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University Hospitals Bristol and Weston NHS Foundation Trust

# Annual Report and Accounts 2024/25

We are
supportive
respectful
innovative
collaborative.
We are UHBW.

**University Hospitals Bristol and Weston NHS Foundation Trust**
**Annual Report and Accounts 2024/25**

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

# Contents

# 1. Group Chair and Group Chief Executive Statement

**Making a difference that matters**

At UHBW, full-hearted care is what we do. We are incredibly proud of all that we've achieved in 2024 - 2025 and would like to extend our heartfelt thanks to everyone at Team UHBW - our people, governors, volunteers and charity partners. Their contributions have been instrumental in making a real difference to the lives we touch across Bristol, Weston and the South West.

We are united by a single purpose at UHBW, helping to make our communities a healthier, happier place. Our exceptional team has worked tirelessly over the past 12 months to do just that by delivering high-quality, timely care to those who need us.

This isn't always easy. We faced significant operational pressures this year, especially during the winter months. Emergency Department attendances were higher than last year but during even the toughest of times, our people showed extraordinary resilience, keeping those in our care safe and supporting each other.

And despite the tests we have faced, there is much to celebrate.

We've made great strides to improve people's experience of our services in our hospitals this year. As part of our new Experience of Care strategy: My Hospitals Know and Understand Me, we've strengthened the infrastructure to support safer care of patients with mental health conditions. We were also proud that that the care we provided was rated as good or very good by 91.8% of inpatients and 96.5% of our outpatients in our monthly surveys90.2% of people who've used our services rated their care as good or better in our monthly maternity and inpatient surveys.

Our work to form a Hospital Group with North Bristol NHS Trust (NBT) to deliver the vision of our Joint Clinical Strategy made significant progress this year too. We've made joint leadership appointments and progressed our first eight Single Managed Service pathfinders. Together, teams at UHBW and NBT are re-imagining future services around the needs of patients, populations and place, putting the foundations in place to remove unnecessary duplication, make best use of our people, expertise and infrastructure, offer more consistent pathways and experiences for patients and enable innovation and improvement at scale.

We've made a difference that really matters to patient safety too, embedding Martha's Rule in adult areas and Bristol Royal Hospital for Children (BRHC) to provide patients and families with a way to seek an urgent review if their or their loved one's condition deteriorates, and they are concerned this is not being responded to.

To ensure our communities have timely access to care, we've continued in our efforts to reduce waiting times and deliver on the ambitions of our new UHBW Clinical Strategy 2025-2030. The Weston Community Diagnostic Centre which opened in April 2024, carried out an amazing 12,598 diagnostic tests in its first year, helping speed up treatment, reduce waiting lists and bring care closer to home.  We've also used robot assisted surgery in procedures, contributing to reduced hospital stays, fewer clinical complications, and fewer re-admissions.

In a UK first, we were thrilled that three-year old Freddie was the first child in the UK to benefit from a new, innovative Extracorporeal Membrane Oxygenation (ECMO) technology in 2024 at BRHC. ECMO supports people with cardiac or respiratory problems, taking over the job of the heart or lungs, and can help both organs at the same time. We are delighted that Freddie is continuing to recover following his life saving treatment.

Research and innovation are essential to the care we provide at UHBW, allowing us to pioneer new standards in treatment and improve outcomes for people. We were the first site in England to launch The Generation Study, sponsored by Genomics England in partnership with NHSE. So far over 600 women have joined the study at St Michael's Hospital, using whole genome technology to identify up

to 240 treatable rare conditions in babies where early diagnosis and treatment can help them live healthier lives.

It's our ambition to become the Trust that does more for its people than any other. This includes tackling discrimination in all its forms in our services. Our pro-equity action plan was created from the ideas and experiences of colleagues to build a place where everyone feels truly safe to be themselves and can expect equity of opportunity and equality of outcome and experience. As part of this work, we created an anti-racism commitment from the words and feedback of our workforce that you can read on our Trust website.

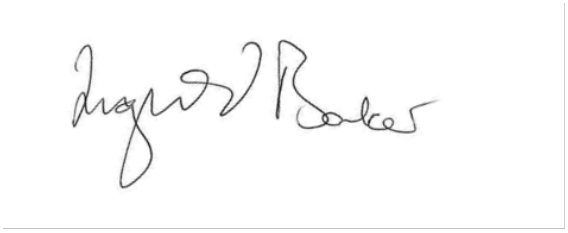
We are incredibly proud to recognise the outstanding achievements of all our dedicated teams across #TeamUHBW in 2024-2025. To name but a few, Professor Gianni Angelini, was honoured with a Lifetime Achievement Award from the International Society for Coronary Artery Surgery and UHBW's Hepatology Clinical Nurse Specialist Sally Tilden was recognised by the European Association for the Study of the Liver Nurses & Allied Health Professionals Rising Star Award 2025.

The Innovative Partnership Workforce Solution to Support Endoscopy Training Lists took home two Health Service Journal partnership gold awards and Bristol Haematology and Oncology Centre received the Myeloma UK Clinical Service Excellence Programme (CSEP) Award in recognition of its outstanding care and dedication to people living with incurable blood cancer.

In 2025-2026 we look forward to doing even more to deliver seamless, high-quality, and equitable care for every person across Bristol, Weston, South Gloucestershire, and the wider South West in partnership with North Bristol NHS Trust as part of the Bristol NHS Group. As two large, ambitious Trusts, we are committed to working together to delivering our Joint Clinical Strategy for the benefit of our 'Four Ps'—Patients, People, Population, and the Public Purse. We'll build on the success of Cardiac Services, our first specialty to develop a Single Managed Service using our combined resources to reduce waiting times, ensure equitable access to treatment and enhance patient experience by aligning patient pathways and improving communication for more seamless care.

Thank you again to our people, partners, governors, volunteers, charities and Board for your continuous commitment to making a difference that matters to the lives of our communities. We are proud to be part of Team UHBW.

***Maria Kane***
***Group Chief Executive***



***Ingrid Barker***
***Group Chair***

# 2. Performance Report

## 2.1 Overview

Following the creation of Integrated Care Boards (ICBs) on 1 April 2022, as successors to Clinical Commissioning Groups, the Trust has been working with the ICB and wider system partners to develop and agree the system's priorities and the system strategic framework. The Trust has been an active member of the system, which has included the agreement of actions to support the performance of the system and system partners. These decisions have related to the accessibility and quality of services, and the delivery of the financial targets. As a progression of this, the Trust has developed a Joint Clinical Strategy with North Bristol NHS Trust, which sets out how the two trusts will make the most of their combined resources to deliver seamless, high quality, equitable and sustainable care to the population of Bristol, North Somerset and South Gloucestershire over the next three years. As the logical conclusion to this work, on 8 April 2025 the two trusts approved the formation of the Bristol NHS Group, bringing together the two NHS organisations with a shared ambition: to deliver seamless, high-quality, equitable and sustainable healthcare to the people they serve.

The Bristol NHS Group has set out the following priorities to improve healthcare for the communities it serves:

- Deliver outstanding care for everyone who needs it
- Support our people to thrive and excel
- Get the most out of our resources for the communities we serve
- Excel in groundbreaking innovation, research and development
- Work with our partners as one team

In respect of Referral to Treatment (RTT), at the end of 2024/25 the Trust reported that no patients were waiting over 65 weeks, achieving the revised target set for it by NHSE, and the Trust expects to sustain this position into 2025/26, focussing on further reducing the length of time patients are waiting to be treated.

Emergency Department attendances during 2024/25 exceeded both the 2023/24 and 2019/20 levels, and this, alongside high bed occupancy levels, impacted delivery of the four-hour standard of care. In February 2025, delivery against the four-hour standard of care, was 71.7%. From March 2025, NHS England requested that Trusts refocus their efforts to achieve the delivery of the March end position of 78%. In addition to the Winter Operational Plan 2024/25, the Trust mobilised a further hospital wide response, achieving 75.2% against this target.

Cancer diagnosis performance met or exceeded the March 2025 target of 77% in each month of 2024/25, and performance is anticipated to continue to improve in line with the 2025/26 operational planning ambition of achieving 80% by March 2026. Patients with cancer should start first definitive treatment within 62 days of referral from a GP, screening programme or upgrade by a consultant. The national standard is that 85% of patients should start their definitive treatment within this standard and NHSE set an interim recovery target for providers of 70% by March 2025. The Trust has performed above NHSE's recovery standard of 70% throughout the year and expects to sustain this in 2025/26, setting the ambition to meet the 2025/26 target of 75% by March 2026.

In respect of diagnostic waiting times, at the end of March 2025 84.8% patients were waiting less than 6 weeks for their diagnostic test, an improvement from 78.9% at end of April 2024, although falling short of the planned 95%. Recovery plans are anticipated to further support improvement in diagnostic waiting times into 2025/26, aiming to recover performance during the year.

The Trust delivered a net income and expenditure surplus of £0.043m (excluding technical items). 2024/25 was the 22nd year in a row that the Trust delivered a surplus or break-even income and expenditure position (excluding technical items).

The Trust is facing a range of challenges and risks with workforce capacity and capability remain a concern, as well as the capacity of the Emergency Department to manage patients arriving in ambulances and the availability of beds. The Trust also needs to progress works associated with modernising its estate.

The Trust Board of Directors and its Committees are monitoring these risks and proactively seek assurance that appropriate action is being taken to mitigate them and address any control issues identified. The Trust continues to prioritise these areas and work to minimise any potential negative impact they may have on patient care and safety. Overall, it has been a challenging year for the Trust and for the wider NHS, but the efforts of our staff to continue to provide the highest quality of care for patients has been exemplary. The Trust will continue to invest in our people to ensure they have the resources they need to deliver the care they aspire to give, and to work with our system partners to deliver the best possible care.

### *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 England, 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 £1,300m.

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 funding secured in 2024/25. 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. During 2024/25 the gender make-up of the nine Executive Directors (including non-voting Executive Directors) was six females and three males. Of the nine Non-executive Directors and one Associate Non-executive members, seven were female and three were male.

### *2.1.2 Our mission, vision and values*

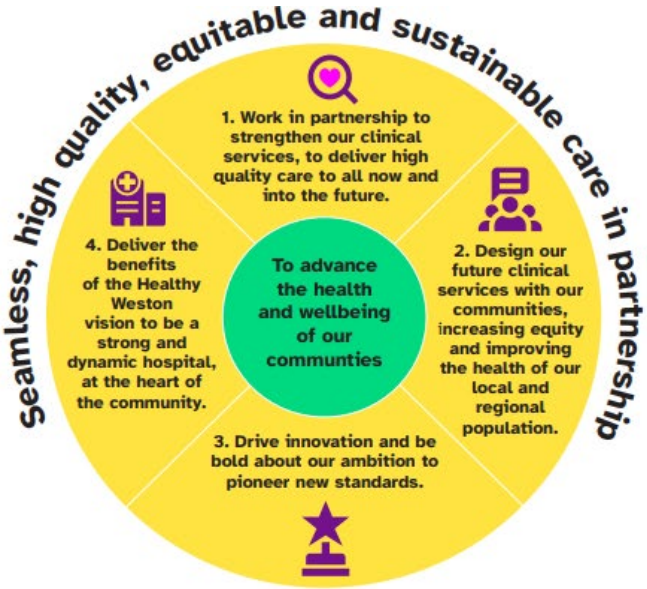
Through 2024/25, our focussing has been on embedding our Trust strategy, '*A difference that matters'.* Our vision, mission and strategic priorities our outlined below.

Our vision: ***To become the trust that pioneers new standards for patients, staff and communities.***

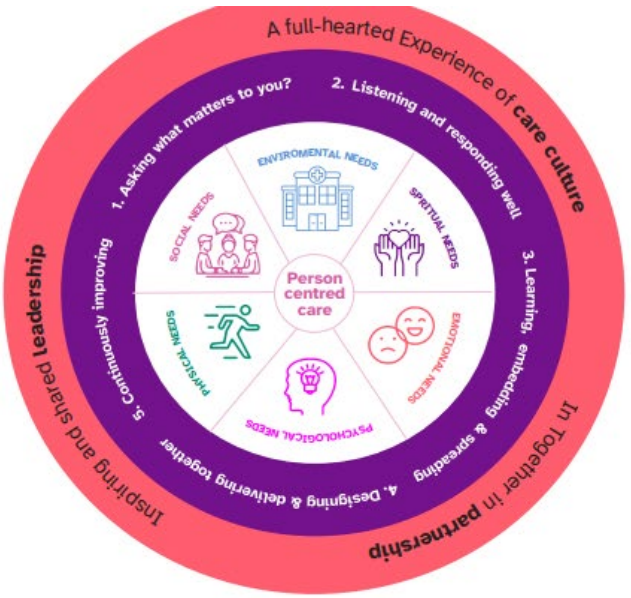
Our mission: ***To advance the health and wellbeing of our community***.

Our Trust values remain as:


In November 2024 our new UHBW Clinical Strategy was approved, this includes our commitment to the delivery of our Joint Clinical Strategy with North Bristol Trust and our ongoing commitment to the delivery of our Healthy Weston Strategy. The picture below summarises the four key goals within our strategy, to drive the development and stability of both our specialist, regional and general local services.




Our clinical strategy describes our ambitions for how our clinical services will deliver care




Our experience of care strategy describes how patients will receive and experience this care

| Our Digital Strategy | Our People Strategy | Our Estates Strategy |
|---|---|---|
| • A resilient and reliable foundation<br>• Accessible clinical information<br>• A Digital First approach<br>• One digital identity | • Growing for the future<br>• New ways of working<br>• Looking after our people<br>• Inclusion and belonging | • UHBW 5 year capital programme<br>• Delivery of Net Zero<br>• Joint UHBW and NBT strategic estates plan<br>• Bristol, North Somerset and South Gloucestershire ICS infrastructure strategy (BNSSG) |

It also outlines the relationship between our Clinical Strategy and our Experience of Care Strategy and our People, Estates and Digital Strategies as our core enabling strategies.

Our Clinical Strategy is now being delivered through our Patient First Operating Framework as part of the Patient Safety Strategic Priority, as outlined below.

### *2.1.3 Our Strategic Priorities*

In June 2023 the Trust Board approved the following strategic priorities, delivered through our Patient First approach which is our long-term, continuous improvement approach to transforming hospital services for the benefit of patients and staff: Delivery against these priorities has remained our focus through 2024/25. Our Strategic Priorities are;

- **Experience of Care:** Together, we will deliver person-centred, compassionate and inclusive care every time, for everyone.
- **Patient Safety:** Together, we will consistently deliver the highest quality, safe and effective care to all our patients.
- **Our People:** Together, we will make UHBW the best place to work.
- **Timely Care:** Together, we will provide timely access to care for all patients, meeting their individual needs.
- **Innovate and Improve:** Together, we will drive improvement every day, engaging our staff and patients in research and innovative ways of working to unlock our full potential.
- **Our Resources:** Together, we will reduce waste and increase productivity to be in a strong financial position to release resources and reinvest in our staff, our services and our environment.

Delivery of our strategic priorities is managed through month Strategy Deployment Reviews (SDRs) with our Senior Leadership Team and are reported to Board monthly. A summary of our progress

#### *2.1.4 Continuous Improvement*

The following is a summary of the progress in 2024/25 of our improvement projects - which enable us to deliver our strategic priorities - and the vision metrics, which are the key measures to know we are making a difference to our patients, public and people.

**A. Experience of Care: Together, we will deliver person-centred, compassionate and inclusive care every time, for everyone.**

**Vision metrics:**

- Overall experience of care (as rated by patients): 90.2% of patients rated their experience of care as good or above in monthly maternity and inpatient surveys, against a trajectory of 94.1%. (2024/25).
- Happy with standard of care (as rated by staff): 0.4 percentage point improvement (73.9% to 74.3%) in staff survey responses that they would be happy with standard of care for friend or relative

**Key achievements:**

The Trust's **Experience of care strategy** has been co-designed with patients, communities and staff, and was approved by the Trust Board in May 2024. The strategy has five goals: asking "what matters to you?"; listening and responding well; Learning, embedding and spreading; designing and delivering together; 'Continually improving across the life course and patient journey'. Colleagues across the Trust have been working on delivering the year one priorities of the strategy.

2024/25 successes:

- Supporting patient / community engagement and involvement approach for UHBW / NBT Single Managed Service pathfinders

- Experience of Care Champion Role designed together with clinicians and roll-out commenced in Medicine and Specialised Services
- Accessible Information Standard (AIS) essential to role training launched including patient-led video and AIS posters have been cascaded across clinical areas
- Easy-read version of Friends and Family Test (FFT) feedback card launched for patients with a Learning Disability
- Developed a teenager-friendly feedback approach created via Patient Feedback Hub (IQVIA)
- Dementia Sanctuary Garden sessions started at Weston General Hospital with charity Alive
- Bristol and Weston Hospital Charity awarded funding for End-of-Life Care volunteer service which will go live in Autumn 2025

**Improving experience of care through better communication** has been a focus in inpatient care settings. The inpatient communication experience score metric has improved by from 82.8 in April 2024 to 86.2 in March 2025, against a target of 88. Examples of improvements include:

- Specialised Services Division have commenced a pilot of bedside handover in the Bristol Heart Institute and are introducing a new experience of care champion role.
- Medicine Division use "You Said We Did" poster displays to give feedback to patients on how their feedback has helped to improve care on the ward and share learning across wards. One ward has introduced pocket size communication cards for patients and visitors with ward information such as phone numbers and visiting times.
- Following a successful pilot at Weston General Hospital in 2023/24, the '**What matters to You'** conversation approach has been rolled out to all inpatient areas across the Trust in 2024/25. The approach helps to provide person-centred care by providing opportunities for meaningful interaction, rather than task-based care and helps ensure staff can better meet the needs of patients.
- Staff have improved the **discharge experience** at Weston General Hospital. Bespoke patient surveys were undertaken focused on discharge experience to provide targeted data to help drive improvements. Discharge information boards have been created to go above patient beds for clarity and consistency of communication.

**Innovative Musculoskeletal Care** Aiming to improve patient care and access, the Musculoskeletal Physiotherapy Outpatient Team has worked with Sirona and NBT colleagues to deliver a new, innovative approach for the increasing number of patients referred to musculoskeletal physiotherapy. This collaboration has led to the creation of **Community Appointment Days** (CAD), held at various venues across the BNSSG region.

The goal of CAD is to provide personalised, patient-centred care for every individual referred for musculoskeletal physiotherapy. Each patient receives tailored advice for their condition and is then guided to the most appropriate management options, including easier access to local community services such as Working Well services. This initiative ensures that patients get the right care at the right time, closer to home. The CAD model supports non-English speaking patients, ensuring that language barriers are no longer an obstacle for those seeking treatment, thereby ensuring inclusivity of treatment and reducing health inequalities in our population.

In Spring 2024, the Experience of Care and Inclusion team launched an A3 thinking project to improve **access to interpreting services**, as part of our commitment to reducing health inequalities. Our analysis showed that there were levels of unfilled interpreting requests that required focussed improvements in order to see an improvement in meeting patients interpreting needs. Staff across all clinical divisions and the Human Factors team collaborated through a process of root cause analysis to understand the contribution of internal process issues, and challenges with our external interpreting providers. So far, we have procured and launched a contract with a new provider for spoken languages and renewed the contract for non-spoken languages (British Sign Language). We are also improving our internal processes for identifying, recording and meeting interpreting needs, supported

by Human Factors. Since launching the new contract for our spoken languages provider, the overall fulfilment rate (e.g. percentage of bookings filled for interpreting requests) has reached the target of 96%. We are also seeing more telephone and video remote interpreting activity which is ensuring that we are meeting more of our patients' communication needs by utilising a variety of interpreting modes especially when face to face may not be available, for example for rare languages.

The **Mental Health Across UHBW** project is aiming to address a 40% increase in mental health presentations across UHBW since 2020. Despite improvements, such as creating new roles and enhanced staff training, mental health provision across sites is inequitable and the current environment, staffing, processes and governance are not able to respond effectively to current and increasing/changing mental health demand. The project will ensure we have a robust infrastructure to support the mental health care of patients, ensuring the improved outcomes and safety of patients. Six priority workstreams have been identified within this project, overseen by a multi-disciplinary steering group

UHBW successfully bid to be part of an NHS England **Enhanced Therapeutic Observation Care** (ETOC) project. Using an A3 thinking structured, problem-solving approach, the project team determined that we do not currently have equitable & consistent approaches to assessing patients requiring enhanced care, leading to variation in the assessment outcome and inconsistent management of patients. Following root cause analysis, three opportunities for improvement have been prioritised: clinical assessment & decision making, training & education, and the digital clinical note. Two working groups have now been established to drive actions forwards using a PDSA approach during the coming year.

### B. Patient Safety: Together, we will consistently deliver the highest quality, safe and effective care to all our patients.

**Vision metrics:**

Improvements have been seen in staff survey responses to the following patient safety culture related questions:

- 0.6 percentage point decline (64.4% to 63.8%) for 'not seen any errors/near misses/incidents that could have hurt staff/patients/service users'.
- 0.7 percentage point improvement (65.4% to 66.1%) for 'staff involved in error/near miss/incident treated fairly'.
- 0.8 percentage point improvement (70.2% to 71.0) for 'organisation ensure errors/near misses/incidents do not repeat'.
- 0.2 percentage point improvement (63.7% to 63.9%) for 'feedback given on changes made following errors/near misses/incidents'.

**Key achievements:**

The **UHBW Clinical Strategy** 2025-2030 sets out our vision for clinical services over the next five years and highlights our ambitious plans to build and grow services and pathways that work for our patients, partners and our people. Key achievements in improvement in 2024/25 include:

A joint UHBW and NBT collaboration to implement **Martha's Rule** is underway, which is a patient safety initiative being implemented in the NHS that empowers patients and their families to request an urgent review of a patient's condition if they feel their concerns are not being adequately addressed. As early implementers of this initiative, we have taken a "testing and learning" approach supported by NHS England and Health Innovation West of England Patient Safety Collaborative. The project aims to deliver the implementation of Martha's Rule across UHBW adult and children's services by developing accessible, sustainable and resilient systems for patients, families and staff to directly raise continuing concerns about patient deterioration and access a Critical Care Outreach Team review. Patients, families and lay partners have been involved in co-design of an inclusive and accessible process and resources that works best for them, including best use of digital technology

for communication with patients, families and carers, including people who don't have English as a first language. The service commenced in the Bristol Royal Hospital for Children in January 2025, and quality improvement testing commenced across 15 adult wards in March 2025 and will be spread across all adult wards during 2025. Patient and family/carer information resources have been developed to support them to raise concerns, and volunteers are visiting wards to raise awareness with patients and families.

Preparation for the implementation of **Careflow Medicine Management (CMM),** an electronic prescribing and medicines administration (ePMA) system for in-patients to minimise medication errors caused by paper-based processes, has progressed during 2024/25. The multi-professional project group has developed the clinical configuration with our partners System-C in preparation for go-live commencing May 2025. Roadshows held for staff across our hospital sites have demonstrated how the new system will be different and the benefits to patients and staff that it will enable. Staff using the new system are undertaking training and will receive "super-user" support from upskilled members of the clinical workforce to ensure the seamless transition to the new system. Proven benefits of ePMA systems include but are not limited to, reduction in prescribing and administration errors, easy and concurrent access to prescription charts, increasing ease of prescribing discharge medication.

Our Trust-Wide **Adult Deteriorating Patient** programme focuses on improvements to delayed recognition and response to patient deterioration which is nationally recognised as one of the significant causes of avoidable harm.

There has been considerable focus in 2024/25 on how we manage patients with sepsis and at risk of sepsis. We have disseminated the new sepsis screening tool and pathway for adults, based on 2024 NICE guidance, and provided training and support for our staff of to embed the new pathway into clinical practice. The Patient Safety Improvement Team has worked with clinical teams to support sepsis data collection and test change ideas to improve timeliness of screening and treatment for patients at high risk of sepsis. In 2025 we will recruit to dedicated medical and nursing sepsis roles to continue to drive our rapid improvement work.

The award nominated **Weston Integration Project** is transforming the way frailty care is integrated across primary, community, and secondary care in Weston-Super-Mare. The original focus of the project was to reduce hospital admissions for frail elderly patients. Attention has now moved to understanding and prioritising individual patient care needs during handovers between clinical teams, using the patient-centred framework "What Matters To Me".

The team has focused on improving communication, training, and documentation to address the challenges of fragmented care, siloed working and a reactive approach to managing frail patients across the hospital, which has resulted in care that prioritises individual patient needs. The project also identified unintended harm, like deconditioning, and underutilisation of services such as NHS@Home as key issues, which will be the subject of ongoing improvement work. Additionally, a new research proposal aims to secure funding to improve health outcomes and reduce hospital admissions for those aged over 75 years, focusing on a more integrated Comprehensive Geriatric Assessment (CGA).

The Women's and Children's Division has piloted the **Paediatric Hub** approach for greater integration of primary and secondary care in paediatrics, which is evidenced by success in other regions and is now embedded in national policy. Demand has risen significantly since the Covid-19 pandemic for outpatient secondary care general paediatrics, leading to long waiting times for patients. In Bristol, North Somerset and South Gloucestershire (BNSSG), a partnership has been established between the Bristol Royal Hospital for Children, General Practice, One Care, Sirona and the Integrated Care Board to pilot this new way of working.

Three pilot sites have been established in Pier Health (Weston), Northern Arc (North/West Bristol) and Swift (South Bristol) Primary Care Networks. The hubs include a monthly integrated clinic focusing on paediatric patients where secondary expertise is felt to be beneficial, and are supported by a "lunch and learn" session and a multi-disciplinary team meeting for wider local shared learning opportunities and relationship building. Over the first nine months of the pilot, 124 patients have been seen in a paediatric hub, with only 6% of these patients needing further general paediatric follow-up. A further 26 patients were reviewed through dedicated paediatric asthma clinics in the hub sites, supported by a children's hospital nurse consultant.

The demographics of the patient group attending the hubs so far shows that we are reaching children in deprived areas and from a range of ethnic backgrounds. Half of the patients attending the hubs were under five years old. Patient and staff experience of the hubs is very positive. A further two hub sites will be established in 2025/26.

### C. Our People: Together, we will make UHBW the best place to work.

**Vision Metric:**

- There has been a 1.2 percentage point improvement (67.4% to 68.6%) in staff survey responses for staff recommending UHBW as a place to work.

**Key achievements:**

Key successes in delivery of the year three actions of the Our People Strategy include:

We have focused in the last year on developing various **career pathways** to enable our staff to learn and develop in their roles. Colleagues now have access to the Nurse career pathway, the Allied Healthcare Professionals career pathway that represents all of the professions in UHBW, the Pharmacy career pathway and the Administrative & Clerical career pathway. The Healthcare Science career pathway is a key priority to develop in 2025, which will enable colleagues to progress in science-based careers including clinical engineering, informatics and physiological, life and physical sciences.

Significant work has been undertaken to improve the **retention of our healthcare support workers and support midwives**, with a 13 percentage point improvement to 80% for this staff group remaining with the Trust for at least one year. Divisional management teams have used quality improvement tools to understand from staff the reasons that they consider leaving their role, allowing focus to be given to improving work-life balance and developing career progression opportunities.

Pro-Equity is inclusion in everything we do and embracing full hearted care to eliminate disparities in staff experience. To develop our **Pro-equity promise** we have held workshops with staff across all professions to understand their views and experiences with sexual safety, anti-racism and anti-ableism. The data collated has informed the development of our pro-equity approach and anti-racist statement to be launched in April 2025, accompanied by an integrated delivery plan for divisions to deliver through their equality, diversity and inclusion forums.

The **Medical Workforce programme** aims to develop the strategic and Trust wide approach to the recruitment, deployment and configuration of our medical staff to support and improve their working lives and optimise career opportunities, and to enable the delivery of the Trust's clinical strategy. Key successes include:

- Deployment of digital medical workforce systems to enable a standardised and more efficient approach to medical workforce planning and management across the Trust.
- Removal of off-framework agencies, and preparation work to achieve the regional rate card by August 2025.
- Creation of a long-term plan for locally employed doctors, to develop attractive roles for all grades of doctor. The Divisions of Medicine, Weston and Specialised Services have developed a joint rotation, and we will recruit 12 doctors to build the supply of staff with general medical training for hard to recruit medical specialities. We have also given focus to succession planning for specialty and specialist doctor roles at Weston General Hospital.

**D. Timely Care: Together, we will provide timely access to care for all patients, meeting their individual needs.**

**Vision Metric:**

10% year on year improvement in ambulance handover times as a measure of improved patient flow through our hospital:

- There has been a 1.9 percentage point improvement (30.1% to 32%) of ambulance handovers within 15 minutes in 2024/25 compared to 2023/24.
- There has been a 2.2 percentage point improvement (63.4% to 65.6%) of ambulance handovers within 30 minutes in 2024/25 compared to 2023/24.

**Key achievements:**

Our **Proactive Hospital programme** focuses on good flow within our hospitals and aims to reduce the time that patients wait in our Emergency Departments. We have delivered a range of improvement projects to improve flow.

We have commenced two projects to understand delays in diagnostic tests while patients are in the BRI Emergency Department (ED). The **ED to CT (Computed Tomography) scan pathway** and the **BRI Emergency Department to Pathology pathway** projects aim to improve efficiency and patient flow. The projects have strengthened collaboration between ED, Radiology/Pathology, and the Portering teams, laying the groundwork for sustainable process improvements. We will measure the reduction in process cycle times from patient presentation in ED to CT imaging verification as each improvement is implemented, ensuring we are improving turnaround times, and ultimately improve patient care and experience.

To assess our Same Day Emergency Care (SDEC) services against NHSE guidance, we supported the collation and analysis of **SDEC self-assessments** across the trust. This work was aligned with the NHSE SAMEDAY strategy and framework, providing a structured approach to evaluating our services. The findings have highlighted areas of strength and opportunities for improvement, ensuring that our SDEC pathways continue to develop in line with national best practice. These insights will inform future service improvements, supporting more effective and timely patient care.

**Front Door Therapy 7-Day Service** Front Door Occupational Therapists, Physiotherapists and Therapy Support Staff at Weston General Hospital have worked together to enhance patient outcomes and streamline care. Commencing January 2025, their services were extended to a full 7-day schedule, covering the Emergency Department, Older Persons Assessment Unit, and Medical Assessment Unit (Sandford Ward). By providing consistent access to therapy services every day of the week, patients benefit from quicker interventions, reduced length of stay and hospital admissions, and more comprehensive support during critical moments in their care journey. The team is gathering patient and staff feedback and monitoring the success, with the aim of ensuring a sustainable vital service long-term for the community.

The **Active Hospitals** project aims to reduce deconditioning of our patients whilst they are in hospital. Following a successful pilot across six wards in Bristol and Weston, the project is now progressing to a trust-wide rollout within adult services, starting in Weston. The pilot demonstrated the benefits of embedding physical activity into patient care by empowering patients to take a more active role in their recovery through activities during their hospital stay. There has been particular focus on those patients that chose not to mobilise despite encouragement from staff. We have trained 1,293 staff members across UHBW in Enablement Skills, which enables staff to have enhanced conversations with patients and families around mobility and develop enablement skills. In addition, pilot wards have encouraged patients to get out of bed for mealtimes, exceeding the target of 75% by two percentage points. In 2025/26 we will focus on expanding implementation, supporting further staff training, and integrating movement into care pathways across the trust, ensuring the benefits of physical activity are embedded throughout the hospital system.

The "**Golden Patient**" initiative brings multi-disciplinary teams to work together, proactively focusing on the shared goal of supporting patients to leave acute care safely and on time. By bringing together diverse expertise and perspectives, we can effectively address patient needs and enhance their overall experience. This collaborative approach has made a real difference in improving patient care and ensuring a smoother discharge process. In 2024/25 wards implementing the golden discharge patient achieved 22.6% of discharges before midday compared to 17.7% on wards yet to implement the golden patient approach.

Once patients are ready to be discharged, they can be transferred from their inpatient ward to the **discharge lounge** while any final administration tasks are finished, or they wait for transport. Use of the discharge lounge frees up inpatient beds so that patients waiting in ED can be admitted to the wards sooner.

The **Weston discharge lounge utilisation** project aims to enable the patients who are medically ready to leave the hospital can do so in a timely and efficient manner. The project has used A3 thinking improvement methodology to gather data, understand current usage patterns, identify barriers, and assess potential improvements. The project has seen a steady increase in discharge lounge utilisation, moving from 30.2% in September 2024 to 47% in March 2025.

Our **Bristol discharge lounge** implemented a 24/7 model in October of 2023. The overnight beds are used for patients who are no longer medically unwell and are due to be discharged the next morning. 24% of the discharges (200-250 patients) through the lounge are attributed to the expansion into a 24/7 service model.

Although Bristol Royal Hospital for Children does not have a traditional discharge lounge set up due to the differing needs of their patients, the **Discharge Waiting area** on Puzzlewood ward offers some similar services. This year, the Puzzlewood team has been working hard to provide pre- and end of admission services that allow patients and their carers to access the waiting area while they await final discharge tasks to be performed, or to start medication ahead of their inpatient bed being ready.

Ensuring our patients are **ready for discharge** aims to bring forward the median time of discharge by two hours, thereby improving flow through our hospitals. A number of wards have used A3 thinking problem solving methodology to understand the causes of delays in patients being ready for discharge, and improvements have been trialled and refined. This includes the use of a visual discharge information board which aims to enhance communication, ensure all ward staff see and understand discharge reporting, and support more timely patient discharges. It includes a summary of ‘discharges today’ and ‘discharges tomorrow’, and track To Take Away medications, transport, and discharge summaries.

In 2025/26 we will focus on reducing the time taken for patients in ED to receive a **specialty review**, which will reduce time spent in ED and create a better experience for both patients and staff. Our multiprofessional teams have started to collect and analyse baseline data, which will inform the reasons for current delays and enable us to target improvements.
Approximately 50% fewer patients are discharged at the weekend compared to weekdays. Plan-Do-Study-Act (PDSA) cycles are underway on adult inpatient wards to trial different approaches to **weekend planning** to help us better understand the barriers to discharging patients at weekends and to inform further improvement work. Some wards are trialling weekend planning documentation while other areas are focussing on improving Criteria Led Discharge for weekends to allow patients to be discharged once they meet set criteria without the need for a further senior review.

The Estates & Facilities Division has supported flow of patients through the hospital through focusing on the longstanding issue of availability of **Trust wheelchairs** across Bristol sites. A multiprofessional team worked with Welcome Centre volunteers and a patient governor to understand the root causes of the lack of wheelchair availability, finding them as there was no official storage area for wheelchairs when not in use and unable to track wheelchairs around the site. Data shows that at the start of the project patients porters were only able to find wheelchairs 30% of the time, and it was taking porters

up to 30 minutes to locate a wheelchair. Additionally, 36% of wheelchairs required maintenance. As a result of the project we now have an official storage area for wheelchairs within the main BRI building Welcome Centre and an additional 53 wheelchairs have been purchased by the Trust. We are exploring cost-effective tracking options for wheelchairs across the site and ensuring the wheelchairs are correctly added to the asset management system so that maintenance issues are dealt with promptly. We are collecting data to show the impact these improvements have made, and there have been many positive comments from the portering staff that wheelchairs are now always available in the Welcome Centre which ensures patients can be transferred quickly and safely across the hospital site.

UHBW provides surgical services in theatre suites across seven hospital sites and covers a wide range of routine and specialist surgery. The **Improve Theatres productivity and efficiency** project aims to increase throughput of procedures in order to reduce elective backlogs and reduce waiting times for patients. The Trust has achieved a 5 percentage points improvement (76% to 81%) to capped touch time utilisation between April 2024 and March 2025, measured from a patient commencing their anaesthetic to leaving theatre, meeting the NHS England target performance for theatres utilisation.

The improvement in utilisation this year has focussed on divisional deep dive into reasons for low utilisation, reviewing theatres staffing and shift patterns, continued adherence to best practice for planning and scheduling activity, ensuring the appropriate administrative capacity is available to support timely booking of theatre lists, and developing data and reporting tools to enable proactive analysis of performance and timely intervention.

In 2025/26 we will continue to improve theatre utilisation to the NHSE target of 85% through focus on pre-operative assessment, patient optimisation and minimising last minute cancellations.

UHBW provides outpatient clinics with 156 specialties across our 10 hospital sites. We are focusing **Improving Outpatients productivity and efficiency** to increase outpatient capacity and reduce waiting times for our patients. In 2024/25 we have focused on Did Not Attend (DNA) reduction and appointment booking processes.

In 2024/25 the average DNA rate is 6.1%, compared to 6.7% in 2023/24, which is the lowest DNA rate on record. The reduction is attributable to the rollout of digital letters to patients – 65% of our patients now access their letters in digital format, and all appointment letters are sent digitally.

In April 2024 we commenced deploying functionality the DrDoctor patient portal for patients to reschedule their appointments. For those specialities where patients are able to reschedule their appointments using the portal there has been a 2.63% reduction in the DNA rate, and a 14% reduction in number of calls to the call centre, providing a better experience to patients. We will continue to roll out the patient rescheduling portal across our specialties in 2025/26.

The corporate Outpatient Team has worked with divisions to benchmark practice against national Getting It Right First Time (GIRFT) guidelines. 21 specialty specific handbooks that have been published providing best practice guidelines and case studies, and these specialties are reviewing against their services and developing improvement plans.

The Division of Medicine has used improvement methodology to review reasons that patients DNA across a number of specialties. Improvements include:

- piloting community/weekend oximeter pick up clinics at South Bristol Community Hospital for sleep patients
- planning to implement flexible polling for the division, starting in respiratory medicine which increases the notice of appointment given to patients and prevents risk of patient referrals "dropping off" the referral system

- supporting hepatology patients from the most deprived areas, focusing on patient specific communication and providing extra clinic navigators.

**E. Innovate and Improve: Together, we will drive improvement every day, engaging our staff and patients in research and innovative ways of working to unlock our full potential**.

**Vision metric**:

- There has been a 0.9 percentage point improvement (74.2% to 75.1%) in staff survey responses reporting they are able to make suggestions to improve the work of their team/department.
- There has been a small fall (59.6% to 59.0%) in staff survey responses reporting they are able to make improvements in their areas of work.

**Key achievements:**

UHBW has continued the **deployment of Patient First,** our long-term approach to transforming hospital services for the benefit of patients and staff. Our focus in 2024 has been providing training and coaching our clinical and non-clinical teams in the continuous improvement tools, techniques and methods that will give frontline staff the freedom to identify opportunities for positive, sustainable change.

18 teams have taken part in Patient First for Teams training in 2024/25, where multiprofessional teams come together to learn how to apply Patient First principles and tools to a team's day-to-day working activities, creating a culture of continuous improvement. Through the establishment of team improvement huddles taking place twice weekly, 540 local improvement ideas have been put forward by staff in those areas, with 327 (60%) being implemented and others still in progress. The implementation of the Lean-based 5S workplace organisation methodology has provided improvements in safety in the workplace and better stock control. Staff have fed back that the Patient First for Teams approach has enabled problems to be identified and addressed more quickly, and improved dialogue and collaboration between team members.

The Trust's Continuous Improvement team continues to support our staff in their improvement work, training and coaching teams to use Lean Six Sigma and other improvement tools, and ensuring health inequalities, equality, diversity and inclusion, and environmental sustainability are woven through all projects.

Teams are encouraged to share their improvements with staff across the Trust using the new Viva Engage internal social media platform. This helps to spread improvement and connect teams together to learn from one another.

Our staff continue to drive improvements in patient services through innovative initiatives:

In summer 2024 the physiotherapy team in Sub-Acute Stroke Rehabilitation at Weston General Hospital introduced the new technique of **neuromuscular and functional electrical stimulation** (NMES/FES), which is recommended by NICE and the Royal College of Physicians for helping stroke patients regain their strength and movement. Staff have learned how to use this technique earlier in a patient's recovery process, and by getting patients started on electrical stimulation sooner, they can significantly improve recovery outcomes right from the beginning.

We commenced **robot assisted surgery** in September 2023 for six specialties. The innovative approach to surgery can support reduction in length of stay, reduced clinical complications and re-admission and prevention of musculoskeletal problems in surgeons. In 18 months of operation we have performed 437 procedures and saved 574 bed days, the biggest savings being seen in colorectal anterior resections and hemicolectomy procedures. We will be installing a second robot in St Michael's Hospital in May 2025 which will enable us to increase robot assisted surgery in five specialties and realise further benefits.

The Women's & Children's Division has introduced a number of innovations to improve patient care and streamline workflows in the **Central Delivery Suite** and **Obstetric Theatres.** In January 2025, the CDS launched new Huntleigh Cardiotocography (CTG) machines which include the additional function of maternal pulse oximetry. These devices connect to the digital patient record creating centralised monitoring and ensuring better oversight of maternal and foetal wellbeing.

Additionally, the Handover Board and White Board functionality on the BadgerNet Maternity Electronic Patient Record has been implemented, improving communication and coordination among staff. The project has been a collaboration of digital and maternity services with MEMO clinical engineering**.** Planning is underway to roll out the CTG machines across all antenatal outpatient and inpatient services, ensuring all CTGs conducted at UHBW will be digitally stored directly to the patient record for ease of access and viewable remotely as part of centralised monitoring.

We have established a multiprofessional group of senior colleagues that will facilitate **innovation** and begin to embed a culture that supports, creates, tests, and adopts cutting-edge solutions, ensuring that innovation becomes an integral part of our operations, complementing research and continuous improvement. The group will provide support to individuals seeking to develop, trial, and adopt innovative solutions to healthcare problems, offering a range of support services including specialist advice, signposting, unblocking barriers and fostering connections.

North Bristol NHS Trust and University Hospital Bristol and Weston NHS Foundation Trust have historically maintained independent digital strategies. Work has been undertaken to design our approach for developing a **unified Hospital Group Digital Strategy**, which will include gathering insights from our organisation, partners and patients to identify key areas for improvement, then working in collaboration with these stakeholders to write the strategy for approval in quarter 3 of 2025/26.

**F. Our Resources: Together, we will reduce waste and increase productivity to be in a strong financial position to release resources and reinvest in our staff, our services and our environment.**

**Vision metrics:**

- The full financial position is included in section 2.3 Finance Review.
- We will treat more patients with elective care needs, exceeding 2019/20 activity levels:

**Key achievements:**

As part of the Trust's Operational Planning submission for 2024/25, demand and capacity modelling were used to determine the activity volumes required to meet the ambition that no patients would be waiting 52 weeks or longer for treatment by 31st March 2025. The modelling also focussed on ensuring that both cancer and diagnostic waiting times could achieve the national and local ambitions. The outputs of the modelling were shared with clinical divisions who subsequently developed plans describing a series of schemes which supported delivery of the activity required to meet these ambitions, primarily focussing on productivity and efficiency.

Despite the challenging No Criteria to Reside position throughout the year, there has been a notable increase in elective activity volumes during 2024/25, with elective inpatient activity increasing by c8.2% when compared with 2023/24 and by c5.3% when compared to 2019/20. The Trust has also seen a c3% increase in non-elective demand at the BRI and Weston during 2024/25 compared with the previous year, which, when considered along with the continued No Criteria to Reside challenge, has had an impact on the volumes of patients with elective care needs that the Trust has been able to see and treat.

Productivity and efficiency improvements have largely counteracted these challenges during the year, and this is evident when reviewing the average length of stay for patients admitted to the BRI and Weston sites during 2024/25, with a c19% reduction in the average length of stay for patients admitted to these two sites when compared with 2022/23.

The Trust has completed its first year with revised approach to the identification of and governance of the Trusts productivity and efficiency programme, through the establishment of a **Productivity and Financial Improvement Group,** chaired by the Chief Executive/Hospital Managing Director and attended by executive directors, divisional directors, and other key department heads. Multiple workstreams, have been established with further in early stages to work trust wide to identify productivity and efficiency initiatives, and feed into and support the existing and ongoing work within divisions. Productivity and efficiency opportunities will continue to be sought using all available

benchmarking data, with an increased use of National Cost Collection Index and Service Line Reporting data being used to drive analysis and review across the organisation, which complements the use of the Model Health System and the Getting it Right First Time (GIRFT) programme.

The **Reduce premium workforce costs** project has focused on the reduction of use of agency nurses, and improvement in bank nurse fill rates delivering the following:

- Nursing agency has reduced by £10.9m (71%) from 23/24 to 24/25.
- Off-framework has reduced by £2.6m (92%) from 23/24 to 24/25.

In addition to reductions in nurse staffing, there has also been a significant change in Medical staff agency reducing by £1.6m (23%).

Bristol and Weston Purchasing consortium (BWPC) have implemented of a new **digital procurement** system across UHBW in 2024/25 and are finalising a new methodology for spend management across UHBW and NBT with enhanced governance structures to support delivery. The change in system coupled with the new approach to spend management is giving the organisation greater data transparency and information to inform our decision making and the tools and processes to greater controls our expenditure.

### *2.1.5 Key risks to delivering our objectives.*

Throughout 2024/25, we have continued to embed a structured and proactive approach to risk management, aligned with our strategic objectives. This year marked a significant shift in our reporting framework, transitioning to a principal risk-based model to enhance clarity and focus on Board-level risk oversight.
Our quarterly risk reports to the Trust Board have provided insight into the principal risks that underpin our approach: Patient Safety & Quality, Workforce, Capacity & Performance, Estate Infrastructure, Financial, Digital & Cybersecurity, Change Management, Emergency Planning, and Fire Safety. This structured framework has enabled us to take a more integrated approach to risk mitigation, ensuring alignment with national requirements and organisational priorities.

Key areas of focus in 2024/25 have included maintaining high standards of patient safety and quality, managing workforce challenges through targeted recruitment and retention strategies, and enhancing IT and cybersecurity resilience to safeguard patient data and digital infrastructure. Significant attention has been given to capacity and performance pressures, ensuring that inpatient flow and service delivery remain sustainable. Investment in estate infrastructure has continued, addressing critical maintenance needs and ensuring compliance with regulatory standards.

Financial sustainability remains a key risk, with budgetary constraints impacting capital investment and the ability to deliver long-term strategic plans. Collaboration across the wider healthcare system has been central to addressing capacity risks, ensuring integrated care pathways and effective partnership working. The scale and pace of change within the NHS have also underscored the importance of effective change management, particularly in the implementation of transformation programmes, workforce planning and establishment of the Bristol group model.

### *2.1.6 Going concern disclosure*

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 2025/26 financial plan, further forecasting has been undertaken in relation to the Trust's cash position for the period from 1st April 2025 through to 30th September 2026. The cashflow forecast predicts positive cash balances throughout the period with a projected minimum cash balance of £53.1m as of 30th September 2026. In addition, downside forecasting has been undertaken, which considers a number of factors, for example, failure to deliver the Trust's savings requirement in full and additional unforeseen cost pressures, to stress test the cashflow forecast. The downside forecast continues to predict positive cash balances throughout the period. The projected

minimum cash balance is £24.2m as of 30th September 2026. After consideration of the cashflow forecasts, the directors have adopted the going concern basis.

### *2.1.7 Overview of financial performance*

Similar to previous years, funding envelopes for 2024/25 were set at an Integrated Care System (ICS) level. Emphasis remained on Bristol, North Somerset and South Gloucestershire Integrated Care System (BNSSG ICS) achieving a break-even income and expenditure plan in aggregate and at organisational level.

As per 2023/24, in 2024/25 the majority of the Trust's NHS income was earned from NHS commissioners under the NHS Payment Scheme (NHSPS) with Aligned Payment and Incentive (API) contracts as the main payment mechanism. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity based on actual activity.

Elective recovery funding (ERF) continued to be available in 2024/25 to provide further non-recurrent, financial incentive to increase elective activity beyond 2019/20 levels. Elective activity delivered by the trust contributed to system performance, with systems receiving elective recovery funding for exceeding their ERF target. The ERF was subsequently distributed to providers.

The Trust's 2024/25 financial plan, was a breakeven revenue income and revenue plan, constructed in accordance with the national planning guidance issued by NHS England (NHSE) and was aligned with the BNSSG ICS system financial envelope including the South West regional specialised commissioners.

The Trust delivered a net income and expenditure surplus of £0.043m (excluding technical items). This is a significant achievement in the context of increasing financial constraints, and the continuing operational challenge of responding to increased urgent care demands, alongside actively reducing waiting lists for elective care. 2024/25 was the 22nd year in a row that the Trust delivered a surplus or break-even income and expenditure position (excluding technical items).

During the financial year, the Trust continued the implementation of a significant revenue and capital investment programme. Key investments included £9m in schemes to enhance elective recovery, £8m to improvement digital systems and infrastructure, and £5m to improve access to diagnostic testing.

The Trust achieved savings of £32.5m against a plan of £41.2m, of which 41% were non-recurrent. The Trust's ability to make recurrent savings during 2024/25 continued to be a challenge as it recovered elective activity back to 2019/20 levels. The Productivity and Financial Improvement Group, launched during 2023/24 and chaired by the Chief Executive, continued to drive the savings programme and assist with the delivery of savings and facilitate improvements in productivity.

The Trust's cash position remained positive with a year-end cash and cash equivalents balance of £72.3m.

Despite the continuing operational challenges of accessing the hospital estate, minimising operational disruption and securing supply chain contractors, the Trust invested £46.8m on capital projects, including reconfiguration and improvements to the Trust's estate, medical equipment purchases, and further investment in information technology.

In accordance with NHSE requirements, the Trust submitted its 2025/26 break-even financial plan on 27th March 2025. The plan was concluded as part of a break-even BNSSG ICS system financial plan in conjunction with system partners and the oversight of BNSSG Integrated Care Board (ICB).

## 2.2 Performance Summary

### 2024/25 Priorities and Operational Planning Guidance

On 27th March 2024, NHS England released the 2024/25 priorities and operational planning guidance.

The guidance outlined the priorities for the NHS in 2024/25 including improvements in elective and urgent and emergency care (UEC) performance.

A range of performance objectives were defined in the document, and the core metrics are summarised in the table below.

***Table 1: Performance Standards against priority areas***

| Priority areas | Performance standards |
|---|---|
| Urgent and Emergency Care (UEC) | - Improve A&E waiting times, compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2025. |
| Elective Care | - Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties) |
| Diagnostics | - Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% |
| Cancer | - Improve performance against the headline 62-day standard to 70% by March 2025<br>- Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026 |

### Development of BNSSG Operating Plan for 2024/25

Following the publication of the 2024/25 Priorities and Operational Planning Guidance, the Trust, with other partner organisations, contributed to the development of the 2024/25 BNSSG Integrated Care System operating plan.

The Trust approach was initiated with a demand-based modelling exercise to inform activity requirements. This model was based on the national ambition of no patients waiting more than 52 weeks by 31st March 2025, whilst it also focussed on ensuring that both cancer and diagnostic waiting times could achieve the national and local ambitions.

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

The modelled requirements met the associated performance standards and also satisfied the value of activity required to meet the Elective Recovery Fund (ERF) threshold.

The Trust's performance trajectories included in the operating plan submission are summarised in the following table.

Following the publication of the 2023/24 Priorities and Operational Planning Guidance, the Trust, with other partner organisations, contributed to the development of the 2023/24 BNSSG Integrated Care System operating plan.

The Trust approach was initiated with a demand-based modelling exercise to inform activity requirements. This model was based on achieving the national ambition of no patients waiting more than 65 weeks by 31st March 2024 and also focussed on ensuring that both cancer and diagnostic waiting times could achieve the national and local ambitions.
Demand modelling was shared with divisions who subsequently developed a series of delivery plans describing schemes that will be introduced, or continued, that would support the levels of activity required to meet the ambitions referenced above. Divisional delivery plans were primarily focused on productivity benefits and were reviewed and stress-tested by corporate colleagues, ensuring that the plans were well defined, feasible and affordable.

The Trust's review of current independent sector utilisation continued to contribute towards a system wide evaluation of contracted and subcontracted services. Whilst a number of existing contracts were extended into 2023/24, the delivery planning process explored opportunities to repatriate activity from the independent sector to be delivered by the Trust.

The modelled requirements met the associated performance standards and also satisfied the value of activity required to meet the Elective Recovery Fund (ERF) threshold.

The Trust's performance trajectories included in the operating plan submission are summarised in the following table.

***Table 2: Performance trajectories in the Trust's operating plan submission***

| | **Waiting time standard** | **Operational Planning Requirement** | **UHBW Plan Submission (by March 2025 unless otherwise stated)** |
|---|---|---|---|
| Urgent and Emergency Care (UEC) | Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours | 78% | 78%[1] |
| Elective Care | The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 65 weeks or more | Zero by September 2024[2] | Zero by September 2024[2] |
| Diagnostics | 6-week wait diagnostic waiting times | 95% by March 2025 | 95% |
| Cancer | 62-day urgent referral to first treatment | 70% by March 2025 | 70% |
| | 28-day Faster Diagnosis Standard | 77% by March 2025 | 77% |

Notes:
[1] The performance standard is set as a system ambition of 78%, with a percentage uplift applied to UHBW based on the performance of Sirona Type-3 Emergency Departments (MIU and UTC).
[2] The Trust will eliminate 65ww backlogs by end of September. The treatment of patients who require corneal graft surgery is dependent on national supply of graft material being sufficient.

## Updates to Performance Standards during the year

Urgent and Emergency Care
2024/25 represents Year 2 of delivery of the NHSE UEC Recovery Plan (UECRP), as set out in the Operational Planning Guidance. A further letter was published by NHSE on 16th September 2025, outlining the Winter & H2 priorities NHS England » Winter and H2 priorities. These being:

- Supporting people to stay well – focus on delivery of the winter vaccination plan for staff and the local population.
- Maintaining patient safety and wellbeing – ensuring the fundamental standards of care were in place in all settings, at all times, including temporary escalation spaces.
- Ensuring Full Capacity plans were reviewed and tested ahead of winter.

During 2023/24, NHS England wrote to trusts on a number of occasions, confirming performance expectations and outlining any additional requests or changes to guidance. In each instance, the Trust responded as required and the headlines from each of these NHS England letters are referenced below.

## Performance during 2024/25

The following sections summarise performance against performance standards in 2024/25.

### *2.2.1 Referral to Treatment (RTT)*

The operational planning guidance required Trusts to eliminate referral to treatment waiting times over 65 weeks by September 2024 (excluding patient choice).

The Trust originally submitted a plan of no patients waiting longer than 65 weeks by September 2024 with good progress made during the first six months of the year. During 2024/25, and in line with the national position, NHSE set a revised ambition that no patients would be waiting 65 weeks or longer by the end of March 2025, noting that all but a small number of Trust specialties (primarily Dental) had already eliminated 65 week waits by the end of September.

On the 31st March 2025, the Trust reported that no patients were waiting over 65 weeks, achieving the revised target and the Trust expects to sustain this position into 2025/26, focussing on further reducing the length of time patients are waiting to be treated. The treatment of patients awaiting cornea graft surgery is reliant upon a nationally directed processes of allocation of graft material based on supply, clinical priority, and relative waiting times. Subject to graft material being available, there are no other constraints to continued delivery into 2025/26.

### *2.2.2 Accident & Emergency four-hour maximum wait and 12-hour trolley waits.*

Overall, ED attendances during 2024/25 have exceeded 2023/24, and 2019/20 levels; activity volumes are shown below.

***Table 3: Total attendances at Emergency Departments***

| | Total Attendances | | |
|---|---|---|---|
| **Hospital Site** | **2019/20** | **2023/24** | **2024/25** |
| Bristol Royal Hospital for Children | 44,499 | 47,879 | 48,079 |
| Bristol Eye Hospital | 24,941 | 26,771 | 27,244 |
| Bristol Royal Infirmary | 73,499 | 78,473 | 79,605 |
| Weston General Hospital | 50,315 | 51,435 | 53,713 |
| **Grand Total** | **193,254** | **204,558** | **208,641** |

***Table 4: Average daily number of attendances at Emergency Departments***

| | Total Attendances | | |
|---|---|---|---|
| **Hospital Site** | **2019/20** | **2023/24** | **2024/25** |
| Bristol Royal Hospital for Children | 122 | 131 | 132 |
| Bristol Eye Hospital | 68 | 73 | 75 |
| Bristol Royal Infirmary | 201 | 214 | 218 |
| Weston General Hospital | 137 | 141 | 147 |
| **Grand Total** | **528** | **559** | **572** |

The operational planning guidance set out the requirement that a minimum of 78% of patients attending an emergency department be seen, treated if necessary, and either discharged or admitted within four hours, by the end of March 2025.

During 2024/25 the Trust saw increased demand in both attendances to its Adult Emergency Departments, and subsequent admissions, which alongside high bed occupancy levels, impacted delivery of the four-hour standard of care. Alongside increased demand for our UEC services, there was further disruption to service delivery as a result of a number of periods of industrial action.

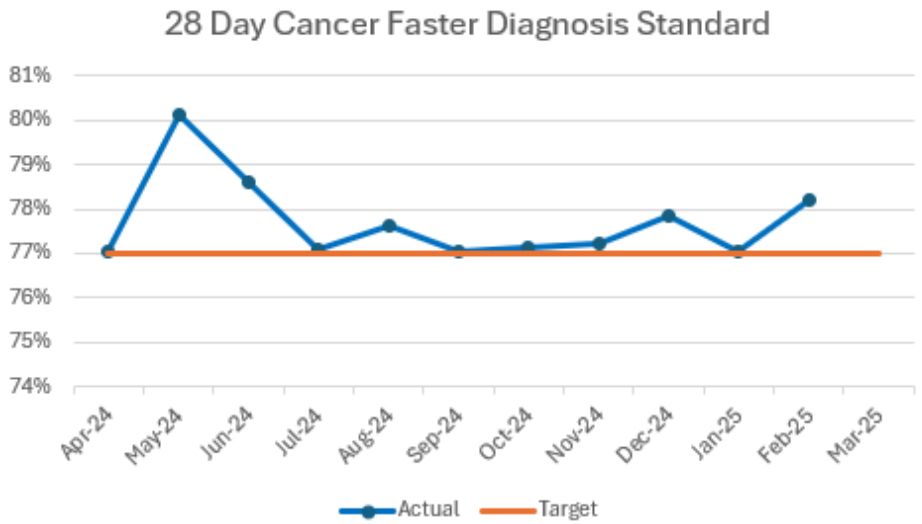
There has been a significant effort to increase patient flow through a range of initiatives, including augmenting same day emergency care units, further developing the front door admission avoidance pathways and a full review of flow and escalation policies. The Trust have also focused on ensuring timely ambulance turnaround times to reduce delays for patients coming to hospital and worked closely with system partners, through the Transfer of Care Hubs, to ensure prompt discharge when patients are ready to leave hospital.

In February 2025, delivery against the four-hour standard of care, was 71.7%. From March 2025, NHS England requested that Trusts refocus their efforts to achieve the delivery of the March end position of 78%. In addition to the Winter Operational Plan 2024/25, the Trust mobilised a further hospital wide response, achieving 75.2% against this target. Of note, this performance includes Type 1, 2 and 3 attendances.

### *2.2.3 Cancer*

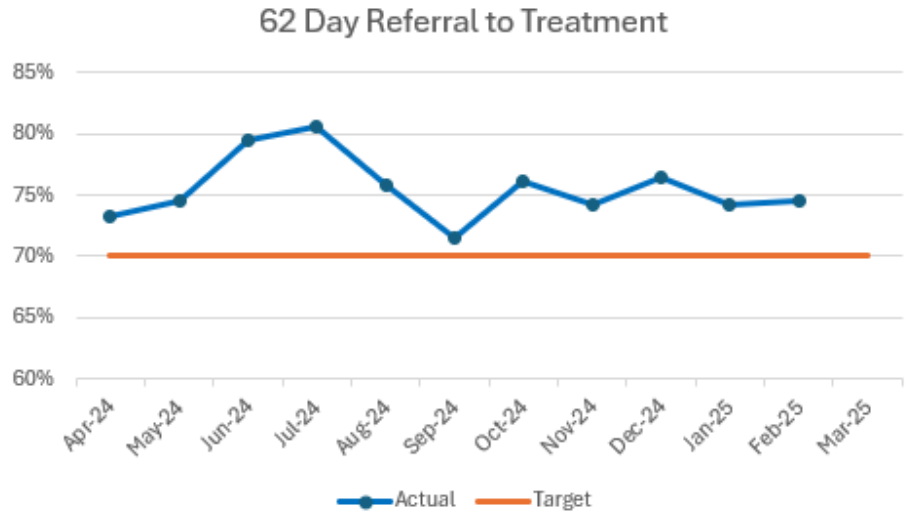
The Faster Diagnosis Standard (FDS) is designed to measure the time from referral to a patient receiving a diagnosis, or having cancer ruled out, within 28 days.

Performance met or exceeded the March 2025 target of 77% in each month and performance is anticipated to continue to improve in line with the 2025/26 operational planning ambition of achieving 80% by March 2026.



Patients with cancer should start first definitive treatment within 62 days of referral from a GP, screening programme or upgrade by a consultant. The national standard is that 85% of patients should start their definitive treatment within this standard and NHSE set an interim recovery target for providers of 70% by March 2025

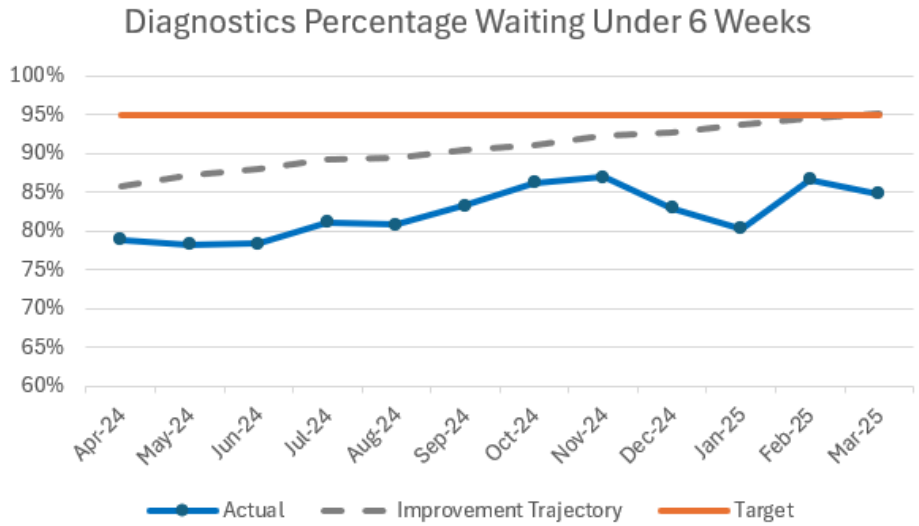
The Trust has performed above NHSE's recovery standard of 70% throughout the year and expects to sustain this in 2025/26, setting the ambition to meet the 2025/26 target of 75% by March 2026.




***2.2.4 Diagnostic waiting times***

The Trust planned to reduce diagnostic waiting times by increasing activity levels for high volume modalities. The plan was intended to increase the percentage of patients waiting under 6 weeks towards 95% at the end of March 2025.

Good progress was made against this standard during the first eight months of the year, tracking just below the forecast trajectory set as part of the 2024/25 Operational Plan. During December and January, unforeseen circumstances adversely impacted performance and recovery plans were enacted which supported improvements through the last two months of the year. At the end of March 84.8% patients were waiting less than 6 weeks for their diagnostic test; a notable improvement from 78.9% at end of April 2024. Recovery plans are anticipated to further support improvement in diagnostic waiting times into 2025/26, aiming to recover performance during the year.



### NHS Oversight Framework Segmentation

When the Trust was last formally assessed in September 2023, the position was reported as below. The national segmentation process is currently under review and, pending the outcome of this consultation, it is anticipated that NHSE will provide a revised segmentation position.

***Table 5: Segmentation for the Trust and partner organisations***

| Type | Organisation | Segment |
|---|---|---|
| **Provider segmentation** | University Hospitals Bristol and Weston NHS Foundation Trust | 3 |
| | North Bristol NHS Trust | 2 |
| **Integrated care system segmentation** | Bristol, North Somerset & South Gloucestershire (BNSSG) ICS | 3 |

## 2.3 Financial Review

#### *2.3.1 Financial analysis*

The Trust delivered a net surplus of £0.043m, excluding technical accounting adjustments as set out in note 2 of the annual accounts. There are a number of items classified as technical which are excluded by NHSE when considering the Trust's financial performance. As in previous years, technical items include depreciation on donated assets, donated income in respect of assets, impairments, and reversal of impairments. The £0.043m surplus compares favourably with the breakeven plan.

Including technical items and as per the annual accounts, the Trust reported a net income and expenditure deficit of £48.495m.

The operating plan for 2024/25 was approved by the Trust's Finance, Estates and Digital Committee on behalf of the Trust Board under agreed delegated authority on 30th April 2024 ahead of the submission of the financial plan to NHSE on 2nd May 2024. Consistent with the national planning guidance and the previous year, the increased national employer pension contributions were excluded from the plan and show as a material adverse variance. In addition, other significant variances in both income and expenditure terms include, the impact of enhanced pay costs, the costs of escalation capacity, recruitment into vacancies higher than planned, the impact of a technical adjustment relating to the valuation of the Trusts building's and in-year changes to contracting arrangements.

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

***Table 6: 2024/25 Financial performance against plan:***

| | Plan<br>£m | Actual<br>£m | Variance Favourable/ (Adverse)<br>£m |
|---|---|---|---|
| Income from Patient Care Activities | 1,117.867 | 1,214.380 | 96.513 |
| Other Operating Income | 121.659 | 132.409 | 10.750 |
| **Total Operating Income** | **1,239.526** | **1,346.789** | **107.263** |
| Employee Expenses | (748.234) | (826.111) | (77.877) |
| Other Operating Expenses | (434.483) | (515.974) | (81.491) |
| Depreciation (owned & leased) | (43.713) | (43.806) | (0.093) |
| **Total Operating Expenditure** | **(1,226.430)** | **(1,385.891)** | **(159.461)** |
| PDC | (14.516) | (12.137) | 2.379 |
| Interest Payable | (2.961) | (2.695) | 0.266 |
| Interest Receivable | 3.500 | 5.587 | 2.087 |
| Other Gains/(Losses) | - | (0.148) | (0.148) |
| **Net Surplus/(Deficit) per Annual Accounts** | **(0.881)** | **(48.495)** | **(47.614)** |
| Remove Capital Donations, Grants, and Donated Asset Depreciation | 0.881 | 48.538 | 47.657 |
| **Adjusted Financial Performance Surplus/(Deficit) Reported to NHSE** | - | **0.043** | **0.043** |

### *2.3.2 Savings*

The Trust achieved savings of £32.5m against a plan of £41.2m. The majority of the savings were recurrent and mainly related to reducing agency costs, electronic rostering and job planning, and non-pay procurement. The Trust continued to develop work streams to deliver savings later in 2024/25 and future years. Focus on transactional efficiencies such as obtaining best value through purchasing, controlling spend, reviewing premium pay spend and further embedding the use of technology also continued in 2024/25.

***Table 7: Savings achieved during 2024/25:***

| Workstream | Plan £m | Actual £m | Variance - Favourable / (Adverse) £m |
|---|---|---|---|
| **Pay Efficiencies** | | | |
| Agency - price cap compliance | 2.68 | 1.18 | (1.50) |
| Agency – eliminate off-framework supply | 2.46 | 1.96 | (0.50) |
| Agency – reduce reliance on agency | 6.34 | 5.70 | (0.64) |
| Establishment reviews | 0.72 | 0.54 | (0.18) |
| E-Rostering / E-Job Planning | 8.83 | 7.72 | (1.11) |
| Corporate Service transformation | 1.89 | 1.20 | (0.69) |
| Digital transformation | 0.69 | 0.47 | (0.22) |
| Service re-design - pay | 4.00 | 4.00 | - |
| **Total Pay Efficiencies** | **27.61** | **22.77** | **(4.84)** |
| **Non-Pay Efficiencies** | | | |
| Medicines optimisation | 0.95 | 1.45 | 0.50 |
| Procurement (excl. drugs) - non-clinical | 1.61 | 1.87 | 0.26 |
| Procurement (excl. drugs) - medical devices and clinical consumables | 3.21 | 3.19 | (0.02) |
| Estates and Premises transformation | 0.05 | 0.24 | 0.19 |
| Pathology & imaging networks | - | 0.02 | 0.02 |
| Corporate services transformation - non-pay1.02 | 1.02 | 0.05 | (0.97) |
| Digital transformation | 0.01 | 0.01 | - |
| Service re-design – non-pay | 5.00 | - | (5.00) |
| Other - non-pay | 0.98 | 0.99 | 0.01 |
| **Total Non-Pay Efficiencies** | **12.83** | **7.82** | **(5.01)** |
| **Income Efficiencies** | | | |
| Income Non-Patient care | 0.70 | 1.60 | 0.90 |
| Other - income | 0.06 | 0.31 | 0.25 |
| **Total Income Efficiencies** | **0.76** | **1.91** | **1.15** |
| **Grand Total** | **41.20** | **32.50** | **(8.70)** |

### *2.3.3 Statement of financial position*

The Trust's cash and cash equivalents balance at 31st March 2025 was £72.3m, a decrease of £24.4m from last year. How the Trust used its cash during the year is shown in the table below:

***Table 8: Use of cash 2024/25***

| | £m | £m |
|---|---|---|
| **Opening Cash Balance** | | **96.723** |
| **Use of cash:** | | |
| Net cash flow from operating activities | 37.832 | |
| Capital investment | (45.456) | |
| Other net cash flows from investing activities | 7.554 | |
| Public Dividend Capital received | 4.093 | |
| Capital loan repayments to the DHSC | (5.834) | |
| Interest (on capital loan) payments to DHSC and other interest | (2.757) | |
| Public Dividend Capital dividend payment | (12.679) | |
| Finance lease payments | (7.181) | |
| **Decrease in cash balance 2024/25** | | **(24.428)** |
| **Closing Cash Balance** | | **72.295** |

The Trust's statement of financial position (balance sheet) reported total assets employed as at 31st March 2025 of £463.286m as summarised in the table below:

***Table 9: Statement of Financial Position 2024/25***

| Statement of Financial Position | £m |
|---|---|
| Total Non-Current Assets | 605.789 |
| Total Current Assets | 144.914 |
| Total Current Liabilities | (154.744) |
| **Net Current Assets** | **(9.830)** |
| **Total Assets Less Current Liabilities** | **595.959** |
| Total Non-Current Liabilities | (132.673) |
| **Total Assets Employed** | **463.286** |
| **Equity:** | |
| Public Dividend Capital | 337.558 |
| Revaluation Reserve | 60.645 |
| Other Reserves | 0.085 |
| Income & Expenditure Reserve | 64.998 |
| **Total Equity** | **463.286** |

### *2.3.4 Capital*

The Trust Board approved the 2024/25 capital investment programme of £36.665m in April 2024. The approach to capital funding in 2024/25 remained the same with capital envelopes allocated to each Integrated Care System (ICS). This envelope set a limit on the capital expenditure within a system and required the partners to work together to prioritise capital expenditure. The Trust was allocated a 45% share of the £81.9m BNSSG ICS capital envelope. During the year, additional capital allocations were approved, including increases by the Department of Health and Social Care (DHSC) in respect of schemes to support estates backlog maintenance, gender service and digitalisation. The Trust's total capital funding for 2024/25 was £46.798m (excluding IFRS16 lease arrangements).

***Table 10: 2024/25 capital funding by source***

| Capital Funding Source | £m |
|---|---|
| UHBW Funded - System Envelope | 40.738 |
| DHSC Approved Funding | 4.093 |
| Grants/Donations/Other | 1.967 |
| **Total** | **46.798** |

The limit on capital expenditure meant that not all the Trust's prioritised capital schemes could be approved for delivery in 2024/25. Schemes which were not approved for implementation have been carried forward for consideration in the prioritisation process for the 2025/26 plan.

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 2024/25 the Trust invested £46.798m on capital schemes. This included the following significant investments:

- Medical Equipment *e.g. slit lamps, bedside pendants, life support system*: £13.111m
- Estates and Building Improvement *e.g. backlog maintenance, fire improvements*: £ 9.525m
- Strategic Projects *including Weston Same Day Emergency Care, CT Scanner and St James Court refurbishment*: £8.985m
- Digital *e.g. new devices, network, systems and server upgrades, cyber security*: £ 7.887m

In addition to the £46.798m invested in capital projects, the Trust also invested £6.186m on leased equipment and properties, totalling £52.984m capital expenditure in 2024/25. Total expenditure against the NHSE plan is shown in the table below.

***Table 11: Funding and expenditure on capital schemes:***

| | 2024/25 NHSE Plan £m | 2024/25 Actual £m | 2024/25 Variance £m |
|---|---|---|---|
| **Source of Funding:** | | | |
| PDC | - | 4.093 | 4.093 |
| Donations - Cash | 1.850 | 1.967 | 0.117 |
| Depreciation | 43.713 | 43.806 | 0.093 |
| Disposals | - | 1.744 | 1.744 |
| Cash Balances | 6.102 | 1.374 | (4.728) |
| **Total Funding** | **51.665** | **52.984** | **1.319** |
| **Expenditure:** | | | |
| Strategic Schemes | 10.930 | 8.985 | (1.945) |
| Medical Equipment | 6.209 | 14.070 | 7.861 |
| Operational Capital | 6.905 | 6.244 | (0.661) |
| Fire Improvement | 2.500 | 3.674 | 1.174 |
| Digital Services | 5.288 | 7.887 | 2.599 |
| Estates Replacement & Infrastructure | 4.833 | 5.938 | 1.105 |
| **Expenditure before leases and remeasurements** | **36.665** | **46.798** | **10.133** |
| Other (New Leases and Remeasurements) | 15.000 | 6.186 | (8.814) |
| **Total Expenditure** | **51.665** | **52.984** | **1.319** |

***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 (NHSCFA) national strategy on countering fraud and to ensure the Trust is working with the LCFS in fully complying with Government, NHSCFA and commissioner requirements. The Trust participates in the National Fraud Initiative.

Work is carried out across all key areas of Counter Fraud activity, ensuring compliance against the 13 components required by the Government Functional Standard 013: Counter Fraud (NHS Requirements). This work is evidenced in the annual completion of the Counter Fraud Functional Standard Return and the annual Counter Fraud report presented to the Audit Committee.

The Local Counter Fraud, Bribery and Corruption policy and legislative background is also available on the Trust's intranet together with contact details of the LCFS and the NHSCFA.

#### *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 the dissemination of Counter Fraud newsletters and regular articles in the Trust's staff communications, on the intranet and via internal digital communication platforms. 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, suppliers and public 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 all decision-making staff 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 NHSCFA 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 NHS England, the Department of Health and Social Care and other organisations.

The Overseas Visitors Team provides a seven day a week eligibility checking service across the Trust. The team, which checks every patient that presents at the Trust, is responsible for establishing an individual's right to free NHS hospital treatment, the raising of invoices to directly chargeable visitors, the processing of reciprocal healthcare claims and for advising clinicians and other staff on their obligations under the regulations.

The Non-NHS Patient income Manager is co-chair of the NHS Overseas Visitors Eligibility Partnership.

### *2.3.9 Task force on climate-related financial disclosures (TCFD)*

NHS England's NHS Foundation Trust Annual Reporting Manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England. However, UHBW does calculate and publish these data to help track our progress against the Green Plan sustainability commitments. This data can be found in Section 3 of this document.
The phased approach incorporates the disclosure requirements of the governance, risk management and metrics, and targets' pillars for 2024-25. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the Annual Report and Accounts and in other external publications.

Governance Pillar
As outlined in section 4 of this document, the Board is responsible for setting the strategic direction of the Trust and monitoring performance against organisational objectives. In performing this role, the Board approves all corporate-level sustainability commitments in the Green Plan, setting our ambition to be a leader in sustainable healthcare.
The Board is updated regularly throughout the year on climate related issues, specifically on progress against the Green Plan commitments and to sign off the Carbon Reduction Plan for publication. Through this process, the Board is made aware of our successes as well as areas for improvement. In any given year, the Board may also be required to review and approve any updates made to the Green Plan. The Green Plan is due for an update during the financial year 2025/26. The current Green Plan can be accessed here: Green Plan for Bristol, North Somerset and South Gloucestershire ICS: 2022 - 2025.

The Trust has a sustainability team which manages, monitors and reports on progress to the Board. The Team sits within the Estates and Facilities Division. Sustainability is managed through the divisional board, with the Head of Sustainability sitting on the Estates management team. The Estates and Facilities Division reports into the corporate Finance, Digital and Estates Committee. As outlined in section 4, this is one of three additional designated committees within the Trust chosen by the Board to augment its monitoring, scrutiny an oversight functions. This year, the Trust has appointed a joint Clinical Director for Green and Sustainable Healthcare with North Bristol NHS Trust. The position will provide clinical leadership on sustainability and embed it into clinical governance processes.

The sustainability team is tasked with working across divisions in the Trust to implement and achieve the Green Plan commitments and ensure environmental legal compliance in our operations. The Trust is currently developing an ICS-wide sustainability policy which will outline the roles and responsibilities of different positions within the Trust in relation to the delivery of the Green Plan. However, at present there is no formal process for climate-related risks to be assessed in wider business strategies and decisions. The UHBW sustainability team provides advice and guidance on some business strategies but this is not part of a systematic, mandatory process.

In addition to the internal process outlined above, sustainability is also governed at an ICS level by the Green Plan Steering Group, reporting into the System Executive and ICB board.

To deliver the breadth and ambition of commitments set out in the Green Plan, the work has been broken down into separate workstreams that cover our main impact areas. These workstreams are:

- Net Zero Carbon
- Sustainable Procurement

- Food and Nutrition
- Travel, transport and clean air
- Biodiversity
- Healthier with nature
- Communications and engagement.

This year has seen the introduction of the food and nutrition workstream and a delivery plan for this workstream will be developed.

Each workstream meets monthly to progress work against its delivery plans. These workstream meetings are chaired by the workstream lead and attended by relevant stakeholders from across the ICS. For example, catering leads and dietitians from both acute trusts are invited to the food and nutrition workstream.

The workstreams report monthly to the Green Plan Implementation Group, overseen by the Head of Sustainability for the ICS. In turn, this group reports on a quarterly basis to the Green Plan Steering Group which is made up of Executive Directors from each partner organisation.

Risk Management Pillar

Transition and physical climate related risks are listed on the Trust's risk management register. In doing so they become part of the corporate risk management process outlined in section 4 of this document.

There are currently three risks that sit on the Trust's risk management register. Two of these risks relate to adaption on our estate. The sustainability team has undertaken climate change scenario analysis for both sea level rise and heat. This involved mapping both sea level rise and maximum summer temperatures for our region in 2050 using publicly available resources from the Inter-governmental Panel on Climate Change. This assessment found that Weston General Hospital is vulnerable to the future impacts of sea level rise through annual flooding. This will impact on patient care, staff availability and the physical estate. This is listed as is one of the two adaptation risks. The second risk relates to the frequency of extreme weather events increasing with a focus on heavy rainfall, flooding and heatwaves. Adaptation is currently a climate related risk that is not regularly reported on to the Board either internally or through the ICS. There is no workstream for this work. It is recognised as a gap in current work and will be assessed at the next Green Plan refresh in 2025/26.

The third risk is the financial investment required for the Trust to decarbonise. This is coupled with the financial risks associated with not doing so through offsetting and carbon taxation. This risk is mitigated through the work undertaken to decarbonise our estate, waste and transport. In doing so, the Trust has applied for and been successful in being awarded grant funding for decarbonisation through the Public Sector Decarbonisation Scheme. We will continue to apply for funding under the scheme as and when appropriate projects are ready to be progressed. The impact of future costs increases through the UK emissions trading scheme and offsetting have also been raised at the Finance, Digital and Estates Committee.

Green Plan workstream risks which focus on project delivery are escalated through the Green Plan governance process as appropriate to ensure that they are managed.

Metrics and Targets

The Trust aims to have a comprehensive and transparent approach to reporting progress against its targets. The Green Plan sets out the range of metrics that are used to demonstrate progress against our commitments. The Green Plan sets out both the timeframe for achieving our overall targets and the interim targets set over a 3-year period. It includes the targets set by NHS England that we are working towards and our own targets that are set to meet the needs of our local area and fit our ambition.

Our carbon emissions, waste, water and air quality impacts are publicly published in this document in section 3. The data published is for this financial year and the previous two years to in order to show progression and trends in our performance. Our carbon emissions are also published in our Carbon Reduction Plan, which is updated annually.

All commitments are absolute reduction targets.

Our Carbon Reduction Plan outlines our baseline year emissions, rationale, calculation methodology and progress for our carbon emissions against our baseline year and can be found by using this link: UHBW Carbon Reduction Plan 23-24.

As already mentioned, there is currently no specific climate change adaptation workstream and therefore UHBW does not currently report on any adaptation related metrics. A set of suggested metrics for adaptation are set out in chapter 18 of the Green Plan but have not been progressed. This will be reviewed as part of the review of the Green Plan due to take place next financial year (2025-26).

**Maria Kane**
**Group Chief Executive**

# 3. Sustainability Report

## 3.1 Overview

The Green Plan sets out three clear sustainability outcomes the Trust is working towards:

1. Net zero carbon by 2030 across scope 1, 2 and 3 emission sources.
2. Improve the environment by reducing waste, improving air quality and restoring biodiversity.
3. Create a BNSSG-wide movement to support a culture change amongst, staff, citizens and businesses.

This report outlines our carbon, waste, water and air quality impact for financial year 2024/25. We also include data for the previous two years to track progress and trends in our impact. We aim to be transparent about the impact our activities have and outline some of the work we have undertaken to improve this. Information on our sustainability governance and risk management processes can be found in section 2.3.9 of this report.

***Table 12: Emissions***

| **Emissions Source** | **Unit** | **2022/23** | **2023/24** | **2024/25** |
|---|---|---|---|---|
| Scope 1 | tCO2e | 19,526 | 19,477 | 19,318 |
| Scope 2 | tCO2e | 1,181 | 1,228 | 1,341 |
| Scope 3 | tCO2e | 140,865 | 155,221 | 156,720 |
| **Total** | **tCO2e** | **161,572** | **175,926** | **177,379** |
| **Energy** | | | | |
| Gas consumption | kWh | 97,905,717 | 98,557,570 | 95,497,366 |
| Oil Consumption | Litres | 43,697 | 27,351 | 27,351 |
| Electricity Consumption | kWh | 6,109,586 | 5,930,672 | 6,475,811 |
| **Anaesthetic Gases** | | | | |
| Anaesthetic Gases | tCO2e | 1,201 | 1,141 | 1,511 |
| **Supply Chain** | | | | |
| Purchased goods and services (including upstream transport and distribution) | tCO2e | 123,543 | 136,617 | 137,312 |
| **Travel and Transport** | | | | |
| Trust owned Fleet | tCO2e | 172 | 212 | 101 |
| Employee Commuting | tCO2e | 3,171 | 3,131 | 3,385 |
| **Waste** | | | | |
| Waste | Tonnes | 3,477 | 3,646 | 3,787 |
| | tCO2e | 1,383 | 1,367 | 1,252 |
| **Water** | | | | |
| Water volume | m3 | 282,440 | 276,797 | 268,015 |
| Waste water | m3 | 254,196 | 249,117 | 241,214 |
| Water volume and waste water | tCO2e | 111 | 99 | 86 |

We have seen some positive reductions in greenhouse gas emissions in 2024/25, particularly in areas such as our use of Desflurane, which as a Trust we stopped using halfway through the year.

Unfortunately, we have seen increases in emissions in other areas such as our use of Entonox, which has resulted in our overall emissions' profile remaining broadly similar to previous years.

### *Air Pollution*

The table below benchmarks time weighted average particulate matter (PM) and nitrous oxide ($NO_2$) air pollution for different sensors around our Bristol campus against various legislative exposure thresholds over 1, 8 and 24 hour periods. It shows how frequently each area of the hospital exceeded those limits in 2024/25. This data shows low or no exposure to harmful air pollution in any 1 or 8 hour period, suggesting low levels of emissions directly from our sites. However, there were between 20 and 30 days in the last year which saw higher PM air pollution and between 130 and 230 days in the last year which saw higher $NO_2$ pollution. This suggests there can be days in the year where we see the ambient air around us rising to harmful levels of pollution. This insight will be guiding our work to focus on $NO_2$ next year and how we can work with partners in the city to reduce the general ambient air pollution within our region.

***Table 13: Air Pollution***

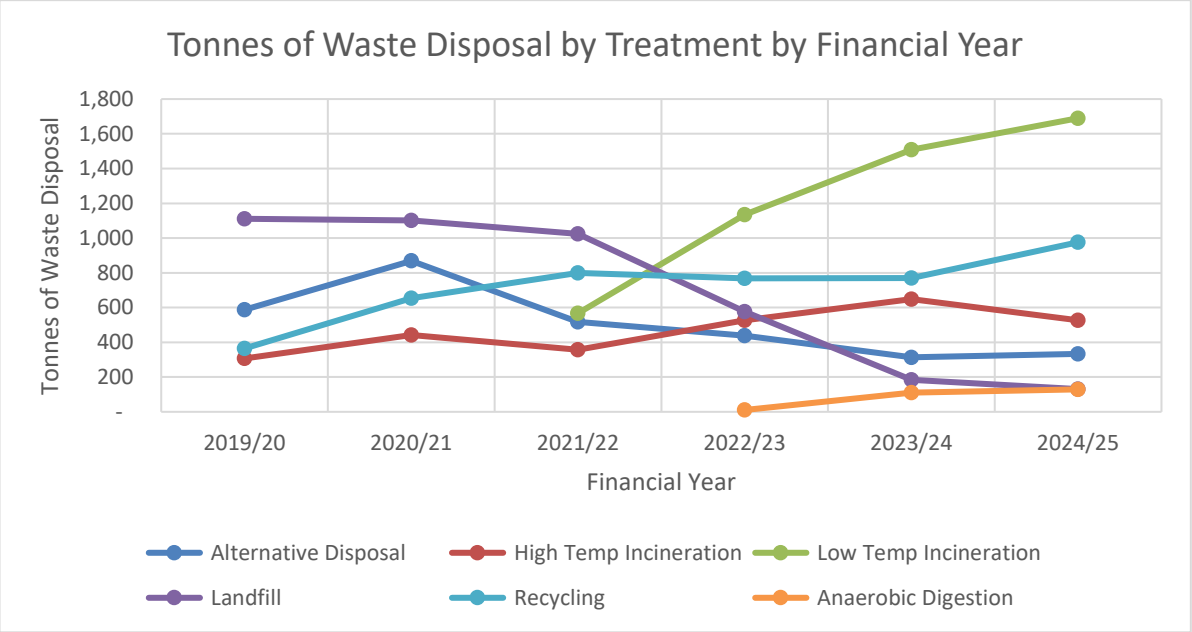
| Sensor | PM | | | $NO_2$ | | |
|---|---|---|---|---|---|---|
| | IAQM 1-hour TWA | WHO 24-hour TWA | HSE 8-hour TWA | WHO 24-hour TWA | EU 1-hour TWA | DEEE 8-hour TWA |
| Alfred parade 2 | 0 | 15 | 0 | 136 | 0 | 0 |
| Ambulance bay fence | 2 | 23 | 0 | 234 | 0 | 0 |
| Bristol Heart Institute | 0 | 2 | 0 | | | |
| Children's A&E Entrance | 3 | 24 | 0 | | | |
| Level 2 drop-off | 3 | 28 | 0 | | | |
| Medical gas plant room | 2 | 13 | 0 | | | |
| St Michael's Entrance | 8 | 24 | 0 | 229 | 0 | 0 |
| St Michael's Loading Bay | 0 | 5 | 0 | 156 | 12 | 0 |
| Total | 18 | 134 | 0 | 755 | 12 | 0 |

### *Waste*

The Trust implemented its new sustainable waste management contracts in October 2024. The Trust now utilises re-usable sharps bins, reducing the amount of single use plastic and carbon associated with this waste stream. The Trust has also achieved zero waste to landfill with 100% diversion achieved since the start of the contracts. This was 6 months ahead of our target date.

Overall, the total amount of waste produced this year has increased; however, the carbon impact of our waste management activities has decreased. This is due to increasing segregation and utilising lower carbon methods of waste disposal. The lowest carbon methods of waste disposal are reducing waste, re-use, recycling and anaerobic digestion. Landfill and high temperature incineration are the most carbon intensive methods. Waste management activities have focused on compliant and sustainable methods of disposing of waste produced. To reduce the amount of waste produced in the first instance, the Trust must look at what it procures, particularly the amount of single use items and the packaging associated with them.

This year, waste to landfill has decreased and is now at zero. The amount of waste sent for high temperature incineration has also decreased after some offensive waste has been moved from this method of disposal to low temperature incineration. As a result, we are sending more waste to low temperature incineration. Recycling has increased to 935 tonnes, the first increase we have seen since 2022.




In anticipation of the new Simpler Recycling Regulations in England that came into effect on 31 March 2025, we continued to implement and support separate food waste collection and disposal for patient and staff catering. These represent the areas that produce the largest amounts of food waste. Work is also continuing to set up food waste segregation in staff rest areas and patient waiting areas, which is logistically more challenging to implement.

The Trust has avoided sending over 1.2 tonnes of single use medical metal instruments to high temperature incineration by recycling the materials and is continuing to work on increasing the use of remanufactured devices available. In 2024/25 our involvement in device re-manufacturing has diverted 256kg of waste from incineration and avoided over 163kg of carbon emissions. The Trust has also continued to advertise surplus furniture and non-medical equipment internally for use before disposal avoiding over £88k as a result of not having to purchase new furniture.

Set out in the table below, is our performance against the NHS clinical waste segregation target. Performance against this target has varied throughout the year with significant improvement seen after October 2024. Performance for the year shows that we are still sending too much clinical waste for high temperature incineration and not enough to the offensive waste stream. However, our performance in March shows that this has improved, aligning more closely to the NHS target. Before October 2024, the Bristol Royal Infirmary was found to be non-compliant with its offensive waste segregation resulting in high levels of contamination. As a result, all offensive waste was sent to high temperature incineration until contamination levels reduced.

***Table 14: Clinical Waste Segregation***

| Clinical Waste Segregation | Hight Temperature Incineration % | Infectious Waste % | Offensive Waste % |
|---|---|---|---|
| 2024/25 UHBW | 38 | 24 | 38 |
| March 2025 UHBW | 22 | 26 | 52 |
| NHS Target | 20 | 20 | 60 |

Key to maintaining and improving waste segregation is ensuring that all staff know how to dispose of waste correctly. The sustainable waste management team continues to work to train staff and has conducted audits of waste in clinical areas. These audits include assessing existing infrastructure, the location of bins and carrying out bin digs to establish rates of compliance. Following audit, bins are relocated, new bins added, and training updated to reflect best practice to ensure correct segregation. Bespoke posters have also been produced to aid correct segregation and include photos of items of waste most likely to be placed in the wrong waste stream.

# 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 Code of Governance for NHS Provider Trusts 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 on the Trust's website: University Hospitals Bristol and Weston NHS Foundation Trust

Alternatively, members of the public by can contact 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 has made no political donations.

### *4.1.3 Internal audit*

The Audit Committee had ensured that there was an effective internal audit function established by management that met Public Sector Internal Audit Standards and provided appropriate independent assurance. The Trust receives its internal audit service from ASW Assurance.

***Table 15: Board of Directors – Terms of Office***

| Board Member |
|---|
| **Jayne Mee, Chair**<br>Appointment as Non-executive Director 1 June 2019<br>End of first term 8 December 2021<br>Appointed as Interim Chair 1 April 2021<br>Appointed as Trust Chair 9 December 2021<br>End of term as Trust Chair and Non-executive Director 30 April 2024 |
| **Ingrid Barker, Group Chair**<br>Appointment 1 June 2024 |
| **Arabel Bailey, Non-executive Director.**<br>Appointment as Associate Non-executive Director 1 July 2022<br>End of term as Associate Non-executive Director 30 June 2023<br>Appointment as Non-executive Director 1 July 2023 |
| **Sue Balcombe, Non-executive Director and Senior Independent Director**<br>Appointment as Non-executive Director (Designate) 1 June 2019<br>Appointment as Non-executive Director 1 April 2020<br>End of first term 31 March 2023<br>Start of second Term 1 April 2023 |
| **Rosie Benneyworth, Non-executive Director**<br>Appointment 1 July 2023 |
| **Bernard Galton, Non-executive Director**<br>Appointment 1 July 2019<br>End of first term 30 June 2022<br>Start of second term 1 July 2022<br>End of second and final term 30 June 2024 |
| **Emma Glynn, Associate Non-Executive Director**<br>Appointment 1 July 2023<br>End of first and final term 30 June 2024 |
| **Marc Griffiths, Non-executive Director**<br>Appointment 1 July 2022 |
| **Susan Hamilton, Associate Non-executive Director**<br>Appointment 1 July 2023 |
| **Linda Kennedy, Non-executive Director**<br>Appointment 1 June 2024 |

| |
|---|
| **Jane Norman, Non-executive Director**<br>Appointment 1 March 2021<br>End of first and final term 30 April 2024 |
| **Roy Shubhabrata – Non-executive Director**<br>Appointment 1 July 2022 |
| **Martin Sykes, Non-executive Director and Vice-Chair**<br>Appointment 4 September 2017<br>End of first term 31 August 2020<br>End of second term 31 August 2023<br>Start of third term 1 September 2023 |
| **Anne Tutt, Non-executive Director**<br>Appointed 1 June 2024 |
| **Maria Kane, Group Chief Executive**<br>Appointed 29 July 2024 |
| **Paula Clarke, Executive Managing Director of Weston General Hospital**<br>Appointed 4 April 2016 |
| **Neil Darvill, Joint Chief Digital Information Officer**<br>Appointed 1 June 2023 |
| **Jane Farrell, Chief Operating Officer**<br>Appointed as Interim Chief Operating Officer 31 October 2022<br>Appointed as Chief Operating Officer 1 April 2023 |
| **Deirdre Fowler, Chief Nurse and Midwife**<br>Appointed as Interim Chief Nurse 18 January 2021<br>Appointed as Chief Nurse and Midwife 29 April 2021 |
| **Neil Kemsley, Chief Financial Officer**<br>Appointed 1 July 2019 |
| **Rebecca Maxwell, Interim Chief Medical Officer**<br>Appointed 1 January 2024 |
| **Stuart Walker, Hospital Managing Director**<br>Appointed as Chief Medical Officer 21 February 2022<br>Appointed as Interim Chief Executive 1 January 2024<br>Appointed as Hospital Managing Director 2 September 2024 |
| **Emma Wood, Chief People Officer and Deputy Hospital Managing Director**<br>Appointed 4 January 2022 |

*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 full cost of the services and where appropriate contributes towards funding patient care.

### *4.1.6 Better Payment Practice Code*

The Better Payment Practice Code Trust 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 management controls ensure all invoices are appropriately checked and authorised before being paid. The complexity of services provided to the Trust requires detailed checking by divisional clinical and operational management staff, both in terms of activity and services provided.

The Trust's performance against this standard is shown in the table below:

***Table 16: Performance against Better Payment Practice Code***

| | Year ended 31 March 2025 | | | Year ended 31 March 2024 | | |
|---|---|---|---|---|---|---|
| | NHS | Non NHS | Total | NHS | Non NHS | Total |
| No. invoices paid within 30 days | 2,917 | 161,279 | 164,196 | 2,984 | 166,160 | 169,144 |
| No. invoices paid | 3,733 | 179,347 | 183,080 | 3,835 | 182,308 | 186,143 |
| Percentage paid within 30 days | 78.1% | 89.9% | 89.7% | 77.8% | 91.1% | 90.9% |
| | | | | | | |
| Value of invoices paid within 30 days | £74.219m | £345.737m | £419.956m | £65.279m | £377.093m | £442.372m |
| Value of invoices paid | £87.484m | £380.832m | £468.316m | £73.284m | £417.498m | £490.782m |
| Percentage paid within 30 days | 84.8% | 90.8% | 89.7% | 89.1% | 90.3% | 90.1% |

Despite continued operational challenges including the implementation of a new ordering system and other system upgrades performance in year was broadly consistent with 2023/24. Although there remains some difficulty in obtaining authorisation across the Trust to pay invoices, engagement with key suppliers has been maintained throughout 2024/25. The continuous review and streamlining of systems and processes has improved the Trust's ability to adapt to the increasing demands and are expected to improve capacity and contribute to further improvement in both the volume and value of invoices paid within the 30-day target.

In 2024/25, £0.001m (2023/24, £0.002m) in interest was payable for three claims made under the Late Payment of Commercial Debts (interest) Act 1998. No other compensation was paid to cover debt recovery cost under this legislation.

### *4.1.7 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 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 of Governors is responsible for regularly feeding back information about the Trust's vision, strategy and performance to the members who elected them and the stakeholder organisations that appointed them. It 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 of Governors are set out in a separate document. Governors and the Board of Directors communicate through the Group Chair who is the formal conduit, and through their meeting schedule, which allows many opportunities for Board-Governor interaction.

Communications and consultations between the Council and the Board include the Trust's annual Quality Report; strategic proposals; 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 Group Chair and Directors, and through the forums of Governor Focus Groups (dealing with matters of constitution and membership engagement; strategy and planning; and quality, people and performance monitoring), as well as 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.

The formal meetings of the Council of Governors are scheduled to fall in the same month as the Trust Board meetings held in public, although on different dates. There has been good attendance by governors at these meetings, which has meant governors are kept up to date on current matters of importance and can follow up on queries in more detail at separate meetings. The Council of Governors meetings have provided an opportunity for Governors to hear in depth from the Chairs and members of the Board Sub-Committees on matters of importance through a different committee theme at each meeting, and all governor and membership activities were formally reported at Council of Governors meetings. Updates from the Group Chair and Group Chief Executive or Hospital Managing Director are standing agenda items and 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. They are also the formal decision-making meetings for governors, with decisions in 2024/25 including the Group Chair Appointment, Non-Executive Director and Associate Director Appointments and re-appointments, Trust Constitution changes, the extension of the current External Auditor Contract, the Membership Strategy, changes to the Nominations and Appointments Committee Membership and the Terms of reference and business cycle for the Nominations and Appointments Committee.

There were three formal Public Council of Governors meetings in the year and all meetings were published on YouTube for public viewing. There was an additional Extraordinary Council of Governors held in private.

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 Joint Chief Corporate Governance Officer at the address given in Appendix B of this report.

***Table 17: Membership and Attendance at Council of Governors meetings 2024/25***

Please note:

- Sickness absence and other reasons for non-attendance are not recorded in the Annual Report.
- Those that have reached the statutory requirement of 50% of public meetings are highlighted.
- Some Governors finished or started their term during the year but are included in this list and therefore all attendances have been calculated by a percentage.

| Number of Council of Governors meetings in the period 1 April 2024 to 31 March 2025: 3 | | | |
|---|---|---|---|
| **Council of Governors** | **Attended** | **Out of a possible** | **Attendance rate** |
| **Outgoing Chair: Jayne Mee** | **1** | **1** | **100%** |
| **Incoming Group Chair: Ingrid Barker** | **2** | **2** | **100%** |
| Ben Argo | 2 | 3 | 67% |
| Grace Burn | 1 | 3 | 33% |
| John Chablo | 2 | 3 | 67% |
| Mary Conn | 0 | 3 | 0% |
| Carole Dacombe | 3 | 3 | 100% |
| Robert Edwards | 3 | 3 | 100% |
| Tom Frewin | 3 | 3 | 100% |
| Lisa Gardiner | 1 | 3 | 33% |
| Sarah George | 2 | 3 | 67% |
| Fi Hance | 0 | 2 | 0% |
| Suzanne Harford | 3 | 3 | 100% |
| Jocelyn Hopkins | 0 | 1 | 0% |
| Karen Low | 1 | 3 | 33% |
| Jude Opogah | 3 | 3 | 100% |
| Mark Patteson | 2 | 3 | 67% |
| Annabel Plaister | 3 | 3 | 100% |
| Richard Posner | 1 | 3 | 33% |
| Janis Purdy | 3 | 3 | 100% |
| Stuart Robinson | 0 | 3 | 0% |
| John Rose | 3 | 3 | 100% |
| Martin Rose | 2 | 3 | 67% |
| John Sibley | 1 | 3 | 33% |
| Tony Tanner | 2 | 3 | 67% |
| Libby Thompson | 1 | 3 | 33% |
| Aalia Herbert | 0 | 1 | 0% |
| David Wilcox | 0 | 1 | 0% |

#### *4.1.8 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 Group Chair and normally has 12 governor members; however as of 31 March 2025 there are 11 members, with a vacancy for a Staff Governor.

The Committee met via videoconference for two extraordinary meetings (April and August) and one meeting of standard business (November) and in between meetings it conducted business via email. Committee members were involved in reviewing activity records and annual performance appraisal reports for each of the Non-Executive Directors and making recommendation on re-appointments. In the year, the Committee electronically recommended the re-appointment of Martin Sykes and a change to the role of Vice Chair.

#### *4.1.9 Performance and development of the Council of Governors*

Governors have been able to carry out their necessary formal statutory duties in the year through hybrid meetings. Governors provided a considerable amount of constructive challenge, questions and feedback on a variety of areas, including the Joint Clinical Strategy and the development to form a Hospital Group model, Patient First Strategic Priorities, launching the new Membership Strategy, Staff Survey Results, Learning and Development updates, communications plans, national survey results, partnership updates, Digital Strategy Updates and Arts and Culture plans. Much of this work was

carried out through meetings of the three governor groups: the Quality Focus Group, Governors' Strategy Group and Membership and Constitution Group.

In terms of formal training, five Governor Development Seminar days took place (in April, June, October, January and February). The seminars form an important part of the programme of development for governors. The programme provided governors with training on their statutory duties and included information on the Trust's Well-led Review, Freedom to Speak Up, Integrated Care Board updates, Bristol and Weston Hospital Charity Update, and sessions on the development of the Hospital Group model. In addition to this, Governors were joined by divisional triumvirates for their annual 'Divisional Update Day', where each Division provided a presentation on its 'Success and Challenges'.

#### *4.1.10 Governor elections*

Governor elections at UHBW are held every two out of three years, and consequently there were no elections due to be held in 2024. In 2025, 14 seats were up for election across six public and staff constituency classes. Elections are due to conclude on 22 April 2025.

The Membership Team works with the Trust's Youth Involvement Group to support the appointment each year of two young governors for a 12-month term of office. Grace Burn continued with a second term of office, and Aaliah Herbert was appointed into her first term of office in September 2024.
The Lead Governor for June 2024 – October 2024 was Mo Phillips, Public Governor. Mo Philips stood down from her role on the Council of Governors in October 2024 and after an internal election process, Ben Argo was elected as the Lead Governor from November 2024. Martin Rose was elected as the Deputy Lead Governor in September 2024 and continued in his role after the internal election.

***Table 18: Governors by constituency – 1 April 2024 to 31 March 2025***

There are 29 governor seats in total. As of 31 March 2025, there were 21 governors in post (13 public, 2 staff and 6 appointed) and eight vacancies. This is a list of all Governors who have held office during this financial year.

| Constituency | Name | Tenure | Elected or Appointed |
|---|---|---|---|
| **Public Governors** | | | |
| Public Bristol | Mary Conn | June 2023 to May 2026 | Elected |
| Public Bristol | John Chablo | June 2022 to May 2025<br>June 2019 to May 2022<br>June 2017 to May 2019 | Elected |
| Public Bristol | Carole Dacombe | June 2022 to May 2025<br>June 2019 to May 2022<br>June 2016 to May 2019 | Elected |
| Public Bristol | Robert Edwards | June 2022 to May 2025 | Elected |
| Public Bristol | Tom Frewin | June 2022 to May 2025<br>June 2019 to May 2022<br>June 2016 to May 2019 | Elected |
| Public Bristol | Mo Phillips | June 2021 to October 2024<br>June 2017 to May 2020 | Elected |
| Public Bristol | Richard Posner | June 2022 to January 2025 | Elected |
| Public Bristol | Janis Purdy | June 2023 to May 2026 | Elected |
| Public Bristol | Martin Rose | June 2022 to May 2025<br>June 2019 to May 2022 | Elected |
| Public North Somerset | Suzanne Harford | June 2023 to May 2026 | Elected |
| Public North Somerset | Annabel Plaister | June 2023 to May 2026<br>June 2021 to May 2023 | Elected |

| | | | |
|---|---|---|---|
| Public North Somerset | John Rose | June 2023 to May 2026<br>June 2021 to May 2023<br>June 2017 to May 2020<br>(extended to May 2021) | Elected |
| Public South Gloucestershire | Ben Argo | June 2022 to May 2025 | Elected |
| Public South Gloucestershire | John Sibley | June 2022 to May 2025<br>June 2019 to May 2022<br>June 2017 to May 2019 | Elected |
| Public South Gloucestershire | Tony Tanner | June 2023 to March 2025<br>June 2016 to May 2017<br>June 2013 to May 2016 | Elected |
| Public Rest of England and Wales | Mark Patteson | June 2022 to May 2025 | Elected |
| **Staff Governors** | | | |
| Non-clinical Staff | Lisa Gardiner | September 2023 to May 2026 | Elected |
| Other Clinical Healthcare | Jocelyn Hopkins | June 2021 to May 2024 | Elected |
| Nursing and Midwifery | Karen Low | June 2022 to September 2024 | Elected |
| Nursing and Midwifery | Karen Marshall | June 2022 to March 2024 | Elected |
| Non-clinical Staff | Jude Opogah | June 2023 to May 2026 | Elected |
| **Appointed Governors** | | | |
| Bristol City Council | David Wilcox | October 2024 to May 2027 | Appointed |
| Bristol City Council | Fi Hance | December 2022 to July 2024 | Appointed |
| Joint Union Committee | Stuart Robinson | December 2023 to May 2026 | Appointed |
| University of Bristol | Sarah George | March 2023 to April 2026<br>April 2022 to March 2023 | Appointed |
| University of the West of England | Libby Thompson | November 2022 to May 2025 | Appointed |
| Youth Involvement Group | Grace Burn | October 2024 to October 2025<br>October 2023 to October 2024 | Appointed |
| Youth Involvement Group | Aalia Herbert | October 2024 to October 2025 | Appointed |
| Youth Involvement Group | Maisy McCollum | October 2023 to October 2024 | Appointed |

#### *4.1.11 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 (see table 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 of a permanent or fixed term role, or once they reach their 12-month anniversary on the bank but may opt out if they wish. Information on opting out of the scheme is on the intranet.

Public membership is open to members of staff who are not eligible to become a member of the Trust's staff constituency and any public who are seven years of age and above that live in England or Wales. 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.

Public members receive news from our hospitals, invitations to come to events or to 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.

Information about the composition of Trust membership is below.

***Table 19: Members of the Foundation Trust***

| **Public constituency** | |
|---|---|
| At year start (1 April 2024) | 3,737 |
| New members | 95 |
| Members leaving | 195 |
| At year end (31 March 2025) | 3,637 |
| **Staff constituency** | |
| At year start (1 April 2024) | 16,360 |
| At year end (31 March 2025) | 16,396 |

### *4.1.12 Membership Strategy*

The Trust launched a new Membership Strategy for 2024-2027 in 2024. The Strategy is easy to read and includes four objectives:

1. Collaborate with system and local partners to raise awareness of the membership of the Trust with the aim to be reflective and representative of the local population.
2. To improve the quality of communication with members, finding more creative and innovative ways to reach and communicate with members so that they can better engage with the work of Governors.
3. Harness the experience, skills and knowledge of members who wish to be more active to support and influence the development of the Trust to achieve its objectives and improve services.
4. To develop the role of the Governor to meet and exceed the statutory duties and to be reflective and representative of our diverse communities.

Members were invited in the year to attend the Annual Members Meeting which was held face-to-face and recorded for online viewing at a later date.

Work is now turning to reaching the objectives as set out above and providing Governors with a first year look at what has been achieved against them. The Strategy will be monitored through the Membership and Constitution Group and Council of Governors meetings periodically.

***Table 20: Analysis of current membership (residents in Bristol, North Somerset and South Gloucestershire only)***

| **Public constituency** | **Number of members (Public members in Bristol, North Somerset and South Gloucestershire)** | **Eligible membership (Population of Bristol, North Somerset and South Gloucestershire)** | **Are we Over or Under Represented?** |
|---|---|---|---|
| **Total** | | | |
| **Age (years):** | **3,010** | **1,020,697** | |
| 0-16* | 17 | 184,898 | Under |
| 17-21 | 144 | 72,748 | Under |
| 22+ | 2,849 | 763,051 | Over |
| **Ethnicity:** | **2,824** | **979,235** | |

| | | | |
|---|---|---|---|
| White | 2,490 | 855,088 | Under |
| Mixed | 58 | 32,047 | Under |
| Asian or Asian British | 166 | 45,659 | Over |
| Black or Black British | 108 | 33,531 | Over |
| Other | 2 | 12,910 | Under |
| **Socio-economic groupings:** | **3,050** | **414,070** | |
| AB | 901 | 101,555 | Over |
| C1 | 915 | 131,836 | Under |
| C2 | 589 | 83,178 | Under |
| DE | 645 | 97,501 | Under |
| **Gender analysis** | **2,937** | **1,020,695** | |
| Male | 1,246 | 504,975 | Under |
| Female | 1,691 | 515,720 | Over |

***Note 1*** *- 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.*

**The data for this age category is not comparable as the minimum age for membership is seven years old according to the Trust's constitution. We currently have no members under the age of 12, but three at 13.*

## 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 strategic priorities for quality, expressed through our Patient First framework, remain focused on ensuring that patients receive timely and safe care, and that they are treated as individuals and involved in decisions about their care. Our Clinical Strategy and our Joint Clinical Strategy with North Bristol NHS Trust are focussed on achieving the best clinical outcomes possible for the people we care for. Together, Patient First and our Clinical Strategy place our patients 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; a summary of our progress will be published in our Quality Account for 2024/25. 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 Stakeholder relations*

As part of our focus to improve the experience of care for our people and communities we continue to work with our local Healthwatch. Representatives from Healthwatch have a long-standing relationship with the Trust and offer an additional external scrutiny to our Experience of Care Group as well as providing quarterly anonymised feedback reports about our services from the people and communities who use them. We have continued to grow our partnerships with the Voluntary, Community and Social Enterprise sector (VCSE), charities and other community partners as part of our work to advance health equity. VCSE and community partner representatives including the Diversity Trust, For All Healthy Living Centre, the African Voices Forum, Caafi Health and the West of England Centre for Inclusive Living have joined partners from the Bristol City Council Sensory Support Team, the Centre for Deaf and Hard of Hearing People, The Bristol Sight Loss Council and Bristol Disability Equality Commission to bring unique insight, expertise and experience to the work of our Health Equity Delivery Group and our Accessible Information Standard Delivery Group. Together with our partners we are driving forward ideas and practices that directly challenge and reduce health inequalities specifically on areas that NHS England's Core20Plus Framework has specified: for

example, asthma and oral health improvements for children and young people, making sure we meet the information and communication needs of our diverse communities across BNSSG and developments in new equality-based staff training. This year we commenced an action learning set programme in partnership with Peer Partnership (part of Brigstowe). This work, funded by the Health Foundation aims to further our approach to designing and delivering services with people through a co-production model. There are 15 participants representing a range of clinical services across the Trust involved in this work. During the year, we have continued to work with a range of other community partners to continually drive forward UHBW as an inclusive organisation. These include AccessAble (to develop Access Guides for patients and carers attending our hospitals), and the Carers Liaison Centre to ensure we continue to support carers as equal partners in care. We are active members of the Bristol Race and Health Equality Group, a group set up to look at the issues raised in the Bristol Manifesto for Race Equality. Throughout the year, many of our VCSE and community partners helped co-create our new Experience of Care strategy “My Hospitals Know and Understand Me” which was published in May 2024.

We also supported engagement exercises with strategic partners on matters which affect our wider health and care system including the Acute Provider Collaborative approach to developing a single managed service for cardiology across UHBW and North Bristol NHS Trust, and Healthy Weston 2 – a programme to join up services for better care in Weston-Super-Mare and the surrounding areas including the future priorities of Weston General Hospital. We have worked in partnership with voluntary sector organisations, service users and health and social care providers to prepare an All Person Autism strategy for North Somerset area and are members of the North Somerset Carers Partnership Board. The Trust maintains close relationships with Local Authorities and relevant Scrutiny Committees to support any major changes in services for our patients.

#### *4.2.2 Research and Development*

As the two acute hospitals in Bristol develop a closer working relationship under a Group Hospital Model, 2024-25 has seen the two R&D teams, working with researchers, patients and partners, develop a joint research strategy. The joint strategy sets out to recognize the unique strengths and opportunities for learning that present themselves as a result of our individual and different relationships with our partners across the region – with the Universities of Bristol and the West of England, and with our primary care and other system colleagues – and of our clinical and research synergies and shared services. Research improves the quality of care that hospitals provide, and research active organisations have better health and care outcomes as a result. Research also brings money into the Trust and often pays for treatments that the NHS would otherwise have had to pay for, saving money. The research we carry out every day at UHBW is therefore an essential part of the care we offer our patients, allowing us to develop treatments and improve outcomes locally and nationally, and an opportunity for supporting ever-stretched finances. During 2024/25, 5,379 patients, staff and volunteers gave their time to take part in the research we lead and host. This compares with the previous year’s level of participation, which was 9,494 and reflects the increasingly specialised and complex portfolio that we develop and deliver.

There are many ways for people working at UHBW to be involved in research. Some doctors, nurses, midwives, and allied health professionals act as Chief Investigators, developing ideas and applying for grants to lead their own research. More act as Principal Investigators for research developed elsewhere and delivered at multiple sites including UHBW, many involving complex interventions or developed specifically for patients with rarer conditions reflecting the nature of the health and care we offer as a tertiary referral centre for many conditions. These earlier phase, more complex, rare disease studies can involve multiple departments across the hospital and be challenging to set-up in a timely way, requiring a highly trained workforce of research nurses, clinical research practitioners, trial co-ordinators, data managers, specialist technical staff and R&D support staff. They also tend to involve very small numbers of participants at our site, making the importance and impact of the research difficult to assess from measures of activity. However, everyone working in the Trust can and should consider research to be a core part of their responsibility to provide high quality care.

R&D builds capacity and capability through training and development and we were delighted that amongst our successes in 2024/25 was our third successful NIHR Senior Nursing and Midwifery Research Leader (SRL). More broadly, our Clinical Research Education Facilitator (CREF) has continued to support the learning of our research teams with standardised research inductions, competency workshops and sharing of best practice across specialties. Together we have developed new e-learning for those with experience of research or wishing to find out about research, and we have adjusted our team, our processes, and our communication with the aim of making things easier for people to deliver research. Working with Medical Illustration we developed a video highlighting the value research brings to patient care and this has been incorporated into Trust induction. An adapted version is now being piloted in a national project aimed at including research in trust induction programmes.

Embedded research champions can be a great way to change culture and attitudes towards research and our Research Links programme, launched two years ago, now has 88 members across a range of clinical areas. These Research Links work within our clinical services and bridge the gap between clinical and research services. We have developed a bespoke training programme for Research Links and deliver this with input from the associated divisional research delivery teams. Our aim is to for patients to have the best opportunity to find out about research, and Research Links are a key part of sharing information. We are collaborating and sharing our Research Links materials with other organisations to enable them to replicate this initiative and improve access to research more broadly.

In April 2024 we held our annual Research Showcase, which was attended by over 100 individuals from a wide range of clinical and non-clinical professions. Our audience was welcomed by our new Director of Research Professor Fergus Caskey and heard about research studies being led by UHBW, including those awarded grants from our local charity and NIHR. There was a special session this year to highlight the achievements of our outgoing Director of Research, Professor David Wynick.

We are hosts for a range of National Institute for Health and Care Research (NIHR) infrastructure. The Bristol NIHR Clinical Research Facility (CRF) and NIHR Bristol Biomedical Research Centre (BRC) and the Applied Research Collaborative West (ARC West) form part of the NIHR @Bristol. Also part of this is the new NIHR Regional Research Delivery Network (RRDN), which took over from the Clinical Research Network (CRN) in October 2024 and is now fully operational. Through this South West Central RRDN, the national NIHR Research Delivery Network (RDN) invests millions in our local health research infrastructure with a view to increasing capacity and capability to carry out high quality research across the health and care system. UHBW also hosts Bristol Health Partners Academic Health Science Centre (BHP AHSC).

As a specialist centre, part of our strategy is to develop our early phase research capacity and capability and this has been facilitated through the award of the NIHR Bristol Clinical Research Facility (CRF), now in its third year of funding. The CRF provides dedicated clinic space to deliver experimental medicine and early translational research. Alongside this, our funding supports a number of early phase research nurses in our core therapeutic areas of Vaccine development and Oncology & Immunotherapy, training capacity and Patient and Public Involvement and Engagement facilitator, who works across the BRC and the CRF. Alongside the NIHR funding, income generated by working with our academic and industry partners are a key part of this strategy and we have growing commercial and academic portfolios. As we look towards shaping our second CRF bid over the next three years, we have reviewed the early phase and experimental research opportunities more widely across the Trust and pivoted some of our funding towards a specialist early phase senior study setup role. We have successfully appointed to the new role, and the postholder will work with teams in specialties across UHBW to set up very complex clinical trials. Paired with this, we have worked to further develop our vaccine clinical research delivery staff. They now have the skills to work flexibly with research teams who need advice or support for early phase research delivery, or to carry out other specific roles at times when the vaccine pipeline of work is less busy.

Our NIHR BRC has made substantial progress against its objectives across its themes and work areas. It was successful in securing additional funding for research career development, some of

which was awarded competitively to four of our UHBW allied health professionals, allowing them to ringfence time to write fellowship applications for further research. Our application for a Translational Research Collaboration in Surgical and Peri-Operative Care has been successful, and this will lead a collaboration of 14 BRCs in driving forwards early phase surgical innovation and developing joint grant applications. Strong progress has been made in developing the subnational South West Secure Data Environment, with the aim of increasing the use of existing data to answer important health and care research questions. Looking ahead to the future of the BRC, Professor Richard Martin was appointed as Director Designate to lead the next BRC application and become Director in 2028, if the application is successful.

Our NIHR ARC has had a strong focus on building capacity and capability with system partners, and additional funding was awarded in 2024/25 to support research capacity in the social care sector, to build knowledge mobilisation capacity and capability to get effective treatments and models of care into practice, and to extend and expand the work in the Mental health Research Initiative. This was all under the new ARC directorship of Professor Sabi Redwood, who worked with the ARC senior leadership team and partners to develop a strong collaborative bid for ARC2, submitted in January 2025.

In 2024/25 we submitted a total of nineteen NIHR grants; three were awarded, totaling £3.7 million, the outcome is awaited for a further nine, and seven were not awarded. Our three newly awarded grants were: an NIHR Invention for Innovation “FAST” grant led by consultant Ela Chakkarapani “Optimising remote aEEG monitoring in newborns with acquired brain injuries” ; An NIHR Health Services and Delivery Research grant lead by UWE researcher Zoe Anchors following on from a small study suggested by our chief nurse Deidre Fowler “A Mixed Methods Realist Evaluation to Understand the Implementation of Nursing Associates in Adult Secondary Care (INSERT)2; and a commissioned NIHR grant led by consultant Sam Amin “Double blind randomised placebo controlled trial of metformin in refractory epilepsies associated with tuberous sclerosis complex (MiTS2)”.

We have continued to see effects of the pandemic, with almost all grants requiring extensions resulting from delays in setup and recruitment. Our Post-award Grant Manager, now a permanent member of the team, is contributing to streamlined and improved management of contracting and finance post-award, which supports robust oversight and invoicing of our grant income. This, along with the increase in NIHR grant submissions over the last three years, will increase our grant income, and should drive an increase in research capability funding in the coming two years. The increase in capacity within the grants team has allowed the Grants Manager to reprioritise development of small grants and mentor and support new researchers in applying for local funding and conversion of small studies into the larger NIHR grants. In the absence of a local NIHR Research Support Service, we have funded specialist methodological support to support our small grant applicants and we continue to work closely with our allied health professional research lead to develop and encourage nurses, midwives, allied health professionals and clinical scientists to apply to our rolling local funding call to release time to develop a small grant application, or early-stage fellowships We value the close collaboration we have with UWE, whose staff support and mentor our current and aspiring non-medical clinical researchers.

We have sustained our levels of commercial research during 2024-25, generating around £3.5m which funds the research staff carrying out these studies, contributes to divisional and corporate income and provides flexibility to invest in strategically important areas, build capacity, and promote more growth. Our relationships with our industry partners are well established and we work with principal investigators and commercial partners to identify studies that may bring benefit to patients through the use of novel treatment options as part of the care UHBW offers, as well as supporting the health and wealth of the nation. We remain a ‘Super Partner’ site with IQVIA, one of the biggest global contract research organisations (CROs) and continue to enjoy a fruitful relationship. We engage directly with pharmaceutical and MedTech companies running research in the UK, explore more collaborative ways of working, and review upcoming pipelines which positions us well to express interest in trials of new compounds. The NIHR has introduced further standardisation to the mechanisms for costing commercial research, aiming to streamline and improve setup times and attract Industry to place trials in the UK, in an increasingly competitive global market. During the last

year, the new costing approach, using the National Contract Value Review (NCVR) process, has been introduced into early phase trials and those involving Advanced Therapy Investigational Medicinal Products (ATIMPs) so that all types of study in secondary care are now covered. As a member of the UK Commercial Costing Reference Group, our Commercial Research Manager continues to represent the views of R&D and researchers from UHBW and NBT in his joint role.

We continue to attract commercial trials in our established areas of strength such as specialist paediatrics, with trials opening in Duchenne Muscular Dystrophy and Juvenile Psoriatic Arthritis, as well as Oncology and Haematology, in particular trials of cellular therapies, such as Car-T therapy in patients with Relapsed/Refractory Multiple Myeloma. Over the last year we have expanded our commercial research portfolio into new areas such as Ear Nose and Throat (a new treatment for Chronic Rhinosinusitis with nasal polyps) and a Radiology-led trial of a new contrast agent for liver ultrasound in paediatric patients.

Underpinning all that we do is a framework of quality and governance, and our Research Operations Manager oversees and manages the quality systems that allow us to sponsor research to high standards, and to host a wide range of non-commercial research alongside the commercial, the early phase and the experimental. We have a wide ranging and complex portfolio of research that we aim to manage for the benefit of the local and more geographically distant populations that we serve, reflecting the services that UHBW provides in an ever more challenging environment, and generating the evidence to develop the care we can offer.

## 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 2024 to 31 March 2025.

### *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 Chief People Officer 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 nine occasions in the reporting period, five of which were held in common with the equivalent committee at North Bristol NHS Trust. The Committee considered the annual review of Executive Directors' performance, the skills and knowledge mix of the Board of Directors, current remuneration levels, and the appointment of the Group Chief Executive and Hospital Managing Director. The Committee also began the process of appointing Group Executive Directors with NBT as part of the ongoing work to create the Bristol NHS Group.

### *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. The Committee approved the appointment of the Group Chief Executive Officer and Hospital Managing Director.

### *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 Committee agreed the following pay principles in the year:

1. Remuneration levels offered will be sufficient to attract, retain and motivate Board Directors with the requisite knowledge, skills, values and experience to effectively lead the Trust.
2. The Trust anticipates the need to pay at and above the median level within the Supra Trust benchmarks and will take into account additional benchmarked data (such as NHS Providers pay data, Executive Search data, model hospital peers).
3. The Trust will utilise responsibility allowances where Executive Directors extend their remit to new and larger portfolio's. Up to an additional 10 per cent award for those taking on temporary significant extra responsibilities should be available.
4. Allowances for relocation and associated expenditure may be offered to new Executive Directors to the value of £8,000 where relevant. This amount can be claimed over a 24- month period and for expenses relating to moving, commuting or living away from their primary residence. HMRC rules will apply to this benefit if claims are deemed to be benefits in kind (BIK).
5. Data regarding pay will be collected annually and reviewed by the Remuneration, Nominations and Appointments Committee.
6. An Equalities Impact Assessment should be conducted to ensure remuneration is fair and adverse impact mitigated especially where there are gender pay gaps.

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.

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 2024/25 and 2023/24. There was no exit package paid to a director in 2024/25 (one in 2023/24). This information has been subject to audit.

***Table 21: Remuneration for the senior managers of the Trust 2024/25 (Audited)***

| **Director's remuneration: salaries and allowances for the 12 months to 31 March 2025** | **Salary (bands of £5,000)** | **Taxable benefits (to nearest £100)** | **Annual performance related bonus** | **All pension-related benefits (band of £2,500)** | **Total (bands of £5,000)** |
|---|---|---|---|---|---|
| **Chair** | | | | | |
| Jayne Mee from 01 April 2024 to 31 May 2024 | 5-10 | - | - | N/A | 5-10 |
| Ingrid Barker; Joint Chair from 01 June 2024 (Notes 1 & 3) | 35-40 | 600 | - | N/A | 35-40 |
| **Executive Directors** | | | | | |
| Maria Kane, Joint Chief Executive from 29 June 2024 (Notes 1 & 3) | 120-125 | 200 | 5-10 | - | 130-135 |
| Stuart Walker, Chief Executive from 01 April 24 to 28 June 24; Hospital Managing Director from 02 Sept 2024 (Note 2) | 325-330 | - | - | N/A | 325-330 |
| Jane Farrell, Chief Operating Officer (Note 2) | 205-210 | - | - | N/A | 205-210 |
| Paula Clarke, Executive Managing Director for Weston | 175-180 | - | - | 40-42.5 | 215-220 |
| Neil Kemsley, Chief Financial Officer | 195-200 | - | - | - | 195-200 |
| Deirdre Fowler, Chief Nurse and Midwife (Note 2) | 200-205 | - | - | N/A | 200-205 |
| Emma Wood, Chief People Officer & Deputy Chief Executive | 200-205 | - | - | 55-57.5 | 255-260 |
| Neil Darvill, Joint Chief Digital Information Officer (Note 3) | 95-100 | - | - | 20-22.5 | 115-120 |
| Rebecca Maxwell, Interim Medical Director | 210-215 | - | - | 65-67.5 | 275-280 |
| **Non-Executive Directors** | | | | | |
| Arabel Bailey | 15-20 | - | - | N/A | 15-20 |
| Sue Balcombe | 15-20 | - | - | N/A | 15-20 |
| Rosemarie Benneyworth | 15-20 | - | - | N/A | 15-20 |

| | | | | | |
|---|---|---|---|---|---|
| Bernard Galton | 0-5 | - | - | N/A | 0-5 |
| Emma Glynn | 0-5 | - | - | N/A | 0-5 |
| Thomas Griffiths | 15-20 | - | - | N/A | 15-20 |
| Susan Hamilton | 5-10 | - | - | N/A | 5-10 |
| Linda Kennedy | 10-15 | - | | N/A | 10-15 |
| Jane Norman | 0-5 | - | - | N/A | 0-5 |
| Roy Shubhabrata | 15-20 | - | - | N/A | 15-20 |
| Anne Tutt (Note 1) | 10-15 | 200 | - | N/A | 10-15 |
| Martin Sykes (Note 1) | 25-30 | 800 | - | N/A | 25-30 |

*Note 1 – Taxable benefits relate to reimbursement of travel cost for home to base mileage*
*Note 2 - No NHS Pension benefits have been disclosed as they are no longer a contributing member of the scheme*
*Note 3 - Remuneration has been apportioned based on split working arrangements with North Bristol Trust*

### *Table 22: Remuneration for the directors of the Trust 2023/24*

| **Director's remuneration: salaries and allowances for the 12 months to 31 March 2024** | **Salary (bands of £5,000)** | **Taxable benefits (to nearest £100)** | **Annual performance related bonus** | **All pension-related benefits (band of £2,500)** | **Total (bands of £5,000)** |
|---|---|---|---|---|---|
| **Chair** | | | | | |
| Jayne Mee (Note 1) | 60-65 | 100 | - | N/A | 60-65 |
| **Executive Directors** | | | | | |
| Eugine Yafele, Chief Executive (Note 2) | 315-320 | - | - | N/A | 315-320 |
| Stuart Walker, Chief Medical Officer & Deputy Chief Executive from 1 April 23 to 31 December 23, Chief Executive from 1 January 24 (Note 2) | 305-310 | - | - | N/A | 305-310 |
| Jane Farrell, Chief Operating Officer (Note 2) | 205-210 | - | - | N/A | 205-210 |
| Paula Clarke, Executive Managing Director for Weston (note 3) | 165-170 | - | - | N/A | 165-170 |
| Neil Kemsley, Chief Financial Officer | 190-195 | - | - | 347.5-350 | 540-545 |
| Deirdre Fowler, Chief Nurse and Midwife (Note 2) | 195-200 | - | - | N/A | 195-200 |
| Emma Wood, Chief People Officer & Deputy Chief Executive | 190-195 | - | - | 45-47.5 | 235-240 |
| Neil Darvill, Joint Chief Digital Information Officer (Note 4) | 70-75 | - | - | 72.5-75 | 145-150 |
| Rebecca Maxwell, Interim Medical Director (Note 5) | 50-55 | - | - | 157.5-160 | 210-215 |
| **Non-Executive Directors** | | | | | |
| Arabel Bailey | 10-15 | - | - | N/A | 10-15 |
| Sue Balcombe | 15-20 | - | - | N/A | 15-20 |
| Rosemarie Benneyworth | 10-15 | - | - | N/A | 10-15 |
| Julian Dennis | 0-5 | - | - | N/A | 0-5 |
| Bernard Galton | 15-20 | - | - | N/A | 15-20 |
| Emma Glynn | 5-10 | - | - | N/A | 5-10 |

| | | | | | |
|---|---|---|---|---|---|
| Thomas Griffiths | 15-20 | - | - | N/A | 15-20 |
| Susan Hamilton | 5-10 | - | - | N/A | 5-10 |
| Jane Norman | 15-20 | - | - | N/A | 15-20 |
| Roy Shubhabrata | 15-20 | - | - | N/A | 15-20 |
| Martin Sykes (Note 1) | 15-20 | 500 | - | N/A | 15-20 |

*Note 1 – Taxable benefits relate to reimbursement of travel cost for home to base mileage*
*Note 2 - No NHS Pension benefits have been disclosed as they are no longer a contributing member of the scheme*
*Note 3 - Pension benefit negative so zeroed, and excluded from total*
*Note 4 - Remuneration has been apportioned based on split working arrangements with North Bristol Trust*
*Note 5 – Calculation of the real terms increase in pension is not possible because the value at 31st March 2023 has not been supplied by the pension scheme. The pension benefit reported assumes that the entire pension entitlement accrued in 23/24.*

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. There were no payments made for loss of office in either 2024/25 or 2023/24.

There were no payments to past senior managers in either 2024/25 or 2023/24.

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

The following tables show the pension benefits for the senior managers of the Trust for 2024/25 and 2023/24. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of any pensions. This information has been subject to audit.

***Table 23: Pension benefits for the year ended 31 March 2025***

| 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 2025 | Lump sum at age 60 related to accrued pension at 31 March 2025 | Cash Equivalent Transfer Value at 31 March 2025 | Cash Equivalent Transfer Value at 31 March 2024 | 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 |
| Maria Kane | - | - | 55-60 | 165-170 | 1,518 | 1,436 | - | N/A |
| Stuart Walker (Note 1) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Jane Farrell (Note 1) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Paula Clarke | 2.5-5 | - | 5-10 | 0-5 | 162 | 103 | 32 | N/A |
| Neil Kemsley | - | - | 0-5 | 0-5 | 36 | 58 | - | N/A |
| Deidre Fowler (Note 1) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Emma Wood | 2.5-5 | - | 35-40 | 0-5 | 551 | 454 | 38 | N/A |
| Neil Darvill | 2.5-5 | - | 80-85 | 210-215 | 172 | 103 | 39 | N/A |
| Rebecca Maxwell | 2.5-5 | 2.5-5 | 30-35 | 80-85 | 643 | 540 | 51 | N/A |

*Note 1 – Not covered by the pension arrangements during the reporting year*

This table includes details for the directors who held office at any time in 2024/25.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just

their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

***Table 24: Pension benefits for the year ended 31 March 2024***

| 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 2024 | Lump sum at pension age related to accrued pension at 31 March 2024 | Cash Equivalent Transfer Value at 31 March 2024 | Cash Equivalent Transfer Value at 31 March 2023 | 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 |
| Eugine Yafele (note 1) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Stuart Walker (note 1) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Jane Farrell (note 1) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Paula Clarke | - | 32.5-35 | 65-70 | 190-195 | 1,431 | 1,737 | 138 | N/A |
| Neil Kemsley | 15-17.5 | 40-42.5 | 80-85 | 240-245 | 2,088 | 1,282 | 379 | N/A |
| Deidre Fowler (note 1) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Emma Wood | 2.5-5 | - | 30-35 | - | 454 | 308 | 89 | N/A |
| Neil Darvill (note 3) | 5-7.5 | 37.5-40 | 70-75 | 200-205 | 103 | 1,353 | N/A | N/A |
| Rebecca Maxwell (note 2) | 5-7.5 | 17.5-20 | 25-30 | 70-75 | 540 | N/A | 130 | N/A |

*Note 1 – Not covered by the pension arrangements during the reporting year*
*Note 2 – Pension data not available for 2022/23*
*Note 3 – NHS Pensions Online have been unable to provide information for a cash equivalent transfer value in 23/24*

This table includes details for the directors who held office at any time in 2024/25.

***Table 25: Future Policy Table***

| Element of pay (component) | How component supports short- and long-term objective/goal of the Trust | Operation of the component | Description of the framework to assess pay and performance |
|---|---|---|---|
| Basic Salary | Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a 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.<br>(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.<br>In addition, any Agenda for Change cost of living pay award, when agreed nationally, is considered for payment to the Executive Directors.<br>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 against the 25th percentile, median, and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median, and 75th percentile is further broken down to disclose the salary component.

The remuneration report shows that the highest paid director's remuneration fell into the £325,000 to £330,000 band (2023/24 £305,000 to £310,000). The relationship to the remuneration of the organisation's workforce is disclosed in the tables below.

***Table 26: Highest Paid Director***

| Year | 2024/25 £000's | 2023/24 £000's | % change |
|---|---|---|---|
| Salary and allowances | 330 | 305 | 8.2% |
| Performance pay and bonuses | - | - | - |

***Table 27: Average Employee***

| Year | 2024/25 £ | 2023/24 £ | % change |
|---|---|---|---|
| Salary and allowances | 49,123 | 48,519 | 1.2% |
| Performance pay and bonuses | - | - | - |

***Table 28: Pay Ratio Disclosure and Information***

| 2024/25 | 25th percentile | Median | 75th percentile |
|---|---|---|---|
| Total remuneration - £ | 29,983 | 40,667 | 52,819 |
| Salary component of total remuneration - £ | 29,983 | 40,667 | 52,819 |
| Pay ratio information | 11.0 | 8.1 | 6.2 |

| 2023/24 | 25th percentile | Median | 75th percentile |
|---|---|---|---|
| Total remuneration - £ | 29,407 | 40,482 | 53,607 |
| Salary component of total remuneration - £ | 29,407 | 40,482 | 53,607 |
| Pay ratio information | 10.4 | 7.5 | 5.7 |

Remuneration of the highest paid director was 8.1 times (2023/24, 7.5 times) the median remuneration of the workforce, which was £40,667 (2023/24, £40,482). Remuneration ranged from £23,615 to £327,979 (2023/24, £22,384 to £305,514).

In 2024/25, nil (2023/24, nil) employees received total remuneration more than 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. The information in the tables above does not include remuneration of temporary staff because the organisation believes it artificially inflates the 25th percentile, median, and 75th percentile remuneration and therefore reduces the ratio with the remuneration of the highest paid director. Including temporary staff would cause year on year changes in the ratios to be driven by the volume of agency workers used, rather than a change in the underlying salaries paid to employees.

To ensure compliance with mandatory reporting requirements, and to provide all available information, remuneration including temporary staff is disclosed in the tables below.

***Table 29: Average Employee (including temporary staff)***

| Year | 2024/25<br>£ | 2023/24<br>£ | % change |
|---|---|---|---|
| Salary and allowances | 60,549 | 52,930 | 14% |
| Performance pay and bonuses | - | - | - |

***Table 30: Pay Ratio Disclosure and Information (including temporary staff)***

| 2024/25 | 25th percentile | Median | 75th percentile |
|---|---|---|---|
| Total remuneration - £ | 31,795 | 43,825 | 60,619 |
| Salary component of total remuneration - £ | 31,795 | 43,825 | 60,619 |
| Pay ratio information | 10.4 | 7.5 | 5.4 |

| 2023/24 | 25th percentile | Median | 75th percentile |
|---|---|---|---|
| Total remuneration - £ | 30,632 | 42,474 | 56,954 |
| Salary component of total remuneration - £ | 30,632 | 42,474 | 56,954 |
| Pay ratio information | 10.0 | 7.2 | 5.4 |

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 Code of Governance for NHS Provider Trusts, 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 Code of governance for NHS provider trusts, and in her 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 31: Expenses paid to governors and directors.***

| | Directors | | | Governors | | |
|---|---|---|---|---|---|---|
| Year | Number in office | Number reimbursed | Amount (£) | Number in office | Number reimbursed | Amount (£) |
| 2024/25 | 23 | 12 | 14,880 | 29 | 8 | 2,011 |
| 2023/24 | 22 | 11 | 29,016 | 35 | 13 | 2,095 |

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

#### *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.

**Maria Kane**
**Group Chief Executive**

## 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 32: Analysis of staff costs***

| | 2024/25 | | | 2023/24 | | |
|---|---|---|---|---|---|---|
| | Total £'000 | Permanent £'000 | Other £'000 | Total £'000 | Permanent £'000 | Other £'000 |
| Salaries and wages | 626,675 | 576,421 | 50,254 | 568,111 | 507,573 | 60,538 |
| Social security costs | 67,462 | 61,958 | 5,504 | 62,694 | 56,329 | 6,365 |
| Pension costs* | 121,672 | 116,291 | 5,381 | 95,289 | 89,809 | 5,480 |
| Apprenticeship levy | 3,122 | 3,122 | - | 2,895 | 2,895 | - |
| Termination benefits | 586 | 586 | - | 179 | 179 | - |
| Agency/contract staff | 12,694 | - | 12,694 | 25,053 | - | 25,053 |
| **Total Gross Staff Costs** | **832,211** | **758,378** | **73,833** | **754,221** | **656,785** | **97,436** |
| Income in respect of salary recharges netted off expenditure | (3,806) | (3,806) | - | (4,102) | (4,102) | - |
| Employee expenses capitalised | (2,294) | (1,857) | (437) | (1,969) | (1,313) | (656) |
| **Net employee expenses** | **826,111** | **752,715** | **73,396** | **748,150** | **651,370** | **96,780** |

### *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 2024/25 and 2023/24 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 33: Average staff numbers (whole time equivalents)***

| | 2024/25 | | | 2023/24 | | |
|---|---|---|---|---|---|---|
| Staff category | Total | Permanent | Other | Total | Permanent | Other |
| Medical and dental | 1,888 | 1,792 | 96 | 1,807 | 1,706 | 101 |
| Administration and estates | 2,564 | 2,497 | 67 | 2,492 | 2,414 | 77 |
| Healthcare assistant and other support | 1,115 | 961 | 154 | 1,111 | 977 | 134 |
| Nursing, midwifery & health visitors | 5,475 | 4,889 | 586 | 5,243 | 4,518 | 725 |
| Scientific, therapeutic and technical | 1,707 | 1,660 | 47 | 1,621 | 1,572 | 48 |
| Healthcare science staff | 262 | 262 | | 246 | 245 | 1 |
| **Total staff** | **13,011** | **12,061** | **950** | **12,519** | **11,433** | **1,086** |

### *4.4.3 Education, Learning and Development*

During the year, the department conducted a major re-organisation aligned to national priorities within the government's long-term workforce plan and Safe Learning Environment Charter. Consequently, the department was renamed Learning and Workforce Development with overarching governance through the Learning and Workforce Development Board.

The Trust's Learning and Development offer includes a wide range of provision, delivered both internally and by external training providers, at a local and national level. The Trust has established relationships with local colleges and universities within the region delivering programmes at academic level 2 through to level 7 post-graduate provision.

The Trust has continued to foster it relations with partners across the BNSSG ICS. Of note is the ability now to passport training records and our joint widening engagement activity and collaboration to share training programmes.

The Trust's 'Leading Together' leadership, management and coaching framework offer is in its second year and an integral element of a mandated programme to develop leaders with line management responsibility. Compliance to the mandated programme (The Compassionate and Inclusive Leader), since its inception 12 months ago, exceeds 78%.

Longer-term leadership programmes are well established with 20 cohorts following the Leading Others programme (first-line leaders), 5 cohorts of Leading Teams (mid-level leaders), and 4 cohorts of Leading the Organisation and System (senior leaders). Bridges (a positive action programme for ethnic minority colleagues) was further developed to increase the opportunities open to participants, with 6 cohorts running to date. A significant proportion of these participants have now progressed within the organisation.

The Trust procured a coaching and mentoring system which has facilitated significant growth in the number of coaches and mentoring activity. A programme of coaching supervision sessions and CPD commenced to support experienced and newly qualified coaches.

The Trust supports 420 apprentices, mainly in the clinical sector and on nursing pathways, across 57 apprenticeship standards. Working with 32 training providers with significant growth in clinical coding, engineering, and data technician roles. The restructure of the department supports the expansion of the apprenticeship pipeline to meet the recruitment targets of the long-term workforce plan, as well as the career ambitions of existing staff through the implementation of career clinics and career pathways to support internal progression and development.

The Trust provides an active widening engagement programme with local schools, colleges, community groups and partners to support young people and those disadvantaged to enter the workforce. Initiatives include Project Search, Pathways to NHS, traineeships, work experience and development opportunities.

The Trust continued to work with national partners to deliver a programme supporting internationally educated nurses (IENs) transitioning into clinical roles and progress and develop within their careers. As acknowledged by Trust's key role in delivering NHS England's 'Stay and Thrive' initiative, to promote retention and career development.

The Trust's Perceptorship programme has supported the professional development of over 400 staff members, culminating in a Graduation Day to celebrate achievement and facilitate transition into roles. Future work with system partners, will incorporate Allied Health Professionals within a system Preceptorship Progress Day.

Training for Healthcare support worker inductees continues to be delivered within a structured programme that includes pastoral care and career guidance. Several healthcare support workers were nominated for the Chief Nurse Award, reflecting the success of this initiative.

The provision of nurse pre-registration placements for full-time and blended learning programmes, with UWE and the University of Gloucestershire, grew over the year. Placements are supported by academics in practice and Practice Learning Educators. Feedback continues to demonstrate the positive impact of the team and support from clinical areas. The Trust is actively working with system partners and educational providers to expand placement capacity whilst ensuring a positive student experience.

The Trust developed a nurse career pathway to registration for new and existing staff and, is therefore, committed to a programme of developing 'home grown talent' to expand and develop the nursing workforce, through its investment in the nursing pipeline. Consequently, the Trust has already supported learner cohorts on the Student Nurse Associate apprenticeship programme, with further cohorts progressing through the programme.

In addition, the Trust facilitated the completion of an accelerated Registered Nursing Degree Apprenticeship cohort over the past year, with future cohorts set to qualify by October 2026.

Undergraduate medical education placement activity continues to expand within both South Bristol and North Somerset Academies. The Trust offers a range of placements, such as working creatively with Allied Health Professionals (AHPs) and other teams to ensure future doctors receive a well-rounded experience.

Both academies received excellent feedback from the University of Bristol and students during the annual Academy Monitoring visits for the administration and organisation within the academies, quality of accommodation, teaching and welcoming and enthusiastic staff being highlighted.

In conjunction with Gloucester Academy, the Trust ran an Out of Hospital Simulation for students, utilising a grounded plane at Cotswold airport. In addition, an innovative Learning to Teach programme has been established which trains 5th Year medical students teaching 2nd Year students on Clinical Contact Placements. The Trust has re-modelled the mix of placement and teaching, to support increased placement capacity.

The Trust continued to develop its provision of Foundation Doctors' programme across the Bristol and Weston sites, drawing upon joint teaching sessions and joint Annual Review of Competency Progression and Quality Panels for Foundation doctors. In collaboration with other Trust departments, the post-graduate medical education team have revamped the resident doctor forum to encourage engagement and feedback from doctors, and the timely resolution of issues. Furthermore, the Trust progressed the quality of its provision demonstrated in NHSE's visit to Trauma and Orthopaedics, which confirmed improvements in the training experience and therefore lifting of enhanced monitoring for the department.

The newly formed Library & Learning Hub oversees the provision of Library and Knowledge Management, and provision of corporate training. The department significantly increased in the number of articles provided for colleagues this year by 300% and literature searching by 20% on 2019/20 figures. The service continues to provide more literature searches than any other similar sized trust, as well as having more accesses to the Knowledge Hub than any other trust in the country – proving a high demand for evidence at UHBW. Key successes include 'Knowvember' - a month-long joint campaign with North Bristol Trust promoting evidence into practice; executive summaries for the Senior Leadership Team; launching a new 'eco shop'; development of neurodiversity resources for learners within the Trust; and decolonising the library collection.

The Learning Hub has launched a new and improved induction model; continued to drive automated training passporting records between UHBW and NBT; improved the provision of training to manage and prevent violence and aggression

The Trust's Simulation Service continues to deliver innovative simulation-based education (SBE) to staff, young people, and learners across the region. We service supports a point-of-care training

programme across the Trust. The service has implemented innovations such as, simulation for parents of long-term ventilated children awaiting discharge, designed to provide life-saving skills, ensuring safer transitions home, and reducing re-admissions.

Co-producing education with patients, amplifies their voices in shaping training, for example a collaboration with a youth involvement group influenced scenarios that enhance staff communication, with young people and families. The service has also supported key major policy rollouts, including Martha's Law, Sepsis protocols, and Respecting Everyone initiatives to combat incivility. Alongside the Human Factors and Patient Safety teams, the service influenced the national Prep-Stop-Block protocol for anaesthesia safety, earning a national patient safety award nomination.

#### *4.4.4 Diversity and Inclusion*

The Trust is committed to 'Inclusion in everything we do' because everyone has the 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 (EDI) Strategy 2020-2025 in partnership with the national WRES team, with an annual strategic plan built on four overarching themes.


The ambition within these themes is delivered through an annual strategic plan underpinning the strategy's objectives aligned to our newly developed people strategy.

To achieve this, the Trust has established robust equality, diversity and inclusion governance and reporting pathways. The people equality, diversity and inclusion steering group is the Trust's key group delivering against the strategic objectives. The Associate Director OD and Wellbeing 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. Progress against the EDI Strategy 2020-2025 is evidenced and published in the EDI Bi-annual Report.

In summer 2024 UHBW launched its 'Pro-equity' trauma informed approach as a mission critical people project. Pro-Equity is inclusion in everything we do, even when people aren't looking. It is embracing full hearted care by making UHBW a better place to work, building a place where everyone feels truly safe to be themselves. Where our differences are our strengths, and everyone feels like they belong here, because they do. As part of our Pro-equity approach, we undertook sexual-safety, anti-racism and anti-ableism listening workshops to understand the experiences and priorities of colleagues. This feedback resulted in over 1600 individual lines of feedback being thematically analysed, with key themes being used to create the Trust's Pro-equity action plan which will be launched in April 2025. The Pro-equity assurance group reports into monthly SLT.

The Chief People Officer is the nominated executive lead for People equality, diversity and inclusion on the Trust Board with delegated responsibility for the delivery of the programme of work sitting with the Associate Director OD and Wellbeing. The Chief Nurse is the executive lead for Health inequalities, with the Patient EDI Manager driving forward this agenda.

A range of equality, diversity and inclusion data is published by the Trust on its external 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), EDS2022 and Gender Pay Gap.

### *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 Black, Asian and Minority Ethnic 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 strategic plan and progress against plan is reported bi-annually. This is the second year we have conducted a deep dive on both the WRES and WDES data, creating the Trust's 'Equality Report' with year-to-year tracking and rating on performance. This has informed our Pro-equity Plan for 2025-26 and is being used at a division level to inform Culture and People plans for 2025-26.

As part of our Pro-equity mission critical project, we ran 14 anti-racism workshops from September to October 2024 to hear the experiences of our colleagues on what anti-racism means to them and what we need to do to tackle racism within the trust. The feedback from the workshops was used to create our anti-racism community commitment and, along with the sexual safety and anti-ableism feedback, was used to create our Pro-equity action plan.

This year, the Trust's nationally recognised talent management programme 'Bridges' for Black, Asian and minority ethnic colleagues in Bands 1-5, underwent a programme review. The programme team ran feedback workshops with graduates and current learners and have created the Bridges steering group made up of current and past participants who will support decisions and changes going forward. The review resulted in a number of recommendations that are being implemented to further strengthen the programme. Out of the 46 colleagues that have already graduated from Bridges, 16 have been successful in career progression. A further 3 graduates have been accepted onto Nursing Degree Apprenticeships to support career development within the Nursing Profession. Cohorts 5 (33 participants) and 6 (35 participants) are underway.

### *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 strategic plan and progress against plan is reported bi-annually. As mentioned under 4.4.5 WRES, this is the second year we have conducted a deep dive on both the WRES and WDES data, creating the Trust's 'Equality Report. This has informed our Pro-equity Plan for 2025-26 and is being used at a division level to inform Culture and People plans for 2025-26.

As part of our Pro-equity mission critical project, we ran 12 anti-ableism workshops from October to November 2024 to hear the experiences of our colleagues on what anti-ableism means to them and what we need to do to tackle ableism within the trust. The feedback from the workshops, along with the sexual safety and anti-racism feedback, was used to create our Pro-equity action plan.

### *4.4.7 The NHS Equality Delivery System (EDS2022)*

EDS2022, is an accountable improvement tool for NHS organisations in England, designed to review and develop their services, workforces, and leadership. It comprises of eleven outcomes spread across three Domains, which are: 1) Commissioned or provided services 2) Workforce health and well-being 3) Inclusive leadership. The Trust has collaborated with BNSSG Integrated Care System partners to align domain 1 commissioned or provided services. EDS22 submission published in April 2025.

#### *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/ The gender pay gap report action plan is integrated into the Trust's yearly equality, diversity and inclusion action plan with progress being reported on bi-annually.

#### *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. In addition to this core training the Trust has a 'cultural awareness' training session to support further development in this area alongside recruiting over 100 EDI advocates who will be trained to provide improved allyship, to support in divisions, and to work alongside our established staff networks. In Summer 2024 the EDI Advocate scheme was redeveloped to formalise the role of an advocate, align the role to best practice and to provide training to advocates.

#### *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 four 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.

Race Equality and Inclusion network supports staff from Black, Asian and minority ethnic groups.

LGBTQIA+ staff network supports lesbian, gay, bi-sexual and transexual staff.

Women's Network brings women together to create positive connections.

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:

- Playing an active part in celebrating the valuable contribution of our diverse staff
- Contributing to the WRES, WDES and LGBTQIA+ reporting pathways and action plans
- Helping to support the programme of work to promote an inclusive organisational culture
- Co-creating our approach to pro-equity and the development of the plan

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

- Equality, diversity and human rights: 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.

- Respecting Everyone: Respecting Everyone aims to resolve issues regarding bullying and harassment, grievances, conduct and capability, as quickly, and as fairly, as possible. Our 'Respecting Everyone' Framework is designed with this principle in mind and builds upon our organisational Values.
- Health and Wellness policy: 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 of 31 March 2025. 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 34: Staff with permanent contract***

| Gender – All staff with a substantive employment contract | Total | % |
|---|---|---|
| Male | 3354 | 23.8% |
| Female | 10714 | 76.2% |
| Grand Total | 14068 | |

***Table 35: Directors by gender***

| Gender– Directors (Executive and non-Executive including CEO & Chair) | Total | % |
|---|---|---|
| Male | 7 | 36.8% |
| Female | 12 | 63.2% |
| Grand Total | 19 | |

***Table 36: Other Senior Managers by gender***

| Gender – Other Senior Managers | Total | % |
|---|---|---|
| Male | 22 | 36.1 |
| Female | 39 | 63.9 |
| Grand Total | 61 | |

***Note 1*** *- For the purposes of the staff section of the report, Senior Managers are defined as all staff at Band 8d & 9, Clinical Chairs of the Trust's Divisions and senior medics.*

***Table 37: Ethnicity***

| Ethnic Origin | Total | % |
|---|---|---|
| A White - British | 8487 | 60.33% |
| B White - Irish | 135 | 0.96% |
| C White - Any other White background | 892 | 6.34% |
| C2 White Northern Irish | 6 | 0.04% |
| CA White English | 16 | 0.11% |
| CB White Scottish | 6 | 0.04% |
| CC White Welsh | 6 | 0.04% |
| CD White Cornish | ≤5 | N/A |
| CF White Greek | ≤5 | N/A |

| | | |
|---|---|---|
| CG White Greek Cypriot | ≤5 | N/A |
| CH White Turkish | ≤5 | N/A |
| CK White Italian | 6 | 0.04% |
| CP White Polish | 27 | 0.19% |
| CQ White ex-USSR | ≤5 | N/A |
| CX White Mixed | 8 | 0.06% |
| CY White Other European | 55 | 0.39% |
| D Mixed - White & Black Caribbean | 82 | 0.58% |
| E Mixed - White & Black African | 53 | 0.38% |
| F Mixed - White & Asian | 91 | 0.65% |
| G Mixed - Any other mixed background | 99 | 0.70% |
| GA Mixed - Black & Asian | ≤5 | N/A |
| GD Mixed - Chinese & White | ≤5 | N/A |
| GE Mixed - Asian & Chinese | ≤5 | N/A |
| GF Mixed - Other/Unspecified | 9 | 0.06% |
| H Asian or Asian British - Indian | 1568 | 11.15% |
| J Asian or Asian British - Pakistani | 123 | 0.87% |
| K Asian or Asian British - Bangladeshi | 45 | 0.32% |
| L Asian or Asian British - Any other Asian background | 315 | 2.24% |
| LA Asian Mixed | ≤5 | N/A |
| LB Asian Punjabi | ≤5 | N/A |
| LC Asian Kashmiri | ≤5 | N/A |
| LE Asian Sri Lankan | 6 | 0.04% |
| LF Asian Tamil | ≤5 | N/A |
| LH Asian British | 13 | 0.09% |
| LK Asian Unspecified | 11 | 0.08% |
| M Black or Black British - Caribbean | 196 | 1.39% |
| N Black or Black British - African | 730 | 5.19% |
| P Black or Black British - Any other Black background | 45 | 0.32% |
| PA Black Somali | 13 | 0.09% |
| PB Black Mixed | ≤5 | N/A |
| PC Black Nigerian | 42 | 0.30% |
| PD Black British | 8 | 0.06% |
| PE Black Unspecified | 5 | 0.04% |
| R Chinese | 124 | 0.88% |
| S Any Other Ethnic Group | 162 | 1.15% |
| SA Vietnamese | ≤5 | N/A |
| SB Japanese | ≤5 | N/A |
| SC Filipino | 114 | 0.81% |
| SD Malaysian | ≤5 | N/A |

| | | |
|---|---|---|
| SE Other Specified | 22 | 0.16% |
| Z Not Stated | 268 | 1.91% |
| (blank) | 247 | 1.76% |
| Grand Total | 14068 | |

***Table 38: Disability***

| Disability | Total | % |
|---|---|---|
| No | 12340 | 87.7% |
| Yes | 698 | 5.0% |
| Not Declared | 1030 | 7.3% |
| Grand Total | 14068 | |

***Table 39: Age profile***

| Age profile | Total | % |
|---|---|---|
| <=20 Years | 167 | 1.2% |
| 21-25 | 1118 | 7.9% |
| 26-30 | 2100 | 14.9% |
| 31-35 | 2314 | 16.4% |
| 36-40 | 2018 | 14.3% |
| 41-45 | 1654 | 11.8% |
| 46-50 | 1406 | 10.0% |
| 51-55 | 1247 | 8.9% |
| 56-60 | 1100 | 7.8% |
| 61-65 | 736 | 5.2% |
| 66-70 | 156 | 1.1% |
| >=71 Years | 52 | 0.4% |
| Grand Total | 14068 | |

***Table 40: Religious belief***

| Religious belief | Total | % |
|---|---|---|
| Atheism | 2982 | 21.2% |
| Buddhism | 148 | 1.1% |
| Christianity | 5557 | 39.5% |
| Hinduism | 408 | 2.9% |
| Islam | 552 | 3.9% |
| Jainism | ≤5 | N/A |
| Judaism | 15 | 0.1% |
| Sikhism | 31 | 0.2% |
| Other | 1019 | 7.2% |
| Not declared | 3354 | 23.8% |
| Grand Total | 14068 | |

***Table 41: Sexual orientation***

| Sexual orientation | Total | % |
|---|---|---|
| Bisexual | 347 | 2.5% |
| Gay or Lesbian | 307 | 2.2% |
| Heterosexual or Straight | 10891 | 77.4% |
| Other sexual orientation not listed | 62 | 0.4% |
| Undecided | 48 | 0.3% |
| Not declared | 2413 | 17.2% |
| TOTAL | 14068 | |

### *4.4.12 Occupational Health and Safety and Wellbeing*

### Wellbeing

The Trust is in the last year of delivering its 5-year Workplace Wellbeing Strategic Framework. The impact of wellbeing is measured through the staff survey. The score for the annual NHS staff survey question "My organisation takes positive action on health and wellbeing" rose from 61.6% to 62.3% in 2024 and represents an increase of over 6% above the benchmark average. Other survey questions related to wellbeing showed improvement, except for musculoskeletal problems experienced in the workplace which had a slight decline and so this area of health and wellbeing will be a priority focus for enhancement in 2025/26.


Figure 1. Infographic depicting the wellbeing results of the NHS staff survey 2024.

Key initiatives undertaken this year which have impacted positively on our colleague experience:

- The Trust initiated a fatigue risk management programme, led by the Head of Human Factors after discussions with experts in workplace wellbeing, health and safety, risk management, and governance. These discussions highlighted the absence of a unified and systematic approach to identifying, evaluating, and mitigating the risks linked to colleague fatigue, particularly concerning

patient safety and operational efficiency. It is acknowledged that existing practices could be improved to develop a structured framework for managing the impacts of fatigue and related risks and so this work will continue into next year and beyond.

- The Trust collaborated with North Bristol NHS Trust (NBT) to implement a pilot programme for workplace cardiovascular health assessments, funded by the Department of Health and Social Care, from September 2024 to March 2025. During this timeframe, more than 700 employees underwent evaluations to measure cholesterol levels, blood pressure, heart health and various lifestyle factors. One-third of the participants received a clinically significant result and were subsequently referred to their General Practitioner for further follow-up.

- In recognition of World Menopause Month, the Trust hosted its sixth menopause conference on 18th October, world menopause day, inviting both Trust colleagues and representatives from partner organisations within the health and care system. The event featured a menopause-themed Schwartz Round, where panellists shared lived-experience of menopause in the workplace. Both events attracted the largest number of participants to date, underscoring the significance of maintaining a proactive approach to perimenopause and menopause support in the upcoming year.

- The Trust is actively working to develop a "Group Model" in collaboration with North Bristol NHS Trust. A key aspect of the Organisational Development plan is to implement a joint workplace wellbeing offer in 2025/26 that is accessible to colleagues working across both Trusts. Several projects are currently underway to facilitate this goal, including the re-tendering of an Employee Assistance Programme aimed at ensuring equitable services and maximising economies of scale.

**Occupational Health**

The Trust hosts Avon Partnership NHS Occupational Health Service (APOHS), this partnership consists of UHBW, NBT and Sirona and provides an integrated occupational health service to all partners. The service also generates income from external contracts, this funding reduces the funds required from NHS partners. This year the service has focused on engaging with key stakeholders from the NHS partners to ensure the service is configured to best support staff health and wellbeing.

Working with colleagues in the Trust, including, recruitment, HR, infection prevention, staff psychology support, and wellbeing, a strategic action plan was developed and agreed by the board. A number of workstreams have been established to focus on the following key areas:

- Improving reporting on the immunity status of staff and to track/target staff when needed during an outbreak of infectious disease using the new G2 capability
- Ensuring the APOHS counselling service model is best positioned to meet the needs of staff and is aligned to other support services available to staff
- Improving rapid access to a high-quality physiotherapy telephone service working effectively alongside the face-to-face physiotherapy treatment services provided by the NHS partners
- Improving the G2 data system configuration to ensure service delivery is optimised and provide high quality business intelligence information for performance management, business planning and service improvement initiatives.
- Improved visibility and communications to staff and managers by developing a new website which will be launched in the new year alongside new resources to provide better advice and guidance on occupational health services.

It is anticipated that this action plan will support the delivery of the national growing Occupational health and wellbeing strategy and will impact significantly on colleague experience and wellbeing.

#### *4.4.13 A Safe and Healthy Working Environment*

The overall model 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.

The Trust continues to recognise 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.

Within this annual period, a review of the health and safety advisory structure took place resulting in an increased service provision to ensure a robust structure for timely advice and support can be maintained at all times.

Internal departmental health and safety audits are undertaken annually with action plans developed and managed by department managers to address any areas of improvement with progress monitored within the Trust Health and Safety Committee meetings. In addition to this, external auditors are engaged to conduct biennial audits to gauge compliance with health and safety legislative requirements. An external Five Star audit for H&S Compliance is next planned for December 2025.

Key areas of focus include reducing workplace violence and aggression and clinical sharps incidents as the highest incident categories reported by staff.

Within this annual period, two 'Violence Reduction Officers' joined the Safety Department team. Their role is to work with staff who have been subjected to incidents of violence and aggression, signposting to appropriate levels of support if required and exploring incidents to identify key learning areas. And, where appropriate, taking action against those who act in a violent or aggressive way towards our staff.

The respirator Fit Test service, first introduced into the Safety Department in 2020 has gone from strength to strength providing a trust wide service with specific focus on high-risk clinical areas. Despite previous concern due to supply issues of respirator models, we now have a choice of sustainable models available. The ongoing service of providing Fit Tests locally to address concerns of releasing clinical staff to attend in high-risk areas has continues to be embraced and supported by service leads.

The service lead has attained British Safety Industry Federation (BSIF) Fit2Fit accreditation for both qualitative and quantitative methods of fit testing to ensure the best possible fit test standards in all methods of testing are adhered to and that training for fit testing staff can be provided in-house with no reliance on external provision.

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.

An annually reviewed Training Delivery Plan 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. Quarterly compliance with risk assessor coverage within each division is monitored within the Trust Health and Safety Committee.

Expert advice for Moving and Handling 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 promote patient safety by providing advice to clinical areas, especially for the management of bariatric or other complex patients.

#### *4.4.14 Sickness Absence*

The Trust's average sickness for 2024/25 was 4.4%.

### *4.4.15 Staff Turnover*

Turnover for all staff groups was 11.5% in April 2024 and reduced to 10.5% March 2025. This was against a turnover target of less than 12%. Turnover increased slightly until June 2024 and then reduced consistently throughout the remainder of the financial year. Turnover is monitored through the Trust Integrated Quality and Performance Report that is shared with Trust Board and People Committee.

### *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 2024/25 the Trust's expenditure on consultancy was £0.560m (2023/24: £0.671m).

### *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, and any off-payroll engagements of board members and/or senior officers with significant financial responsibility. The Trust defines officers with significant financial responsibility as executive directors, divisional directors and clinical chairs.

***Table 42: Highly paid off-payroll worker engagements as at 31 March 2025, earning £245 per day or greater***

| | |
|---|---|
| No. of existing engagements as of 31 March 2025 | 2 |
| *Of which...* | |
| *No. that have existed for less than one year at time of reporting.* | *1* |
| *No. that have existed for between one and two years at time of reporting.* | *1* |
| *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 43: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater***

| | |
|---|---|
| Number of off-payroll workers engaged during the year ended 31 March 2025 | 2 |
| *Of which:* | |
| *Not subject to off-payroll legislation* | *2* |
| *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 44: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1st April 2024 and 31 March 2025***

| | |
|---|---|
| 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. | 35 |

### *4.4.18 Exit packages*

The table below shows the number and cost of staff exit packages in 2024/25 with 2023/24 provided for comparison. 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. This information has been subject to audit.

***Table 45: Exit packages***

| | 2024/25 | | | 2023/24 | | |
|---|---|---|---|---|---|---|
| Exit package cost band | Number of compulsory redundancies | Number of other departures agreed | Total number of exit packages by cost band | Number of compulsory redundancies | Number of other departures agreed | Total number of exit packages by cost band |
| <£10,000 | - | 10 | 10 | - | 10 | 10 |
| £10,000 - £25,000 | 1 | 2 | 3 | - | - | - |
| £25,001 - £50,000 | 2 | 2 | 4 | 2 | - | 2 |
| £50,001 - £100,000 | 3 | - | 3 | - | 1 | 1 |
| £100,001 - £150,000 | - | - | - | 1 | 1 | 2 |
| £150,001 - £200,000 | - | - | - | - | - | - |
| >£200,000 | 1 | - | 1 | - | - | - |
| **Total number of exit packages by type** | **7** | **14** | **21** | **3** | **12** | **15** |
| | | | | | | |
| **Total cost (£'000)** | **586** | **140** | **726** | **179** | **264** | **443** |

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

***Table 46: Analysis of non-compulsory departures***

| | 2024/25 | | 2023/24 | |
|---|---|---|---|---|
| | No. | £'000 | No. | £'000 |
| Voluntary redundancies including early retirement contractual costs | - | - | 1 | 148 |
| Mutually agreed resignation contractual costs (MARS) | - | - | - | - |
| Contractual payments in lieu of notice | 13 | 124 | 11 | 116 |
| Non-contractual payments requiring HMT approval | 1 | 16 | - | - |
| **Total** | **14** | **140** | **12** | **264** |
| Of which:<br>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.

Our Trust values remain as:


Staff Values and leadership behaviours reflect the team here at University Hospital Bristol and Weston they were developed with our people, by our people in November 2021. 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, 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 organisational and local action plans to improve staff experience at work.

The 2024 National Staff Survey response rate was 54% with over 7200 staff taking time to provide feedback on their experience at work.

Staff engagement is a key measure of how colleagues experience at work in the organisation, which is determined through nine questions in the national staff survey which measure three engagement themes: Motivation, Involvement, and Advocacy. The Trust engagement remained in a stable position score at 7.1 out of 10, which is above the benchmark group the national acute average.

Colleague feedback in the 2024 staff survey demonstrates that there is a pride in working at the Trust and the care they provide for patients knowing that patients are a top priority for the organisation.

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

- Happy with the standard of care provided by the organisation.
- Colleagues feel safe to speak up about concerns.
- Colleagues fee they do not work any additional hours paid or unpaid.

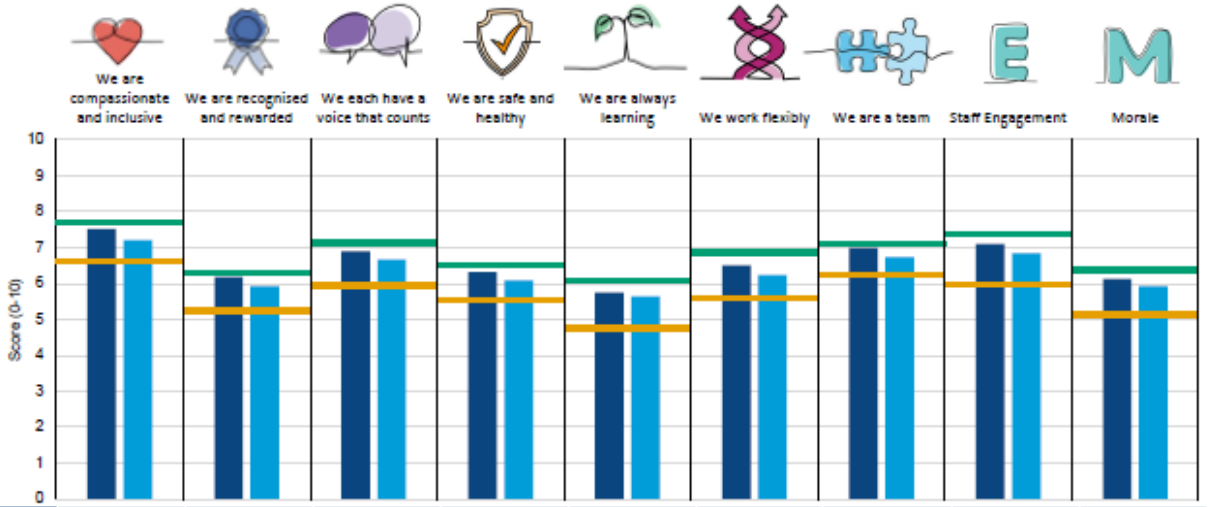
### *4.4.21 Staff Survey Reporting*

The National Staff Survey results are aligned to the NHS People Promise and are benchmarked against NHS Acute and Acute Community Trust. The reporting themes are a combination of the seven elements of the people promise with the addition of Staff Engagement and Morale, making nine themes altogether.

The following table demonstrates the Trust's performance in the line with the benchmarking group and in line with the nine themes. In 2024, the Trust performed above the national average in all the of the nine NHS People Promise Themes.

***Table 47: NHS Staff survey Results 2024***

People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.




| | We are compassionate and inclusive | We are recognised and rewarded | We each have a voice that counts | We are safe and healthy | We are always learning | We work flexibly | We are a team | Staff Engagement | Morale |
|---|---|---|---|---|---|---|---|---|---|
| Your org | 7.52 | 6.19 | 6.90 | 6.32 | 5.75 | 6.50 | 6.99 | 7.10 | 6.13 |
| Best result | 7.69 | 6.30 | 7.14 | 6.53 | 6.09 | 6.86 | 7.12 | 7.39 | 6.38 |
| Average result | 7.21 | 5.92 | 6.67 | 6.09 | 5.64 | 6.24 | 6.74 | 6.84 | 5.93 |
| Worst result | 6.61 | 5.24 | 5.95 | 5.54 | 4.76 | 5.60 | 6.26 | 5.98 | 5.13 |
| Responses | 7241 | 7239 | 7152 | 7169 | 6751 | 7179 | 7222 | 7244 | 7248 |

### *4.4.22 Key areas for improvement*

The Staff Survey data provides the largest feedback from UHBW colleagues on their experience at work, utilising this data to develop local and organisational plans and priorities is the key to engaging, motivating and delivering a workplace where colleagues are proud to work and recommend.

The response to the feedback is shared across the organisation as part of the cascade of the results, as well as in the development of organisational and local Divisional culture and people plans. The priorities are aligned to the People Strategy milestones and People Patient First measures and intentions.

The Trust recognises that it needs to continuously engage and listen to its workforce and seeks to respond to all suggested areas for improvement. Working in partnership with the business to develop robust plans and priorities in response to the staff survey feedback, in line with the People Strategy miles stones and the Divisional culture and people plans will shape improved staff experience and create a workplace where colleagues continue to take pride, feel valued and recommend to others to work and have treatment.

#### *4.4.23 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:

- Completion of Phase 1 of consultation and implementation of the transfer of the Clinical Research Network to the Regional Research Delivery Network in support of the transformation of National Institute of Health Research. Phase 2 commences in 2026.
- Restructure of Unity Sexual Health Services in line with a change to clinical delivery specifications.
- Commencement of consultations for Group Single Managed Services in support of the delivery of the Joint Clinical Strategy.

#### *4.4.24 Staff policies and actions applied during the financial year.*

The UHBW Respecting Everyone Policy was reviewed and changes made to support the sexual safety charter and changing employment law, these changes are detailed in section 4.4.25.

- Work began to align HR policies across the group and therefore changes were made to the Consultation Policy, Redundancy Policy and the Protection of Pay and Conditions of Service Policies.
- A full review of the Uniform and Dress Code Policy took place in support of the roll out of a new national Nursing Uniform.
- A new Pregnancy and Baby Loss Policy was developed and launched in line with changes to legislation relating to baby loss.
- A review of the Social Media Policy took place, the Policy was reallocate to the Communications team as part of the full hearted care rebrand and a SOP for staff use of social media was created and launched.

#### *4.4.25 Tackling Harassment and Bullying*

Building on the launch of our Respecting Everyone early resolution policy; this year we undertook a six-month review of the policy and worked with our stakeholders, People Teams and JUC to add clarification and more resources to support the early resolution of concerns. The feedback received from this review highlighted that the early resolution approach was received positively by both managers and wider colleagues.

The data relating to Respecting Everyone showed a significant decline in formal cases and an increase of some 7% of cases being resolved informally.

In October 2024 we revised the Respecting Everyone to include guidance on Sexual Safety in the workplace and special considerations for formal investigations into incidents of sexual misconduct.

This was launched across the organisation alongside the launch of the NHS Sexual Safety Framework and the change to the Workers Protection Act in October 2024.

In February 2025, we launch UHBW sexual misconduct reporting and as part of the Pro Equity patient first program, made plans to widen this reporting to other areas such as racism, ableism and incidences of bullying and harassment.
Work to continue to provide opportunities to report, resolve and reduce incidences of bullying and harassment continues into 2025/2026 in the form of the Pro Equity Action Plan.

#### *4.4.26 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 whole time equivalent 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 48: Relevant union officials***

| Number of employees who were relevant union officials during 2024/25 | Full-time equivalent employee number |
|---|---|
| 56 | 51 |

***Table 49: Percentage of time spent on facility time.***

| Percentage of time | No of employees |
|---|---|
| 0% | - |
| 1-50% | 53 |
| 51%-99% | - |
| 100% | 3 |

***Table 50: Percentage of pay bill spent on facility time.***

| | |
|---|---|
| The total cost of facility time | £161,817 |
| The total pay bill | £707,399,000 |
| The percentage of the total pay bill spent on facility time | 0.0229% |

***Table 51: Paid trade union activities***

| | |
|---|---|
| Time spent on paid trade union activities as a percentage of total paid facility time hours | 25% |

#### *4.4.27 Freedom to Speak Up (FTSU)*

At UHBW we are 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 so that we can improve services for our patients. We want our staff to feel psychologically safe and empowered to raise concerns and have confidence that those concerns will be addressed.

The Director of Corporate Governance is the Freedom to Speak Up (FTSU) Guardian and is supported by a deputy FTSU Guardian. The service also has a network of approx. 80 volunteer FTSU staff champions, who work in diverse roles and locations across the Trust. FTSU champions help raise awareness of FTSU by being visible and accessible, role-modelling the values and behaviours linked to speaking up, and signposting and supporting individuals who raise concerns.

The National Guardian's Office/Health Education England's 'Speak Up' core training is mandatory for UHBW staff (with compliance at 91.4%) and the 'Listen Up' module is accessible to all.

A revised FTSU strategy was approved by the Board in January 2025. The strategy focuses on three key priorities relating to FTSU, namely: raising awareness; inspiring confidence and removing barriers. The strategy also requires a commitment from the Board to demonstrate leadership and accountability and learning from concerns.

FTSU is just one mechanism to raise concerns in UHBW. In practice, most concerns are raised and resolved through conversations with managers. In 2024/25, 110 concerns were raised with the FTSU Guardian (compared to 95 in the previous financial year). The most frequently raised concerns were around the category of inappropriate attitudes and behaviours (34.5%), followed by worker safety or wellbeing (30%). Three cases were raised anonymously. One case of detriment was reported.

More details about the FTSU programme can be found in the FTSU annual report, which is available on the UHBW website.

***Table 52: Number and themes of concerns raised via the FTSU Guardian in 2024/25 as reported to the National Guardian's Office***

| | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| Number of cases raised with the FTSU Guardian | 23 | 27 | 28 | 32 | 110 |
| Cases relating to quality/patient safety | 1 | 1 | 0 | 5 | |
| Cases relating to bullying or harassment | 1 | 2 | 3 | 0 | |
| Cases relating to worker safety or wellbeing | 5 | 10 | 9 | 9 | |
| Cases relating to inappropriate attitudes or behaviours | 4 | 11 | 6 | 6 | |

## 4.5 Code of governance for NHS provider trusts

University Hospitals Bristol and Weston NHS Foundation Trust has applied the principles of the NHS Code of governance for NHS provider trusts, which was issued on 1 April 2023, on a comply or explain basis. The Board considers that it was fully compliant with the provisions of the Code in 2024/25. 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 15.

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

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

### *4.5.1 Board Performance*

Boards of NHS Foundation Trusts have faced significant challenges, financial and operational, in 2024/25. Good governance is essential if we are to continue providing safe, sustainable and high-quality care for patients.

The Board monitors performance of the organisation against Leadership Priorities set as part of the annual Operating Plan via the Performance Report, which is presented to the Board each month, to ensure that these priorities are being delivered. This assessment is considered alongside the strategic and operational risks to the Trust, to ensure a comprehensive overview is considered by the Board, in addition the Board considers performance against the NHS England 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 Integrated Quality and Performance Report.

The Trust has a policy for Fit and Proper Persons and as part of this policy, 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.

During the year, the Board has undertaken a range of development activities. This has been supported by a Board Development Partner and with individuals with specific expertise to assist the Board in changing how it operates and to help shape the strategy and culture of the Trust.

#### *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.

#### *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 constituency. 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.

#### *4.5.4 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, Digital and Estates Committee and the People Committee. The role, functions and summary activities of the Board's committees are described below.

The Board of Directors discharged its duties during 2024/25 in 7 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.

***Table 53: Board and Sub-Committee Attendance 2024/25***

| | Board of Directors | Remuneration & Nomination & Appointments Committee | Audit Committee | Quality & Outcomes Committee | People Committee | Finance, Digital & Estates Committee |
|---|---|---|---|---|---|---|
| No. of meetings | 13 | 9 | 5 | 10 | 6 | 8 |
| **Chair** | | | | | | |
| Jayne Mee | 0 (C) | 1 (C) | (0) | (1) | (0) | (1) |
| **Group Chair** | | | | | | |
| Ingrid Barker | 9 (C) | 8 (C) | (1) | (0) | (0) | (0) |
| **Interim Chief Executive / Hospital Managing Director** | | | | | | |
| Stuart Walker | 13 | (2) | (4) | (4) | (4) | (4) |
| **Group Chief Executive** | | | | | | |
| Maria Kane | 7 | (5) | (0) | (0) | (0) | (1) |
| **Non-executive Directors** | | | | | | |
| Arabel Bailey | 11 | 8 | (1) | (0) | 4 | 6 |
| Sue Balcombe | 12 | 5 | 3 | 10 (C) | (0) | (0) |
| Rosie Benneyworth | 10 | 2 | (2) | 9 | 5 | (0) |
| Bernard Galton | 1 | 2 | 2 | (0) | 1 (C) | (0) |
| Marc Griffiths | 13 | 5 | (0) | 8 | 4 | (0) |
| Emma Glynn | 2 | 0 | (0) | (0) | (0) | 1 |
| Susan Hamilton | 9 | 3 | (0) | 8 | (0) | (0) |
| Linda Kennedy | 10 | 8 | 4 | (0) | 4 (C) | (0) |
| Jane Norman | 0 | 0 | 1 (C) | (0) | (0) | 3 |
| Martin Sykes | 13 | 9 | 4 | (0) | 0 | 7 (C) |
| Roy Shubhabrata | 13 | 6 | (0) | (0) | (4) | 5 |
| Anne Tutt | 9 | 5 | 4 (C) | (0) | (0) | 6 |
| **Executive Directors** | | | | | | |
| Paula Clarke | 13 | (0) | (0) | (6) | 4 | (0) |
| Neil Darvill | 13 | (0) | (0) | (0) | (0) | 5 |
| Jane Farrell | 11 | (0) | (0) | 7 | (0) | 3 |
| Deirdre Fowler | 9 | (0) | (1) | 8 | (3) | (0) |
| Neil Kemsley | 13 | (0) | (5) | (0) | 0 | 8 |
| Rebecca Maxwell | 13 | (0) | (0) | 10 | 4 | (0) |
| Emma Wood | 13 | (3) | (0) | (0) | 4 | (0) |

### *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 Chief People Officer 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 five occasions during the year with the Chief Executive, Chief Financial Officer, 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 2024/25, 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 KPMG LLP (KPMG). 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. KPMG 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, KPMG 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 KPMG, the Audit Committee accepts these as reasonable assurances of continued independence and objectivity in the audit services provided by KPMG 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, including the Annual 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, counter fraud arrangements, information governance arrangements and the management of procedural documents within the Trust.

#### *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 or as necessary.

The Audit Committee regularly undertakes an evaluation of the Trust's Board Assurance Framework, paying particular attention to the stated objectives detailed in 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. The committee also reviewed the Head of Internal Audit's Opinion and the External Auditor's year-end report for 2023/24.

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:

- Encouraging improvements to the management of policies, procedures and Standard Operating Procedures.
- Reviewed the Trust's Information Governance arrangements (including the Data Security and Protection Toolkit) on a regular basis.
- Rigorously followed up outstanding recommendations arising from internal audit reports and held detailed discussions on internal audit reports which had a limited or no assurance rating.

In summary, the Audit Committee has encouraged 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's membership includes three Non-executive Directors, one of whom is the Chair, the Chief Nurse and Midwife, Chief Medical Officer, and Chief Operating Officer. 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 10 occasions and considered a set of standard reports as follows:

- The integrated quality and performance report.
- The strategic and corporate risk registers.
- The clinical quality group meeting report (including clinical audit).
- Complaints and patient experience reports.
- Maternity update reports, including the Maternity Perinatal Quality Surveillance Matrix.
- Serious Incident Reports and Never Events.

Ad hoc reports and deep dives were also requested and received on particular areas of concern to the Committee.

#### *4.5.9 Finance, Digital & Estates Committee*

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

The Committee's membership includes three Non-executive Directors, and the Chief Financial Officer, Chief Executive, Joint Chief Digital Information Officer and Chief Operating Officer. The Committee is also supported by the Director of Corporate Governance or Head of Corporate Governance in an advisory role.

The Finance and Digital Committee met on 8 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 Committee's membership includes three Non-executive Directors, and the Chief People Officer, Chief Financial Officer, Chief Medical Officer, Chef Nurse and Midwife, Executive Managing Director of Weston General Hospital.

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***

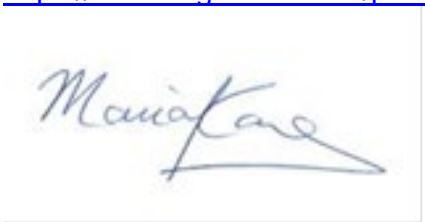
NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities).

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions. The Trust is currently placed in segment 3. This segmentation information is the trust's position as of 8th May 2025. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-oversight-framework-segmentation/



**Maria Kane**
**Group Chief Executive**
**Date: 16 June 2025**

## 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 England.

NHS England, 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 England, 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.

**Maria Kane**
**Group Chief Executive**
**Date 16 June 2025**

## 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 2025 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 and the Department of Health and Social Care in respect of governance.

The Trust's Executive Committee 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.

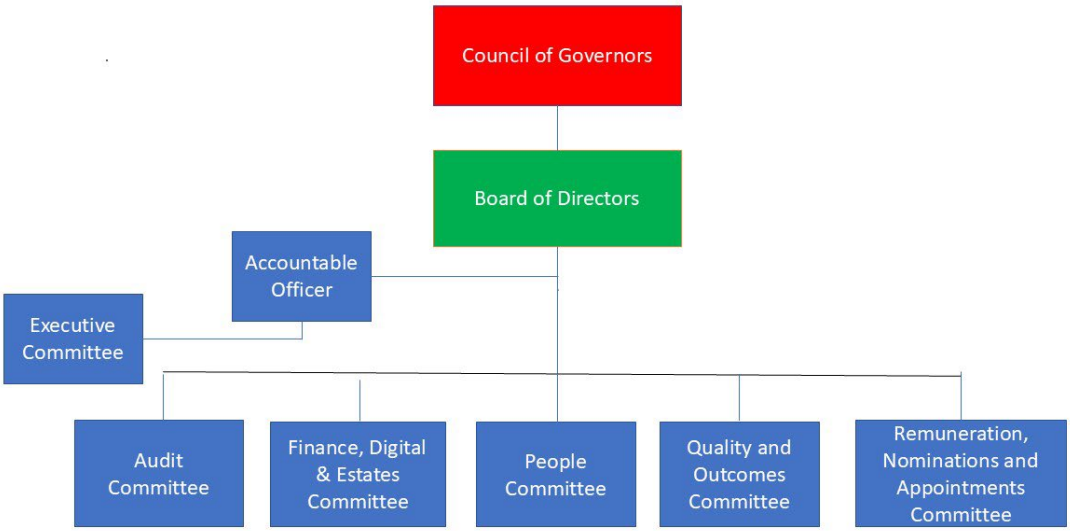
Day to day management of risks is undertaken by operational management, who are charged with ensuring risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where problems are identified. There is a process of escalation to executive directors, 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, Digital & Estates 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.

The Board committee structure is below:




As part of the work towards forming a group with North Bristol NHS Trust (NBT), the Remuneration, Nominations and Appointments Committee has been meeting in common with its equivalent committee at NBT and following the approval of the formation of the Bristol NHS Group in April 2025 this will be expanded to the other committees in the early part of 2025/26.

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.

In 2023/24 DCO Partners undertook an external review against the Well-Led Framework, which included a comprehensive document review, observation of several Board and Committee meetings, interviews with Board members and senior managers, and engagement with key clinical and non-clinical staff within the Trust. The review was generally positive but did make a number of recommendations on where improvements could be made. The Board, in considering the report, agreed to focus on a small number of priority areas which were incorporated into an action plan, which was completed during 2024/25.

The CQC, in its inspection report of 2022 into University Hospitals Bristol & Weston NHS Foundation Trust, gave it a rating of Good for the Well-led domain which recognised this domain was performing well and meeting the CQC's expectations.

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. 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.

***4.7.4 The risk and control framework***

Our Trust's risk management policy remains the foundation of our approach to risk governance, outlining the structures, responsibilities, and processes that support effective risk management. This

policy is subject to continuous improvement, with a comprehensive review conducted at least once every three years to ensure it remains aligned with best practices and organisational needs.

In 2024/25, we fully transitioned to a principal risk framework, structured around principal risk categories: Patient Safety & Quality, Workforce, Capacity & Performance, Estate Infrastructure, Financial, Digital & Cybersecurity, Change Management, Emergency Planning, and Fire Safety. This shift enhances clarity, aligns risk reporting with strategic objectives, and strengthens Board oversight of key threats to the organisation.

Our risk appetite statement and thresholds for acceptable risk levels are reviewed annually and ratified by the Trust Board of Directors. In 2024, the Board conducted a dedicated session to refine risk appetite integration within decision-making, ensuring our approach remains proportionate and aligned with our strategic ambitions.

We continue to adopt an enterprise-wide risk management approach, systematically identifying, evaluating, and controlling risks across clinical, operational, regulatory, and financial domains. Risk registers are maintained at the departmental, divisional, and corporate levels, ensuring appropriate escalation of risks with broader organisational impact. Divisional risk management teams review risks monthly, with significant risks escalated to executive leadership and Board committees for oversight.

Risk identification remains a multi-source process, incorporating:

- Regulatory inspections and external guidance (e.g., Care Quality Commission, NHS England)
- Internal audits, risk assessments, complaints, and incident reporting
- Staff-reported risks and concerns, ensuring operational teams remain empowered to escalate risks promptly

The Audit Committee continues to provide independent assurance over the effectiveness of risk management, working closely with internal and external auditors to assess control measures and address any system weaknesses.

The Trust maintains compliance with Care Quality Commission registration requirements and maintains a ‘Good’ rating. We have also ensured compliance with Managing Conflicts of Interest in the NHS guidance, maintaining an up-to-date register of interests, gifts, and hospitality for decision-making staff, published on our website.

As part of our commitment to financial governance, robust controls remain in place to ensure compliance with NHS Pension Scheme obligations, including accurate contributions and timely record updates. We also continue to meet our legal obligations under equality, diversity, and human rights legislation.

In response to the climate change agenda, the Trust has updated its Green Plan in line with the Greener NHS programme, ensuring compliance with the Climate Change Act and Adaptation Reporting requirements.

Over the past year, fire safety risk management has remained a priority, with Fire Risk Assessments and Fire Strategies undertaken across all Trust sites. Additional focus has been placed on estates-wide fire safety governance, driven by previous concerns identified in the Neonatal Intensive Care Unit (NICU) at St Michael’s Hospital.

By embedding these strengthened governance arrangements, we continue to evolve our risk management approach, ensuring we remain responsive to emerging challenges while maintaining high standards of patient care, operational resilience, and regulatory compliance.

### *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 delivers the highest quality standards. The Board and Senior Leadership Team of the Trust have a critical role in leading a culture which promotes excellence. This requires both vision and action to ensure all efforts are focused on creating an environment for positive change. We have much to be proud of. Our continuous improvement programmes continue to show us what is possible when we have a relentless focus on quality improvement.

Throughout 2024/25 we have continued to work towards achieving the quality priorities set out in our annual Quality Account and brought to life through Patient First.

Our vision for quality expressed through Patient First is:

- To deliver person-centred, compassionate and inclusive care every time, for everyone.
- To consistently deliver the highest quality, safe and effective care to all our patients
- To provide timely access to care for all patients, meeting their individual needs.

For more information about the Trust's quality objectives, please refer to our annual Quality Account.

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 and Equality Impact Assessment process involves a structured risk assessment using a standardised framework. The Chief Medical Officer and Chief Nurse and Midwife 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's comprehensive programme of clinical audit effectively also supports improving clinical quality in alignment with the Trust's quality priorities.

The Trust has a robust quality governance reporting structure in place through its Clinical Quality Group and Quality and Outcomes Committee, both of whom monitor performance against a range of quality standards. The Trust currently has an overall rating of 'Good' with the Care Quality Commission. Our internal business planning and associated monitoring processes underpin the triangulation of our quality, workforce and finance objectives.

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.

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 Equality and Quality Impact Assessment process involves a structured risk assessment using a standardised framework. The Chief Medical Officer and Chief Nurse and Midwife 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's comprehensive programme of clinical audit effectively also supports improving clinical quality in alignment with the Trust's quality objectives.

The Trust has a robust quality governance reporting structure in place through its Clinical Quality Group and Quality and Outcomes Committee, both of whom monitor performance against a range of quality standards. The Trust currently has an overall rating of 'Good' with the Care Quality Commission. Our internal business planning and associated monitoring processes underpin the triangulation of our quality, workforce and finance objectives. Our Operating Plans are developed through our divisions, with regular reviews conducted with the Executive team.

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.

#### *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, Digital & Estates, 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*

The Trust's Information governance processes serve as the framework for safeguarding information with utmost security and confidentiality. Encompassing the collection, storage, and sharing of data, it ensures that personal and sensitive information is handled legally, securely, and efficiently, ultimately aiming to deliver optimal care and service.

At the forefront of our information governance efforts is the Information Risk Management Group (IRMG), led by the Trust's Chief Data & Analytics Officer, who acts as the Trust's Data Protection Officer, under the delegated authority of the Chief Digital Information Officer, who acts as the Senior Information Risk Owner.

Our control and assurance mechanisms for information governance encompass several key elements:

- Designated Information Asset Owners and Information Asset Administrators responsible for maintaining systems containing patient and staff personal data.
- A trained Caldicott Guardian, Senior Information Risk Owner, and Data Protection Officer to uphold stringent standards of data protection.
- Implementation of a robust risk management and incident reporting process to swiftly address any breaches or incidents.
- Continuous staff training programs to ensure awareness and adherence to information governance protocols.
- Maintenance of an information governance risk register to systematically monitor and mitigate risks.
- Regular reviews to assess compliance with the Data Security and Protection Toolkit criteria.
- Internal audit reviews to validate the evidence provided for compliance with toolkit requirements.

In the financial year 2024/25, one case recorded in the Information Governance Incident Reporting Tool were promptly reported to the Information Commissioner's Office. Detailed information regarding these cases is provided in the subsequent table for full transparency and accountability.

***Table 54: Incidents reported to the Information Commissioner's Office 2024/25***

| Date of Incident | Incident description | Number affected | How individuals were informed | Lessons Learned |
|---|---|---|---|---|
| 28/06/24 | UHBW received notification from a 3rd party provider that their systems had been breached in cyberattack.<br><br>UHBW send a small number of samples to this provider but cannot confirm if our patients were affected by the breach.<br><br>Whilst the investigation by the provider is ongoing, UHBW reported the incident to the Information Commissioner's Office to comply with our GDPR responsibilities. | Unconfirmed | Awaiting confirmation of if UHBW patients were affected from 3rd party provider | Maintain ongoing work to risk assess supply chains and ensure appropriate technical and contractual measures are in place. |

#### *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 'Performance' page. This data is reviewed by the various leads; exception reports and commentaries are compiled, collated and signed off by relevant Exec lead 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. NHS England's Elective Care Intensive Support Team (ECIST) have reviewed our processes and are satisfied with our approach to reporting waiting times.

#### *4.7.9 Significant Internal Control Issues*

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

#### *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, Digital & Estates Committee, People 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 Board Assurance Framework (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 2024/25 Annual Governance Statement. Their opinion supported that overall, there is an effective system of internal control to manage the principal risks identified by the organisation.

The Board reviews risks to the delivery of the Trust's performance objectives through bi-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 2024/25 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.

***4.7.11 Conclusion***

The Board is committed to continuous improvement of its governance arrangements to ensure that systems are in place which ensure risks are correctly identified and managed and that serious incidents and incidents of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action, so that the patients, service users, staff and stakeholders of University Hospitals Bristol 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.

**Maria Kane**
**Group Chief Executive**

## Appendix A – Biographies of Members of the Board of Directors

### Maria Kane – Group Chief Executive

Maria Kane OBE was appointed as Group Chief Executive of North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust in July 2024. Prior to this she was Chief Executive of NBT from April 2021.

Maria previously worked as Chief Executive of North Middlesex University Hospital NHS Trust from 2017 until 2021, as Chief Executive of Barnet, Enfield and Haringey Mental Health NHS Trust between 2007 and 2017, and as Executive Director at North West London Strategic Health Authority between 2002 and 2006. Maria has held a variety of senior roles in corporate and strategic development for the Royal College of Midwives, Medical Protection Society and the National Council of Voluntary Organisations.

In 2019, Maria was made an OBE for services to health care leadership over two decades, particularly in North London.

Maria is Chair of Bristol Health Partners, a member of the Bristol, North Somerset and South Gloucestershire Integrated Care Board, and sits on the board of Health Innovation West of England. She is also the South West representative for the NHS Genomics Board, and is the representative for the South West on the NHS Impact National Improvement Board.
Maria has previously been a trustee of Open Door, Umbrella Mental Health, and Young Minds, as well as an adviser to the Lullaby Trust and a special adviser to the Care Quality Commission. She was also chair of governors of a primary school for ten years.

### Professor Stuart Walker – Interim Chief Executive / Hospital Managing Director

Professor Stuart Walker is an experienced NHS Executive Medical Director and previous Deputy Chief Executive Officer. He has a background in a broad range of senior leadership positions and, as a prior Cardiologist of 18 years standing, significant senior clinical experience. Before coming to UHBW in Feb 2022 he worked at Cardiff and Vale University Health Board as MD, Deputy CEO and then Interim CEO. He has also held prior Executive, and senior leadership, roles in the English NHS for example as MD at Taunton and Somerset NHS FT, and Chief Medical Officer at TSFT and Somerset Partnership FT. He was awarded the title of Honorary Professor by Cardiff University in 2021.

Professor Walker joined the Trust as Chief Medical Officer in February 2022 before being appointed as Interim Chief Executive on 1 January 2024 following the departure of the previous Chief Executive. He was appointed as Hospital Managing Director on 2 September 2024.

### Paula Clarke – Executive Managing Director, Weston General Hospital

Paula is an experienced Executive who has held senior manager and Executive roles in commissioning, provider and primary care organisations over the last 30 years. She worked for 23 years in the integrated health and social care system in Northern Ireland bringing this experience of multidisciplinary and collaborative delivery into UHBW and the ICS. Paula has 14 years Board level experience, including serving as the interim chief executive of Southern Health and Social Care Trust in 2015/16. Over the pandemic, Paula was national lead for establishing large-scale mass vaccination centres and also led on delivery of the Bristol Nightingale Hospital. Paula has extensive experience in integrated care operational delivery, strategic planning, continuous improvement, partnership working and service transformation programmes. Paula joined the Trust on 1 April 2016.

**Neil Darvill – Joint Chief Digital Information Officer**

Neil has Board level responsibility for Digital Information at both University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust. Neil has over 30 years of experience working in healthcare environments. Neil is responsible for setting and driving forward the IM&T Strategy at both Trusts and developing key partnerships with suppliers and customers alike to ensure targets and expectations are met, year on year. Neil joined the Trust on 1 June 2023.

**Jane Farrell – Chief Operating Officer**

Jane has experience of working in and across large complex organisations and systems, including 19 years as an executive director. Her previous roles have included Executive Managing Director, Deputy Chief Executive, Director of Transformation and Chief Operating Officer across NHS organisations including Kings College Hospitals, Mid & South Essex FT, and Western Sussex Hospitals. Jane is a dual registered nurse, specialising in paediatric critical care. Jane joined UHBW on 31 October 2022 as Interim Chief Operating Officer and was appointed on a permanent basis from 1st April 2023.

**Professor Deirdre Fowler – Chief Nurse and Midwife**

Deirdre is an experienced executive 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 also has a role as visiting professor at the University of the West England.

**Neil Kemsley – Chief Financial Officer**

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. He spent three-and-a-half years at University Hospitals Plymouth NHS Trust before returning to Bristol in 2019.

**Dr Rebecca Maxwell – Interim Chief Medical Officer**

Dr Rebecca (Becky) Maxwell was appointed to the role of Interim Chief Medical Officer from 1 January 2024. Dr Maxwell has significant clinical experience working as an Emergency Department Consultant, Clinical Chair and as Deputy Medical Director in the Chief Medical Officer team.

**Emma Wood – Chief People Officer & Deputy Hospital Managing Director**

Emma is an experienced executive whose specialisms include employee relations and engagement, inclusion, organisational design and development, resourcing and talent development. With a strong track record across both private and public sector, Emma previously worked at South Western Ambulance Service NHS Foundation Trust as well as Avon and Somerset Constabulary. Emma holds a BA in Psychology and Education and an MSC in Integrated Professional Practice from UWE. She is a Chartered Fellow of the Chartered Institute of Personnel and Development and an Executive Coach. Emma started in the Trust on 4 January 2022.

**Jayne Mee - Chair**

Jayne was appointed as a Non-Executive Director in June 2019 before taking on the role of Interim Chair in April 2021. She was appointed into the substantive role of Trust Chair on 9 December 2021. Jayne’s term of office came to an end on 30 April 2024.

**Ingrid Barker – Group Chair**

A qualified social worker, Ingrid has over 25 years of NHS board level experience. This has included roles as Chair at Gloucestershire Health and Care NHS Foundation Trust, Joint Chair of Gloucestershire Care Services NHS Trust and ²gether NHS Foundation Trust and as a Non-Executive Director of NHS Gloucestershire Primary Care Trust. She is also an active Governor at the University of Gloucestershire.

Ingrid's drive and commitment to the provision of high-quality services, accessible to all, is evidenced in her national policy and service redevelopment roles, notably leading on the transformation of mental health services community provision. She was also a Trustee and Board member of NHS Providers between 2013 and 2021, elected to represent Community Trusts across England.

Ingrid was appointed as Group Chair of University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust on 1 June 2024.

**Arabel Bailey – Non-executive Director**

Arabel brings 30 years' experience of technology-driven transformation in the private sector, across a wide range of industries. She is an experienced business leader and has held numerous senior executive positions in the areas of Technology, Digital Transformation and Innovation. She is also a Non-executive Director at the Department for Work and Pensions working as part of their Transformation Advisory Committee. She provides expertise and insight around modernising and transforming the Department's citizen services. Arabel has long been a champion for Diversity and Inclusion, and for the need to bring a better gender balance to the Technology industry. She is recognised as a role model in this area and has received industry recognition for her leadership roles.

Arabel was appointed as an Associate Non-executive Director of the Trust on 1 July 2022 and was appointed as a Non-executive Director on 1 July 2023.

**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.

Sue is the chair of the Quality and Outcomes Committee and the Trust's Senior Independent Director.

**Dr Rosie Benneyworth – Non-executive Director**

Rosie is the Chief Executive Officer of the Health Services Safety Investigations Body (HSSIB). Rosie was a GP and clinical commissioner in Somerset for many years, and prior to her role with HSSIB, she was Chief Inspector for Primary and Integrated Care and the

CQC. Rosie also spent two years as Managing Director of Southwest Academic Health Science Network during which time she led the national patient safety collaboratives. She was a Non-Executive Director and Vice Chair of the National Institute of Health and Care Excellence and is also a Trustee of the National Children's Orchestras of Great Britain.

Rosie was appointed as a Non-executive Director on 1 July 2023.

**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. 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.

Bernard was chair of the People Committee until his term of office as a Non-executive Director on 30 June 2024.

**Professor Marc Griffiths – Non-executive Director**

Marc is the Pro Vice-Chancellor and Executive Dean of the Faculty of Health and Applied Sciences at the University of the West of England, Bristol. He has responsibility for approximately 10,500 students across Health and Social Care, Applied Sciences and Social Sciences at all levels of education from foundation degree through to doctoral level. He also has overall responsibility for circa 450 staff and work with a number of external partners across the city and region of Bristol and beyond.

Marc's research and knowledge exchange areas include exploring the development of hybrid practitioners within healthcare and education, Leadership redesign for Allied Health Professions, EDI work and service provision mapping.

Marc was appointed as a Non-executive Director of the Trust on 1 July 2022.

**Linda Kennedy – Non-executive Director**

Linda has over 40 years of HR experience, working internationally across various geographies and covering many sectors, such as oil and gas, mining, support services, advertising, distribution, telecommunications and manufacturing. During her executive career, she has operated in both public PLC and PE backed organisations, having successfully led business change programmes delivering growth and improving performance. Roles of note include VP People and Chief Change Officer for EE during the merger of Orange and T Mobile, delivering transformation when Group HR Director of SIG plc, a FTSE 250 business for 5 years and laterally driving value as Chief HR Officer of kp films, a large PE backed manufacturing business. She is also a qualified coach and a Fellow of the CIPD.

From a non-executive perspective, Linda was a Member of Sheffield Hallam University Business School Advisory Board from 2015 to 2020 and is currently a Non-executive Director/Trustee of NEBOSH (the National Examination Board in Occupational Safety and Health).

Linda was appointed as a Non-executive Director of the Trust on 1 June 2024 and is the chair of the People Committee.

**Professor Jane Norman – Non-executive Director**

Professor Jane Norman became Deputy Vice Chancellor and Provost at the University of Nottingham in December 2022, and prior to this was the Dean of the Faculty of Health Sciences at the University of Bristol. She was the academic lead for diversity and inclusion at the University of Edinburgh and in addition, she was a Non-Executive Director of the Equality Challenge Unit from 2014 until it was absorbed into Advance, HE in 2018. She has held executive roles in many other organisations, including the Academy of Medical Sciences and (currently) the Medical Schools Council.

Jane was appointed as a Non-executive Director of the Trust on 1 March 2021 and her term of office came to end on 30 April 2024. Jane was the chair of the Audit Committee.

**Roy Shubhabrata – Non-executive Director**

Roy has spent the last two decades focused on digital transformation in healthcare across Europe, North America, Asia and Australia. His interest lies is in the collaboration of government, academia, charities and providers in the adoption of innovative technologies in health and care settings.

Roy is the Chief Executive of Healthinnova, an international health technology solutions company based in Bath. He is a Trustee of Age UK, the country's leading charity focused on older people, as well as HelpAge International UK, which focuses on ageing issues in low and middle-income countries.

Roy was appointed as a Non-executive Director of the Trust on 1 July 2022.

**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.

**Anne Tutt – Non-executive Director**

Anne is a qualified Chartered Accountant (FCA) with more than 30 years' experience at Board level. In her early career she held commercial finance director roles. Anne's non-executive experience includes board roles for the Social Investment Business Foundation Group, DEFRA's Animal and Plant Health Agency and Her Majesty's Passport Office where she was also Chair of Audit Committee and DFID. Between 2009 and November 2023, Anne was Non-executive Director of Oxford University Hospitals NHS Foundation Trust, where she was also over time Vice Chair, Senior Independent Director, Chair of Audit and Risk Committee and Chair of Investment Committee.

Anne is currently a Trustee and Chair of the Finance Committee of Pancreatic Cancer UK, Trustee and Chair of Audit and Risk Committee at Action Aid UK, and Treasurer and Chair of the Finance and Strategy Committee of Swansea University, a Trustee and Chair of the Finance & Risk Committee at Katharine House Hospice Trust, a Trustee and Chair of the Audit Committee at Oxford Hospitals Charity and a Trustee of the Education Development Trust.

Anne was appointed as a Non-executive Director of the Trust on 1 June 2024 and is the chair of the Audit Committee.

**Emma Glynn - Associate Non-executive Director**

Emma is a Senior Director and Head of Healthcare Advisory at JLL UK, a professional services firm specialising in real estate and investment management. She is a Non-Executive Director at not-for-profit care provider Somerset Care. Emma joined King Sturge in 2002 as a Graduate Trainee, progressing to a Senior Associate and joining the Healthcare Division on its formation in 2006. King Sturge merged with JLL in 2011, and Emma was appointed Director two years later. Emma is a Member of the Royal Institution of Chartered Surveyors and a Registered Valuer.

Emma was appointed as an Associate Non-executive Director of the Trust on 1 July 2023 and her term of office came to an end on 30 June 2024.

**Susan Hamilton - Associate Non-executive Director**

Susan has spent over 20 years in public health in the NHS, local government and charity sector and is currently Chief Executive of St Peter's Hospice. Prior to this she was Director of Public Health for North Northamptonshire Council. She is also a Board member and Vice Chair of the social housing and support provider Taff Housing. Susan spent her earlier career in public health and management research roles at the University of Bristol and the University of Birmingham. She then completed NHS speciality training and has held Consultant in Public Health roles in several organisations including NHS North Somerset and South Gloucestershire Council. Susan has also worked in the charity sector in the role of Executive Director for Strategic Development at the Royal Osteoporosis Society. Susan holds a BSc (Hons) in Medical Microbiology, a Master of Public Health and an MBA. She is a Fellow of the Faculty of Public Health and has served on the National Institute for Health Research Public Health Research Prioritisation Committee.

Susan was appointed as an Associate Non-executive Director of the Trust on 1 July 2023.

**Appendix B – Contact Details**

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

Joint Chief Corporate Governance Officer
University Hospitals Bristol and Weston NHS Foundation Trust
Trust Headquarters
Marlborough Street
BRISTOL
BS1 3NU

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

Email: FoundationTrust@uhbw.nhs.uk

## Appendix C – Annual Accounts 2024/25

University Hospitals Bristol and Weston NHS Foundation Trust

# Accounts for the year ended 31 March 2025

**Neil Kemsley**
Chief Financial Officer

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 2025

## FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2025 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 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4)(a) of the National Health Service Act 2006.

Signed

**Maria Kane**
Chief Executive Officer

Date 16 June 2025

## Statement of Comprehensive Income for the year ended 31 March 2025

| | Note | Year Ended 31 March 2025 £000 | Year Ended 31 March 2024 £000 |
|---|---|---|---|
| Operating income from patient care activities | 3.1 | 1,214,380 | 1,115,213 |
| Other operating income | 4.1 | 132,409 | 125,234 |
| Operating expenses | 5.1 | (1,385,891) | (1,262,387) |
| **OPERATING DEFICIT** | | **(39,102)** | **(21,940)** |
| Finance income | 8.1 | 5,587 | 6,839 |
| Finance expenses | 8.2 | (2,694) | (2,750) |
| Public dividend capital dividend expense | | (12,137) | (13,695) |
| **NET FINANCE COSTS** | | **(9,244)** | **(9,606)** |
| Other losses | 7 | (148) | (351) |
| Gains arising from transfer by absorption | | - | - |
| **DEFICIT FOR THE YEAR** | | **(48,494)** | **(31,897)** |
| **OTHER COMPREHENSIVE EXPENDITURE** | | | |
| **Will not be reclassified to income and expenditure** | | | |
| Impairments | 8.3 | (31,763) | (19,511) |
| Revaluations | 10 | - | 2,586 |
| Other reserves movements | | - | (238) |
| **TOTAL COMPREHENSIVE EXPENDITURE FOR THE YEAR** | | **(80,257)** | **(49,060)** |

All revenue and income is derived from continuing operations.

The notes on pages 6-41 form part of these accounts.

## Statement of Financial Position for the year ended 31 March 2025

| | Note | 31 March 2025 £000 | 31 March 2024 £000 |
|---|---|---|---|
| **NON-CURRENT ASSETS** | | | |
| Intangible assets | 9 | 16,322 | 17,997 |
| Property, plant and equipment | 10 | 480,444 | 547,215 |
| Right of use assets | 10.2 | 107,520 | 111,068 |
| Receivables | 12.1 | 1,503 | 1,489 |
| **TOTAL NON-CURRENT ASSETS** | | **605,789** | **677,769** |
| **CURRENT ASSETS** | | | |
| Inventories | 11 | 18,712 | 16,722 |
| Receivables | 12.2 | 53,803 | 64,853 |
| Other financial assets | 13 | 104 | 104 |
| Cash and cash equivalents | 14 | 72,295 | 96,723 |
| **TOTAL CURRENT ASSETS** | | **144,914** | **178,402** |
| **CURRENT LIABILITIES** | | | |
| Trade and other payables | 15 | (130,780) | (150,727) |
| Borrowings | 17.1 | (13,368) | (13,335) |
| Provisions | 18.1 | (364) | (392) |
| Other liabilities | 16 | (10,232) | (9,727) |
| **TOTAL CURRENT LIABILITIES** | | **(154,744)** | **(174,181)** |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | | **595,959** | **681,990** |
| **NON-CURRENT LIABILITIES** | | | |
| Borrowings | 17.1 | (130,588) | (139,109) |
| Provisions | 18.1 | (2,085) | (3,431) |
| **TOTAL NON-CURRENT LIABILITIES** | | **(132,673)** | **(142,540)** |
| **TOTAL ASSETS EMPLOYED** | | **463,286** | **539,450** |
| **EQUITY** | | | |
| Public dividend capital | | 337,558 | 333,465 |
| Revaluation reserve | | 60,645 | 92,408 |
| Other reserves | | 85 | 85 |
| Income and expenditure reserve | | 64,998 | 113,492 |
| **TOTAL EQUITY** | | **463,286** | **539,450** |

The accounts on pages 2 to 41 were approved by the Board on 10 June 2025 and signed on its behalf by:

Maria Kane, Chief Executive Date: 16 June 2025

## Statement of Changes in Equity for the year ended 31 March 2025

| Changes in Equity in the current year | Public Dividend Capital | Revaluation Reserve | Other Reserves | Income & Expenditure Reserve | Total Equity |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Equity at 1 April 2024 | 333,465 | 92,408 | 85 | 113,492 | 539,450 |
| Surplus/(deficit) for the year | - | - | - | (48,494) | (48,494) |
| Net impairments | - | (31,763) | - | - | (31,763) |
| Transfers between reserves | - | - | - | - | - |
| Revaluations – PPE | - | - | - | - | - |
| Transfer to retained earnings on disposal of assets | - | - | - | - | - |
| Other reserve movements | - | - | - | - | - |
| PDC Received | 4,093 | - | - | - | 4,093 |
| PDC Paid | - | - | - | - | - |
| **Equity at 31 March 2025** | **337,558** | **60,645** | **85** | **64,998** | **463,286** |

| Changes in Equity in the prior year | Public Dividend Capital | Revaluation Reserve | Other Reserves | Income & Expenditure Reserve | Total Equity |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Equity at 1 April 2023 | 326,605 | 111,348 | 85 | 143,612 | 581,650 |
| Surplus/(deficit) for the year | - | - | - | (31,897) | (31,897) |
| Net impairments | - | (19,511) | - | - | (19,511) |
| Transfers between reserves | - | (1,992) | - | 1,992 | - |
| Revaluations – PPE | - | 2,586 | - | - | 2,586 |
| Transfers to retained earnings on disposal of assets | - | (23) | - | 23 | - |
| Other reserve movements | - | - | - | (238) | (238) |
| PDC Received | 7,291 | - | - | - | 7,291 |
| PDC Paid | (431) | - | - | - | (431) |
| **Equity at 31 March 2024** | **333,465** | **92,408** | **85** | **113,492** | **539,450** |

**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.

## Statement of Cash Flows for the year ended 31 March 2025

**Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

| | Note | Year Ended 31 March 2025 £000 | Year Ended 31 March 2024 £000 |
|---|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | | |
| Operating surplus from continuing operations | | (39,102) | (21,940) |
| **OPERATING SURPLUS** | | **(39,102)** | **(21,940)** |
| | | | |
| **NON-CASH INCOME AND EXPENDITURE** | | | |
| Amortisation | 9 | 3,306 | 3,696 |
| Depreciation | 10 & 10.2 | 40,500 | 38,491 |
| Net impairments | 8.3 | 47,665 | 30,342 |
| Income recognised in respect of capital donations | | (1,967) | (1,523) |
| (Increase)/decrease in trade and other receivables | 12.1 & 12.2 | 11,578 | (484) |
| (Increase)/decrease in inventories | 11 | (1,990) | (1,694) |
| Increase/(decrease) in trade and other payables | 15 | (21,289) | (11,617) |
| Increase/(decrease) in other liabilities | 16 | 505 | 1,197 |
| Increase/(decrease) in provisions | 18 | (1,374) | (342) |
| Other movements in operating cash flows | | - | (238) |
| **NET CASH GENERATED FROM OPERATIONS** | | **37,832** | **35,888** |
| | | | |
| **CASH FLOWS FROM INVESTING ACTIVITIES** | | | |
| Interest received | | 5,587 | 6,839 |
| Purchase of property, plant and equipment | | (44,611) | (51,286) |
| Purchase of intangible assets | | (845) | (284) |
| Receipt of cash donations to purchase capital assets | | 1,967 | 1,523 |
| **NET CASH USED IN INVESTING ACTIVITIES** | | **(37,902)** | **(43,208)** |
| | | | |
| **CASH FLOWS FROM FINANCING ACTIVITIES** | | | |
| Public dividend capital received | | 4,093 | 7,291 |
| Public dividend capital repaid | | - | (431) |
| Loans repaid to DHSC | 17.4 | (5,834) | (5,834) |
| Capital element of lease liability repayments | 17.4 | (7,181) | (7,284) |
| Other interest | 17.4 | - | (2) |
| Interest paid | 17.4 | (1,369) | (1,559) |
| Interest element of lease liability repayments | 17.4 | (1,388) | (1,241) |
| PDC dividend paid | | (12,679) | (14,932) |
| **NET CASH GENERATED/(USED) IN FINANCING ACTIVITIES** | | **(24,358)** | **(23,992)** |
| | | | |
| **INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS** | | **(24,428)** | **(31,312)** |
| | | | |
| **CASH AND CASH EQUIVALENTS AT START OF YEAR** | 14 | **96,723** | **128,035** |
| | | | |
| **CASH AND CASH EQUIVALENTS AT END OF YEAR** | 14 | **72,295** | **96,723** |

The accompanying notes form part of these financial statements.

## 1. Accounting policies

### 1.1 Basis of preparation

NHS England, in exercising its statutory functions, 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 2024/25 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. These 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.

### 1.2 Going concern

These 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 this will continue to be the case.

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

The timing of satisfaction of performance obligations relates to the typical timing of payment (i.e. credit terms).

***Revenue from NHS contracts***

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as

variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BTP on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular Integrated Care Board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to Integrated Care Boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

***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. Some research income alternatively falls within the provisions of IAS 20 for government grants.

***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 performance obligations are satisfied. In practical terms this means that when treatment has been given, 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 an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

**1.4 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 service income***

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition of the benefit.

## 1.5 Expenditure on employee benefits

***Short-term employee benefits***

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy, are recognised in the period 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.

***Pension costs***

***NHS Pension Scheme***

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded, defined benefit schemes that cover NHS employers, general 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 Trust is taken as equal to the employer's pension contributions payable to that scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. 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.

## 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and are measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

## 1.7 Property, plant and equipment

***Recognition***

Property, Plant and Equipment is capitalised where:

- 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
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, for example, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

***Subsequent expenditure***

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs, and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

***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 are measured subsequently at valuation. Assets that are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or corporate functions) are measured at their current value in existing use. Assets that are surplus with no plan to bring them back into use are measured at fair value, where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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, on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Assets in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Costs include professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery 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*

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

*Revaluation gains and losses*

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged 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.'

*Impairments*

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. 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 recognised in operating expenditure 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. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

*De-recognition*

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged, and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

***Donated and grant funded assets***

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

***Useful lives of property, plant and equipment***

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

| Asset Type | Minimum Life Years | Maximum Life Years |
|---|---|---|
| Buildings excl. dwellings | 8 | 48 |
| Dwellings | 14 | 22 |
| Plant and machinery (incl. medical equipment) | 1 | 31 |
| Transport equipment | 1 | 5 |
| Information technology | 1 | 11 |
| Furniture and fittings | 1 | 10 |

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

## 1.8 Intangible assets

***Recognition***

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only 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.

***Internally generated intangible assets***

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

***Software***

Software, which is integral to the operation of hardware, for example, 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, for example,

application software, is capitalised as an intangible asset where it meets recognition criteria.

***Measurement***

Intangible assets 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. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

*Amortisation*

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

*Useful lives of intangible assets*

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

| Asset Type | Minimum Life Years | Maximum Life Years |
|---|---|---|
| Software (purchased) | 1 | 10 |

## 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. Between 2020/21 and 2023/24 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. Distribution of inventories by the Department ceased in March 2024.

## 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

## 1.11 Financial assets and financial liabilities

***Recognition***

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

***Classification and measurement***

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is 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 or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing

arrangements 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 and financial liabilities 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 (for financial assets). The effective interest rate is the rate that discounts estimated future cash payments or receipts through the expected 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 as 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 including lease receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses at an amount equal to lifetime expected 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.

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.

***De-recognition***

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

## 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

***The Trust as lessee***

*Initial recognition and measurement*

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It

also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

*Subsequent measurement*

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

***The Trust as lessor***

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

*Finance leases*

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

*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.

## 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

| Expected cash outflows | Years | HMT nominal rate | |
|---|---|---|---|
| | | 2024/25 | 2023/24 |
| Short-term | Up to 5 | 4.03% | 4.26% |
| Medium-term | > 5 to 10 | 4.07% | 4.03% |
| Long-term | > 10 to 40 | 4.81% | 4.72% |
| Very long-term | >40 | 4.55% | 4.40% |

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

| Year | HMT inflation rate | |
|---|---|---|
| | 2024/25 | 2023/24 |
| Year 1 | 2.60% | 3.60% |
| Year 2 | 2.30% | 1.80% |
| Into perpetuity | 2.00% | 2.00% |

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.40% in real terms (prior year: 2.45%).

***Clinical negligence costs***

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution and in return all clinical negligence claims are settled. Although 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 NHS Resolution on behalf of the Trust is disclosed at note 18.2 but is not recognised in the Trust's accounts.

***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 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.

## 1.14 Contingencies

Contingent assets (that is, assets arising 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 would be disclosed in note 20 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but disclosed in note 20, 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.

## 1.15 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. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to and require repayments of PDC from the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as PDC dividend. The charge is calculated at the rate set by 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 the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the 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 (as the issuer of PDC), 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 calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

## 1.16 Value added tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. 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.

**1.17 Corporation tax**

The Trust has assessed that it has no liabilities (£nil prior year) for corporation tax under the activities for which tax may be payable as described below:

- if activity is not related to the provision of core healthcare as defined under the HSCA. (Private healthcare falls under this legislation and is therefore not taxable).
- If activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax; and
- If activity has annual profits of over £50,000.

**1.18 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.

**1.19 Foreign exchange**

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

The Trust has no assets or liabilities denominated in a foreign currency at the Statement of Financial Position date, nor any exchange gains or losses on monetary items.

**1.20 Third party assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in note 23 to the accounts in accordance with the requirements of HM Treasury's FReM.

**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 managed. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note 24 is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

**1.22 Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

**1.23 Transfers of functions to/from other NHS bodies**

For functions that have been transferred to the Trust from another NHS government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value 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.

For functions that the Trust has transferred to another NHS government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets / liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

## 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been subject to early adoption in 2024/25.

## 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

No new accounting standards, amendments or interpretations have been issued but not yet effective or adopted in 2024/25.

***Other standards, amendments and interpretations***

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 2024/25.

| Standards and Interpretations | Financial year for which the change first applies |
|---|---|
| IFRS 17 *Insurance Contracts* | Application required for accounting periods beginning on or after 1 January 2023. IFRS17 has been adopted by the FReM from 01 April 2025. Adoption of the standard for NHS contracts will therefore be in 2025/26. The standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements. |
| IFRS 18 *Presentation and Disclosure in Financial Statements* | Effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed. |
| IFRS 19 *Subsidiaries without Public Accountability: Disclosures* - | Effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed. |

***Changes to non-investment asset valuation***

Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5-year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £369,254m as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £366,366m at 31 March 2025. The revised valuation assumption may have a material or significant impact on PPE measurement in future periods.

## 1.26 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.

The Trust has made no judgements in applying the accounting policies other than those involving accounting estimates.

**1.27 Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

***a) Depreciation***

Depreciation is based on automatic calculations within the Trust's Fixed Asset Register and is calculated on a monthly basis throughout the year. When an asset is added to the Fixed Asset Register, it is given a useful economic life by the capital accountant, depending on the class of asset (i.e. vehicle, IT equipment etc.). Buildings can be assigned a useful economic life of up to 50 years by the Trust's approved 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 Trust's approved Valuer This estimate will consider past experience. Typically, more expensive items have a longer lifespan which reduces the degree of sensitivity of charges.

The value of depreciation in the accounts is identified in note 10.

***b) Revaluation***

The Trust's assets are subject to a 5-year cycle of 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.

Specialised assets and attached land are valued on a depreciated replacement cost basis using hypothetical modern equivalent assets (MEA). An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

The value of revaluations in the accounts is identified in note 10.

***c) Impairment***

Impairments are based on the Trust's approved Valuer's revaluation 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.

The value of impairments in the accounts is identified in note 8.3.

## 2 Segmental analysis

The Trust's healthcare segment delivers a range of healthcare services, predominantly to Integrated Care Boards and NHS England. The Trust is operationally managed through five clinical divisions, two support divisions and one business unit, 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-contract income is reported against the operational areas for management information purposes. The outturn position reported for 2024/25 is shown below with comparator figures for 2023/24.

| | Year Ended 31 March 2025 £000 | Year Ended 31 March 2024 £000 |
|---|---|---|
| Corporate income | 1,192,773 | 1,102,605 |
| Corporate expenditure* | (18,456) | (19,256) |
| Divisions/functions net expenditure** | | |
| Division of Diagnostic and Therapies | (109,931) | (99,420) |
| Division of Medicine | (161,970) | (154,266) |
| Division of Specialised Services | (194,312) | (179,823) |
| Division of Surgery | (214,494) | (194,745) |
| Division of Women's and Children's | (245,276) | (220,591) |
| Weston General Hospital | (58,795) | (56,372) |
| Facilities and Estates | (59,698) | (57,005) |
| Trust Services | (79,588) | (72,239) |
| Total division/function net expenditure | (1,124,064) | (1,034,461) |
| **Earnings before Interest, Tax, Depreciation & Amortisation** | **50,253** | **48,888** |
| Financing costs | (50,210) | (48,847) |
| **Net surplus before technical adjustments reported to NHSE** | **43** | **41** |
| | | |
| Technical accounting adjustments | | |
| Donations & Grants (PPE/Intangible Assets) | 1,967 | 1,523 |
| Depreciation & Amortisation - Donated | (2,839) | (2,942) |
| Gains /(Losses) on asset disposals - peppercorn leased | - | (159) |
| Net impact on DHSC donated consumables | - | (18) |
| Impairments | (47,665) | (30,342) |
| Total technical accounting adjustments | (48,537) | (31,938) |
| **Surplus/(Deficit) for the year** | **(48,494)** | **(31,897)** |

* Expenditure is not attributed to a specific division or function.

**There has been an increase in expenditure in all divisions due to the nationally determined pay awards, additional costs related to industrial action and other inflationary pressures.

## 3. Operating income from patient care activities

All income from patient care activities related to contract income recognised in line with accounting policy 1.3.

### 3.1 Income by nature

| | Year ended 31 March 2025 £000 | Year ended 31 March 2024 £000 |
|---|---|---|
| Aligned payment & incentive (API) income - Fixed | 695,518 | 644,884 |
| Aligned payment & incentive (API) income - Variable | 224,261 | 214,472 |
| Other high-cost drug and device income from commissioners | 202,611 | 184,190 |
| Other NHS clinical income (See significant items below) | 12,578 | 9,604 |
| Private patients | 1,454 | 1,502 |
| Pay award central funding | 2,893 | 531 |
| Additional pension contribution central funding | 48,127 | 28,950 |
| Other clinical income (see significant items below) | 26,938 | 31,080 |
| **Total** | **1,214,380** | **1,115,213** |

| | | |
|---|---|---|
| **Aligned payment & incentive (API) income - Fixed - Significant items** | | |
| Industrial Action support payments | 5,302 | 14,729 |
| Pay award additional funding | 26,950 | 21,972 |
| **Other NHS Clinical Income - Significant items include:** | | |
| Cross provider charges under maternity pathways | 1,132 | 1,090 |
| Bone Marrow Transplants and CAR- T Therapy | 4,488 | 4,104 |
| **Other Clinical Income - Significant items include:** | | |
| Genito-urinary medicine (Local Authorities) | 8,447 | 8,498 |
| Injury cost recovery | 1,444 | 1,402 |
| Devolved Administration clinical income | 16,550 | 20,800 |

### 3.2 Income from patient care activities (by source)

| | Year ended 31 March 2025 £000 | Year ended 31 March 2024 £000 |
|---|---|---|
| NHS England | 570,500 | 506,074 |
| Integrated Care Boards | 614,068 | 575,216 |
| NHS Foundation Trusts | 37 | 28 |
| NHS Trusts | 1,383 | 1,312 |
| Local Authorities | 8,447 | 8,498 |
| Non-NHS private patients | 1,454 | 1,502 |
| Non-NHS overseas patients | 438 | 381 |
| NHS Injury Scheme | 1,444 | 1,402 |
| Non-NHS: other | 16,609 | 20,800 |
| **Total** | **1,214,380** | **1,115,213** |

### 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 2025 £000 | Year ended 31 March 2024 £000 |
|---|---|---|
| Income from services designated as commissioner requested services | 1,143,472 | 1,060,732 |
| Income from services not designated as commissioner requested services | 70,908 | 54,481 |
| **Total** | **1,214,380** | **1,115,213** |

### 3.4 Income from overseas visitors

| | Year Ended 31 March 2025 £000 | Year Ended 31 March 2024 £000 |
|---|---|---|
| Income recognised this year | 438 | 381 |
| **For invoices raised in this and previous years:** | | |
| Cash payments received | 166 | 96 |
| Increase to credit losses of receivables | 485 | 146 |
| Amounts written off | 73 | - |

## 4 Other operating income

### 4.1 Income by type

| | Year ended 31 March 2025 | | | Year ended 31 March 2024 | | |
|---|---|---|---|---|---|---|
| | Contract Income £000 | Non-Contract Income £000 | Total £000 | Contract Income £000 | Non-Contract Income £000 | Total £000 |
| Research and development | 29,548 | 8,452 | 38,000 | 25,169 | 7,863 | 33,032 |
| Education and training | 39,749 | 2,282 | 42,031 | 41,065 | 1,571 | 42,636 |
| Non-patient care services to other bodies | 18,811 | - | 18,811 | 20,418 | - | 20,418 |
| Salary recharges | 7,980 | - | 7,980 | 7,447 | - | 7,447 |
| Receipt of capital grants and donations | - | 1,967 | 1,967 | - | 1,523 | 1,523 |
| Charitable and other contributions to operating expenditure | - | 950 | 950 | - | 777 | 777 |
| Contribution to expenditure – inventory donated by DHSC | - | - | - | - | 271 | 271 |
| Rental income from operating leases | - | 2,476 | 2,476 | - | 2,786 | 2,786 |
| Other* | 20,194 | - | 20,194 | 16,344 | - | 16,344 |
| **Total recognised operating income** | **116,282** | **16,127** | **132,409** | **110,443** | **14,791** | **125,234** |

***Significant items include:**

| | Year ended 31 March 2025 | Year ended 31 March 2024 |
|---|---|---|
| | £000 | £000 |
| Clinical excellence awards | 2,257 | 2,400 |
| Trading services - MEMO | 573 | 538 |
| Trading services – Pharmacy | 1,743 | 1,653 |
| Catering | 2,426 | 2,126 |
| Staff accommodation rentals | 743 | 509 |
| Car park income | 1,521 | 1,038 |
| Energy income | 1,544 | 281 |
| Use of healthcare facilities | 1,664 | 1,079 |

### 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 2025** | **£000** | **£000** | **£000** | **£000** |
| Revenue recognised in reported period that was included within contract liabilities at the previous period end | 44 | 4,752 | 5,436 | 10,232 |
| **Year ended 31 March 2024** | **£000** | **£000** | **£000** | **£000** |
| Revenue recognised in reported period that was included within contract liabilities at the previous period end | 3 | 3,949 | 5,775 | 9,727 |

### 4.3 Obligations

| | Year ended 31 March 2025 | Year ended 31 March 2024 |
|---|---|---|
| | £000 | £000 |
| **Revenue from contracts entered into but expected to be recognised:** | | |
| - within one year | 10,232 | 9,727 |
| - 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.

### 4.4 Lease income

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

| | Year ended 31 March 2025 £000 | Year ended 31 March 2024 £000 |
|---|---|---|
| Rental income – minimum lease receipts | 2,476 | 2,786 |

**Future minimum lease receipts due to the Trust**

| | Year ended 31 March 2025 £000 | Year ended 31 March 2024 £000 |
|---|---|---|
| - no later than one year | 1,859 | 2,020 |
| - between one and five years | 4,438 | 5,275 |
| - after five years | 2,467 | 2,529 |
| **Total** | **8,764** | **9,824** |

## 5. Operating expenses

### 5.1 Operating expenses by type

| | Year Ended 31 March 2025 £000 | Year Ended 31 March 2024 £000 |
|---|---|---|
| Services from other bodies: | | |
| - NHS & DHSC bodies | 8,983 | 8,846 |
| - non-NHS & non DHSC bodies | 3,039 | 2,479 |
| Purchase of healthcare from non-NHS bodies | 11,987 | 13,081 |
| Employee expenses excluding Board members | 823,928 | 746,101 |
| Employee expenses – Board members | 2,183 | 2,049 |
| Trust chair and non-executive directors | 244 | 219 |
| Supplies and services: clinical | 126,299 | 110,710 |
| Supplies and services: general | 15,764 | 14,740 |
| Drug costs | 187,968 | 183,205 |
| Establishment costs | 20,050 | 20,395 |
| Premises costs – business rates | 4,256 | 3,791 |
| Premises costs - other | 22,783 | 20,439 |
| Transport – business travel | 1,474 | 1,824 |
| Transport – other (including patient travel) | 10,120 | 5,045 |
| Depreciation on property, plant and equipment and right of use assets | 40,500 | 38,491 |
| Amortisation on intangible assets | 3,306 | 3,696 |
| Net impairments | 47,665 | 30,342 |
| Movement in contract credit loss allowance | (2,589) | 1,607 |
| Change in provisions discount rate | (2) | (276) |
| Auditor's remuneration - statutory audit | 180 | 121 |
| Internal audit | 326 | 362 |
| Clinical negligence | 26,640 | 25,949 |
| Research and development – other | 7,462 | 7,999 |
| Research and development – hosting payments | 13,170 | 9,872 |
| Other* | 10,155 | 11,300 |
| **Total** | **1,385,891** | **1,262,387** |

*Significant items include:

| | £000 | £000 |
|---|---|---|
| Education and training | 2,738 | 4,074 |
| Legal fees | 954 | 347 |
| Parking and security | 762 | 937 |
| Insurance | 963 | 907 |
| International Nurse Recruitment Fees | - | 2,607 |
| Apprenticeships | 2,282 | 1,571 |
| Childcare Vouchers | 213 | 255 |
| Immigration Surcharge | 346 | 649 |

### 5.2 Other auditor remuneration and limitation of auditor's liability

There is no other non-audit service remuneration in note 5.1 for 2024/25. No other non-audit work at all was undertaken in 2024/25.

There is a limitation of liability of £138,000 in respect of external audit services unless unable to be limited by law, related to death or personal injury caused by negligence, bribery or fraud, or breach of obligation as to title implied by section 12 of the Sale of Goods Act 1979 or section 2 of the Supply of Goods and Services Act 1982.

### 5.3 Lease expenses

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

| | Year Ended 31 March 2025 | Year Ended 31 March 2024 |
|---|---|---|
| **Minimum lease payments** | **£000** | **£000** |
| Land | 33 | 34 |
| Buildings | 7,808 | 7,797 |
| Plant and machinery | 728 | 694 |
| **Total** | **8,569** | **8,525** |

| **Future minimum lease payments due under operating leases** | **£000** | **£000** |
|---|---|---|
| Before one year | 8,508 | 8,367 |
| Between one and five years | 32,317 | 31,817 |
| After five years | 77,258 | 81,108 |
| **Total** | **118,083** | **121,292** |

The Trust leases various equipment and buildings. The most significant is the South Bristol Community Hospital. A 20-year lease was signed in March 2022, which contributes to the significant value reflected in the minimum lease payments due after five years.

## 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 2025 £000 | Year Ended 31 March 2024 £000 |
|---|---|---|
| Salaries and wages | 626,675 | 568,111 |
| Social security costs | 67,462 | 62,694 |
| Apprenticeship levy | 3,122 | 2,895 |
| Pension costs – employer contributions | 73,545 | 66,339 |
| Pension costs – employer contribution funded by NHSE | 48,127 | 28,950 |
| Termination benefits | 586 | 179 |
| Temporary staff - agency/contract staff | 12,694 | 25,053 |
| **Gross employee expenses** | **832,211** | **754,221** |
| Income in respect of salary recharges | (3,806) | (4,102) |
| Employee expenses capitalised | (2,294) | (1,969) |
| **Net employee expenses** | **826,111** | **748,150** |

### 6.2 Retirement benefits

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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 2025, is based on valuation data as 31 March 2023, updated to 31 March 2025 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 Statement by Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

### 6.3 Retirements due to ill health

During the year ended 31 March 2025 there were 7 (2023/24: 12) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill health retirements are £0.226m (2023/24: £0.661m). 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 £0.148m (2023/24: net loss of £0.351m) 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 2025 £000 | Year ended 31 March 2024 £000 |
|---|---|---|
| Interest on bank account. | 5,587 | 6,839 |
| **Total** | **5,587** | **6,839** |

### 8.2 Finance expenses

| | Year ended 31 March 2025 £000 | Year ended 31 March 2024 £000 |
|---|---|---|
| Loan interest on DHSC loans | 1,306 | 1,507 |
| Interest on Late Payment of Commercial Debt | - | 2 |
| Interest on lease obligations | 1,388 | 1,241 |
| **Total** | **2,694** | **2,750** |

In 2024/25, £nil (2023/24, £0.002m) interest was 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 2025 £000 | Year ended 31 March 2024 £000 |
|---|---|---|
| Impairment following valuation of assets brought into use | 1,852 | 21,609 |
| Changes in valuation | 48,840 | 8,955 |
| Reversal of impairments from change in valuation | (3,027) | (387) |
| Unforeseen obsolescence | - | 165 |
| **Total net impairment charged to operating surplus** | **47,665** | **30,342** |
| Net impairments charged to the revaluation reserve | 31,763 | 19,511 |
| **Total net impairments** | **79,428** | **49,853** |

Property impairments occur when the carrying amounts are reviewed by the Valuation Office through formal valuation. Plant and equipment impairments are identified following an assessment of whether there is any indication that an asset may be impaired e.g. obsolescence or physical damage.

Property reviews are undertaken to ensure assets are reflected at fair value in the accounts, when they are brought into use or when they are identified as assets held for sale. At the first valuation after the asset is brought into use any write down of cost is treated as an impairment and charged into the Statement of Comprehensive Income.

The impairment losses charged to the Statement of Comprehensive Income relate to the following:

| | Year Ended 31 March 2025 £000 | Year Ended 31 March 2024 £000 |
|---|---|---|
| **Impairment following valuation of assets brought into use:** | | |
| Urgent, Emergency Care scheme | - | 9,588 |
| General Intensive Care Unit | - | 12,021 |
| Infrastructure scheme | 1,852 | |
| **Unforeseen obsolescence** | | |
| Plant & machinery | - | 165 |
| **Change in valuation** | | |
| Valuation Office's revaluation of land & buildings | 45,813 | 8,568 |
| **Total** | **47,665** | **30,342** |

Where a revaluation increases an asset's value and reverses a revaluation loss previously recognised in operating expenses it is credited to operating expenses as a reversal of impairment and netted against any impairment charge.

## 9. Intangible assets

| | Software Licences £000 | Assets Under Construction £000 | Total £000 |
|---|---|---|---|
| Cost at 1 April 2024 | 43,817 | 110 | 43,927 |
| Additions – purchased | 843 | 2 | 845 |
| Additions – donated | - | - | - |
| Reclassifications with PPE | 786 | - | 786 |
| Disposals | (7) | - | (7) |
| **Cost at 31 March 2025** | **45,439** | **112** | **45,551** |
| | | | |
| Accumulated amortisation at 1 April 2024 | 25,930 | - | 25,930 |
| Charged during the year – purchased | 3,299 | - | 3,299 |
| Charged during the year – donated | 7 | - | 7 |
| Disposals | (7) | - | (7) |
| **Accumulated amortisation at 31 March 2025** | **29,229** | **-** | **29,229** |
| | | | |
| Net book value at 31 March 2025 | | | |
| Purchased | 16,191 | 112 | 16,303 |
| Donated | 19 | - | 19 |
| **Total net book value at 31 March 2025** | **16,210** | **112** | **16,322** |

| | Software Licences £000 | Assets Under Construction £000 | Total £000 |
|---|---|---|---|
| Cost at 1 April 2023 | 44,890 | 13 | 44,903 |
| Additions – purchased | 150 | 97 | 247 |
| Additions – donated | 25 | - | 25 |
| Reclassifications with PPE | 1,471 | - | 1,471 |
| Disposals | (2,719) | - | (2,719) |
| **Cost at 31 March 2024** | **43,817** | **110** | **43,927** |
| | | | |
| Accumulated amortisation at 1 April 2023 | 24,886 | - | 24,886 |
| Charged during the year – purchased | 3,696 | - | 3,696 |
| Charged during the year – donated | - | - | - |
| Disposals | (2,652) | - | (2,652) |
| **Accumulated amortisation at 31 March 2024** | **25,930** | **-** | **25,930** |
| | | | |
| Net book value at 31 March 2024 | | | |
| Purchased | 17,861 | 110 | 17,971 |
| Donated | 26 | - | 26 |
| **Total net book value at 31 March 2024** | **17,887** | **110** | **17,997** |

## 10. Property, plant and equipment

The Valuation Office undertook a desktop valuation at the 31 March 2025 which valued the Trust's land and buildings on a depreciated replacement cost, Modern Equivalent Asset valuation (MEA), adopting the optimised alternative asset approach. The valuation resulted in a net decrease at 31 March 2025 of £77.576m compared with the book values, with £45.813m charged to the Statement of Comprehensive Income as a net impairment and £31.763m movement 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 Manual (DHSC GAM). They are also prepared in accordance with the professional standards of the Royal Institution of Chartered Surveyors: RICS Valuation – Global Standards and RICS UK National Supplement, commonly known together as the Red Book, in so far as these are consistent with IFRS and the above-mentioned guidance; RICS VPGA1 and UKVPGA 5 refer.

The following are the agreed departures from the RICS Professional Standards and special assumptions:
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 those set out in the RICS Professional Standards, subject to the additional special assumptions that:

- 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 and in the respect of the Fair Value of 'held for sale' assets only.
- the NHS is assumed not to be in the market for the property interest; and
- regard has been had to appropriate lotting to achieve the best price.

| | 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 2024 | 17,765 | 417,791 | 2,715 | 35,135 | 134,100 | 1,385 | 35,380 | 1,019 | 645,290 |
| Transfers by absorption | - | - | - | - | - | - | - | - | - |
| Additions – purchased | - | 4,377 | 14 | 34,453 | 5,028 | - | 114 | - | 43,986 |
| Additions – donated | - | 4 | - | 1,491 | 472 | - | - | - | 1,967 |
| Impairments | (9,025) | (70,403) | - | - | - | - | - | - | (79,428) |
| Reclassifications with intangibles | - | - | - | (786) | - | - | - | - | (786) |
| Reclassifications within PPE | - | 22,606 | 38 | (32,209) | 4,556 | - | 5,003 | 6 | - |
| Revaluations | 68 | (16,847) | 151 | - | - | - | - | - | (16,628) |
| Disposals | - | - | - | - | (6,013) | (93) | (92) | - | (6,198) |
| **Cost or valuation at 31 March 2025** | **8,808** | **357,528** | **2,918** | **38,084** | **138,143** | **1,292** | **40,405** | **1,025** | **588,203** |
| | | | | | | | | | |
| Accumulated depreciation at 1 April 2024 | - | - | - | - | 75,253 | 772 | 21,249 | 801 | 98,075 |
| Transfers by absorption | - | - | - | - | - | - | - | - | - |
| Charged during the year – purchased | - | 15,092 | 125 | - | 10,007 | 134 | 4,267 | 58 | 29,683 |
| Charged during the year – donated | - | 1,411 | - | - | 1,253 | - | 14 | 1 | 2,679 |
| Revaluations | - | (16,503) | (125) | - | - | - | - | - | (16,628) |
| Disposals | - | - | - | - | (5,869) | (89) | (92) | - | (6,050) |
| **Total at 31 March 2025** | **-** | **-** | **-** | **-** | **80,644** | **817** | **25,438** | **860** | **107,759** |
| | | | | | | | | | |
| Net book value at 31 March 2025 | | | | | | | | | |
| Purchased | 8,808 | 325,430 | 2,918 | 36,584 | 53,150 | 475 | 14,951 | 163 | 442,479 |
| Donated | - | 32,098 | - | 1,500 | 4,349 | - | 16 | 2 | 37,965 |
| Finance leases | - | - | - | - | - | - | - | - | - |
| **Total at 31 March 2025** | **8,808** | **357,528** | **2,918** | **38,084** | **57,499** | **475** | **14,967** | **165** | **480,444** |

| | Land | Buildings Excluding Dwellings | Dwellings | Assets Under Construction & Payments on Account | Plant & Machinery | Transport | Information Technology | Furniture & Fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Cost or valuation at 1 April 2023 | 33,495 | 419,101 | 2,251 | 58,310 | 122,822 | 1,323 | 36,214 | 1,077 | 674,593 |
| Transfers by absorption | - | - | - | - | - | - | - | - | - |
| Additions – purchased | - | 1,810 | - | 40,268 | 5,596 | 62 | 462 | | 48,198 |
| Additions – donated | - | - | - | 311 | 1,187 | - | - | - | 1,498 |
| Impairments | - | (21,609) | - | - | (90) | - | (75) | - | (21,774) |
| Reclassifications with intangibles | - | - | - | (1,471) | - | - | - | - | (1,471) |
| Reclassifications within PPE | - | 44,964 | 303 | (62,283) | 12,251 | - | 4,765 | - | - |
| Revaluations | (15,730) | (26,475) | 161 | - | - | - | - | - | (42,044) |
| Disposals | - | - | - | - | (7,666) | - | (5,986) | (58) | (13,710) |
| **Cost or valuation at 31 March 2024** | **17,765** | **417,791** | **2,715** | **35,135** | **134,100** | **1,385** | **35,380** | **1,019** | **645,290** |
| | | | | | | | | | |
| Accumulated depreciation at 1 April 2023 | - | - | - | - | 72,854 | 619 | 23,216 | 798 | 97,487 |
| Transfers by absorption | - | - | - | - | - | - | - | - | - |
| Charged during the year – purchased | - | 15,032 | 120 | - | 8,617 | 146 | 3,967 | 61 | 27,943 |
| Charged during the year – donated | | 1,399 | - | - | 1,359 | 7 | 14 | - | 2,779 |
| Revaluations | - | (16,431) | (120) | - | - | - | - | - | (16,551) |
| Disposals | - | - | - | - | (7,577) | - | (5,948) | (58) | (13,583) |
| **Total at 31 March 2024** | **-** | **-** | **-** | **-** | **75,253** | **772** | **21,249** | **801** | **98,075** |
| | | | | | | | | | |
| Net book value at 31 March 2023 | | | | | | | | | |
| Purchased | 17,765 | 383,311 | 2,715 | 34,238 | 53,852 | 612 | 14,100 | 214 | 506,807 |
| Donated | - | 34,480 | - | 897 | 4,995 | 1 | 31 | 4 | 40,408 |
| Finance leases | - | - | - | - | - | - | - | - | - |
| **Total at 31 March 2024** | **17,765** | **417,791** | **2,715** | **35,135** | **58,847** | **613** | **14,131** | **218** | **547,215** |

## 10.1 Net book value of land building and dwellings

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

| | Year Ended 31 March 2025 | Year Ended 31 March 2024 |
|---|---|---|
| | £000 | £000 |
| Freehold | 369,254 | 438,271 |
| Long leasehold | - | - |
| **Total** | **369,254** | **438,271** |

### 10.2 Right of use assets

The net book value of assets held under leases:

| | Property (Land and Buildings) | Plant & Machinery | Total | Of which: Leased from Provider Org. | Of which: Leased from Other DHSC Group Bodies |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Valuation / gross cost at 1 April 2024 - brought forward | 119,022 | 7,173 | **126,195** | 2,581 | 104,003 |
| Additions | 1,865 | - | **1,865** | - | 1,527 |
| Remeasurements of the lease liability | 4,321 | - | **4,321** | - | 4,271 |
| Disposals/derecognition - lease termination | (2,583) | (50) | **(2,633)** | - | (441) |
| **Valuation/gross cost at 31 March 2025** | **122,625** | **7,123** | **129,748** | **2,581** | **109,360** |
| Accumulated depreciation at 1 April 2024 - brought forward | 14,028 | 1,099 | **15,127** | 627 | 10,247 |
| Provided during the year | 7,546 | 592 | **8,138** | 314 | 5,663 |
| Disposals/derecognition - lease termination | (987) | (50) | **(1,037)** | - | (441) |
| **Accumulated depreciation at 31 March 2025** | **20,587** | **1,641** | **22,228** | **941** | **15,469** |
| **Net book value at 31 March 2025** | **102,038** | **5,482** | **107,520** | **1,640** | **93,891** |

| | Property (Land and Buildings) | Plant & Machinery | Total | Of which: Leased from Provider Org. | Of which: Leased from Other DHSC Group Bodies |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Valuation / gross cost at 1 April 2023 - brought forward | 105,857 | 884 | **106,741** | 3,187 | 91,566 |
| Additions | 1,517 | 6,263 | **7,780** | - | - |
| Remeasurements of the lease liability | 12,371 | 26 | **12,397** | (121) | 12,437 |
| Disposals/derecognition - lease termination | (485) | - | **(485)** | (485) | - |
| Disposals / derecognition - peppercorn | (238) | - | **(238)** | - | - |
| **Valuation/gross cost at 31 March 2024** | **119,022** | **7,173** | **126,195** | **2,581** | **104,003** |
| Accumulated depreciation at 1 April 2023 - brought forward | 6,998 | 514 | **7,512** | 374 | 4,778 |
| Provided during the year | 7,184 | 585 | **7,769** | 328 | 5,469 |
| Disposals/derecognition - lease termination | (75) | - | **(75)** | (75) | - |
| Disposals / derecognition - peppercorn | (79) | - | **(79)** | - | - |
| **Accumulated depreciation at 31 March 2024** | **14,028** | **1,099** | **15,127** | **627** | **10,247** |
| **Net book value at 31 March 2024** | **104,994** | **6,074** | **111,068** | **1,954** | **93,756** |

## 11. Inventories

| Year ended 31 March 2025 | Drugs | Consumables | Energy | High-cost devices | Totals |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Carrying value at 1 April 2024 | 6,909 | 7,632 | 297 | 1,884 | 16,722 |
| Additions | 94,666 | 72,092 | - | 23,125 | 189,883 |
| Consumed – recognised in expenses | (94,285) | (71,139) | (239) | (22,230) | (187,893) |
| **Carrying value at 31 March 2025** | **7,290** | **8,585** | **58** | **2,779** | **18,712** |

| Year ended 31 March 2024 | Drugs | Consumables | Energy | High-cost devices | Totals |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Carrying value at 1 April 2023 | 6,310 | 6,867 | 356 | 1,495 | 15,028 |
| Additions | 100,404 | 64,580 | - | 18,774 | 183,758 |
| Consumed – recognised in expenses | (99,805) | (63,815) | (59) | (18,385) | (182,064) |
| **Carrying value at 31 March 2024** | **6,909** | **7,632** | **297** | **1,884** | **16,722** |

The year-end stock balance for high-cost devices 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 2025 | Year Ended 31 March 2024 |
|---|---|---|
| | £000 | £000 |
| Clinical pension tax provision reimbursement from NHS England | 1,503 | 1,489 |
| **Total** | **1,503** | **1,489** |

### 12.2 Current Receivables

| | Year Ended 31 March 2025 | Year Ended 31 March 2024 |
|---|---|---|
| | £000 | £000 |
| NHS contract receivables | 22,196 | 38,411 |
| Other contract receivables | 17,568 | 15,256 |
| Contract receivable not yet invoiced | 8,646 | 6,254 |
| VAT receivable | 924 | 1,281 |
| Allowance for credit losses | (3,947) | (6,536) |
| Prepayments | 7,015 | 9,346 |
| Clinical pension tax provision reimbursement from NHS England | 38 | 20 |
| **Subtotal** | **52,440** | **64,032** |
| Capital receivables | - | - |
| PDC dividend receivable | 1,363 | 821 |
| **Total current receivables** | **53,803** | **64,853** |

### 12.3 Allowance for credit losses

| | Year Ended 31 March 2025 £000 | Year Ended 31 March 2024 £000 |
|---|---|---|
| **Allowance as at 1 April** | **6,536** | **4,929** |
| New allowances arising | 1,421 | 3,625 |
| Reversals of allowances | (4,010) | (2,018) |
| **Balance at 31 March** | **3,947** | **6,536** |

### 13. Other financial assets

| | Year Ended 31 March 2025 £000 | Year Ended 31 March 2024 £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 2025 £000 | Year ended 31 March 2024 £000 |
|---|---|---|
| Balance at 1 April | 96,723 | 128,035 |
| Net change in year | (24,428) | (31,312) |
| **Balance at 31 March** | **72,295** | **96,723** |
| | | |
| **Broken down into:** | | |
| Cash with the government banking service | 71,973 | 96,429 |
| Commercial bank and cash in hand | 322 | 294 |
| **Total cash and cash equivalents** | **72,295** | **96,723** |

## 15. Trade and other payables

| | Year Ended 31 March 2025 | Year Ended 31 March 2024 |
|---|---|---|
| **Current amounts:** | **£000** | **£000** |
| NHS payables – revenue | 7,509 | 30,173 |
| Amounts due to related parties – revenue | 10,015 | 9,227 |
| Other payables – revenue | 28,592 | 24,126 |
| Tax and social security | 16,442 | 15,583 |
| Accruals | 54,963 | 55,484 |
| Annual leave accrual | 2,787 | 7,004 |
| **Subtotal** | **120,308** | **141,597** |
| Capital payables | 10,472 | 9,130 |
| **Total** | **130,780** | **150,727** |

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

Outstanding pension contributions of £9.979m (2023/24: £9.445m) to the NHS Pension scheme and £0.008m (2023/24: £0.011m) for National Employment Savings Trust (NEST) local pensions are included in amounts due to related parties. PAYE of £8.796m (2023/24: £7.888m) and £7.646m National Insurance (2023/24: £7.695m) are included in tax and social security.

## 16. Other liabilities

| | Year ended 31 March 2025 | Year ended 31 March 2024 |
|---|---|---|
| Current liabilities: | **£000** | **£000** |
| Deferred income – contract liabilities | 10,232 | 9,727 |
| **Total** | **10,232** | **9,727** |

## 17 Borrowings

### 17.1 Borrowings split

| Current borrowings: | Year ended 31 March 2025 | Year ended 31 March 2024 |
|---|---|---|
| | **£000** | **£000** |
| Capital loans from Department of Health and Social Care | 6,174 | 6,236 |
| Lease liabilities | 7,194 | 7,099 |
| **Total** | **13,368** | **13,335** |
| Non-current borrowings: | | |
| Capital loans from Department of Health and Social Care | 29,585 | 35,420 |
| Lease liabilities | 101,003 | 103,689 |
| **Total** | **130,588** | **139,109** |

### 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 2025 | Year ended 31 March 2024 |
|---|---|---|
| **Payable:** | **£000** | **£000** |
| Before one year | 6,174 | 6,236 |
| Between one and five years | 22,352 | 22,936 |
| After five years | 6,894 | 12,082 |
| **Net obligation** | **35,420** | **41,254** |

### 17.3 IFRS16 Lease obligations

Future lease obligations due under lease agreements where the Trust is the lessee.

The Trust leases various equipment and buildings. The most significant is the South Bristol Community Hospital. A 20-year lease, signed in March 2022, contributes to the significant value reflected in the minimum lease payments due after five years.

| | Year ended 31 March 2025 | Of which leased from DHSC group bodies 31 March 2025 |
|---|---|---|
| **Payable:** | **£000** | **£000** |
| Before one year | 8,508 | 6,541 |
| Between one and five years | 32,317 | 25,800 |
| After five years | 77,258 | 72,489 |
| **Sub-total** | **118,083** | **104,830** |
| Less finance charges allocated to future years | (9,886) | (8,058) |
| **Net lease liabilities** | **108,197** | **96,772** |
| | | |
| **Of which:** | | |
| Leased from other NHS providers | | 1,663 |
| Leased from other DHSC group bodies | | 95,109 |

| | Year ended 31 March 2024 | Of which leased from DHSC group bodies 31 March 2024 |
|---|---|---|
| **Payable:** | **£000** | **£000** |
| Before one year | 8,367 | 6,180 |
| Between one and five years | 31,817 | 24,122 |
| After five years | 81,108 | 74,496 |
| **Sub-total** | **121,292** | **104,798** |
| Less finance charges allocated to future years | (10,504) | (8,256) |
| **Net lease liabilities** | **110,788** | **96,542** |
| | | |
| **Of which:** | | |
| Leased from other NHS providers | | 1,972 |
| Leased from other DHSC group bodies | | 94,570 |

**17.4 Reconciliation of liabilities arising from financing activities**

| | DHSC Loans | Lease liability | Total |
|---|---|---|---|
| **Year ended 31 March 2025** | **£000** | **£000** | **£000** |
| Carrying Value at 01 April 2024 | 41,656 | 110,788 | 152,444 |
| **Cash Movements** | | | |
| Principal | (5,834) | (7,181) | (13,015) |
| Interest | (1,369) | (1,388) | (2,757) |
| **Non-Cash Movements** | | | |
| Additions | - | 1,865 | 1,865 |
| Lease liability remeasurements | - | 4,321 | 4,321 |
| Interest Charge arising in year | 1,306 | 1,388 | 2,694 |
| Early termination | - | (1,596) | (1,596) |
| **Carrying Value at 31 March 2025** | **35,759** | **108,197** | **143,956** |

| | DHSC Loans | Lease liability | Total |
|---|---|---|---|
| **Year ended 31 March 2024** | **£000** | **£000** | **£000** |
| Carrying Value at 01 April 2023 | 47,542 | 98,307 | 145,849 |
| **Cash Movements** | | | |
| Principal | (5,834) | (7,284) | (13,118) |
| Interest | (1,559) | (1,241) | (2,800) |
| **Non-Cash Movements** | | | |
| Additions | - | 7,780 | 7,780 |
| Lease Liability remeasurements | - | 12,397 | 12,397 |
| Interest Charge arising in year | 1,507 | 1,241 | 2,748 |
| Early termination | - | (412) | (412) |
| **Carrying Value at 31 March 2024** | **41,656** | **110,788** | **152,444** |

## 18. Provisions

### 18.1 Provision for liabilities:

| Year ended 31 March 2025 | Clinicians Pension Tax Reimbursement £000 | Pension Injury Benefits £000 | Pensions Early Departure £000 | Legal Claims £000 | Total £000 |
|---|---|---|---|---|---|
| At 1 April 2024 | 1,509 | 1,863 | 236 | 215 | 3,823 |
| Change in discount rate | (14) | (2) | - | - | (16) |
| Arising during the year | 29 | 69 | 17 | 105 | 220 |
| Utilised during the year | (58) | (50) | (32) | (45) | (185) |
| Reversed unused | - | (1,439) | - | (29) | (1,468) |
| Unwinding of discount rate | 75 | - | - | - | 75 |
| **At 31 March 2025** | **1,541** | **441** | **221** | **246** | **2,449** |

| Timing of economic outflow | Clinicians Pension Tax Reimbursement £000 | Pension Injury Benefits £000 | Pensions Early Departure £000 | Legal Claims £000 | Total £000 |
|---|---|---|---|---|---|
| Not later than one year | 38 | 49 | 31 | 246 | 364 |
| Between one and five years | 197 | 185 | 119 | - | 501 |
| After five years | 1,306 | 207 | 71 | - | 1,584 |
| **Total** | **1,541** | **441** | **221** | **246** | **2,449** |

There are no other provisions.

| Year ended 31 March 2024 | Clinicians Pension Tax Reimbursement £000 | Pension Injury Benefits £000 | Pensions Early Departure £000 | Legal Claims £000 | Total £000 |
|---|---|---|---|---|---|
| At 1 April 2023 | 1,847 | 1,935 | 253 | 130 | 4,165 |
| Change in discount rate | (228) | (260) | (16) | - | (504) |
| Arising during the year | - | 315 | 30 | 131 | 476 |
| Utilised during the year | (32) | (127) | (31) | (26) | (216) |
| Reversed unused | (78) | - | - | (20) | (98) |
| **At 31 March 2024** | **1,509** | **1,863** | **236** | **215** | **3,823** |

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 £329.9m provision in its accounts (2023/24: £340.7m) in respect of clinical negligence liabilities of the Trust.

## 19. Capital commitments

| | Year Ended 31 March 2025 £000 | Year Ended 31 March 2024 £000 |
|---|---|---|
| Property, plant and equipment | 3,945 | - |
| **Total** | **3,945** | **-** |

There are two capital schemes with contractual commitments of more than £1m, Same Day Emergency Care at Weston General (£1.6m) and replacement of a Linear Accelerator (£2.3m).

### 19.1 Leases: exposure to future cash outflows not included in lease liabilities

| | Leases from Other NHS Providers £000 | All Other Leases £000 | Total £000 |
|---|---|---|---|
| Commitments for leases not yet commenced to which the Trust is contractually committed | - | 268 | **268** |

## 20. Contingencies

The Trust has no contingent assets at 31 March 2025 (2023/24: £nil).

The Trust has no material contingent liabilities at 31 March 2025. 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.

## 21. 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 between the Trust and these bodies are shown below.

| | 31 March 2025 (£m) | | 31 March 2024 (£m) | | 2024/25 (£m) | | 2023/24 (£m) | |
|---|---|---|---|---|---|---|---|---|
| | Receivables | Payables | Receivables | Payables | Income | Expenditure | Income | Expenditure |
| Avon and Wiltshire Mental Health Partnership NHS Trust | 0.26 | 0.12 | 0.15 | 0.07 | 1.32 | 0.99 | 1.23 | 0.91 |
| Bristol City Council | 0.84 | 0.02 | 0.72 | 0.47 | 8.85 | 1.83 | 8.64 | 0.27 |
| CHKS Ltd | - | 0.07 | - | - | - | - | - | 0.10 |
| City of Bristol College | - | - | - | - | - | - | - | 0.01 |
| NHS Confederation | - | - | - | 0.02 | - | 0.02 | - | 0.02 |
| North Bristol NHS Trust | 2.22 | 3.59 | 2.65 | 3.46 | 10.21 | 21.80 | 8.91 | 17.51 |
| St Peter's Hospice | 0.08 | - | 0.01 | - | 0.19 | 0.01 | 0.11 | 0.01 |
| Swansea University | - | - | 0.01 | - | - | 0.01 | - | - |
| Torbay and South Devon NHS FT | 0.29 | 0.06 | 0.04 | - | 0.48 | 0.44 | 0.04 | 0.07 |
| University of Bristol | 0.35 | 1.33 | 0.26 | 1.07 | 3.30 | 9.14 | 2.81 | 10.19 |
| University of Gloucestershire | - | - | 0.01 | - | - | 0.01 | 0.01 | 0.03 |
| University of Nottingham | - | - | - | - | - | 0.01 | - | - |
| University of the West of England | 0.04 | 0.04 | 0.06 | 0.15 | 0.72 | 1.13 | 0.74 | 1.18 |
| Associated Charities | See notes 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 2025 (£m) | | 31 March 2024 (£m) | | 2024/25 (£m) | | 2023/24 (£m) | |
|---|---|---|---|---|---|---|---|---|
| | Receivables | Payables | Receivables | Payables | Income | Expenditure | Income | Expenditure |
| Bristol City Council | 0.84 | 0.20 | 0.72 | 0.47 | 8.85 | 1.83 | 8.64 | 0.27 |
| Community Health Partnerships | 0.37 | 0.74 | - | - | - | 6.98 | - | 7.21 |
| Department for Work and Pensions | - | 9.98 | - | 9.45 | - | 0.15 | - | - |
| Department of Health and Social Care | 1.12 | 0.40 | - | - | 30.98 | 0.28 | 25.48 | - |
| HM Revenue & Customs | 0.92 | 16.44 | - | 15.58 | - | 70.60 | - | 65.59 |
| Macmillan Cancer Support | 0.03 | - | 0.01 | - | 0.41 | - | 0.39 | - |
| NHS Bath and North East Somerset, Swindon and Wiltshire ICB | 0.46 | 0.05 | - | - | 20.93 | - | 19.23 | - |
| NHS Blood and Transplant | - | 1.34 | - | - | 0.23 | 9.04 | - | 7.96 |
| NHS Bristol, North Somerset and South Gloucestershire ICB | 6.11 | 0.69 | 10.20 | 12.31 | 547.70 | 0.46 | 506.40 | - |
| NHS England - Core (now including expenditure and payables for all regions) | 0.65 | 7.94 | - | 14.39 | 42.43 | 0.03 | 40.94 | - |
| NHS England - Central Specialised Commissioning Hub | 5.22 | - | 11.65 | - | 62.21 | - | 59.38 | - |
| NHSE South West Regional Office (including commissioning hub 14F) | 5.98 | - | 6.29 | - | 458.38 | - | 413.23 | - |
| NHS Gloucestershire ICB | 0.56 | 0.03 | 0.03 | 0.03 | 5.89 | - | 5.76 | - |
| NHS Pension Scheme | - | - | - | - | - | 121.63 | - | 95.22 |
| NHS Resolution | - | - | - | - | - | 26.64 | - | 25.95 |
| NHS Somerset ICB | 0.05 | 0.56 | 0.03 | 0.05 | 31.24 | - | 37.42 | - |
| North Bristol NHS Trust | 2.22 | 3.59 | 2.65 | 3.46 | 10.21 | 21.80 | 8.91 | 17.51 |
| Welsh Assembly Government | - | - | - | - | 13.90 | - | 17.56 | - |

In addition, the Trust pays HM Revenue and Customs tax and national insurance on behalf of employees; £128.4m in 2024/25 (£128.2m in 2023/24). The Trust pays the NHS Pension Scheme for employees' contributions which totalled £48.4m in 2024/25 (£43.6m in 2023/24).

The Trust also has transactions with charitable bodies including Bristol & Weston Hospitals Charity which is the official charity for all hospitals within the Trust and, the Grand Appeal which is the Bristol Children's Hospital Charity. The Grand Appeal charities is independently managed by a board of trustees and is not consolidated within the Trust's accounts. The transactions are as follows:

| | 31 March 2025 (£m) | | 31 March 2024 (£m) | | 2024/25 (£m) | | 2023/24 (£m) | |
|---|---|---|---|---|---|---|---|---|
| | Receivables | Payables | Receivables | Payables | Income | Expenditure | Income | Expenditure |
| Bristol & Weston Hospitals Charity (formally Above and Beyond) | 0.23 | 0.01 | 0.95 | - | 0.53 | 0.01 | 1.41 | - |
| Grand Appeal | 0.21 | - | 0.02 | - | 0.52 | - | 0.21 | - |

## 22. Financial Instruments

### 22.1 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 conducted 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 Integrated Care Boards, which are financed from resources voted annually by Parliament. Therefore, the Trust has little exposure to liquidity risk.

**22.2 Carrying Value of Financial assets by category**

| | 31 March 2025 | 31 March 2024 |
|---|---|---|
| | £000 | £000 |
| Receivables with DHSC group bodies | 29,053 | 42,531 |
| Receivables with other bodies | 16,951 | 12,034 |
| Other financial assets | 104 | 104 |
| Cash and cash equivalents | 72,295 | 96,723 |
| **Total** | **118,403** | **151,392** |

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.

**22.3 Carrying Value of Financial liabilities by category**

| | 31 March 2025 | 31 March 2024 |
|---|---|---|
| | £000 | £000 |
| DHSC Loans | 35,759 | 41,656 |
| Obligation under leases | 108,197 | 110,788 |
| Trade and other payables with DHSC group bodies | 12,895 | 31,931 |
| Trade and other payables with other bodies | 88,669 | 96,209 |
| **Total** | **245,520** | **280,584** |

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 flows**

| | Year Ended 31 March 2025 | Year Ended 31 March 2024 |
|---|---|---|
| | £000 | £000 |
| Less than one year | 117,069 | 143,711 |
| In more than one year but not more than five years | 57,699 | 58,630 |
| In more than five years | 84,402 | 93,818 |
| **Total** | **259,170** | **296,159** |

### 22.4 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.

### 23. Third party assets

At 31 March 2025, the Trust held £nil (31 March 2024: £nil) cash and cash equivalents relating to third parties.

### 24. Losses and special payments

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

| | 2024/25 | | 2023/24 | |
|---|---|---|---|---|
| | **No.** | **£000** | **No.** | **£000** |
| Cash losses | 52 | 9 | - | - |
| Bad debts and claims abandoned | 257 | 100 | 57 | 12 |
| Damage to buildings, property etc. | 5 | 655 | 4 | 333 |
| Ex gratia payments | 74 | 38 | 84 | 29 |
| **Total** | **388** | **802** | **145** | **374** |

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

### 25. Post Statement of Financial Position events

No post statement of financial position events to note.

## Appendix D – Independent Auditor's Report (including final audit certificate)

# INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF UNIVERSITY HOSPITALS BRISTOL & WESTON NHS FOUNDATION TRUST

## REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

### Opinion

We have audited the financial statements of University Hospitals Bristol & Weston NHS Foundation Trust ("the Trust") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

### Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

### Fraud and breaches of laws and regulations – ability to detect

#### *Identifying and responding to risks of material misstatement due to fraud*

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Trust by NHS England
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the mainly fixed nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to completeness of expenditure around year end, in response to possible pressures to meet delegated targets.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected account combinations and material post-closing journal entries.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- inspecting a sample of payments made in the period around 31 March 2025, to determine whether expenditure had been recognised in the correct accounting period and whether accruals were complete

***Identifying and responding to risks of material misstatement related to compliance with laws and regulations***

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Trust is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and other management and inspection of regulatory and

legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

***Context of the ability of the audit to detect fraud or breaches of law or regulation***

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

**Other information in the Annual Report**

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

***Remuneration and Staff Reports***

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

**Accounting Officer's and Audit Committee's responsibilities**

As explained more fully in the statement set out on page 88, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They 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; 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 they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

The Audit Committee is responsible for overseeing the Trust's financial reporting process.

**Auditor's responsibilities**

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

## REPORT ON OTHER LEGAL AND REGULATORY MATTERS

### Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

### Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 88, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

### Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

## THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

**DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT**

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of University Hospitals Bristol & Weston NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

**Jonathan Brown**

**for and on behalf of KPMG LLP**
*Chartered Accountants*
66 Queen Square
Bristol
BS1 4BE

24 June 2025