Directors (Executive and non-Executive)	**Total**	**%**
Male	11	68.8%
Female	5	31.3%
Grand Total	16	100.0%

Table 30: Other Senior Managers by gender	March 2021	
Gender – Other Senior Managers *	**Total**	**%**
Male	4	20.0%
Female	16	80.0%
Grand Total	20	100.0%

*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 31: Ethnicity

	March 2021	
Ethnicity	**Total**	**%**
A - White – British	8,670	71.9%
B - White – Irish	146	1.2%
C - White - Any other White background	1,011	8.4%
D - Mixed - White & Black Caribbean	63	0.5%
E - Mixed - White & Black African	38	0.3%
F - Mixed - White & Asian	56	0.5%
G - Mixed - Any other mixed background	85	0.7%
H - Asian or Asian British – Indian	503	4.2%
J - Asian or Asian British – Pakistani	58	0.5%
K - Asian or Asian British - Bangladeshi	20	0.2%
L - Asian or Asian British - Any other Asian background	187	1.6%
M - Black or Black British – Caribbean	174	1.4%
N - Black or Black British – African	296	2.5%
P - Black or Black British - Any other Black background	71	0.6%
R – Chinese	53	0.4%
S - Any Other Ethnic Group	218	1.8%
Z - Not Stated	405	3.4%
Grand Total	12,054	100.0%

Table 32: Disability	March 2021	
Disability	**Total**	**%**
No	10,644	88.3%
Not Declared	1,079	9.0%
Yes	331	2.7%
Grand Total	12,054	100.0%

Table 33: Age profile	March 2021	
Age profile	**Total**	**%**
16 – 20	131	1.1%
21 – 25	1,125	9.3%
26 – 30	1,780	14.8%
31 – 35	1,741	14.4%
36 – 40	1,549	12.9%
41 – 45	1,386	11.5%
46 – 50	1,277	10.6%
51 – 55	1,217	10.1%
56 – 60	1,104	9.2%
61 – 65	598	5.0%
66 – 70	114	0.9%
71 – 75	29	0.2%
76 – 80	3	0.02%
Grand Total	12,054	100.0%

Table 34: Religious belief	March 2021	
Religious belief	**Total**	**%**
Atheism	2,097	17.4%
Buddhism	67	0.6%
Christianity	4,300	35.7%
Hinduism	134	1.1%
Islam	244	2.0%
Jainism	3	0.02%
Judaism	14	0.1%
Sikhism	18	0.1%
Other	827	6.9%
I do not wish to disclose my religion/belief	3,760	31.2%
Undefined	590	4.9%
Grand Total	12,054	100.0%

Table 35: Sexual orientation	March 2021	
Sexual orientation	**Total**	**%**
Bisexual	111	0.9%
Gay or Lesbian	203	1.7%
Heterosexual or Straight	8,494	70.5%
Other sexual orientation not listed	9	0.1%
Not stated (person asked but declined to provide a response)	2,618	21.7%
Undecided	29	0.2%
Undefined	590	4.9%
TOTAL	12,054	100.0%

4.4.12 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.

2020/21 has been a challenging and exciting year for APOHS, the long serving and respected Business Manager left the service in October and was replaced by a Business Development Manager with over 15 years strategic management experience in the Public Sector. The service was also able to recruit a new consultant, relieving some of the pressure on the service and increasing consultant time from 1 WTE to 2 WTE. In addition following a successful Business Case the service was able to recruit additional band 5 and 7 nurses to meet the increasing demands on the service.

Unfortunately during this period the service lost one its main external contracts and this has led to a 15% reduction in funding to the service.

The pandemic has increased demand for occupational health support, a Covid Advice Line was set up for managers and staff to provide quick support and advice, our consultants have supported managers to interpret national guidance in relation to Covid and the nursing team has experienced a significant increase in management referrals to the service. At times it has felt relentless, to address this the team have worked evenings and weekends to ensure staff and managers feel supported.

Although this has been a challenging time for APOHS the team has actively sought out opportunities to improve the service, undertaking a number of process reviews to ensure the service is as efficient as it can be. As a result the service now has a fully functional online support service to staff and managers via its web portal, this has reduced 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.

APOHS has recently secured additional funding on behalf of the BNSSG Healthier Together programme to develop a Mental Health and Wellbeing hub. This service will be available to health and social care staff working across BNSSG. The service will complement the UHBW holistic Wellbeing Framework and respond to gaps in service provision and where appropriate support staff to access a rapid clinical assessment.

The UHBW holistic framework brings together the three key components of psychological, physical and healthy lifestyles. The delivery of this strategy is supported by a multi-professional steering group and over 250 Workplace Wellbeing Advocates who act as the nominated wellbeing advisor within their respective teams and ensure staff are signposted to wellbeing initiatives both corporately and locally.

The Trust continues to fulfil the requirements of the NHS England Commissioning for Quality and Innovation (CQUIN) for Staff Health and Wellbeing and works within the guidance of the Stevenson Farmer regulations to ensure staff are equipped with a wealth of resources to support their wellbeing at work including a 24/7 helpline.

4.4.13 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 review by topic Leads and monitored within the Trust Health and Safety

Committee with summary reports to the Risk Management Group. In addition, external audits are conducted biennially with internal departmental health and safety audits undertaken annually.

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

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

An annually reviewed risk management training prospectus includes all risk management training programmes. Coverage of this is monitored by the Trust Health and Safety Committee for compliance each quarter.

Expertise within the Manual Handling Team has enabled the Trust to access the most up to date knowledge and skills to reduce the risk of musculoskeletal disorders to the workforce and deliver efficient service improvement e.g. enhancement to training for Manual Handling Link Practitioners which gives clinical staff more responsibilities including competency training for hoist and falls equipment.

Changes within the Safety department in 2020/2021 have included introducing a new central service for FFP3 respirator 'Fit Testing' which was mostly undertaken at department level prior to this. This central service will continue as a permanent function available to all departments across all Trust sites. Challenges encountered earlier in this annual period included frequently changing makes/models of disposable respirators however the Trust maintained supplies to meet demand and are now 'Fit Testing' against sustainable supplies within the UK.

The merger with the Weston General Hospital site has seen the introduction of health and safety training for Managers and Risk Assessors plus a welcomed opportunity for additional development of on-site H&S Advisors who have commenced training for Institute of Occupational Safety and Health (IOSH) accreditation. The ongoing aim is to replicate the existing health and safety structure within the Weston General Hospital site. This has included the introduction of a Manual Handling Advisor to assist with both complex patient needs and in-situ training for specialist equipment.

4.4.14 Sickness absence

Data in respect of the Trust's average sickness for 2020/21 can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

4.4.15 Staff Turnover

Outturn at the end of 20/21 was 12.0% against a target of 13.1%. Staff retention was more balanced through the year, which is likely to be due to the impacts of the pandemic. The focus on retention in 2021/22 links to the priorities of the People Strategy and as a critical part of the Trust's focus on restoration and recovery.

4.4.16 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 2020/21 the Trust's expenditure on consultancy was £0.497m (2019/20: £0.435m).

4.4.17 Off-payroll engagements

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 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 36: Highly paid off-payroll worker engagements as of 31 March 2021, earning £245 per day or greater

No. of existing engagements as of 31 March 2021	-
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 37: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater

No. of off-payroll workers engaged during the year ended 31 March 2021	-
Of which:	
Not subject to off-payroll legislation	
Subject to off-payroll legislation and determined as in-scope of IR35	-
Subject to off-payroll legislation and determined as out-of-scope of IR35	-
Number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: number of engagements that saw a change to IR35 status following review	-

Table 38: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1st April 2020 and 31 March 2021

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.	37

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

4.4.18 Exit packages

The table below shows the number and cost of staff exit packages in 2020/21. 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 2019/20 are shown in brackets. This information has been subject to audit.

Table 39: Exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1 (-)	8 (5)	9 (5)
£10,000 - £25,000	1 (3)	2 (1)	3 (4)
£25,001 - £50,000	4 (-)	- (-)	4 (-)
£50,000 - £75,000	1(-)	2 (-)	3 (-)
Total number of exit packages by type	**7 (3)**	**12 (6)**	**19 (9)**
Total cost (£'000)	205 (45)	166 (34)	371 (79)

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

Table 40: Analysis of non-compulsory departures

	2020/21		2019/20	
	No.	£'000	No.	£'000
Voluntary redundancies including early retirement contractual costs	2	115	-	-
Mutually agreed resignation contractual costs (MARS)	-	-	-	-
Contractual payments in lieu of notice	10	51	6	34
Non-contractual payments requiring HMT approval	-	-	-	-
Total	12	166	6	34
Of which: Non contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

4.4.19 Engaging with staff

The Trust values provide the foundation for 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 development of the Trust cultural integration plan in 2020; as a result of our merger; will result in a full review of our values and leadership behaviours. This will create and build on the existing values culture creating newly developed UHBW Values co-designed and owned by the newly merged organisation.

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 the Board of Directors on behalf of their staff constituents to ensure that the Board remains focused on staff issues on the frontline.

4.4.20 NHS staff survey

The Trust continues to be committed to 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 2020 National Staff Survey response rate was 53% with over 6000 staff taking time to provide feedback on their experience at work.

Staff engagement with each other, the organisation, and our patients remains positive with an engagement score of 7.1. The staff engagement score remains above the average for an acute Trust which is 7.0.

The pride that staff have in organisation and their contribution is reflected in the responses to recommending the organisation as a place to work and receive treatment which is demonstrated in the results, with 72% of staff confirming that they would recommend University Hospitals Bristol NHS Foundation Trust as a place to work, and 83% saying they would recommend the Trust as a place to receive treatment. Wellbeing at work was a key focus this year for the Trust this is ranked as one of the most improved scores in the survey feedback.

This is further supported and demonstrated by positive improvements in the following questions:

- 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
- the organisation made adequate adjustments to enable me to carry out my work
- Staff satisfied with opportunities for flexible working patterns

As an additional theme in the 2020 Staff Survey there were a number of free text questions related to Covid-19. The National Co Ordination Centre will develop themes from the comments which will support to shape the development of the Trust Staff Restoration plans coming out of the pandemic.

4.4.21 Staff Survey Reporting

As a result of the merger the 2020 results are now representative of University Hospitals Bristol and Weston NHS Foundation Trust as a newly merged organisation.

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. The comparison data is University Hospitals Bristol NHS Foundation Trust for 2017, 2018 and 2019 and University Hospitals Bristol and Weston NHS Foundation Trust for 2020.

Table 41: NSS 2020 10 Indicator Scores

	2020		**2019**		**2018**		**2017**	
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	9.1	9.2	9.0	9.2	9.1	9.1	9.1
Health and well Being	6.3	6.1	6.1	5.9	6.0	5.9	6.1	6.0
Immediate Managers	6.8	6.8	6.9	6.8	6.8	6.7	6.7	6.7
Morale	6.3	6.2	6.4	6.1	6.3	6.1	N/A**	N/A**
Quality of Appraisal	N/A*	N/A*	5.6	5.6	5.5	5.4	5.3	5.3
Quality Of Care	7.4	7.5	7.4	7.5	7.3	7.4	7.3	7.5
Safe Environment Bullying and Harassment	8.3	8.1	8.2	7.9	8.2	7.9	8.1	8.0
Safe environment Violence	9.5	9.5	9.6	9.4	9.6	9.4	9.4	9.4
Safety Culture	6.9	6.8	6.9	6.7	6.8	6.6	6.7	6.6
Staff Engagement	7.1	7.0	7.2	7.0	7.2	7.0	7.1	7.0
Team Working	6.4	6.5	6.6	6.6	6.5	6.5	6.6	6.5

* Theme removed for 2020 **New theme from 2018

4.4.22 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.

The staff survey results are the greatest form of feedback and the priorities emerging from this enable the shaping of future corporate cultural plans supported by local Divisional plans to target hotspot areas.

Key areas of focus for 2021/22:

- A full review our Values and leadership behaviours; further developing our cultural integration as a newly merged organisation
- Continue to deliver our robust and holistic plan for wellbeing which includes:

- Embedding the positive behaviours framework
- Team interventions which provide staff with a safe space to check in and 'hold' the space

- Delivery of our strategy plan for equality, diversity and inclusion- focusing on the cultural influencing priorities including reciprocal mentoring and a detailed plan for WRES/WDES
- Working in partnership with the business to develop robust culture and people plans in response to the staff survey and staff experience during the pandemic, with an emphasis on listening and responding, and developing conversation frameworks which demonstrate evidenced based 'you said … we did', which have a foundation in creating the space where action is reality.

4.4.23 Pause Reflect and Rebuild

Covid-19 has brought the practice and possibility of immediate culture change into a reality and has demonstrated that a greater shift in behaviour is possible and as such a collaborative programme of work has been embarked on to set a pathway to recovery and change as we come out of the pandemic.

4.4.24 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 NHS Foundation Trust.

4.4.25 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.

4.4.26 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 and supporting positive behaviours framework 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.

4.4.27 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 42: Relevant union officials

Number of employees who were relevant union officials during 2020/21	Full-time equivalent employee number
47	10440

Table 43: Percentage of time spent on facility time

Percentage of time	No of employees
0%	-
1-50%	44
51%-99%	-
100%	3

Table 44: Percentage of pay bill spent on facility time

The total cost of facility time	£159,117
The total pay bill	£580,701,000
The percentage of the total pay bill spent on facility time	£0.027%

Table 45: Paid trade union activities

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

4.4.28 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 supporting 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 (FTSU) Guardian. The Director of Corporate Governance is the FTSU Guardian who is supported by a Deputy FTSU Guardian since 1 April 2020, and a network of around 80 voluntary FTSU staff advocates, who work in diverse roles and locations across the Trust.

The three objectives of the Trust's Freedom to Speak Up strategy focus on raising awareness of and building confidence in the speaking up programme, and ensuring that our leadership and management training is informed by the feedback from the programme.

The FTSU Guardian and advocates are visible across the Trust by attending key meetings, holding training sessions and talking to staff groups to promote speaking up messages. Promotional materials advertising the contact details for the FTSU Guardian (a dedicated phone number and email address) are available across the Trust. There are regular communications about speaking up which are shared in the weekly newsletter to all staff (Newsbeat), including profiles of the advocates and case studies on concerns which have been resolved.

The FTSU Guardian reports quarterly to the Board or People Committee on numbers and themes of concerns, feedback from those who have spoken up, and learning. The impact of the coronavirus pandemic and the merger with Weston Area Health NHS Trust in April 2020 were evident in the increase in the numbers of concerns raised via the FTSU Guardian in 2020/21. 47 concerns referenced the pandemic, including concerns around ward moves, social distancing, and appropriate rest space for staff, mask wearing, and vaccinations. 56 of the total number of concerns for the year were raised from Weston General Hospital, with the remainder of concerns split fairly evenly across the remaining divisions. In summary, for 2020/21 there were 112 referrals to the FTSU Guardian from all areas of the workforce, with the majority of concerns relating to attitudes and behaviours, which is reflective of the national picture.

In the year, the FTSU Guardian started a series of 'speaking up summits', which brought together individuals within the Trust whose key role is giving staff a voice (including the Head of Patient Safety, Chair of the Joint Union Committee, Guardian of Safe Working, Head of Employee Relations, and Associate Director of Education). The aim of the summits is to share themes and data around areas of concern and determine a multidisciplinary approach to tackle them. Speaking up summit participants are also working together to ensure that improvements to leadership and management training meet the needs of the diverse workforce and help staff to create a positive workplace culture in which people are supported to deliver their best.

In October 2020, the National Guardian, Dr Henrietta Hughes, spoke to the Board as part of Speak Up month and secured a commitment from the Board to undertake the three levels of speak up e-learning developed by Health Education England and the National Guardian's Office. From 1 February 2021, the first module of this e-learning became essential training for all staff in the Trust. In the year, face to face training was also introduced for the FTSU staff advocates to help them better support staff to speak up.
More details about the Freedom to Speak Up programme can be found in the Freedom to Speak Up annual report 2020/21, which is available on the UHBW website.

Table 46: Number and themes of concerns raised via the FTSU Guardian in 2020/21

	Q1	Q2	Q3	Q4	Totals
Number of cases raised to the FTSU Guardian	25	33	26	28	112
Cases relating to patient safety	4	3	4	1	12
Cases relating to attitudes and behaviours	12	14	9	13	50
Other cases	9	16	13	14	50

4.5 NHS Foundation Trust Code of Governance

University Hospitals Bristol and Weston 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 2020/21, 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, they 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 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.

4.5.1 Board Performance

Boards of NHS Foundation Trusts have faced significant challenges, financial and operational, in 2020/21. 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.

4.5.2 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.

4.5.3 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, people and digital services. These are the Quality and Outcomes Committee, the Finance and Digital Committee and the People Committee. The role, functions and summary activities of the Board's committees are described below.

Table 47: Board and Sub-Committee Attendance 2020/21

The Board of Directors discharged its duties during 2020/21 in 12 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 & Digital Committee
No. of meetings	18	6	6	11	6	9
Chairman						
Jeff Farrar	18 (C)	6 (C)	(2)	(8)	(5)	(8)
Chief Executive						
Robert Woolley	18	(5)	(5)	(0)	(0)	8
Non-executive Directors						
David Armstrong	18	3	6 (C)	(4)	(0)	9
Sue Balcombe	18	5	(0)	10	6	(0)
Madhu Bhabuta	5	1	(0)	(0)	(0)	(0)
Julian Dennis	18	6	6	11 (C)	(1)	(6)
Kam Govind	17	(0)	(0)	(0)	(5)	(0)
Bernard Galton	15	4	5		6 (C)	(0)
Jayne Mee	15	5	(0)	10	6	(0)
Anthony (Guy) Orpen	9	5	(0)	(0)	(0)	(0)
Martin Sykes	18	5	6	(0)	(0)	9 (C)
Steven West	14	4	(0)	(0)	(0)	6
Executive Directors						
Paula Clarke	8	(0)	(0)	(0)	2	(0)
Matthew Joint	17	6	(0)	(0)	6	(0)
Neil Kemsley	18	(0)	(6)	(0)	(0)	9
Deidre Fowler	4	(0)	(0)	3	1	(0)
Carolyn Mills	12	(0)	(0)	6	2	(0)
William Oldfield	18	(0)	(0)	8	4	(0)
Mark Smith	15	(0)	(0)	10	(0)	7

4.5.5 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.

4.5.6 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 and Digital 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 six 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 2020/21, 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's External Auditors are PricewaterhouseCoopers LLP (PwC). 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 Estates and Fire risks to ensure progress was being made in addressing the issues previously identified in these areas. The Committee also oversaw the appointment of KPMG as the new External Auditor for the Trust who will take on this role with effect from 1st August 2021.

4.5.7 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 and External Audit findings, 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 Terms of Reference) to ensure the Committee addresses all of its responsibilities in timely fashion. This is 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 and Digital 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 actions that are overdue.
- 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.
- 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.

4.5.8 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 2020/21, the Committee spent much of its time working closely with Executive members of the Board to monitor and support the Trust's response to the Covid-19 pandemic, and well as continuing to improve the quality of serious incident reporting and how the Trust can demonstrate Trust wide learning from such incidents.

4.5.9 Finance and Digital Committee

The Finance and Digital 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.
- Oversight of the delivery of the Trust's Digital Strategy

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 and Digital 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.

4.5.10 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 People Committee met on 6 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.

4.5.11 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

This segmentation information is the Trust's position as at 9th June 2021. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Robert Woolley
Chief Executive
9th June 2021

4.6 Statement of the Chief Executive's Responsibilities as the Accounting Officer of University Hospitals Bristol and Weston 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 and Weston 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 and Weston 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. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities."

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
9th June 2021

4.7 Annual Governance Statement

4.7.1 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.

4.7.2 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 and Weston 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 and Weston NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

4.7.3 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 England/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.

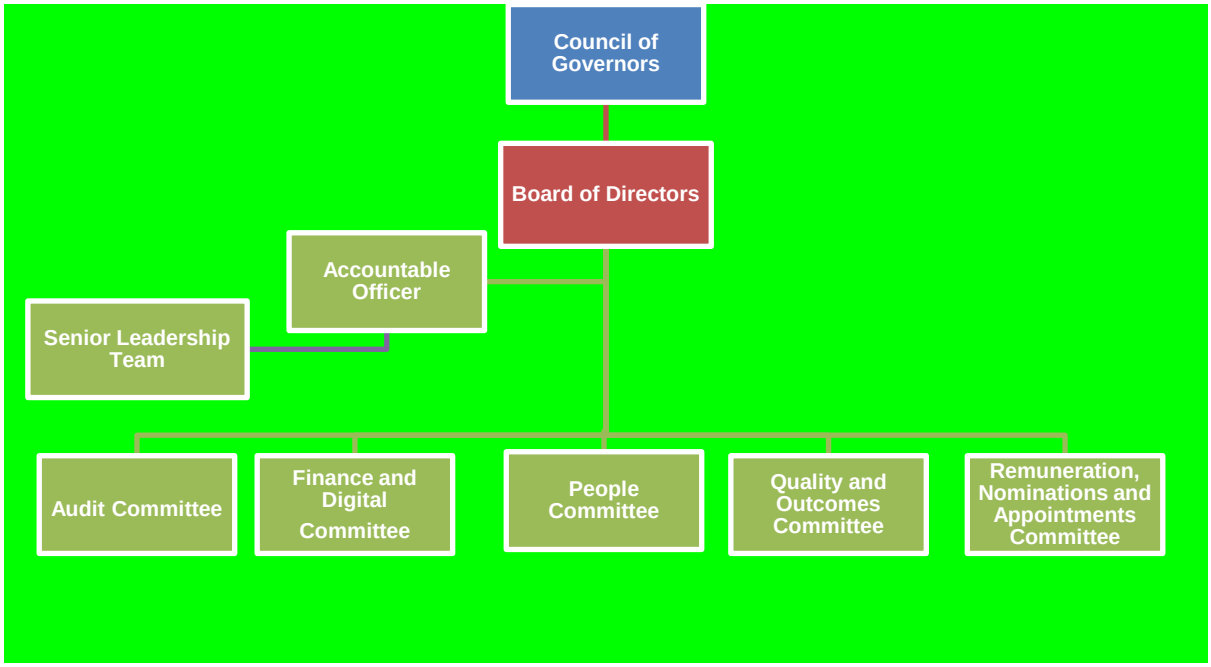
Day to day management of risks is undertaken by operational management, who are charged with ensuring risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where problems are identified. There is a process of escalation to executive directors,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

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.

Staff receive appropriate training to equip themselves to manage the identification, analysis, evaluation and reporting of 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 of this is 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 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.

Each of the Board Committees (the Finance and Digital Committee, the People Committee, the Quality and Outcomes Committee and the Audit Committee) reviews the risks appropriate to their remit. The Trust's performance information, and the quality of this information, is also assessed by each of the Board Committees and by the Board as a whole at each meeting.

Table 48: Board Committee structure



Board members receive training in risk management which includes an overview of the risk systems. The Board is responsible for the periodic review of the overall governance arrangements, both clinical and non-clinical, to ensure that they remain effective.

Prior to the merger, University Hospitals Bristol NHS Foundation Trust, commissioned an externally facilitated review against the Well-Led Framework in 2019. The conclusions of this review was that there was no reason, in the view of the Good Governance Institute, why the Trust should not maintain its overall rating of 'outstanding'; however, some small areas for improvement were identified, and these were delivered through the Board Development Plan through 2019 and 2020. UHBW will undertake a further external review against the Well-led Framework in 2022/23. The CQC, in its inspection report in 2019 into University Hospitals Bristol NHS Foundation Trust, gave it a rating of Outstanding for the Well-led domain which recognised the strong culture of good governance throughout the organisation. 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.

The Trust uses the national Electronic Staff Record (ESR) system which is managed by IBM. IBM are responsible for the design, implementation and operation of controls with regard to ESR, producing an annual ISAE 3000 report to provide reasonable assurance that the control objectives are achieved. This is subject to independent audit. For 2020/21 two exceptions were identified during the audit testing of the controls. Having reviewed the

control points raised, the Trust does not consider these to have any impact when assessing the risks of material misstatements of the Trust's financial statements.

4.7.4 The risk and control framework

The Trust's risk management 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. The policy sets out the key responsibilities and accountabilities to ensure that risk is identified, evaluated and controlled. The Board has overall responsibility for the management of risk but it delegates the work to the Senior Leadership Team and Risk Management Group.

The Trust's risk appetite statement and thresholds of individual risks (risk tolerance levels) that are deemed acceptable are reviewed and approved by the Trust Board of Directors on an annual basis.

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), 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. At year end, the corporate risk registers tracked 11 strategic risks and 36 operational risks.

A summary of the strategic risks for 2020/21 is outlined below:

- That the Trust fails to achieve the objectives of its financial strategic plan
- That the Trust is unable to recruit sufficient numbers of substantive staff
- That Trusts IM&T Systems fail to deliver the required levels of efficiencies
- That services are not commissioned at levels of forecasted demand
- That the Trust is unable to invest in modernising the Trust estate
- That the STP fails to deliver a system strategy
- That the Trust has insufficient leadership capacity
- That the Trust is unable to retain members of the substantive workforce
- That Research and Innovation is not adequately supported
- That the benefits of transformation, improvement and innovation are not realised
- That the Trust fails to make a positive impact on combatting climate change

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 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 implementation of a new People Strategy 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.
- The People Committee supports the discharge of the Board's strategic priorities and responsibilities relating to its workforce and education. It is intended to focus primarily on all people working within and educated by the Trust, but also take a broader view that encompasses the wider stakeholder base of the Trust.

4.7.5 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 objectives set out the actions we will take to ensure that this is achieved.

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

- To make quality the first priority for every member of staff – the 'why' that's behind everything we do;
- To reduce unwanted variation in the quality and safety of services through an unswerving focus on continuous evidence-informed improvement;
- To work closely with patients, families and other healthcare partners to improve healthcare experience and co-design better joined up care;
- To be recognised by our patients, staff and regulators for delivering consistently outstanding patient care.

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 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 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 Trust has undertaken risk assessments and has a Sustainable Development Strategy 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.

4.7.6 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 and Digital, 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.

4.7.7 Information governance

Information governance 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 Information Asset Owners and Information Asset Administrators who maintain the Trust's systems containing 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 Data Security and Protection Toolkit
- Internal audit review of the evidence provided to comply with the criterion of the Data Security and Protection Toolkit.

Six cases were recorded in the Information Governance Incident Reporting Tool were reported to the Information Commissioner's Office in 2020/21. The details are provided in the following table.

Table 49: Incidents reported to the Information Commissioner's Office 2020/21

Date of Incident	Incident description	Number affected	How individuals were informed	Lessons Learned
May 2020	Details of Rheumatology patients awaiting follow up were accidently uploaded to the NHS Digital Shielding List	4,269	No risks to the rights and freedoms of the individuals, they were not informed.	Human error during the beginnings of the pandemic. The Trust has now set up a process for sending letters to patients who need to shield. No further action recommended by the ICO.
October 2020	An employee received some personal documents that had been sent to an address they have not lived at for some time.	1	The individual reported the incident to the Trust.	Trust policy on retention of recruitment documentation not adhered to by manager. No further action recommended by the ICO.
December 2020	A copy of a clinical letter was sent to an incorrect address.	1	A letter of apology was written to the patient.	Summary Care Record and GP had the address recorded incorrectly which was then fed into the Trust's patient administration system. No further action recommended by the ICO.
February 2021	Patient notes scanned into electronic document management system not showing under patients record.	1	Patient informed by a senior clinician.	Investigations into what happened to ascertain any future preventative action necessary to avoid reoccurrence, ongoing. No further action recommended by the ICO.
March 2021	Patients results letter had been sent to the incorrect address. The address on the letter contained the incorrect door number.	1	The data subject reported the incident to the Trust.	Human error as no explicit instructions were placed onto PAS to request change. No further action recommended by the ICO.
March 2021	Part of a patient's record stored on a digital viewing system was unable to be retrieved because of a technical issue corrupting the file.	1	TBC as the notes may still be retrievable on another system.	Investigations into what happened to ascertain any future preventative action necessary to avoid reoccurrence, ongoing. No further action recommended by the ICO.

4.7.8 Data Quality and Governance

In respect of data accuracy, our quality and performance data follows a set pattern each month. Data is processed on the 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 NHSI's Intensive Support Team (IST) have reviewed our processes and are satisfied with our approach to reporting waiting times.

4.7.9 Significant Internal Control Issues

Three significant internal control issues have been identified during the year, as follows:

- The impact of the Covid-19 outbreak, and the consequent reduction of elective operating and outpatient activity to allow the release of clinical staff to support wards, had a significant impact on the Trust throughout 2020/21. For instance, during the second wave of the pandemic in December 2020 the levels of inpatient elective activity were tracking at approximately 150 fewer cases a month compared to 2019/20 levels. Similarly, day case activity was tracking around 1,000 fewer cases a month comparing the same period. As a result of this, significant delays in elective operating and outpatients have been experienced and will continue throughout 2021/22.
- As a result of a Covid-19 outbreak the Weston General Hospital site was temporarily closed to new attendances on 25 May 2020. The decision was made on the basis of an increasing number of patients with a diagnosis of Covid-19 in Weston General Hospital, evidence of hospital acquired Covid-19 infection and an increasing incidence in the North Somerset population. This decision was made based on advice from Public Health England (PHE) and with the support of regional healthcare partners. A detailed root cause analysis (RCA) investigation was carried out which covered the period immediately before the closure of the hospital and it was found that in total, 39 patients cared for by the hospital during that period died with, or from, community or hospital acquired Covid-19. In addition, another 7 Covid-positive patients died whose admission was outside of the RCA period. The RCA found that the causes of hospital acquired Covid-19 were focused on four key areas: The Hospital estate; the number and configuration of beds; staff vacancies and the use of small teams; and the incidence of asymptomatic patients and staff within the hospital. The investigation resulted in 13 recommendations and an action plan to implement these recommendations has now been completed. The Trust also undertook Harm Panel Reviews for all of the deaths identified through the RCA and Duty of Candour conversations took place with relatives where the requirement for these had been met.
- The Trust had detailed plans in place for the integration of the former Weston Area Health NHS Trust in advance of the merger which took place on 1 April 2020. The impact of the Covid-19 pandemic has resulted in the implementation of these plans being delayed due to a lack of operational capacity within the Trust as it responded to the pandemic. Corporate services integration is almost complete but the clinical integration schedule has been adjusted and elements of this have been pushed back towards the end of the 2 year integration period. A key part of the original plan had been to undertake a cultural review to develop a new set of values for the merged organisation. This work could not commence during the pandemic but has started in April 2021.

4.7.10 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the 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 and Digital 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 2020/21 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 2020/21 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.

4.7.10 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 and Weston 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 and Weston 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
9th June 2021

Appendix A – Biographies of Members of the Board of Directors

Jeff Farrar – Chairman
Prior to becoming Chair of the Trust in December 2017 Jeff had a 35-year career in the police service, reaching the rank of Chief Constable in Gwent Police. He has a BSc (Hons) from Portsmouth University, a Masters in Public Administration from Cardiff University, and a Doctorate in Social Policy from Bath University. The themes of his research have been homophobic hate crime; citizen centred models of service delivery; and the incentives and disincentives in cross sector collaborative working.

He is a Non-Executive Director on the Welsh Government Board, Chairman of the Welsh Government Remunerations Committee and formerly Chaired 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 three League Cup finals, The Ryder Cup (2010), numerous rugby and cricket Internationals, and world championship boxing events.

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 several 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 Chairman 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 event, and is the recipient of a Police Sport UK Award of Excellence for his achievements in Basketball. He has completed half and full marathon races.

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.

Jeff has been appointed as interim Independent Chair of the Integrated Care System in Bristol, North Somerset and South Gloucestershire for a 6 month period with effect from 1st April 2021.

Robert Woolley – Chief Executive
Robert was appointed Chief Executive in 2010, having served on the Trust Board since 2002 in operational and strategic roles. He was also Chief Executive at Weston Area Health NHS Trust from 2019, in anticipation of the merger of the two Trusts in April 2020. Before moving to Bristol, he spent nine years at Barts Health NHS Trust in a range of planning and general manager posts.
Robert is co-Executive Lead for Healthier Together, the integrated care system for Bristol, North Somerset and South Gloucestershire. He is also chair of the University Hospitals Association, chair of the South West Genomic Medicine Services Alliance and chair of the Bristol Health Partners Academic Health Science Centre.

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 health 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 before joining University Hospitals Bristol and Weston NHS Foundation Trust in 2018.

Deidre Fowler – Chief Nurse
Deirdre is an experienced nurse and midwife whose career in healthcare now spans over 30 years. Deirdre has worked in community, acute and academic sectors. She has held positions in senior midwifery leadership and commenced her first executive nurse post in 2013. Deirdre has worked at senior level in a range of organisations, more recently at South Tees Hospitals NHS Foundation Trust in the North East. Deirdre took up the position of Interim Chief Nurse in January 2021 and was appointed as Chief Nurse in April 2021.

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 13 years' experience at Board level, including serving as the interim chief executive of Southern Health and Social Care Trust in Ireland 2015/16. Paula has extensive experience in integrated care delivery, strategic planning, continuous improvement, provider collaboration, partnership working and service transformation programmes. In 2020/21 Paula was seconded as COO/Chief Officer for Nightingale Hospital Bristol and from November 2020, as National lead for Covid Vaccination Centres.

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 15 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.

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 and Digital 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.

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 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. Jayne was appointed as Interim Chair of the Trust with effect from 1st April 2021.

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 and Weston NHS Foundation Trust.

Anthony (Guy) Orpen – Non-executive Director
Guy was the Deputy Vice-Chancellor, New Campus Development of the University of Bristol. He served on and is past chair of the Board of the GW4 research alliance with Bath, Exeter and Cardiff universities 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. Guy retired from his role as Deputy Vice-Chancellor in December 2020 and stood down as a Non-executive Director of the Trust at the same time.

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. Carolyn stood down from the role of Chief Nurse in January 2021.

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. Madhu 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. Madhu’s term of office as Non-executive Director (Designate) ended on 2nd July 2020.

Kam Govind – Associate Non-executive Director
Kam has a background in Management Information in local government, spending 12 years working in North Somerset Council and then Bristol City Council. During this time she oversaw a period of significant change to the way Information and Intelligence is used in Bristol City Council, establishing governance around information products and introducing self-service information products. Kam also works in Diversity & Inclusion, taking part in citywide Inclusion projects and events. She is a Trustee at Vision North Somerset.

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 2020/21

University Hospitals Bristol and Weston NHS Foundation Trust

Accounts for the year ended 31 March 2021

Neil Kemsley
Director of Finance and Information

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

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

Accounts for the year ended 31 March 2021

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2021 have been prepared by the University Hospitals Bristol and Weston 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 09 June 2021

Statement of Comprehensive Income for the year ended 31 March 2021

	Note	Year ended 31 March 2021 £000	Restated * Year ended 31 March 2020 £000
Operating income from patient care activities	3	816,949	649,105
Other operating income	4	154,513	113,510
Operating expenses	5	(958,233)	(740,895)
OPERATING SURPLUS		**13,229**	**21,720**
Finance income	8.1	-	842
Finance expenses	8.2	(2,284)	(2,517)
Public dividend capital dividends payable		(9,683)	(9,423)
NET FINANCE COSTS		**(11,967)**	**(11,098)**
Other losses		(74)	(64)
Gains arising from transfer by absorption	20	16,583	-
SURPLUS FOR THE YEAR		**17,771**	**10,558**
OTHER COMPREHENSIVE INCOME/(EXPENDITURE)			
Will not be reclassified to income and expenditure			
Impairments *	8.3	(2,724)	(1,070)
Revaluations *	10	-	11,494
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**15,047**	**20,982**

On 01 April 2020 University Hospitals Bristol NHS Foundation Trust acquired Weston Area Health NHS Trust becoming University Hospitals Bristol and Weston NHS Foundation Trust. See note 20 for the analysis of balances transferred.

Restated

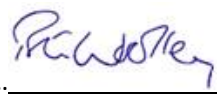
In line with the Regulator reporting requirements the 2019/20 other comprehensive adjustments have been restated to record the gross transactions; downward revaluations are classified as impairments and not netted off within revaluations.

All revenue and income is derived from continuing operations.

The notes on pages 113-147 form part of these accounts.

	Note	31 March 2021	31 March 2020
		£000	£000
NON CURRENT ASSETS			
Intangible assets	9	12,617	14,099
Property, plant and equipment	10	514,070	401,180
Receivables	12.1	1,802	1,094
TOTAL NON CURRENT ASSETS		**528,489**	**416,373**
CURRENT ASSETS			
Inventories	11	12,638	11,724
Receivables	12.2	34,815	51,111
Other financial assets	13	104	104
Cash and cash equivalents	14	169,644	129,840
TOTAL CURRENT ASSETS		**217,201**	**192,779**
CURRENT LIABILITIES			
Trade and other payables	15	(130,989)	(88,282)
Borrowings	17.1	(6,818)	(6,839)
Provisions	18	(853)	(814)
Other liabilities	16	(8,545)	(6,098)
TOTAL CURRENT LIABILITIES		**(147,205)**	**(102,033)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**598,485**	**507,119**
NON CURRENT LIABILITIES			
Borrowings	17.1	(56,097)	(62,336)
Provisions	18	(4,325)	(1,273)
TOTAL NON CURRENT LIABILITIES		**(60,422)**	**(63,609)**
TOTAL ASSETS EMPLOYED		**538,063**	**443,510**
EQUITY			
Public dividend capital		312,135	216,046
Revaluation reserve		75,704	63,753
Other reserves		85	85
Income and expenditure reserve		150,139	163,626
TOTAL EQUITY		**538,063**	**443,510**

The accounts on pages 109 – 147 were approved by the Board on 09 June 2021 and signed on its behalf by:

Signed … 

Date: 09 June 2021

Robert Woolley, Chief Executive

Statement of Changes in Equity for the year ended 31 March 2021

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 2020	216,046	63,753	85	163,626	443,510
Surplus/(deficit) for the year	-	-	-	17,771	17,771
Transfers by absorption – transfers between reserves *	16,583	16,988	-	(33,571)	-
Net impairments	-	(2,724)	-	-	(2,724)
Transfers between reserves		(2,313)	-	2,313	-
PDC Received	79,506	-	-	-	79,506
Equity at 31 March 2021	**312,135**	**75,704**	**85**	**150,139**	**538,063**

* - Absorption transfers are recorded based on the book values of the assets and liabilities transferring.

See note 20 for the full impact of Weston Area Health NHS Trust on reserves.

Changes in Equity in the previous year	Public Dividend Capital £000	Restated ** 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
Net impairments **	-	(1,070)	-	-	(1,070)
Revaluations on property plant and equipment and intangible assets **	-	11,494	-	-	11,494
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**

***** - Restated***

In line with the Regulator reporting requirements the 2019/20 Revaluation Reserve has been restated to record the gross transactions; downward revaluations are classified as impairments and not netted off within revaluations.

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 2021

	Note	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus from continuing operations		13,229	21,720
OPERATING SURPLUS		**13,229**	**21,720**
NON CASH INCOME AND EXPENDITURE			
Amortisation	9	4,642	3,472
Depreciation	10	26,346	22,389
Net impairments	8.3	2,269	3,669
Income recognised in respect of capital donations		(4,093)	(2,266)
(Increase)/decrease in trade and other receivables	12	27,728	16,341
(Increase)/decrease in inventories	11	198	(318)
Increase/(decrease) in trade and other payables	15	24,175	4,566
Increase/(decrease) in other liabilities	16	2,078	787
Increase/(decrease) in provisions	18	2,526	1,691
Other movements in operating cash flows		-	1
NET CASH GENERATED FROM OPERATIONS		**99,098**	**72,052**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		-	842
Purchase of property, plant and equipment	10	(66,216)	(33,718)
Purchase of intangible assets	9	(831)	(1,411)
Receipt of cash donations to purchase capital assets		1,582	2,260
NET CASH USED IN INVESTING ACTIVITIES		**(65,465)**	**(32,027)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received *		79,506	8,290
Loans repaid to DHSC *		(63,416)	(5,834)
Capital element of finance lease rental payments		(369)	(357)
Interest paid		(2,323)	(2,343)
Interest element of finance leases		(194)	(218)
PDC dividend paid		(11,426)	(9,578)
NET CASH GENERATED/(USED) IN FINANCING ACTIVITIES		**1,778**	**(10,040)**
INCREASE IN CASH AND CASH EQUIVALENTS		**35,411**	**29,985**
CASH AND CASH EQUIVALENTS AT START OF YEAR	14	**129,840**	**99,855**
Transfer by absorption		4,393	-
CASH AND CASH EQUIVALENTS AT END OF YEAR	14	**169,644**	**129,840**

* As part of the reforms to the NHS Cash regime, effective from 01 April 2020, interim revenue loans at 31 March 2020 were extinguished during 2020/21. The Trust was issued with Public Dividend Capital to enable the principal repayment of the outstanding balance transferred from Weston Area Health NHS Trust at 01 April 2020.

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 GAM 2020/21 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 GAM 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.

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

1.1 Going concern

The annual report and accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual (FReM), defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that University Hospitals Bristol and Weston NHS Foundation Trust will continue in operational existence for the foreseeable future.

1.2 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.

1.3 Interest in other entities

In line with IFRS 10 Consolidated Financial Statements, the Trust has established that as the Trust is corporate Trustee of the linked NHS Charity, Weston Health General Charitable Fund, it effectively has the power to exercise control so as to obtain economic benefits.

However, the Charitable Fund's transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties' notes (note 22).

1.4 Income

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulation which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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 the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is recognised when services are delivered.

Comparative period 2019/20

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

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.

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 for 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.

1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship levy income

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, the corresponding notional expense is also recognised at the point of recognition of the benefit.

Sale of non-current assets

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.

1.6 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 to the extent that employees are permitted to carry-forward leave into the following period.

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.

Pension costs

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 for Health and Social Care in England and Wales. The scheme is 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, the 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. The contributions are charged to operating expenses as they become due.

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.

1.7 Expenditure on other goods and services

Other operating expenses are recognised when, and to the extent that they have been received, and are 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.

1.8 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.

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.

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 historical 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.

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	8	50
Dwellings	16	19
Plant and machinery (incl. medical equipment)	1	19
Transport equipment	1	6

Information technology	1	6
Furniture and fittings	1	7

When assets are revalued, the accumulated 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.

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

1.9 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	9

Purchased computer software licences are amortised over the shorter of the term of the licence and their estimated economic lives.

1.10 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.

1.11 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.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at £ nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department of Health and Social Care.

1.12 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.

1.13 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.

Classification and measurement

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 income and expenditure. 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 or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. There are no material differences between amortised costs and net book values of financial assets and liabilities. As a result, all financial assets and liabilities are held at net book value..

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, 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.

For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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.

1.14 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.

1.15 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 minus 0.95% (minus 0.50% 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 (%)	
		2020/21	2019/20
Short term	1-5	-0.02	0.51
Medium term	6-10	0.18	0.55
Long term	>10	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 18.2.

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.

1.16 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.

1.17 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, with certain additions and deductions as defined by Department of Health and Social Care.

This policy is available at:

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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.

1.18 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.

1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption

1.20 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.

1.21 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.

1.22 Transfers of functions from other NHS bodies

For functions that have been transferred to the Trust from another NHS government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / (loss) corresponding to the net assets/ (liabilities) transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Absorption transfers are recorded based on the book values of the assets and liabilities transferring with inter body balances removed on consolidation.

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

1.24 Accounting standards that have been issued but not yet been adopted

The following table presents a list of recently issued IFRS standards and amendments that have not yet been adopted within the HM Treasury FReM, and are therefore not applicable in 2020/21.

Standards and Interpretations	Financial year for which the change first applies
IFRS14 Regulatory Deferral Accounts	N/A. Applies to fist time adopters of IFRS after 01 January 2016.
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 which is expected to be from April 2023: early adoption is not therefore permitted.

IFRS 16

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 2022. 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 2022, 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 0.91% 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 2022 for existing finance leases.

For leases commencing in 2022/23, 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.

Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and the net impact on the Statement of Comprehensive Income.

1.25 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

With the exception of IFRS 10 Consolidated Financial Statements the Trust has made no judgements in applying the accounting policies other than those involving accounting estimates.

For IFRS 10 the Trust's judgement is that the Charitable Fund's transactions are immaterial in the context of the group and transactions have not been consolidated.

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 estimate 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 revaluations by the Trust's approved valuer. In the interim years the Trust's assets are revalued using desktop revaluations undertaken by the Valuation Office. The Valuation Office is an expert therefore there is a high degree of reliance on the valuer's expertise.

c) Impairment

Impairments are based on the Valuation Office's revaluation, on application of indices or on revaluation of individual assets e.g. when brought into operational use, or identified for disposal. Estimates and judgments are used where the 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) Annual leave accrual

The Trust's approach to calculating the cost of annual leave entitlement earned but not taken by employees at the end of the year multiplies the number of days carried forward by average costs for each staff group.

To reasonably estimate the number of days carried forward, the Trust's rostering systems' Healthroster and Softworks were used to provide the data for a sample of a cross section of employees by staff group. This differs from previous years when a random sample of staff were selected and asked to complete a questionnaire. The change reflects the fact that a significant number of staff, across staff groups, now use electronic systems to record their annual leave.

The average cost of the staff group continues to be calculated using the mid-point of the pay scale which is then weighted based on the number of staff in each band and increased to reflect allowances paid in addition to base rate.

In March 2021 the Trust approved an additional wellbeing annual leave day for all staff. The estimate assumes that this will not be taken by staff before 31 March 2021 and has been recognised in the financial statements using the average cost of each staff group.

e) Provisions

For the purposes of calculating provisions balances, estimates are based on information supplied by third parties such as NHS Resolution and NHS Pension Agency. Inflation and discount rates are notified to the Trust. The probability and timing of settlements are also estimated, based upon previous experience and robust estimation techniques. Provisions in respect of payments to NHS Pension Agency are calculated based on actuarial tables covering life expectancy and are regularly reviewed.

The clinician pension tax provision is calculated based on the number of consultants in posts at the Trust on 31 March 2020 multiplied by the average discounted value as provided by DHSC.

f) Critical accounting estimates and judgements for the comparative period 2019/20

During 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements and therefore estimates for month 12 income from activities, partially completed spells and maternity pathways was not required. The estimate approaches for 2019/20 were:

Month 12 Income from activities

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.

Partially completed spells

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 was accrued and agreed with local Clinical Commissioning Groups and NHS England.

Maternity Pathways

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.

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 six clinical divisions and two 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 2020/21 is shown below with comparator figures for 2019/20.

	Year Ended 31 March 2021 £000	Year Ended 31 March 2020 £000
Corporate income	867,412	658,757
Corporate expenditure*	(71,269)	(2,373)
Divisions/functions net expenditure		
Division of Diagnostic and Therapies	(71,180)	(60,864)
Division of Medicine	(99,648)	(91,794)
Division of Specialised Services	(131,812)	(119,827)
Division of Surgery	(123,185)	(127,823)
Division of Women's and Children's	(155,975)	(143,909)
Division of Weston	(75,657)	-
Facilities and Estates	(49,549)	(41,292)
Trust Services	(47,839)	(32,886)
Total division/function net expenditure	(754,845)	(618,395)
Earnings before Interest, Tax, Depreciation & Amortisation	**41,298**	**37,989**
Financing costs	(40,955)	(35,321)
Net surplus before PSF and technical accounting adjustments	**343**	**2,668**
Provider Sustainability Funding	**-**	10,222
Net surplus before technical accounting adjustments reported to NHS Improvement	**343**	**12,890**
Prior year PSF received in year	-	710
Technical accounting adjustments		
Donations received for Property Plant and Equipment	4,094	2,266
Depreciation on donated assets	(1,999)	(1,639)
Impairment charge when assets brought into use	-	(2,111)
Impairment (charge) / reversal from revaluation	(2,269)	(1,558)
Net impact of DHSC donated consumables	337	-
Retain impact of DEL I&E (impairments)	682	-
Transfer by absorption	16,583	-
Total technical accounting adjustments	17,428	(2,332)
Surplus for the year	**17,771**	**10,558**

***** Expenditure is not attributed to a specific division or function. The increase in 2020/21 is a combination of increased corporate costs reflecting the larger Trust and Covid specific expenditure.

3. Operating income from patient care activities

All income from patient care activities related to contract income recognised in line with accounting policy 1.4.

3.1 Income by nature

	Year ended 31 March 2021 £000	(* Restated) Year ended 31 March 2020 £000
NHS patient activity income *	764,831	611,697
High cost drug income from commissioners *	861	994
Other NHS clinical income *(See significant items below)	5,530	5,595
Private patients (Note 1)	274	1,709
Additional pension contribution central funding (Note 2)	22,938	18,415
Other clinical income *(see significant items below)	22,515	10,695
Total	**816,949**	**649,105**
Other NHS Clinical Income - Significant items include:		
Cross provider charges under maternity pathways	1,711	2,755
Establishment of Adult Critical Care retrieval service	1,343	-
Pass through income (Note 3)	235	218
Bone Marrow Transplants and CAR- T Therapy	759	452
Other Clinical Income - Significant items include:		
Annual leave accrual (Note 4)	10,963	-
Genito-urinary medicine (Local Authorities)	8,301	8,119
Corrective payment for claims in respect of holiday pay (Note 5)	1,663	-
Injury cost recovery	1,045	731

**** Restated*** There is no change in total income. The comparative 2019/20 values have been restated to bring them into alignment with the financial framework put in place in 2020/21 by NHSEI in response to COVID-19. The majority of the Trust's income became subject to block contract arrangements and system envelopes, rather than being driven by actual activity. For comparative purpose the analysis by nature disclosed in 2019/20 accounts (elective/outpatient/high cost drug/other NHS clinical income) have been consolidated within NHS patient activity income. The remaining values in 'High cost drug income' and 'Other NHS clinical income' relate to income from territorial bodies and other Provider Trusts, whilst 'Other clinical income' relates to Local Authorities.

Note 1 Private patient income has reduced in 2019/20 as a direct result of the COVID-19 pandemic; private patient activity was not undertaken as part of the national response to the pandemic.

Note 2 The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3 Pass through income refers to arrangements for the funding of the cost of specified high cost drugs and devices by commissioners, where the agreement is that the actual costs incurred will be reimbursed by the commissioner.

Note 4 There has been an increase in the annual leave accrual due to an increase in leave entitlement earned but not taken at the end of the year. The increase has been funded by NHS England.

Note 5 Funding from DHSC to cover the cost of backdated claims for overtime payments and pay accrued during annual leave (Flowers case).

3.2 Income from patient care activities (by source)

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
NHS England	378,246	328,301
Clinical Commissioning Groups	411,083	291,972
NHS Foundation Trusts	253	163
NHS Trusts	1,795	2,459
Local Authorities	8,301	8,119
Non-NHS private patients	274	1,709
Non-NHS overseas patients	810	769
NHS Injury Scheme	1,045	731
Territorial Bodies	15,142	14,882
Total	**816,949**	**649,105**

3.3 Income from patient care activities arising from Commissioner Requested Services

Under the terms of the provider license, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested services and non-commissioner requested services. Commissioner requested are defined in the provider license and are services that commissioners believe would need to be protected in the event of failure. This information is provided in the table below:

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Income from services designated as commissioner requested services	767,939	608,805
Income from services not designated as commissioner requested services	49,010	40,300
Total	**816,949**	**649,105**

3.4 Income from overseas visitors

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Income recognised this year	810	769
For invoices raised in this and previous years;		
Cash payments received	155	312
Increase to credit losses of receivables	352	236
Amounts written off	216	199

4.1 Other operating income

	Year ended 31 March 2021			Year ended 31 March 2020		
	Contract Income	Non Contract income	Total	Contract Income	Non Contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	18,686	8,243	26,929	18,298	8,592	26,890
Education and training	40,973	466	41,439	35,870	216	36,086
Non-patient care services to other bodies	11,188	-	11,188	12,337	-	12,337
Provider Sustainability Fund and reimbursement and top up funding *(Note 1)*	41,061	-	41,061	10,932	-	10,932
Salary recharges	4,194	-	4,194	7,738	-	7,738
Receipt of capital grants and donations	-	4,093	4,093	-	2,266	2,266
Charitable and other contributions to operating expenditure	-	914	914	-	910	910
Contribution to expenditure – inventory donated by DHSC	-	13,691	13,691	-	-	-
Rental income from operating leases	-	1,467	1,467	-	1,575	1,575
Other*	9,537	-	9,537	14,776	-	14,776
Total recognised operating income	**125,639**	**28,874**	**154,513**	**99,951**	**13,559**	**113,510**

*Significant items include:	£000	£000
Clinical excellence awards	2,840	3,022
Trading services - MEMO	557	1,028
Trading services – Pharmacy	1,380	1,386
Trading services - IT	208	321
Clinical testing	168	472
Catering	686	1,124
Staff accommodation rentals	120	188
Car park income	490	953
Staff contribution to employee benefit schemes	587	945
Property rentals	4	29
Global Digital Exemplar income	-	1,000
Insurance income	-	1,060

Note 1 There was a change in the national financial funding regime from 2019/20 to 2020/21. Provider sustainability funding was paid in 2019/20 and was no longer available in 2020/21. Reimbursement and top up funding was received as part of the national Covid-19 response to support providers. This comprised of £31.1m top up funding for service delivery for the first six months of the year, £0.9m of additional Covid-19 funding for the second half of the year and £9.1m in respect of reduced year on year income.

4.2 Additional Information on contract revenue recognised in the period

	NHS Providers	Other DHSC group bodies	Non DHSC group bodies	Total
Year ended 31 March 2021	**£000**	**£000**	**£000**	**£000**
Revenue recognised in reported period that was included within contract liabilities at the previous period end	5	2,179	3,914	6,098
Year ended 31 March 2020	**£000**	**£000**	**£000**	**£000**
Revenue recognised in reported period that was included within contract liabilities at the previous period end	8	2,006	3,026	5,040

Obligations	**Year ended 31 March 2021 £000**	**Year ended 31 March 2020 £000**
Revenue from contracts entered into but expected to be recognised:		
- within one year	8,545	6,098
- after one year but not later than five years	-	-
- after five years	-	-

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

4.3 Operating lease income

This note discloses income generated in operating lease arrangements where the University Hospitals Bristol and Weston NHS FT is the lessor.

	Year ended 31 March 2021 £000	**Year ended 31 March 2020 £000**
Rental income – minimum lease receipts	1,467	1,575

Future minimum lease receipts due to the Trust

	Year ended 31 March 2021 £000	**Year ended 31 March 2020 £000**
- no later than one year	1,563	1,495
- between one and five years	2,045	1,618
- after five years	2,527	1,020
Total	**6,135**	**4,133**

5. Operating expenses

5.1 Operating expenses by type

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Services from other bodies:		
- NHS & DHSC bodies	11,436	11,681
- non NHS & non DHSC bodies	2,145	1,906
Purchase of healthcare from non NHS bodies	10,693	4,732
Employee expenses excluding Board members	594,171	452,207
Employee expenses – Board members	1,600	1,460
Trust chair and non-executive directors	197	193
Supplies and services: clinical	85,374	69,188
Supplies and services: general	9,982	7,615
Drug costs	120,852	96,245
Inventory write down	74	-
Establishment costs *(Note 1)*	16,293	9,472
Premises costs – business rates	4,126	3,170
Premises costs - other	14,368	12,276
Transport – business travel	543	1,313
Transport – other (including patient travel)	3,306	1,607
Depreciation on property plant and equipment	26,346	22,389
Amortisation on intangible assets	4,642	3,472
Net impairments	2,269	3,669
Movement in contract credit loss allowance	(675)	(1,496)
Change in provisions discount rate	64	-
Auditor's remuneration - statutory audit	203	84
Auditor's remuneration – other non-audit services	-	2
Internal audit	379	468
Clinical negligence	20,602	13,762
Research and development – other	7,488	7,410
Research and development – hosting payments	7,281	6,878
Rentals under operating leases	7,201	6,883
Other*	7,273	4,309
Total	**958,233**	**740,895**

*Significant items include:

	£000	£000
Consultancy	498	435
Education and training	2,530	2,643
Legal fees	1,094	544
Parking and security *(Note 2)*	1,222	539
Insurance	379	318

Year on year increases will primarily be related to the increased size of the Trust following the Weston acquisition. Further movements are noted below;

Note 1 Additional digital services costs were incurred in year due to the implementation of Office 365 and the costs of supporting remote working during the pandemic.

Note 2 Additional front entrance security was required in response to Covid-19.

5.2 Other auditor remuneration and limitation of auditor's liability

There is no other non-audit service remuneration in note 5.1 for 2020/21. The 2019/20 other non-audit service costs related to the work undertaken over the Trust's Quality Report prior to the work ceasing in line with national guidance. No work at all was undertaken in 2020/21, in line with national guidance.

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

5.3 Nightingale hospitals

The following gross costs of running the Nightingale hospitals are included in operating expenses above:

	Year ended 31 March 2021 £000
Set up costs	
Staff costs	72
Other operating costs	424
Running costs	
Staff costs	161
Other operating costs	-
Total costs	**657**

5.4 Operating lease expenses

This note discloses costs and commitments incurred in operating lease arrangements where the University Hospitals Bristol and Weston NHS FT is the lessee.

Minimum lease payments	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Land	34	34
Buildings	6,181	5,848
Plant and machinery	986	1,001
Total	**7,201**	**6,883**

Future minimum lease payments due under operating leases	**£000**	**£000**
Before one year	1,716	1,588
Between one and five years	3,503	4,313
After five years	4,433	5,249
Total	**9,652**	**11,150**

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 29 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 2021 £000	Year ended 31 March 2020 £000
Salaries and wages	461,805	351,388
Social security costs	41,054	32,237
Apprenticeship levy	2,130	1,691
Pension costs – employer contributions	52,454	42,258
Pension costs – employer contribution funded by NHSE	22,938	18,415
Termination benefits	320	45
Temporary staff - agency/contract staff	20,310	11,816
Gross employee expenses	**601,011**	**457,850**
Income in respect of salary recharges	(3,456)	(3,206)
Employee expenses capitalised	(1,784)	(977)
Net employee expenses	**595,771**	**453,667**

The increase in employment expenses is a direct result of the absorption transfer and the increased size of the Trust following the acquisition of Weston Area Health NHS Trust.

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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.
The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

6.3 Retirements due to ill health

During the year ended 31 March 2021 there were 10 (2019/20: nil) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill health retirements are £0.3m (2019/20: nil). These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

7. Other Gains/Losses

The net loss on the disposal of property, plant and equipment of £0.074m (2019/20: net loss of £0.064m) 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 2021 £000	Year ended 31 March 2020 £000
Interest on bank account and National Loan Fund Investments	-	842
Total	**-**	**842**

National Loan Fund investments were suspended from March 2020, therefore there was no investment of surplus cash in 2020/21.

8.2 Finance expenses

	Year ended	Year ended

	31 March 2021 £000	31 March 2020 £000
Loan interest on DHSC loans	2,095	2,299
Finance leases	194	218
	2,289	2,517
Unwinding of discount on provision	(5)	-
Total	**2,284**	**2,517**

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 2021 £000**	**Year ended 31 March 2020 £000**
Impairment of enhancements to existing assets	-	2,110
Abandonment of assets in the course of construction	682	-
Changes in valuation	1,729	2,290
Reversal of impairments from change in valuation	(142)	(731)
Total net impairment charged to operating surplus	**2,269**	**3,669**
Net impairments charged to the revaluation reserve	2,724	1,070
Total net impairments	**4,993**	**4,739**

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:

Statement of Comprehensive Income		**Year ended 31 March 2021 £000**	**Year ended 31 March 2020 £000**
Impairment of enhancements to existing assets			
Myrtle Road		-	2,110
Abandonment of assets in the course of construction			
Transport Hub	**1.**	682	-
Change in valuation			
Valuation Office's revaluation of land & buildings		1,587	1,559
Total		**2,269**	**3,669**

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	**Assets under construction**	**Total**

	£000	£000	£000
Cost at 1 April 2020	24,883	2,208	27,091
Transfers by absorption	5,184	-	5,184
Additions – purchased	518	433	951
Additions – donated	43	-	43
Reclassifications with PPE	61	-	61
Cost at 31 March 2021	**30,689**	**2,641**	**33,330**
Accumulated amortisation at 1 April 2020	12,992	-	12,992
Transfers by absorption	3,079	-	3,079
Charged during the year – purchased	4,600	-	4,600
Charged during the year – donated	42		42
Accumulated amortisation at 31 March 2021	**20,713**	**-**	**20,713**
Net book value at 31 March 2021		-	
Purchased	9,874	2,641	12,515
Donated	102	-	102
Total net book value at 31 March 2021	**9,976**	**2,641**	**12,617**

	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**

10. Property, plant and equipment

The Valuation Office undertook a desktop exercise at the 31 March 2021 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 March 2019. The valuation resulted in a net decrease at 31 March 2021 of £4.311m compared to the book values, with £1.587m charged to the Statement of Comprehensive Income as a net impairment and £2.724m 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.

2.

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2020	26,245	312,428	2,450	14,323	93,235	807	24,477	691	**474,656**
Transfers by absorption	6,870	56,751	-	1,474	21,502	-	6,498	1,513	**94,608**
Additions – purchased	-	15,799	-	43,030	5,952	-	1,138	18	**65,937**
Additions – donated	-	7	-	1,313	2,716	-	14	-	**4,050**
Impairments	(30)	(4,281)	-	(682)	-	-	-	-	**(4,993)**
Reclassifications with intangibles	-	-	-	-	-	-	(61)	-	**(61)**
Reclassifications within PPE	-	2,420	(10)	(6,214)	2,143	-	1,661	-	**-**
Revaluations	(25)	(14,057)	(75)	-	-	-	-	-	**(14,157)**
Disposals	-	-	-	-	(4,514)	-	(226)	(28)	**(4,768)**
Cost or valuation at 31 March 2021	**33,060**	**369,067**	**2,365**	**53,244**	**121,034**	**807**	**33,501**	**2,194**	**615,272**
Accumulated depreciation at 1 April 2020	**-**	**-**	**-**	**-**	**57,566**	**468**	**14,780**	**662**	**73,476**
Transfers by absorption	-	-	-	-	13,739	-	5,086	1,406	**20,231**
Charged during the year – purchased	-	13,326	127	-	7,225	72	3,612	28	**24,390**
Charged during the year – donated	-	704	-	-	1,209	8	34	1	**1,956**
Revaluations	-	(14,030)	(127)	-	-	-	-	-	**(14,157)**
Disposals	-	-	-	-	(4,440)	-	(226)	(28)	**(4,694)**
At 31 March 2021	**-**	**-**	**-**	**-**	**75,299**	**548**	**23,286**	**2,069**	**101,202**
Net book value at 31 March 2021									
Purchased	33,060	342,258	2,365	51,708	38,557	235	10,115	121	**478,419**
Donated	-	20,634	-	1,536	7,178	24	100	4	**29,476**
Finance leases	-	6,175	-	-	-	-	-	-	**6,175**
Total at 31 March 2021	**33,060**	**369,067**	**2,365**	**53,244**	**45,735**	**259**	**10,215**	**125**	**514,070**

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport £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**

10.1 Donations of property plant and equipment

As part of the coronavirus pandemic response the Trust was donated property, plant and equipment assets from the Department of Health and Social Care and NHS England.

	£000
Ventilators and associated medical equipment	1,485
Imaging equipment	1,026
Total	**2,511**

10.2 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 2021 £000	Year ended 31 March 2020 £000
Cost or valuation at 1 April	6,721	6,721
Additions	11	188
Revaluation	(486)	(188)
Cost or valuation at 31 March	**6,246**	**6,721**
Accumulated depreciation at 1 April	71	70
Provided during the year	740	744
Revaluation	(740)	(743)
Accumulated depreciation at 31 March	**71**	**71**
Net book value at 31 March	**6,175**	**6,650**

10.3 Net book value of land building and dwellings

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

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Freehold	398,317	334,473
Long leasehold	6,175	6,650
Total	**404,492**	**341,123**

11. Inventories

3.

Year ended 31 March 2021	Drugs	Consumables	Energy	High cost devices	Totals
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	4,413	7,176	135	-	11,724
Transfer by absorption	395	713	4	-	1,112
Additions	65,913	65,476	80	1,840	133,309
Consumed – recognised in expenses	(65,846)	(67,494)	(93)	-	(133,433)
Write down of inventories	-	(74)	-	-	(74)
Carrying value at 31 March 2021	**4,875**	**5,797**	**126**	**1,840**	**12,638**

Year ended 31 March 2019	Drugs	Consumables	Energy	High cost devices	Totals
	£000	£000	£000	£000	£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**

In response to the Covid-19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed to NHS providers free of charge. During 2020/21 the Trust received £13.691m of items purchased by DHSC, consumed £13.280m, with a write down of £0.074m. The remaining balance of £0.337m is recorded within the consumables balance. These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of the items is included in the expenses disclosed above.

In 2020/21, there was a national change of approach to the funding and accounting of high cost devices, which are funded by NHS England. The year end stock balance held is agreed with the Specialist Commissioners with a corresponding income balance included within deferred income.

12. Receivables

12.1 Non-Current Receivables

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Clinical pension tax provision reimbursement from NHS England	1,802	1,094

Notes to the Accounts

12.2 Current Receivables

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
NHS contract receivables	7,863	27,025
Other contract receivables	11,026	10,078
Contract receivable not yet invoiced	4,573	14,432
Annual leave accrual – accrued income	6,146	-
Capital receivables	1,063	-
VAT receivable	2,663	453
Allowance for credit losses	(4,880)	(5,435)
PDC dividend receivable	2,074	41
Prepayments	3,761	3,852
Clinical pension tax provision reimbursement from NHS England	526	665
Total current receivables	**34,815**	**51,111**

12.3 Allowance for credit losses

	Year ended 31 March 2021 £000
Allowance as at 1 April 2020	**5,435**
Transfers by absorption	361
Changes in existing allowances	(675)
Utilisation of allowances	(241)
Balance at end of year	**4,880**

	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**

13. Other financial assets

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Other receivables	104	104
Total	**104**	**104**

This relates to a section 106 deposit paid to Bristol City Council.

14. Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
At 01 April	129,840	99,855
Transfers by absorption	4,393	-
Net change in year	35,411	29,985
At 31 March	**169,644**	**129,840**
Broken down into:		
Cash with the government banking service	169,342	129,680
Commercial bank and cash in hand	302	160
Total cash and cash equivalents	**169,644**	**129,840**

15. Trade and other payables

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Current amounts:		
NHS payables – revenue	13,534	14,930
Amounts due to related parties – revenue	8,070	6,092
Other payables – revenue	20,765	21,692
Capital payables	11,215	5,853
Tax and social security	11,673	9,282
Accruals	52,878	28,542
Annual leave accrual	12,854	1,891
Total	**130,989**	**88,282**

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

Outstanding pension contributions of £7.4m (2019/20: £6.0m) to the NHS Pension scheme and £0.1m (2019/20: £0.1m) for National Employment Savings trust (NEST) local pensions are included in amounts due to related parties. PAYE of £5.4m (2019/20: £4.3m) and £6.3m National Insurance (2019/20: £5.1m) are included in tax and social security.

16. Other liabilities

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Current liabilities:		
Deferred income – contract liabilities	8,545	6,098
Total	**8,545**	**6,098**

17.1 Borrowings

Current borrowings:	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Capital loans from Department of Health and Social Care	6,401	6,458
Finance lease obligations	417	381
Total	**6,818**	**6,839**

Non-current borrowings:		
Loans from Department of Health and Social Care	52,923	58,757
Finance lease obligations	3,174	3,579
Total	**56,097**	**62,336**

17.2 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

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Payable:		
Before one year	6,401	6,458
Between one and five years	23,337	23,337
After five years	29,586	35,420
Net obligation	**59,324**	**65,215**

17.3 Finance lease obligations

Future lease receipts due under finance lease agreements where the Trust is the lessee.

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Payable:		
Before one year	575	575
Between one and five years	2,300	2,300
After five years	1,401	1,965
Sub-total	**4,276**	**4,840**
Less finance charges allocated to future years	(685)	(880)
Net lease liabilities	**3,591**	**3,960**

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

17.4 Net finance lease obligations

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Payable:		
Before one year	417	381
Between one and five years	1,862	1,766
After five years	1,312	1,813
Net obligation	**3,591**	**3,960**

17.5 Reconciliation of liabilities arising from financing activities

	DHSC Loans £000	Finance Lease £000	Total £000
Carrying Value at 01 April 2020	65,215	3,960	69,175
Transfer by absorption	57,753	-	57,753
Cash Movements			
Principal	(63,416)	(369)	(63,785)
Interest	(2,323)	(194)	(2,517)
Non Cash Movements			
Interest Charge arising in year	2,095	194	2,289
Carrying Value at 31 March 2021	**59,324**	**3,591**	**62,915**

As part of the reforms to the NHS Cash regime, effective from 01 April 2020, interim revenue loans at 31 March 2020 were extinguished during 2020/21. The Trust was issued with £57.582m of Public Dividend Capital to enable the principal repayment of the outstanding balance transferred from Weston Area Health NHS Trust at 31 March 2020.

	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**

18. Provisions

18.1 Provision for liabilities:

Year ended 31 March 2021	Clinicians pension tax reimbursement £000	Pension Injury Benefits £000	Pensions Early departure £000	Legal Claims £000	Total £000
At 01 April 2020	1,759	211	-	117	2,087
Transfers by absoption	224	144	202	-	570
Change in discount rate	345	36	28	-	409

Arising during the year	-	2,001	133	99	2,233
Utilised during the year	-	(46)	(31)	(21)	(98)
Unwinding of discount rate	-	(3)	(2)	-	(5)
Reversed unused	-	-	-	(18)	(18)
At 31 March 2021	**2,328**	**2,343**	**330**	**177**	**5,178**

Timing of economic outflow					
Before one year	526	119	31	177	853
Between one and five years	840	502	138	-	1,480
After five years	962	1,722	161	-	2,845
Total	**2,328**	**2,343**	**330**	**177**	**5,178**

There are no other provisions.

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**

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 at 31 March 2020 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

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.

18.2 Clinical negligence

NHS Resolution has included a £393.1m provision in its accounts (2019/20: £330.5m) in respect of clinical negligence liabilities of the Trust.

19. Capital commitments

	Year ended 31 March 2021 £000	**Year ended 31 March 2020 £000**
Property, plant and equipment	17,609	6,900
Intangible assets	1,312	3,500
Total	**18,921**	**10,400**

20. Transfer by absorption

4.

Analysis of balances transferred

Amounts transferred from: Weston Area Health NHS Trust	**£000**	**Amounts transferred to: University Hospitals Bristol NHS FT**	**£000**
Non-Current Assets	76,482	Non-Current Assets	76,482
Current Assets	14,839	Current Assets	14,839
Current Liabilities	(74,436)	Current Liabilities	(74,436)
Non-Current Liabilities	(302)	Non-Current Liabilities	(302)
Net Assets	**16,583**	**Net Assets**	**16,583**

The transaction by absorption has been transacted through the SOCI accounting statement in line with the instructions set out in the Group Accounting Manual.

On 1 April 2020 University Hospitals Bristol NHS FT acquired Weston Area Health NHS Trust (WAHT), as approved by NHS Improvement. The net assets of WAHT were transferred at book value to University Hospitals Bristol NHS FT, which was subsequently renamed University Hospitals Bristol and Weston NHS FT by mean of a deed of transfer, as approved by the Secretary of State for Health. All of the services previously provided by WAHT continue to be provided as part of the acquisition.

21. Contingencies

The Trust has no contingent assets at 31 March 2021 (2019/20: £nil).

The Trust has no material contingent liabilities at 31 March 2021. 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 and Weston 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. Transactions of more than £0.5m between the Trust and these bodies are shown below.

	31 March 2021 (£m)		31 March 2020 (£m)		2020/21 (£m)		2019/20 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Bristol City Council	0.40	0.43	0.14	0.23	8.57	-	8.47	3.27
University of Bristol	0.51	0.03	0.23	3.68	1.92	12.23	1.98	8.30
University of the West of England	0.10	0.12	0.07	0.08	0.46	0.56	0.48	0.70
Torbay and South Devon NHS FT	0.19	0.04	0.15	0.04	0.43	0.54	0.43	0.68
Oxford Health NHS FT	-	-	-	-	-	0.53	-	0.06
Above and Beyond Charity	See notes below							
Health Education England	See WGA table below							

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 an income or expenditure, or outstanding balances as at 31 March, exceeds £5m are listed below.

	31 March 2021 (£m)		31 March 2020 (£m)		2020/21 (£m)		2019/20 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Bristol City Council	0.40	0.43	0.14	0.23	8.57	0.10	8.47	3.27
Community Health Partnerships	-	0.17	-	0.81	-	6.55	-	4.46
Department of Health and Social Care	0.18	-	0.13	0.98	23.19	-	22.74	-
Health Education England	0.23	0.65	1.42	-	41.20	0.15	37.07	-
HM Revenue and Customs	-	6.25	0.45	9.28	-	43.18	-	36.32
NHS Bath and North East Somerset CCG	-	0.04	0.46	0.41	14.98	-	14.22	-
NHS Blood and Transplant	0.02	0.68	-	0.62	-	6.86	-	6.35
NHS Bristol, N Somerset & S Gloucestershire CCG	-	14.63	2.36	2.69	362.14	0.44	257.51	1.11
NHS England - Core	8.00	4.45	4.95	0.19	50.82	-	13.26	-
NHS England – Central Specialised Commissioning	0.21	-	0.07	-	18.53	-	0.10	-
NHS England - South West Commissioning Hub	2.59	-	16.98	-	325.05	-	307.70	-
NHS England - South East Commissioning Hub	-	-	2.36	-	-	-	7.27	-
NHS Pension Scheme	-	-	-	-	-	75.08	-	60.62
NHS Resolution	-	-	-	-	-	20.60	-	13.75
NHS Somerset CCG	0.14	-	0.25	-	27.05	-	9.69	-
North Bristol NHS Trust	1.58	3.433	4.23	9.36	7.81	13.95	5.43	13.28
Welsh Assembly Government	-	-	-	-	12.02	-	-	-
Welsh Health Bodies – Cwm Taf LHB	-	-	-	-	0.99	-	12.72	-

In addition the Trust pays HM Revenue and Customs tax and national insurance on behalf of employees; £86.5m in 2020/21 (£72.2m in 2019/20). The Trust also pays the NHS Pension Scheme for employees' contributions which totalled £35.4m in 2020/21 (£28.6m in 2019/20).

The Trust also has transactions with charitable bodies including Above and Beyond which is the official charity for all hospitals within the Trust, the Grand Appeal which is the Bristol Children's Hospital Charity, and Weston Health General Charitable Fund which is the Weston General Charity. The Above and Beyond and Grand Appeal charities are independently managed by boards of trustees and are not consolidated within the Trust's accounts. The Weston Health General Charitable Fund is not consolidated in these financial statements on the grounds of materiality.

The transactions are as follows:

	31 March 2021 (£m)		31 March 2020 (£m)		2020/21 (£m)		2019/20 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Above and Beyond	0.23	-	1.68	-	0.45	0.30	1.90	0.29
Grand Appeal	0.07	-	0.02	-	0.39	-	0.27	-
Weston Health General Charitable Fund	0.30	-	-	-	0.84	0.30	-	-

23. Financial Instruments

23.1 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 and foreign exchange risk

As the Trust does not deal in currencies, invest in cash over the long term, borrow at variable rate or hold any equity investment in companies its exposure to market risk (either interest rate, currency, or price) is limited.

Market risk is managed by limiting investments to fixed rate and fixed term with credit worthy institutions, based upon market knowledge as to the likely movements in interest rates.

All financial assets and liabilities are recorded in sterling. Therefore, the Trust has no exposure to foreign exchange risk.

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. 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.

23.2 Carrying Value of Financial assets by category

	31 March 2021 £000	31 March 2020 £000
Receivables with DHSC group bodies	18,276	40,320
Receivables with other bodies	9,651	7,539
Other financial assets	104	104
Cash and cash equivalents	169,644	129,840
Total	**197,675**	**177,803**

There are no material differences between amortised costs and net book value of the above financial assets. As a result, all financial assets are held at net book value.

23.3 Carrying Value of Financial liabilities by category

	31 March 2021 £000	31 March 2020 £000
DHSC Loans	59,324	65,215
Obligation under Finance lease	3,591	3,960
Trade and other payables with DHSC group bodies	22,741	15,825
Trade and other payables with other bodies	96,575	63,175
Total	**182,231**	**148,175**

There are no material differences between amortised costs and net book value of the above financial liabilities. As a result, all financial liabilities are held at net book value.

Maturity of financial liabilities based on undiscounted cashflows

	Year ended 31 March 2021 £000	(* Restated) Year ended 31 March 2020 £000

Less than one year	128,247	88,186
In more than one year but not more than five years	31,490	32,275
In more than five years	33,920	41,487
Total	**193,657**	**161,948**

*** Restated**
Prior year has been restated to reflect undiscounted future contractual cash flows (i.e. gross liabilities including finance charges) and net book values as per the Regulator requirements.

23.4 Fair values

The carrying value of the financial liabilities is considered to be approximate to fair value as the arrangement is of a fixed interest and equal instalment repayment nature and the interest rate is not materially different to the discount rate.

The carrying value of short term financial assets and financial liabilities are considered to be approximate to fair value.

24. Third party assets

At 31 March 2021 the Trust held £nil (31 March 2020: £nil) cash and cash equivalents relating to third parties.

25. Losses and special payments

Losses and special payments were made during the year as follows:

	2020/21		2019/20	
Losses	**No.**	**£000**	**No.**	**£000**
Cash losses	10	40	55	34
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	285	248	452	331
Damage to buildings, property etc	3	382	1	272
Special payments				
Ex gratia payments	41	12	51	8
Total	**339**	**682**	**559**	**645**

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

26. Post Statement of Financial Position events

No post statement of financial position events to note.

Appendix D – Independent Auditor's Report to the Board of Governors (including final audit certificate)

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

Report on the audit of the financial statements

Opinion

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

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of its income and expenditure and cash flows for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21.

We have audited the financial statements, included within the Annual Report and Accounts 2020/21 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2021; the Statement of Comprehensive Income, the Statement of Cash Flows, and the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Conclusions relating to going concern

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

However, because not all future events or conditions can be predicted, this conclusion is not a guarantee as to the Trust's ability to continue as a going concern.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

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 2020/21 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 2021 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

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 required to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21 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 has no realistic alternative but to do so.

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.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud, is detailed below.

Based on our understanding of the Trust and industry, we identified that the principal risks of non-compliance with laws and regulations related to the Data Protection Act 2018, and we considered the extent to which non-compliance might have a material effect on the financial statements. We also considered those laws and regulations that have a direct impact on the financial statements such as the National Health Service Act 2006 and related legislation governing NHS Foundation Trusts. We evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls), and determined that the principal risks were related to the use of journals to manipulate financial performance and overstating costs to claim COVID-19 funding during the year as well as year-end top up funding. Audit procedures performed by the engagement team included:

- identifying and testing journal entries using a risk based targeting approach for unexpected account combinations;
- testing a sample of COVID-19 related expenditure to supporting documentation to verify that the Trust had correctly included expenditure that related to COVID-19 costs;
- testing a sample of unsettled transactions and accruals at the year-end, which included validating the assumptions made; and
- enquiring with management, internal audit, the local counter fraud specialist and those charged with governance to understand the relevant laws and regulations applicable to the Trust, including their assessment of fraud related risks and consideration of known or suspected instances of non-compliance with laws and regulations.

There are inherent limitations in the audit procedures described above. We are less likely to become aware of instances of non-compliance with laws and regulations that are not closely related to events and transactions reflected in the financial statements. Also, the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion.

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.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of University Hospitals Bristol and Weston 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

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Under the Code of Audit Practice we are required to report, by exception, whether any significant weaknesses were identified during our work on the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources, and to refer to any associated recommendations. As explained further in our Auditor's Annual Report, our work was performed in the context of the COVID-19 pandemic and resulting changes in both the operating and financing regimes for the NHS for the year.

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

Other matters on which we report by exception

We are required to report to you if, in our opinion:

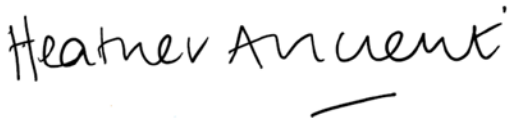
- the statement given by the directors on page 88, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for patients, regulators, and other 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 83, 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 2020/21 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 of 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
14 June 2021