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University Hospitals Bristol and Weston NHS Foundation Trust

Annual Report and Accounts 2021/22

We are
supportive
respectful
innovative
collaborative.
We are UHBW.

University Hospitals Bristol and Weston NHS Foundation Trust
Annual Report and Accounts 2021/22

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

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1. Joint Chief Executive and Trust Chair Statement

The global COVID-19 pandemic has had a profound impact on us all since it began in early 2020, and it's fair to say that 2021/22 was another challenging year due to the impact of coronavirus. For much of the early part of the year, the focus of our staff – like the rest of the NHS – was very much on the response to the pandemic. We cared for patients ill with the virus and continued to have protective measures in place such as face masks, enhanced PPE (personal protective equipment), and social distancing. We remain immensely proud of the way all our staff rose to the huge challenges brought by the pandemic and continued to provide high quality care to our patients despite these difficult circumstances.

As we write this, the world has begun to feel a little bit more normal, with restrictions removed outside of healthcare settings and normality returning for many. However, in healthcare settings, like our hospitals, life is still a bit different as we continue to have safety precautions in place like face masks and social distancing. Thankfully, at the time of writing, we are seeing far fewer COVID-19 patients and we have been able to safely open up our wards more to visiting.

Whilst COVID-19 remains a threat and we continue to be vigilant, our focus has turned to working through the backlog of patients which has built up during the pandemic, and who are waiting to be seen, as quickly and safely as possible. We don't underestimate the impact on our patients of having a planned appointment rescheduled or postponed. We would again like to thank our patients and their relatives for their understanding and support. Reducing the backlog has, and continues to be, a focus for the Trust.

We work very closely with other health and care organisations in the Bristol, North Somerset and South Gloucestershire (BNSSG) area and beyond, and the past couple of years where we have responded to the COVID-19 pandemic has seen us further strengthen this partnership working. This provides a very solid foundation for us to build on going forward with all health and care organisations in BNSSG having the same aim of trying to provide the best, highest quality, health and care services for our patients.

During the year we continued to integrate our hospitals following our merger to become UHBW in April 2020. This included integrating and bringing together teams from our Bristol and Weston sites, as well as developing our new shared Trust Values. More than 5,000 members of staff were part of the process which helped to choose our Values which are we are supportive, we are respectful, we are innovative, and we are collaborative. We hope these Values truly reflect who we are as an organisation and how we should go about our daily work as individuals and teams at UHBW. Alongside this work, the second phase of Healthy Weston, which aims to secure Weston General Hospital as a thriving and sustainable hospital at the heart of the Weston community, also started to take shape. You'll hear a lot more about this and have an opportunity to share your views during the rest of 2022.

We also continued to be at the forefront of innovation, both in the fight against COVID-19 and in other areas of healthcare. For example, we continued to recruit to various COVID-19 trials to test vaccines and to investigate immunity against the virus. Towards the end of the year Bristol's new Clinical Research Facility (CRF), which is run by UHBW, received national funding from the National Institute for Health Research (NIHR). The funding was part of a £161 million investment to expand the delivery of early phase clinical research in NHS hospitals across England. The Bristol CRF will bring together early phase translational and experimental medicine research studies at UHBW and the University of Bristol into a single management and governance structure, covering research in a variety of areas that include cancer and immunity-based treatments, vaccine development and testing, cardiovascular medicine, neurosciences and respiratory medicine.

Another area where we are committed to playing our part, is in sustainability and helping to tackle climate change and its effects on the health of our population. In 2019 we joined with our partners at North Bristol NHS Trust to declare a climate emergency and pledge our commitment to be more sustainable, and during 2021/22 we reaffirmed this commitment. For example, 2021 and into 2022 we switched off our old steam system and moved to low carbon district heating, which will cut our gas use by 9,732,011kWh, amounting to a huge saving of 1,701.65 tonnes of CO2 per year.

Throughout the year our staff were involved a number of major success stories including “Retrieve” – hosted by UHBW and funded by NHS England and Improvement South West, being named as the Critical Care Team of the Year in the BMJ (British Medical Journal) Awards. Retrieve is the South West’s Adult Critical Care Transfer Service and is one of the first of its kind in the country. It is responsible for transferring critically ill and injured patients who are already in hospitals across the region to specialist centres for treatment and specialist intensive care. It also repatriates patients to a hospital closer to home, when they no longer need specialist care.

Colleagues at UHBW were part of the PreciSSIon Collaborative which won the Infection Prevention and Control Award at the HSJ (Health Service Journal) Patient Safety Awards. The award recognised the team’s hard work and dedication to nearly halving the rate of surgical site infection (SSI) – common after colorectal surgery – in the West.

Professor Jonathan Benger, a consultant in emergency medicine at the Bristol Royal Infirmary (BRI) and Chief Medical Officer for NHS Digital, was awarded a CBE in the Queen’s New Year Honours list for services to the NHS. In the Queen’s Birthday Honours List, Ruth Hendy, lead cancer nurse for the Trust, was awarded a British Empire Medal (BEM) in recognition for her services to people living with and affected by cancer. Also in the birthday honours, Dr Tom Wells, a medical oncology consultant at Weston General Hospital, was honoured with an MBE for his services to medicine and people with disabilities in the medical profession.

Thank you to all of these staff. It’s important to note that these are just a few of the successes recorded this year, and we would like to thank every member of Team UHBW for all of their efforts and achievements in 2021/22.

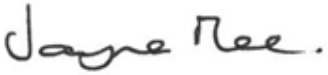
Looking towards 2022/23, the Trust has set five leadership Priorities which will guide the primary activities of our workforce. These are focused on developing and improving the quality and safety of the care we provide, supporting the development and wellbeing of our people, improving the flow through our hospitals, delivery of integration plans following the merger and supporting the Healthy Weston strategic changes, and finally ensuring effective use of our resources. To support the need to work differently, given the local, regional, and national priorities as we emerge from the pandemic, the Trust is implementing Patient First, an approach to organisational change and embedding a culture of continuous improvement involving all staff from across the Trust.

In addition, the Trust will be supporting the implementation of the new Integrated Care Board, being formed as part of the Health and Care Act, which will seek to ensure a more joined up and consistent approach to health and care delivery across the Bristol, North Somerset and South Gloucestershire system. As part of this we will continue to develop our provider collaborative with North Bristol NHS Trust and seek to optimise clinical service delivery and non-clinical services for the benefit of our staff and patients.

Finally, we want to thank everyone for your continued support for our hospitals and for the NHS – members of the public, our fantastic community of hospital volunteers, Trust Governors and members, and supporters of the Bristol & Weston Hospitals Charity, the Grand Appeal, and other charities. Your support for our staff continues to be phenomenal, and really does have a positive impact.

With best wishes,

Eugine Yafele
Chief Executive



Jayne Mee
Trust Chair

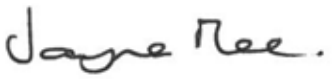
A thank you and welcome from our Trust Chair

At the end of 2021/22, we said goodbye to chief executive Robert Woolley, who retired after a long and distinguished career in the NHS spanning more than three decades, with 12 years leading the Trust.

On behalf of the Trust I would like to thank Robert for his superb leadership during his tenure and for his tireless commitment to our staff and patients.

Following the announcement that Robert would be retiring, we were delighted to announce the appointment of Eugine Yafele as our new chief executive. Eugine started in post in May 2022, having joined from Dorset HealthCare University Foundation Trust, where he led the Trust to achieve a CQC rating of Outstanding in his first year as chief executive and, under his leadership, the Trust was ranked amongst the top four in the annual staff survey for three consecutive years.

Eugine brings with him a strong track record and has proved himself as an excellent CEO. It's clear he has a real passion and skill for nurturing talent at all levels of the organisation and brings extensive experience, knowledge and skills to lead UHBW on the next part of its journey.



Jayne Mee

Trust Chair

2. Performance Report

2.1 Overview

Since March 2020, the Trust has been a key responder to the COVID-19 pandemic which has had a significant impact on the Trust's services, including its ability to care for patients in a timely way. The pressures have also had a huge impact on our people, who have worked tirelessly to provide high quality, safe care to our patients in often very difficult circumstances.

During 2021/22, the Trust continued to experience these pressures which have resulted in long waits in the Emergency Department, and an increasing number of 12 Hour trolley waits and ambulance handover delays. Patients waiting for elective care have also seen their waiting times increase and, at the end of the year, the Trust had 3,920 patients waiting over 52 weeks, and 346 patients waiting over 104 weeks. Coupled with the decrease in performance of emergency care and elective care, the Trust has seen an increase in the number of patients who are classified as No Criteria to Reside. These patients are those whose ongoing care and assessment can safely be delivered in a non-acute hospital setting, but the patient is still in an acute bed whilst the support is being arranged to enable their discharge.

To address the performance issues described, the Trust is actively working with system partners to identify and implement solutions which improve the outcomes for patients. This includes supporting a system wide Discharge to Assess business case, which seeks to enhance the capacity in community provision to alleviate some of the issues with patients being in acute beds when their care could be undertaken elsewhere. The Trust has also been trialling ways in conjunction with the South Western Ambulance NHS Foundation Trust to assess patients before they come into hospital, so that they can remain at home with an appropriate package of care.

Performance against the Trust's quality metrics continued to be good, with the Trust's Summary Hospital Mortality Indicator and Hospital Standardised Mortality Ratio both within the expected range, and good performance against the number of Clostridium Difficile (C.Diff) cases and rates of infection with C.Diff.

The Trust has also prioritised supporting its people, through a programme of well-being initiatives, which have included enhancements to rest areas and access to psychological support. The Trust is actively recruiting to all vacancies to ensure that appropriate levels of staff are available to care for our patients. This has included a significant programme to recruit internationally, and the Trust welcomed 248 international nurses into the Trust during the year. The Trust also consulted on and launched its new Trust Values and leadership behaviours –

- We are supportive. We're always there for each other.
- We are respectful. We always look for the best in people.
- We are innovative. We're full of bright ideas.
- We are collaborative. We do things together.

These Values were developed with staff, from across all parts of the organisation and replaced the separate Values from the two previous organisations. Work is progressing across the Trust to share and implement these new Values and embed them in everything that we do.

The CQC undertook an unannounced inspection in June 2021 of the medical care services at the Bristol main hospital site and at Weston General Hospital, and of the Trust's outpatient services at Weston General Hospital. The inspection came at a time during which the Trust was still responding to the COVID-19 pandemic, and for periods of time the NHS was in a level 4 emergency incident. These events had had a significant impact on the plans for integration of services post-merger of University Hospitals Bristol and Weston Area Health. As a result of the inspection the CQC changed its rating for the whole Trust to Good and maintained its Outstanding rating for Caring. This again demonstrates the fantastic efforts by staff, during a very difficult period for the NHS, to maintain the highest levels of care for our patients.

The main risks facing the Trust throughout the year, beyond responding to the COVID-19 pandemic related to: workforce capacity and capability; the availability of beds; and investing in management and leadership skills. The Trust also noted risks, as identified through its internal audit programme, relating to fire safety compliance, Emergency Planning Resilience and Response (EPRR), cyber security, governance within the Weston division and in relation to mental health assessments for children and young people. The risks and internal audit responses are monitored by the Board and its Committees to ensure that appropriate and timely action is taken to mitigate the risks occurring and to address any control issues identified.

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 ambitions of the NHS, specifically to address the significant backlogs of patients who are waiting to be treated and to improve the timeliness of care to patients requiring urgent or emergency 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 Improvement, the Independent Regulator of NHS Foundation Trusts on 1 June 2008.

We have more than 13,000 staff who deliver over 100 different clinical services across ten different sites, providing care to the people of Bristol, North Somerset and the South West from the very beginning of life to its later stages. We are one of the country's largest acute NHS Trusts with an annual income of over £950m.

The Trust provides services in the three principal domains of clinical service provision; teaching and learning, and research and innovation. The most significant of these with respect to income and workforce is the clinical service portfolio consisting of general and specialised services.

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

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

As a University Teaching Trust, we also place great importance on teaching and research. The Trust has strong links with both of the city's universities and teaches students from medicine, nursing and other professions allied to health. Research is a core aspect of our activity and has an increasingly important role in the Trust's business with a significant grant secured in partnership with University of Bristol from the National Institute for Health Research in 2019/20 for an Applied Research Collaboration. The Trust is a full member of Bristol Health Partners, and of the West of England Academic Health Science Network, and also hosts the recently established Collaboration for Leadership in Applied Health Research for the West of England.

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

2.1.2 Our mission, vision and values

Our mission as a Trust is to improve the health of the people we serve by delivering exceptional care, teaching and research, every day.
UHBW published its new five-year strategy, Embracing Change, Proud to Care; our 2025

Vision in June 2019. Our five-year strategic vision is to;

- Anchor our future as a major specialist service centre and a beacon of excellence for education.
- Work in partnership within an integrated care system, locally, regionally, and beyond.
- Excel in world-class clinical research and our culture of innovation.

In November 2021, as part of the Trust's merger programme to develop a common organisational culture, the Trust launched our new staff values and leadership behaviours. Over 5,000 staff were involved in shaping these new shared values and behaviours.

	our values – It's who we are	We are supportive	We are respectful	We are innovative	We are collaborative
LEADERSHIP BEHAVIOUR THEMES	Lead by example	Put staff first	Enable openness and accountability	Show strategic and agile leadership	Harness difference and togetherness
STRATEGIC IMPACT	• Sets the standard for a strong, open and trusting community within all leadership groups	• Promotes a culture that puts staff first, and enables everyone to contribute to it	• Builds the Trust's ability to listen, be inclusive and welcome challenge	• Continuously improves processes in response to changing demands on the Trust	• Highlights local contributions as a source of Trust-wide pride and recognition
IMPACT ON OTHERS	• Promotes an environment of belonging, where all staff feel welcome and valued • Demonstrates best-practice care, where all decisions are based on evidence and strive for better outcomes for staff and patients	• Puts the staff experience and their development at the heart of everything we do, because quality care depends on staff wellbeing • Shows care and curiosity in all interactions with staff (especially in times of change and adversity) and is visible and approachable • Supports everyone in contributing to the success of the Trust as a whole, not just their own jobs	• Creates safe space to discuss and evaluate how work has gone, what can be learned and improved on • Sets clear goals and gives feedback to support continuous improvement • Sees the team as individuals, and values the skills and knowledge they offer	• Encourages all staff to use evidence and try new ways of working to learn and grow and deliver better patient experiences and care • Inspires others - guided by the Trust's vision and purpose - and in doing so presents change as necessary and positive • Promotes organisational learning for the benefit of all staff	• Encourages others to work together and treat each other fairly across all divisions and teams • Seeks different views when making decisions, especially from people who might be affected by potential outcomes • Encourages staff with different roles, skills, and experiences to work together, promoting diversity of thought, learning and innovation • Recognises and celebrates the contributions different divisions and teams make to the Trust-wide vision
PERSONAL IMPACT	• Gathers regular feedback from different people / teams to ensure standards are being met • Models the Trust's values • Stays calm under pressure and keeps focus on shared goals	• Considers the direct and indirect impact that decisions and behaviours have on others. • Shows empathy and respect for everyone – in words and actions • Puts outcomes for all staff and patients before self-interest	• Demonstrates open, honest and respectful conversations • Leads the way in speaking up if something is wrong • Makes personal commitments to improve the Trust, and keeps everyone informed of your progress	• Thinks strategically, anticipating and adapting to future trends and changing patient needs • Explores new ways of meeting changing demands placed on the Trust • Open to trying new ideas and approaches, believing that even those that do not work still help us to learn and improve	• Actively seeks out and listens to opinions from everyone • Creates opportunities to collaborate so that different perspectives inform decision-making

2.1.3 Our Strategic Priorities

Our Strategy outlines six Strategic Priorities which set the direction for the organisation over this 5-year period:

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

Our priorities and strategic objectives were reviewed in Autumn 2020 in the context of our changed operating environment and the following Strategic Objectives were added as an addendum to our strategic document through Trust Board in September 2020.

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

We remain committed to addressing the aspects of care that matter most to our patients, remaining responsive to the changing needs of our population and significant changes within both the national and local planning environment. Our strategy supports delivery of the objectives and vision of our local and regional partners and our commitment to our developing Healthier Together Integrated Care System.

Our intention in 2019/20 was to develop an annual ‘strategy into action’ assurance look back that also informed decisions and prioritisation of milestones for strategic delivery in the year/s ahead. To maintain agility in responding to the pandemic, we deferred completion of the first assurance look back to the mid-point of our 2025 strategy (Q3 2021/22).

This stocktake demonstrated that despite the unprecedented challenges posed by the Coronavirus outbreak, our teams have made considerable progress towards delivering our 2025 strategy across the four domains:

- Specialist and regional services.
- Local acute and integrated care.
- Education and workforce.
- Research and innovation.

We will continue the annual strategy into action review, recognising and celebrating progress made by our teams and engaging on our priorities ahead.

2.1.4 Transforming Care

Our focus remains on ensuring our patients are at the heart of all we do around our six strategic priorities: Our Patients, Our People, Our Portfolio, Our Partners, Our Potential, Our Performance. To achieve this, we seek to continually improve and learn.

Key areas of progress made in 2021/22 for each priority follows:

Our Patients: We will excel in consistent delivery of high quality, patient centred care, delivered with compassion.

In response to the national maternity transformation programme and the national ambition to halve the 2010 rates of still births, neonatal deaths, maternal deaths and brain injuries occurring during or after birth by 2025, UHBW has set up five continuity of carer teams targeting geographical areas of Bristol with highest opportunities to improve outcomes. At the heart of the continuity of carer vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth. Evidence shows that continuity models improve safety and clinical outcomes, as well as the experience of women and families.

Addressing the backlog of planned care and improving timely access to assessment and treatment for our patients is one of our highest priorities.

Through the national accelerator programme to reduce elective waiting lists, UHBW has implemented a range of initiatives, including:

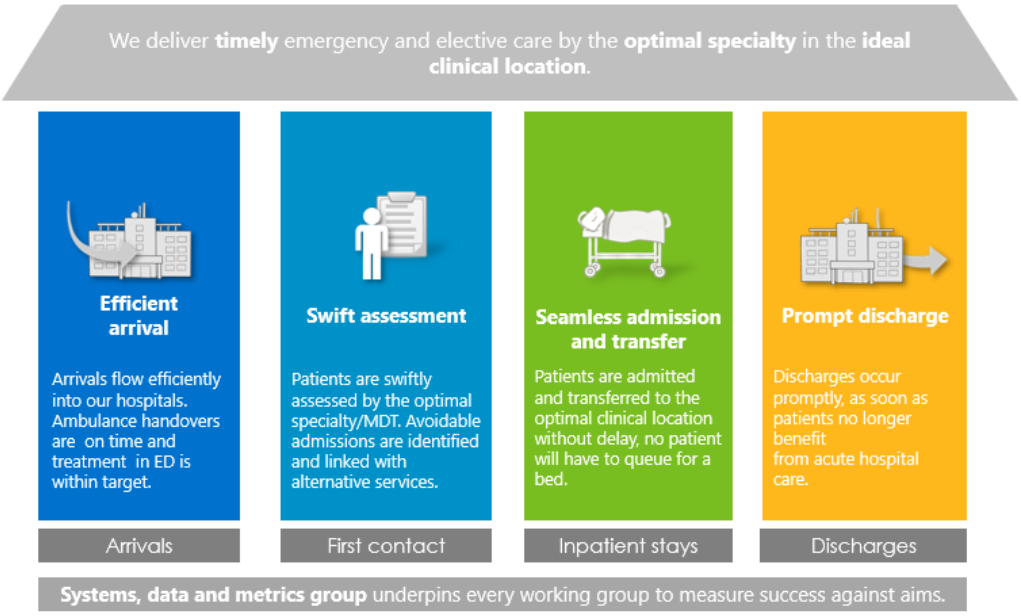
- An Admissions Lounge to support flow into the hospital, was established within Bristol Royal Hospital for Children (BRHC) as a response to the COVID-19 pandemic. In October 2021, funding to extend the Admission Lounge until March 2023 was agreed, enabling the BRHC to undertake an additional 10 elective patient cases per week.
- A new elective facility opened in Knightstone Ward at Weston General Hospital (WGH) in January 2022, allowing us to restart elective orthopaedic and surgical activity at WGH. The additional clinical area will enable between seven to twelve elective cases per week.
- Bristol Eye Hospital established a dedicated **diagnostic assessment** hub off the hospital campus to support surveillance of chronic irreversible eye conditions, due to the success of the hub a permanent location is being sourced. 15,000 patients have attended the “hub” in the three different locations to date reducing the risk of irreversible sight loss for our Glaucoma and Medical Retina patients by ensuring appropriate ongoing treatment. Patient feedback has been extremely positive and the staff in the Hub have enjoyed the new way of working.

Within UHBW’s response to the NHS Long Term plan **our Redesign of Outpatients programme** has focussed on increasing the use of Patient Initiated Follow Up (PIFU), to empower patients to take control of their health and follow ups. Patients are able to arrange an appointment that suits them when they need it based on clinical triggers for their condition, rather than attending a fixed follow up appointment unnecessarily. In 2021/22, 29,993 patients have been added to a PIFU pathway, which is 4.1% of outpatients who have attended an appointment.

As part of the national response to the COVID-19 pandemic, UHBW expanded our clinical prioritisation and validation processes to include diagnostic and outpatient waiting lists, building on the process developed for prioritisation of elective waiting lists implemented in 2020/21. This ensures we assess and treat the patients with the highest priority clinical needs first.

In August 2021, a new medically stable for discharge model was introduced on Kewstoke ward at WGH. The model facilitates proactive discharges for patients requiring a discharge to assess (D2A) pathway one or two. Care is provided by an integrated nursing and therapy team with a rehabilitative approach towards activities of daily living, patients are supported to 'do themselves' rather than being 'done to', minimising the risk of patient deterioration whilst awaiting discharge home. The model helps generate effective working relationships between social care, community providers and UHBW leading to greater awareness of patients awaiting discharge and their care needs. Work to embed the model and monitor the benefits of the model for patient, staff and the organisation will continue in 2022/23.

Proactive Hospital launched in May 2021. The model aims to improve quality and efficiency by supporting agile improvements to the way we assess, admit and discharge patients through our hospitals. Improvements are prioritised to support the delivery of four key drivers:



Four Proactive Hospital Improvement coaches have been recruited to work with clinical/non-clinical staff to develop their improvement capability and promote culture of continuous improvement across the organisation.

Example of improvements underway under this transformation programme include:

- Digitally allocating beds for patients awaiting admission in one of our Emergency Departments (ED), reducing phone calls to ED from assessment units by 40%. 75% of staff (in recent survey to identify further improvements to reduce transfer times), felt the digital process has simplified communication about beds and 88% agreed that it makes admission plans clear.
- Proactive Board rounds, using national best practice to ensure adult board rounds consistently and effectively progress a clear plan of care towards timely discharge.

Development of our **Every Minute Matters** (Foundations of Care) programme commenced in Q4 2021/22, which will work in conjunction with Proactive Hospital to support clinical teams to sustain and improve key ward processes to ensure quality, good patient experience and hospital flow.

Work was commenced to refresh the Trust's approach to compliance with the NHS **Accessible Information Standard** (AIS). The focus of our new AIS plan is to ensure we consistently meet the

communication and information support needs of patients with a disability or sensory loss. We involved community partners in developing the plan to ensure effective improvements are made. Successful improvements so far include having the ability to provide audio versions of patient letters and Bristol Eye Hospital, in partnership with Bristol Sight Loss Council, have launched an e-learning package for staff on how to better meet the needs of patients with a Visual Impairment (VI).

Our People: We will invest in our staff and their wellbeing, supporting them to care with pride and skill, educating and developing the workforce for the future.

The organisation's new values and leadership behaviours, shared in section 3.1.2, were developed with our staff. Through surveys and a series of focus groups staff were able to provide feedback on existing values, share ideas to shape the new values and leadership behaviours, and then choose their preferred option from four proposals created from their feedback and ideas.

Following the success of the hospital hub vaccinations as part of the Bristol, North Somerset and South Gloucestershire (BNSSG) vaccination programme in 2020/21, the hubs were re-established in September 2021 to deliver a joint Flu and COVID-19 booster vaccination programme across our Bristol and Weston sites. Over 11,000 COVID-19 booster and 8,000 flu vaccinations had been delivered by the end of March 2022.

Expansion of our **Advanced Care Practitioner (ACP)** workforce was identified as a priority to support workforce challenges, as well as retain experienced staff by offering new career pathways.

To achieve this ambition a range of work has been completed:

- Secured HEE funding for trainee ACP posts.
- Retaining 14 qualified ACP posts and increasing trainee ACP's from 11 to 24.
- Delivered a regional ACP conference to celebrate the role and its impact on patient care in UHBW, which was attended by eighty delegates, raising awareness of the role and its contribution to workforce transformation.
- Improvement in organisation readiness for developing the ACP role, demonstrated when updating the Health Education England Organisational readiness assessment.

In November 2021, the Trust launched a Leaders Connected information platform, which enables staff to access stories of successful leaders within our organisation, who share their leadership journey, and how they use the values and behaviours in practice.

Our Portfolio: We will consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focusing on core areas of excellence and pursuing appropriate, effective out of hospital solutions.

There has been a long-standing strategic aim to develop a V-V ECMO (Extra Corporeal Membrane Oxygenation) and Severe Acute Respiratory Failure (SARF) service for the South West. ECMO is a life-saving intensive care treatment for severe respiratory illness which our patients need to transfer to London to receive currently. In December 2021 national commissioning was agreed to develop a service, based at UHBW, with both North Bristol NHS Trust (NBT) and UHBW providing staffing. The proposal is based on a transitional plan over a 12-18 month period to build up the capacity to treat 30 ECMO patients per annum. The first phase will involve treating local patients, before progressing to provide a regional retrieval service. Mentoring is being provided from Guys and St Thomas's, a nationally commissioned ECMO centre.

In January 2022, Trust Board approved the General Intensive Care Unit (GICU) Stage 2 Expansion Full Business Case (FBC), and the scheme is now in the construction phase. This scheme will expand the GICU on the BRI site by a further 11 beds to 40 GICU beds in total (across the Bristol and Weston sites). The beds are planned to become available to the Trust by August 2023. The expansion of the GICU is a key deliverable within the Trust's Clinical Strategy Programme, supporting both the consolidation and growth of our specialist portfolio and elective recovery.

Our Bristol Haematology and Cancer Hospital (BHOC) was commissioned as one of the first wave Chimeric Antigen Receptor T-cell (CAR-T) centres in the UK at end of 2018 and treated our first patient in December 2018, who remains in remission to this date. The CAR-T service has continued to evolve and is now ahead of the original estimates for the number patients treated. To support the service an extra bed has been created on one of our BHOC wards, and proposals are in development for an ambulatory Bone Marrow Transplant services to free bed capacity and facilitate future expansion of inpatient Car-T treatment. Future expansion will also be facilitated by the agreed expansion of critical care in order to support the proportion of CAR-T patients who require an ICU bed post-infusion

BNSSG Integrated Care System identified children and young people (CYP) asthma as a key priority area. A pilot commenced in March 2022 to deliver community-based asthma clinics, led by a UHBW paediatric consultant asthma nurse, where CYP and their carers will be offered a clinical review and education to manage their condition. The pilot will continue through 2022/23 with the aim of improving the links between primary and secondary care to optimise community asthma management and streamline referrals to specialist services.

Significant expansion of operational delivery networks (ODNs) hosted by our Women and Children's Division has been undertaken. In addition to the pre-existing congenital heart disease and neonatal ODNs, a CYP cancer network, a surgery in children network, a paediatric critical care network and a fetal network have been established. Funding has been secured to deliver a new obesity hub and spoke network in 2022/23.

Following the rapid implementation as part of UHBW COVID-19 pandemic response the use of **advice and guidance** services has been sustained. Advice and guidance enables primary care clinicians to access specialist expertise to support patient care and prevent patients having to attend hospital. During 2021/22, 17,635 advice and guidance requests have been received by UHBW clinicians.

In April 2020, Weston Area Health NHS Trust (WAHT) and University Hospitals Bristol NHS Foundation Trust (UHB) merged to form University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). Over the last two years, clinical and corporate teams across the Trust have worked together, collaborating across Bristol and Weston during the pandemic response. Teams have also been working hard to realise the benefits of integrated services for patients, staff, and local people, driving improvement across a range of services, systems, and clinical specialities.

Almost two years on, our key achievements of note are:

- Despite significant operational pressures across the Trust, integration across a range of clinical specialities has continued, with 13 (of 34) clinical services now fully integrated, with the process expected to be completed by October 2022. Collaborative working brings a number of benefits such as offering more resilience, sharing best practice and supporting a wider range of clinical services to be available to the patients of Weston. An example of this is the integrated Audiology service, which has been able to modernise the hearing test equipment and improve the standard hearing aid of choice to the more modern rechargeable Bluetooth hearing aid, previously only available to patients attending the Bristol site. The Audiology service is now also benefitting from being on a single patient management system for all new appointments and hearing aid fittings. This allows more flexibility for staff and patients and includes the option for patients to use the e-referral system to book their own appointments at their own convenience. Going forward, core clinical services on our Weston General Hospital site (including wards, theatres, and outpatients) will be operated by a strengthened management model under a Site Director, working in partnership with the Trusts five clinical divisions.
- All 21 corporate support services are now integrated and managed on a Trust-wide, with increased resilience and capacity.
- Our five-year plan to achieve recruitment of more permanent staff across the clinical professions at Weston General Hospital is being supported by dedicated recruitment and retention resources. Despite the challenging operational conditions over the last 18 months,

registered nursing numbers in post remains on track, supported by both local, regional, and international nursing recruitment initiatives. In the medical workforce, the Trust has been successful recruiting clinical fellow doctors to the Weston Division, filling almost all available posts, however consultant recruitment remains challenging, despite extensive recruitment and retention initiatives. There is a national shortage across a range of medical specialties, and we are competing for talent with other local and national Trusts. Whilst we are developing comprehensive and targeted recruitment campaigns and range of incentives, the situation is only expected to improve over time as the long-term clinical models of care at Weston are agreed and rolled out as part of the Healthy Weston programme.

- Through increased development of local partnerships, the Trust is seeking to position itself as an 'anchor institution' in North Somerset with a reputation for providing great training and education to the benefit of existing staff and prospective employees. The aim is to ultimately support improvements at Weston General Hospital with recruitment and retention as well enabling the support and development of new healthcare roles. An example of this is the Weston apprenticeship programme, which is now integrated Trust-wide, with Increased numbers of apprenticeships coming online, as well as a first cohort of trainee nursing associate's starting with Weston College in September 2021. The recent introduction of a new UHBW wide staff learning management system - Kallidus Learn, is another example of how the Trust is enabling staff across the organisation easier access to a wider range of learning and development opportunities to support high standards of clinical practice and patient safety.
- The estates and building infrastructure is steadily improving at Weston General Hospital (WGH), with the first £2.5m investment into essential works, as part of a wider £10m improvement programme over 5 years.
- Our 5-year Digital systems convergence programme is replacing outdated legacy IT systems at WGH and moving to modern cross-site solutions that enable better and more flexible management of patient care by clinicians. The next important step on this journey is to merge the two versions of our patient administration system (Medway), planned for April 2022.

Future clinical vision (Healthy Weston): We have an ambitious vision for Weston General Hospital to lead the country as a successful small hospital delivering truly integrated, safe, and high-quality services that meet the specific needs of local people, now and in the future, working in new and innovative ways with our health and care partners.

We are already on the way to achieving this ambition through the changes implemented at Weston General Hospital a couple of years ago. These have made services safer and more sustainable, particularly for urgent and emergency care, critical care, emergency surgery and acute children's services; closer working was established with local GPs and put more focus on providing the services needed by the majority of local people, most of the time.

These improvements were all delivered as part of the initial phase of the Healthy Weston programme. It was made clear at the time that more work would be required, building on these improvements, and exploring more opportunities to bring further resilience and stability to Weston General to fully achieve the ambition and create a centre of excellence in Weston, playing to the unique strengths and further developing the new ways of working already underway.

As a local health and care system we are now looking in detail at how to move forward; building on the learning and changes made in response to COVID-19. This second and final phase of the Healthy Weston programme will focus on securing Weston as a thriving hospital at the heart of the community.

Our Partners: We will lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve.

As part of the new Integrated Care System (ICS) arrangements nationally, provider organisations are being asked to step forward in formal collaboratives to better enable them to work together to continuously improve quality, efficiency and outcomes for the populations they serve together.

As our local ICS “Healthier Together” develops, a key part of system improvement will be through our ongoing partnership with North Bristol NHS Trust (NBT), now referred to as our “Acute Provider Collaboration” or APC. (This was formerly referred to as the Acute services Review or ASR). During 2021, we updated the APC governance arrangements in line with the new ICS guidance.

Our APC Partnership Board is now jointly chaired by UHBW Chair Jayne Mee and Michelle Romaine, Chair at NBT. The APC Board includes CEOs, executive and non-executive directors from both organisations and has delegated decision making and investment authority for collaboration activities from both Trust Boards.

Within the APC, our Joint Clinical Sponsorship Board brings our clinical leaders together to share learning and develop aligned clinical plans to deliver the best outcomes for our patients.

Despite the challenging operating conditions, UHBW and NBT have made significant progress together over the past year, including:

- The formal commitment of both Trust Boards and CCG Governing Body to the reconfiguration of BNSSG Stroke Services, with a target implementation date of November 2022.
- A decision to implement the ‘Patient First’ continuous improvement methodology in both Trusts. Patient First uses proven improvement methodologies to empower staff to make improvements across all areas of an organisation, which leads to measurable improvements for patients and staff.
- Both NBT and UHBW are being mentored by University Hospitals Sussex who successfully use the Patient First methodology.
- Support and funding for a Bristol-based South West V-V ECMO service agreed by National commissioners in December 2021, as per Our Portfolio section.
- Jointly developed critical care expansion cases, culminating in the approval by UHBW’s board of a capital scheme, as per Our Portfolio section.
- Progressing the integration in Neonatal Intensive Care, including capital design work to inform a full business case.
- Ongoing digital collaboration, including the joint procurement of a maternity clinical system to support collaboration across the units, a joint digital outpatient system and the alignment of critical care clinical information systems across the BRI, Weston and Southmead.
- Investment in an Enhanced Supportive Care service secured to improve quality of life & reduce unplanned admissions for patients with incurable cancer.
- Development and delivery of the Healthier Together @Home programme, supporting the delivery of care in the most appropriate place, including the person's home environment. Adult patients are being managed remotely on the following ‘virtual ward’ pathways:
    - COVID-19 Virtual Ward Oximetry@Home for Adult and Maternity patients
    - Outpatient Parenteral Antibiotic Therapy (OPAT), saving 272 bed days for UHBW patients since the launch in November 2021. Additional patients have switched to oral antibiotics following review by O-PAT team.

Acute Respiratory pathway, supporting patients with an exacerbation of their Chronic Obstructive Pulmonary Disease (COPD) to receive earlier community treatment, avoid admission or have an earlier discharge.

The continued commitment of both organisations to work together will be a key factor in tackling our shared challenges of elective restoration and emergency demand as we recover from the acute phase of the COVID-19 pandemic.

Working with wider partners in our ICS, we have also:

- Built on the pilot in 2020/21 for community phlebotomy pathways, expanding across BNSSG and enabling 12,347 blood tests for UHBW patients to be undertaken closer to home via their GP surgeries.
- Working with our system partners, a patient temporary care facility was established until the end of March 2022, enabling patients awaiting a community package of care to receive nursing and therapy care outside of the acute hospital environment. 101 patients with No Criteria to Reside were discharged from UHBW hospitals to the patient temporary care facility (from opening to March 2022), releasing 811 bed days across our adult wards.

Our Potential: We will be at the leading edge of research (2.3.4) and transformation that is translated rapidly into exceptional clinical care and embrace innovation.

We continue to recognise and support our great people in continuously improving services and delivering best care for our patients and populations.

In 2021/22, in addition to continuing Bronze, Silver and Gold courses, the Quality Improvement Academy expanded the awareness and training offer to include a session on the Trust induction for all new staff and a foundation e-learning course accessible by all staff. Bright Ideas, our competition for small innovations was held once in 2021/22 with continued support from the West of England Academic Health Science Network and our Bristol and Weston Hospital Charity. Ideas were submitted with three winners selected:

- Biodegradable dental disposables
- Make Bristol your home information pack
- Cardiac surgery discharge information video

In March 2022, leads from UHBW quality improvement faculty commenced delivery of the first **Quality Improvement in Healthcare module**, as part of University of Bristol's (UoB) Post Graduate certificate in Healthcare Improvement and the MSc in Healthcare Management.

Work has continued to **develop quality improvement clinical leaders of the future**. Developing our relationship with UoB, we have appointed two Year 5 Medical Student as Student Leads for NHS Leadership and Transformation, with huge interest in this role when advertised. They will be 'champions' and raise awareness of medical leadership in their practice, and how improvement and transformation is central to this. They are also developing resources for UoB Medical Student 'Blackboard' as curriculum resources.

In addition, we have developed opportunities for year 3 students to either undertake an elective placement (from 2023) or, from June 2022, a 'Study in depth' (eSSC) project in Leadership and Transformation at UHBW; these have been submitted and are awaiting student selection.

We are continuing work with the South West Deanery and have had initial approval for new dedicated F2 posts in Leadership and Transformation, with the curriculum for this under development. Training for F1/2 Educational Supervisors on supporting QI Leadership is now also on the curriculum with first session delivered March 2022.

Our Performance: We will deliver financial sustainability for the Trust and contribute to the financial recovery of our health system to safeguard the quality of our services for the future.

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

Following a successful pilot in 2020/21 Gooroo planner, software which uses algorithms to model the impact of different demand and activity scenarios on waiting lists, is being used across UHBW to support planning of multi-year recovery requirements.

A Trust wide theatres efficiency project has focused on the development of a performance dashboard, which along with benchmarking data will be used by our clinical teams to identify where improvements can be made to ensure all theatre capacity available is used effectively, supporting the management of our elective waiting list and foster access.

The work of our Clinical Divisions "Working Smarter Groups" is key to improving efficiency and productivity. Examples of the impact this Working Smarter approach has on the quality of our services include the roll out of the Trust's managed inventory system (MIS). Like most large NHS trusts, UHBW has experienced significant issues with stock control. To resolve this problem, the Trust has invested in a Managed Inventory System (MIS). Pre-set maximum stock and re-order levels can now be quickly and easily adjusted as required so that the system knows when to replenish stock. In addition to this, the storing of product transaction and ordering history makes product recall and other product searches much easier for both clinical and non-clinical staff.

Starting with Theatres in the Division of Surgery, MIS has been gradually rolled out to nine other clinical and non-clinical settings, with more areas in the pipeline. The considerably improved stock control has enabled efficiency savings approaching £300,000 in the form of a 'payment holiday' (a temporary pause in purchasing) this financial year and is providing invaluable spending insight. A wide range of monthly reports are also available through an online reporting tool; these reports are beneficial to both clinical and non-clinical staff. By standardising on certain generic products, the system will also facilitate cost savings in the years to come, releasing resource to reinvest in care.

2.1.5 Key risks to delivering our objectives

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

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

The COVID-19 pandemic continues to negatively impact on the delivery timescales of action plans in relation to the mitigation of strategic risks as it has been necessary in many cases to re-direct resources to assist with the operational response.

The move towards establishing an Integrated Care System (ICS) may lead to a number of changes that may impact on Trusts financial regime and its ability to invest in Capital projects.

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

- That the Trust fails to achieve the objectives of its financial strategic plan;
- That the Trust is unable to recruit sufficient numbers of substantive staff;
- That Trusts IM&T Systems fail to deliver the required levels of efficiencies;
- That the Trust is unable to invest in modernising the Trust estate;
- That the Trust has insufficient leadership capacity;
- That the Trust is unable to retain members of the substantive workforce;
- That Research and Innovation is not adequately supported;
- That the benefits of transformation, improvement and innovation are not realised;
- That the Trust fails to make a positive impact on combatting climate change;
- That the objectives of the Trust wide multi-disciplinary education strategy are not delivered;
- That the Integrated Care System (ICS) Implementation reduces the Trusts decision making powers;

- That the Trust is unable to deliver a suitable service model for Weston General Hospital.

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 2022/23 financial plan, further forecasting has been undertaken in relation to the Trust's cash position for the period from 1st April 2022 through to 30th September 2023. The cashflow forecast predicts significant cash balances throughout the period with a projected minimum cash balance of c£100m as at 30th September 2023. In addition, downside forecasting has been undertaken, which considers a number of factors, for example, failure to deliver the NHSEI savings requirement in full and additional cost pressures, to stress test the cashflow forecast. The downside forecast continues to predict significant cash balances throughout the period. The projected minimum cash balance is £71m as at 30th September 2023. After consideration of the cashflow forecasts, the directors have adopted the going concern basis.

2.1.7 Overview of financial performance

The financial regime for 2021/22 is similar to the arrangements in place through 2020/21, with a strong focus on financial balance being achieved at system level. Support was in place to cover the on-going costs of the Pandemic, but there remained uncertainty in terms of the level of recurrent funding available moving into 2022/23.

The regime in place for 2021/22 enabled a balanced position for the system with opportunities to attract non-recurrent funding through the Elective Recovery Fund (ERF). However, an increased efficiency and productivity requirement in the second half of the year supported the expectation that systems return to levels of funding set out in the NHS Long Term Plan (LTP) published in January 2019 and the LTP Implementation Framework issued in June 2019.

The Trust's 2021/22 financial plan, was a breakeven revenue income and expenditure plan, constructed in accordance with the national planning guidance issued by NHS England and NHS Improvement (NHSEI) and aligned with the Bristol, North Somerset & South Gloucestershire Sustainability & Transformation Partnership (BNSSG STP) or system funding envelope issued by NHSEI.

The Trust delivered a net income and expenditure surplus of £5.071m (excluding technical items), which is a major achievement considering the operational pressures and additional costs due to the ongoing impact of COVID-19 combined with the implementation of a significant revenue investment programme.

During the financial year, the Trust incurred £12.049m on COVID-19 related expenditure such as staff testing and vaccination costs. The Trust also invested £30m in 2021/22 (in addition to £23m in 2020/21) on services such as phase 1 adult intensive care expansion, the adult intensive care retrieve service, and an expansion in cancer services. This was the 19th year in a row that the Trust delivered a surplus or break-even income and expenditure position (excluding technical items).

The Trust achieved savings of £12.245m against a plan of £15.515m. Understandably, the continuation of the COVID-19 pandemic significantly reduced the Trust's ability to make recurrent savings during 2021/22.

The Trust's statement of financial position remained positive with net current assets of £69.996m and a year-end cash and cash equivalents balance of £168.091m.

Despite the continuing challenges of the pandemic in accessing services and the estate, the Trust invested £66.519m on capital projects, reconfiguring and improving the Trust's estate, purchasing medical equipment, and investing in information technology.

In accordance with NHSEI requirements, the Trust submitted its 2022/23 financial plan on 28th April 2022. A further submission of system and providers 2022/23 financial plans was requested by NHSEI on 20th June 2022.

Eugine Yafele
Chief Executive
22 June 2022

2.2 Performance Summary

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

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

The national standards are:

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

2.2.1 Referral to Treatment (RTT)

The national standard for Referral to Treatment (RTT) is 92%. This has not been achieved for the whole of 2021/22.

Month End	Total List Size	18 Week Backlog	Percentage Under 18 Weeks
Mar-21	46,532	17,813	61.7%
Mar-22	55,021	22,466	59.2%

Change	8,489	4,653
% Change	18.2%	26.1%

The backlog growth in the main related to the COVID-19 pandemic, with step-down of capacity to support the pressures in the hospital relating to admitted COVID-19 patients. This was further exacerbated with winter pressures as well as periods in the year when critical incidents and decompression activities took place, resulting in the temporary closure of theatres and the step-down of all patients requiring routine treatment, whether as an inpatient admission or an outpatient attendance.

Across the Trust, all services have seen backlog increases and patients waiting longer for an appointment or treatment. The largest areas of growth have been seen in dental services, ophthalmology, cardiac, trauma and orthopaedic (T&O) in both adult and paediatric areas. The dental and ophthalmology growth was a result of step-down of theatres from four to one in the Bristol Eye Hospital and the suspension of dental treatments due to the guidance received during the pandemic relating to the use of air-flow equipment. Furthermore, staff have been redeployed to support wards and other pressured areas within the Trust during the pandemic. The T&O growth has occurred from patients referred into the Referral Assessment Service (RAS) and the lack of clinic capacity to book an appointment slot for these routine patients. Overall the waiting list as a whole has increased by 8,489 patients.

With the COVID-19 pandemic, the winter pressures and step-down of many of the lower priority routine patients, the focus for the Trust is to continue with the national clinical prioritisation programme and to identify capacity to treat those patients who have been clinically prioritised as P2 – require treatment within one month. However, recovery of RTT performance is expected to be difficult given the volume of more urgent patients, especially those on cancer pathways who require the majority of the capacity that is available.

Month End		40+ Weeks	52+ Weeks	78+ Weeks	104+ Weeks
Mar-21		6,740	5,409	515	27
Mar-22		8,002	3,920	833	346

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

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

The Trust did not meet the national 95 per cent standard for the number of patients discharged, admitted or transferred within four hours of arrival in our emergency departments. Annual performance for all sites combined was 66.8 per cent (April 21-March 22). For the four emergency departments (EDs):

- The Bristol Royal Hospital for Children (BRHC) ED achieved the 95 per cent standard in zero months during 2021/22, and achieved 78.0 per cent for the year
- The Bristol Eye Hospital (BEH) ED achieved the 95 per cent standard in all 11 months so far in 2021/22 and achieved 97.2per cent for the year
- The Bristol Royal Infirmary (BRI) ED did not achieve the 95 per cent standard in any month of 2021/22, and achieved 50.4 per cent for the year
- The Weston General Hospital (WGH) ED did not achieve the 95 per cent standard in any month of 2021/22 and achieved 67.3 per cent for the year.

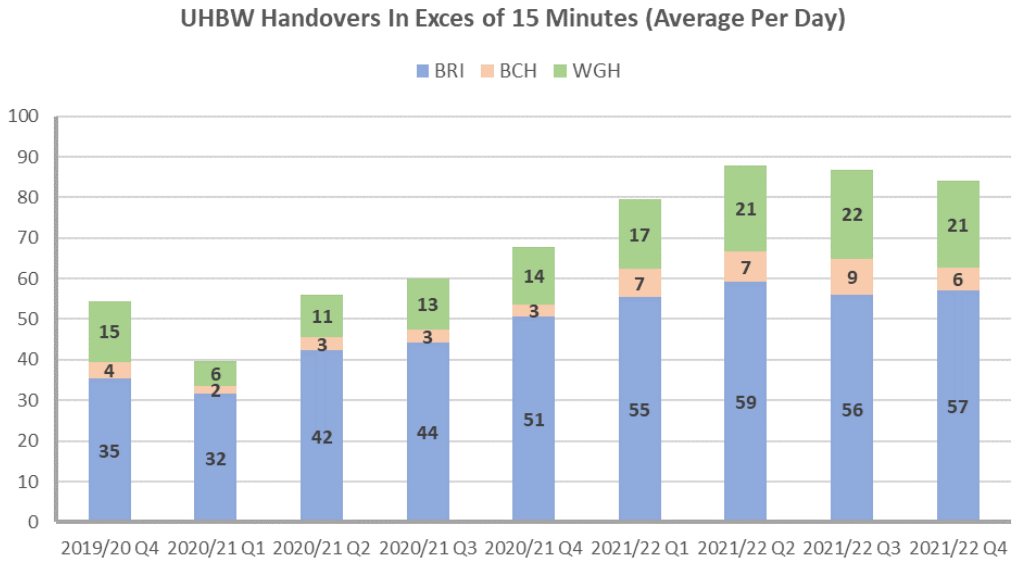
Overall A&E attendances have now normalised with 98% of the 2019/20 outturn experienced in 21/22. Higher volumes were experienced in the BRI (102% of 19/20) and Bristol Royal Hospital for Children (106% of 19/20), although the conversion rate to admission on the adult BRI site remains suppressed when compared to 2019/20. Overall Activity Volumes below:

	Total Attendances		
Hospital	**2019/2020**	**2020/2021**	**2021/2022**
Bristol Royal Hospital For Children	44,499	28,417	47,205
Bristol Eye Hospital	24,941	18,110	22,325
Bristol Royal Infirmary	73,499	59,952	74,852
Weston General Hospital	50,228	33,582	45,481
UHBW Total	**193,167**	**140,061**	**190,223**

Average Attendances Per Day

Hospital	2019/2020	2020/2021	2021/2022
Bristol Royal Hospital For Children	122	78	129
Bristol Eye Hospital	68	50	61
Bristol Royal Infirmary	201	164	205
Weston General Hospital	138	92	125
UHBW Total	**529**	**384**	**520**

In 2021/22 there were 5,761 12 Hour Trolley Wait Breaches (2999 BRI, 154 BCH and 2608 Weston). As a comparison, there were 1,440 breaches in 2020/21.



Although A&E attendances were suppressed, challenges to flow were experienced throughout the year due to ED and inpatient ward reconfiguration to stream and isolate patients during the COVID-19 pandemic, which significantly affected bed capacity, productivity and ambulance handover performance. The other most significant impact of the pandemic was on staffing, with impacts related to staff illness, self-isolating and individual risk assessment considerations.

2.2.3 Cancer

The COVID-19 pandemic has affected the Trust's delivery of cancer standards in terms of compliance throughout the year, however, the Trust has maintained services despite the challenging circumstances, with patient safety at the forefront of delivery. Every cancer patient treated outside the 62 or 31 day standards is assessed for potential harm as a result of their additional waiting time, with fewer than ten patients during the year identified with potential harm as a result of the extra time waited. The Trust's cancer performance has been reported in an integrated way (across Bristol and Weston hospital sites) since the point of merger on 1 April 2020.

The Trust achieved the 62-day GP referral to treatment standard of 85% in zero out of 12 months in the period. The impact of the COVID-19 pandemic on service delivery was responsible for this underperformance, contributing to the majority of 'breaches' of the standard, including many of those principally due to patient choice or medical reasons. Performance became particularly challenging in late autumn and winter due to the surge in COVID-19 cases as a result of the Omicron variant. Cancer performance was more seriously affected at that stage of the pandemic than any previous one, due to the numbers of staff and patients who became unwell with the disease, and because demand did not fall as it did in previous waves of COVID-19. The Trust has well designed pathways and rigorous performance management processes, therefore recovery of compliance with the standards should be possible as soon as the impacts of the pandemic decrease.

The Trust achieved the two-week wait standard of 93% for first appointment following GP suspected cancer referral in one month out of twelve (May 2021). This standard was heavily impacted by the COVID-19 pandemic, and by system wide changes to the referral pathway for suspected colorectal cancers. Vacancies in the Dermatology service were also a factor in underperformance in some months when locum staff were not available. Dermatology is a national shortage area and recruitment is challenging, which the Trust partially mitigates through use of other appropriate skilled professionals to deliver relevant parts of the pathway, such as medical photographers. Towards the end of the year, staff sickness due to the very high prevalence of COVID-19 in the community contributed to a deterioration in performance against the standard. Patient sickness was also a factor in this. With increasing use of 'straight to test' pathways (which is good practice and required to comply with many national 'best practice timed pathways'), first contacts by necessity must be face-to-face and cannot be replaced by a telephone call. This means if either the patient or staff members are unwell with COVID-19, the appointment has to be delayed.

The 31-day decision-to-treat to treatment standards have performed better overall than the earlier pathway standards. The 31-day first definitive treatment standard of 96% was achieved in five out of 12 months (May-Sep 2021). The compliant performance over the spring and summer months reflects the Trust's prioritisation of patients with cancer. However, the Omicron wave of the Covid pandemic affected these standards more adversely than at previous times in the pandemic, due to the numbers of patients and staff who suffered infection. Although the Trust continued to prioritise cancer work, this did not enable treatments to go ahead if the patient or critical specialist staff were unwell with COVID-19.

The 28-day Faster Diagnosis Standard was introduced in October 2021. The Trust complied with the GP referred standard in 5 out of 6 months. The non-compliant position in January was caused by impact of the COVID-19 pandemic and patient choice over the festive period (in particular, patients delaying tests requiring bowel preparation).

Ensuring equality of access remains a priority for the Sustainability and Transformation Partnership's cancer working group, and for the Cancer Alliance. The Trust participates fully in this work, with the Cancer Manager and Lead Nurse representing their peers on the Alliance's Equalities Group. Equalities data in cancer is still at an early stage of development, but progress was made on that at system level throughout the year. Lung cancer was a particular area of focus and the Alliance has worked to introduce Targeted Lung Health Checks. This service will launch in June 2022 and aims to reduce inequalities in the outcomes of people with lung cancer by increasing early diagnosis of the disease in targeted demographic groups.

2.2.4 Diagnostic waiting times

The NHS constitutional standard for 99 per cent of patients waiting for a diagnostic test within six weeks was not met at any point during the year. Month-end performance for diagnostic waiting times varied between 60.6 and 65.4 percent of patients waiting under 6 weeks.

Month End	Under 6 Weeks	Total Waiting	% Under 6 Weeks	13+ Weeks	Percentage 13+ Weeks
Mar-21	9,413	14,448	65.15%	3,016	20.9%
Mar-22	10,124	16,610	60.95%	3,372	20.3%

Diagnostic performance across the Trust has been sustained throughout the year, despite a 15% increase in the overall waiting list size. The bulk of the long waiting patients are concentrated in Endoscopy, Cardiac MRI and echocardiography. Echocardiography performance includes several planned surveillance patients on the Weston hospital site that are not waiting for an initial diagnostic appointment and is therefore a data quality issue in the Trust patient tracking list. This is expected to be resolved during the Summer of 2022, when new diagnostic interface services will be introduced.

Test Name	Under 6 Weeks	Total Waiting	% Under 6 Weeks	13+ Weeks	% 13+ Weeks
Audiology	499	520	96.0%	0	0.0%
CT	1,664	1,965	84.7%	95	4.8%
DEXA Scan	452	762	59.3%	25	3.3%
Echocardiography	1,332	3,442	38.7%	1,169	34.0%
Endoscopy	732	2,083	35.1%	937	45.0%
MRI	1,903	2,888	65.9%	590	20.4%
Neurophysiology	155	160	96.9%	0	0.0%
Sleep Studies	14	52	26.9%	35	67.3%
Ultrasound	3,373	4,738	71.2%	521	11.0%
Grand Total	**10,124**	**16,610**	**60.95%**	**3,372**	**20.3%**

Diagnostic activity levels continued to be at or above pre-pandemic levels in 2019/20, although there were some capacity issues in Endoscopy experienced during the winter period and Omicron surge that have contributed towards a higher backlog. The Trust is planning to increase diagnostic activity and recover services with the scaling up of a Community Diagnostic hub across the local healthcare system by 2023. Waiting lists also continue to be validated and data cleansed to ensure patients are correctly on new and planned surveillance waiting lists respectively. An extension of the principles introduced via the national elective waiting list clinical validation and prioritisation exercise was also implemented for diagnostic tests during the Autumn of 2022. Activity levels in 2021/22 as a percentage of 2019/20 levels are shown below.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Computed Tomography	118%	113%	120%	114%	119%	118%	112%	118%	111%	105%	112%	131%
Magnetic Resonance Imaging	115%	99%	118%	101%	116%	115%	98%	108%	88%	93%	97%	112%
Echocardiography	108%	113%	108%	105%	115%	105%	90%	112%	109%	89%	85%	126%
Endoscopy	114%	76%	92%	92%	116%	147%	140%	113%	125%	93%	74%	121%

2.2.5 Outpatients

The COVID-19 pandemic has affected the Trust's delivery of outpatient services. Follow up backlogs have increased with 101,471 patients currently overdue follow up.

Table 1: Patients Overdue an Outpatient Follow Up as at Feb-22:

	Under 9 Months	9-11 Months	12+ Months	Total
Diagnostics & Therapies	9,978	147	303	10,428
Medicine	13,567	1,526	4,225	19,318
Specialised Services	8,601	1,244	565	10,410
Surgery	24,114	3,087	5,540	32,741
Weston	9,965	2,248	9,373	21,586
Women's and Children's	5,565	612	759	6,936
UHBW TOTAL	**71,790**	**8,864**	**20,765**	**101,419**
Bristol Subtotal	*61,825*	*6,616*	*11,392*	*79,833*

This has largely been the result of Outpatient activity being de-prioritised and cancelled during the COVID-19 response, with resources diverted to meet the urgent care response. During the restoration of activity urgent new patient and procedure activity has been prioritised, further impacting on the delay of follow up care. The outpatient waiting list validation programme has been progressed to understand the risks associated with our longest waiting patients. Over 24,000 patients have now been reviewed and work continues with BNSSG partners to progress mitigation of the risks to patients waiting.

The UHBW outpatients redesign programme was paused during the 2021/22 second wave of the pandemic due to a lack of clinical and operational capacity. Some Transformation resource was

diverted to the delivery of COVID-19 projects, and the remainder focused on supporting specialities with capacity to continue outpatient transformation and the progression of toolkits.

Non-face to face activity has fallen from 30 per cent in 2020/21 to 22.4 per cent in 2021/22. This is because of the continued urgent care response and the impact on consultant capacity. The BNSSG digital patient programme has procured a replacement virtual consultation provider for Attend Anywhere, which is to be deployed in April 2022. The “DrDoctor” patient portal includes additional functionality to support patients accessing services including appointment letters, text message reminders and waiting list management functionality. Plans are in progress to promote the benefits of the “DrDoctor” platform and recover non-face to face activity.

Advice and Guidance activity has deteriorated during 2021/22. Services are being delivered from 44 specialities. Referrals numbers have fallen from 24,048 referrals in 2020/21 to 18,325 in 2021/22. Performance has fallen from over 90 percent response rate within 7 days to 72 per cent. Plans are in progress to review the sustainability of this rapid redesign of outpatient delivery with the CCG and Healthier Together for 2022/23.

Patient feedback from the delivery of community phlebotomy hubs in 2020 has shaped the development of the BNSSG primary care community phlebotomy model, with the view of supporting patients to access care as close to home as possible. The new model went live across BNSSG in October 2021. Since the launch over 12,000 requests have been made with the Trust reaching the target of 1,900 requests a month in March 2022.

Patient initiated follow up supports patients to engage in managing their long term conditions and make appropriate choices about how to access on going care. Over 4% of outpatient attendances have received the outcome of patient initiated follow up, exceeding the 2% national target set for 2021/22.

To support patients attending outpatient departments for face-to-face care, changes continue to be needed to support social distancing. New processes and risk assessments have been embedded into operational practice. Patient communications are continually reviewed to provide patients with information on how to access care.

Table 2: Performance against Outpatient Transformation Priorities in 2022/23

	Non Face To Face		Non Face To Face (Video)		Advice & Guidance		Advice & Guidance Responses		Patient Initiated Follow-Up	
	Total	% of All Attendances	Total	% of All Non Face To Face	Total Responses	% of New Attendances	Responses Within 7 Days	% Responses Within 7 Days	Total PIFU'ed Outcomes	% of All Attendances
Diagnostic & Therapy	1,227	16.5%	232	18.9%	43	1.1%	43	100.0%	392	5.2%
Medicine	3,298	42.2%	327	9.9%	251	9.9%	182	72.5%	458	5.6%
Specialised Services	5,458	45.0%	265	4.9%	308	12.7%	291	94.5%	239	1.9%
Surgery	1,300	6.0%	45	3.5%	182	3.3%	158	86.8%	349	1.6%
Weston	1,564	23.8%	0	0.0%	172	6.6%	140	81.4%	533	7.2%
Women's & Children's	2,122	13.9%	257	12.1%	518	10.1%	305	58.9%	856	5.5%
TOTAL	**14,969**	**21.1%**	**1,126**	**7.5%**	**1,474**	**6.6%**	**1,119**	**75.9%**	**2,827**	**3.9%**

2.2.6 Important events since the end of the financial year

The COVID-19 pandemic continues to have an impact on the Trust’s performance and the ability to see and treat patients in a timely way. The changes to the Infection Prevention and Control Guidance in April 2022 has supported improvements in the Trust’s ability to provide care to patients and the Trust is continuing to seek to improve performance in key operational metrics relating to ambulance handover delays, cancer waits and the number of patients waiting over 104 weeks.

Table 3: Performance against national standards

National standard	Target	2018/19	2019/20	2020/21	2021/22
A&E maximum wait of four hours	95%	86.3%	80.4%	80.1%	66.8%
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	95.6%	97.2%	81.1%	83.5%
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	49.3%	50.2%	68.0%	48.3%
A&E Unplanned re-attendance within seven days	<5%	3.3%	3.6%	4.5%	2.9%
A&E Left without being seen	<5%	1.7%	1.6%	1.0%	3.0%
Cancer – Two-week wait (urgent GP referral)	93%	95.3%	93.4%	81.9%	82.4%
Cancer – 31-day Diagnosis To Treatment (first treatment)	96%	97.2%	95.8%	95.1%	93.4%
Cancer – 31-day Diagnosis To Treatment (subsequent surgery)	94%	96.1%	92.5%	84.1%	85.1%
Cancer – 31-day Diagnosis To Treatment (subsequent drug therapy)	98%	98.4%	98.6%	99.4%	99.3%
Cancer – 62-day Referral To Treatment (urgent GP referral)	85%	85.6%	85.5%	78.7%	76.0%
Cancer – 62-day Referral To Treatment (screenings)	90%	66.7%	71.1%	57.1%	50.3%
Cancer – 62-day Referral To Treatment (upgrades)	85%	83.7%	86.6%	86.8%	85.1%
18-week Referral to Treatment Time (RTT) incomplete pathways	92%	89.0%	83.2%	61.7%	59.2%
Six-week diagnostic wait	99%	96.7%	95.2%	65.2%	61.0%

2.3 Finance Review

2.3.1 Financial analysis

The Trust reported a net surplus of £5.071m, 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 NHSEI 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 £5.071m surplus compared with the breakeven plan was primarily due to additional income from non-patient care activities of £2.782m and lower than planned elective activity resulting in reduced non-pay expenditure.

Including technical items and as per the annual accounts, the Trust reported a net income and expenditure surplus of £7.713m.

The financial plan for 2021/22 was approved by the Trust Board on 27 May 2021. The plan was submitted by the Trust to NHSEI in June 2021, covering the first six months only. NHSEI also requested a financial forecast for the remaining half of the financial year in November 2021. Consistent with the national planning guidance and 2020/21, the increased national employer pension contributions were excluded from the plan and show as a material adverse variance i.e., additional employee expenses of £24.306m in respect of the increased contributions was matched with corresponding additional income from patient care activities.

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

Table 4: 2021/22 Financial performance against plan:

	Plan £m	Actual £m	Variance Favourable/ (Adverse) £m
Income from Patient Care Activities	914.690	937.560	22.870
Other Operating Income	131.097	134.259	3.162
Total Operating Income	**1,045.787**	**1,071.819**	**26.032**
Employee Expenses	(590.227)	(621.693)	(31.466)
Other Operating Expenses	(405.206)	(396.298)	8.908
Depreciation (owned & leased)	(28.072)	(32.042)	(3.970)
Total Operating Expenditure	**(1,023.505)**	**(1,050.033)**	**(26.528)**
PDC	(12.084)	(11.929)	0.155
Interest Payable	(2.161)	(2.068)	0.093
Interest Receivable	0.000	0.090	0.090
Other Gains/(Losses)	0.000	(0.066)	(0.066)
Gains/(Losses) on Transfer by Absorption	0.000	(0.100)	(0.100)
Net Surplus/(Deficit) per Annual Accounts	**8.038**	**7.713**	**(0.324)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	(8.038)	(2.643)	5.395
Adjusted Financial Performance Surplus/(Deficit) Reported to NHSEI	**0.000**	**5.071**	**5.071**

2.3.2 Savings

The Trust achieved savings of £12.245m against a plan of £15.515m. The majority of the savings were non-recurrent and mainly related to activity related non-pay costs due to low elective activity volumes. Although, the ongoing effects of the COVID-19 pandemic significantly reduced the Trust's ability to make recurrent productivity and efficiency savings in 2021/22, the Trust continued to develop work streams that concentrated on transactional efficiencies such as obtaining best value through purchasing, controlling spend and further embedding the use of technology.

Table 5: Savings achieved during 2021/22:

Workstream	Plan £m	Actual £m	Variance Fav/ (Adv) £m
Nursing Pay & Productivity	0.700	0.759	**0.059**
Medical Pay & Productivity	0.565	0.145	**(0.420)**
Non-Pay	3.912	8.839	**4.927**
Productivity	0.050	0.590	**0.540**
HR Pay and Productivity	0.018	0.011	**(0.007)**
Income, Fines and External	0.035	0.100	**0.065**
Medicines	0.477	0.489	**0.012**
Allied Healthcare Professionals Productivity	0.024	0.025	**0.001**
Estates & Facilities	0.805	0.805	**-**
Trust Services	0.364	0.481	**0.117**
Weston Merger	1.500	-	**(1.500)**
Plans to be developed from Pipeline	7.065	-	**(7.065)**
Total	**15.515**	**12.245**	**(3.270)**

2.3.3 Statement of financial position

The Trust's cash and cash equivalents balance at 31 March 2022 was £168.091m, a decrease of £1.553m from last year. How the Trust used its cash during the year is shown in the table below:

Table 6: Use of cash 2021/22:

	£m	£m
Opening Cash Balance		**169.644**
Use of cash:		
Net cash flow from operating activities	56.541	
Capital investment	(67.998)	
Other net cash flows from investing activities	17.269	
Public Dividend Capital received	11.023	
Capital loan repayments to the DHSC	(5.834)	
Interest (on capital loan) payments to the DHSC	(1.958)	
Public Dividend Capital dividend payment	(10.010)	
Finance lease payments	(0.586)	
Decrease in cash balance 2021/22		**(1.553)**
Closing Cash Balance		**168.091**

The Trust maintained a positive statement of financial position (balance sheet) throughout the year with net current assets at 31 March 2022 of £69.996m.

Table 7: Statement of Financial Position

Statement of Financial Position	£m
Total Non-Current Assets	528.489
Total Current Assets	217.201
Total Current Liabilities	(147.205)
Net Current Assets	**69.996**
Total Assets Less Current Liabilities	**598.485**
Total Non-Current Liabilities	(60.422)
Total Assets Employed	**538.063**
Equity:	
Public Dividend Capital	312.135
Revaluation Reserve	75.704
Other Reserves	0.085
Income & Expenditure Reserve	150.139
Total Equity	**538.063**

2.3.4 Capital

The Trust Board approved the 2021/22 capital investment programme of £84.743m in May 2021. This was an ambitious plan, but it reflected the priority of the Trust to continue to invest in its estate, infrastructure, and equipment for the benefit of patients and staff.

The approach to capital funding in 2021/22 remained the same as that introduced by NHSEI in 2020/21 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 70% share of the system envelope at £56m of the ICS/system envelope. During the year additional capital allocations were approved by the Department of Health and Social Care (DHSC) in addition to the envelope, particularly in respect of schemes to support elective activity recovery. The Trust's final NHSEI approved capital plan for 2021/22 was £89.543m. Performance against this plan is shown in the table below.

Table 8: 2021/22 Capital Plan by Source

	£m
System Funded	56.110
DHSC Approved Funding	15.798
Grants/Donations	17.635
Total	**89.543**

The limit on capital expenditure meant that not all the Trust's approved capital schemes could be prioritised for delivery in 2021/22. Schemes which were not prioritised for implementation in 2021/22 have been carried forward for consideration and inclusion in the in 2022/23 plan.

Capital funding is allocated to individual schemes in eight areas which are monitored during the year. The Trust's capital programme is managed through the Trust's Capital Programme Steering Group. In 2021/22 the Trust invested £66.519m on capital schemes. This included the following significant investments:

- Salix energy - decarbonisation £16.549m
- Medical Equipment e.g., MRI scanner, CT scanners, patient monitors £14.698m
- Strategic Projects – Including BHOC & Cardiac/GICU £ 5.761m
- Operational Capital e.g., department and system upgrades, emergency lighting £30.358m
- Digital e.g., new devices, network, systems and server upgrades, cyber security £ 6.053m

Table 9: Funding and expenditure on capital schemes:

	2021/22 Plan £m	2021/22 Actual £m	2021/22 Variance £m
Source of Funding:			
PDC	15.798	11.023	(4.775)
Donations - Cash	1.0856	0.631	(0.455)
Salix Grant	16.549	16.549	0.000
Depreciation	32.042	29.885	(2.157)
Cash Balances	24.068	8.431	(15.637)
Total Funding	**89.543**	**66.519**	**(23.024)**
Expenditure:			
Strategic Schemes	9.955	5.761	(4.194)
Medical Equipment	17.619	14.698	(2.921)
Operational Capital	40.410	30.358	(10.052)
Fire Improvement	2.268	1.404	(0.864)
Digital Services	5.734	6.053	0.319
Estates Replacement	8.606	6.149	(2.457)
Weston	2.291	2.096	(0.195)
Other	2.660	0.000	(2.660)
Total Expenditure	**89.543**	**66.519**	**(23.024)**

2.3.5 Countering Fraud, Bribery and Corruption

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

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

Work is carried out across all key areas of Counter Fraud activity, ensuring compliance against the 12 components required by the Government Functional Standard 013: Counter Fraud (NHS Requirements).

The Local Counter Fraud, Bribery and Corruption policy and legislative background is also available on the Trust's intranet along with contact details of the LCFS and the 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 posters in workplaces, the dissemination of Counter Fraud newsletters and regular articles in the Trust's staff newsletter. All materials contain details of the FCRL.

2.3.7 Anti-Bribery Statement

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

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

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

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

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

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

- Staff Conduct Policy;
- Local Counter Fraud, Bribery and Corruption Policy;
- Freedom to Speak Up Policy;
- Register of Interests, Gifts and Hospitality Policy.

A register of interest for 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 NHSEI's Cost Recovery Programme and other organisations involved in this field.

The Overseas Visitors Team provides a seven day a week eligibility checking service across the Trust. The team, which works in a non-discriminatory way, is responsible for establishing an individual's right to free NHS hospital treatment, the raising of invoices to directly chargeable visitors, the processing of European Health Insurance Card, other reciprocal healthcare agreements and for advising clinicians and other staff on their obligations under the regulations.

Eugine Yafele
Chief Executive
22 June 2022

3. Sustainability Report

3.1 Overview

The past year has been unlike any other. The continuing impacts and pressures of COVID-19 have remained, whilst major strides have been made nationally and locally to develop the sustainability ambition for the NHS.

Reconfiguring healthcare services to meet the needs of our communities over the course of the pandemic has brought both sustainability opportunities and challenges. The COVID-19 pandemic has exposed and exacerbated health inequalities, with disproportionate effects on disadvantaged communities. The effects of climate change will similarly affect and disrupt our communities, if action is not taken to reduce our carbon emissions and adapt to an already changing climate. It is not enough for the NHS to treat the problems caused by air pollution and climate change – from asthma to heart attacks and strokes – we need to play our part in tackling them at source. The NHS has already made significant progress decarbonising our care, but as the largest employer in Britain, responsible for around 4% of the nation's carbon emissions, if this country is to success in its overarching climate goals, the NHS has to be a major part of the solution.

At the Trust we have made significant progress over the past year, including:

- New combined heat and power plant becoming operational – 80% reduction in imported grid electricity;
- Increased cycle capacity to over 200 bikes;
- Biodiversity Action plans produced for Bristol and Weston sites;
- Installed over 5500 LED light fittings;
- Recruited 32 Sustainable Healthcare Advocates;
- Introduced recycling coffee cups, bread bags, crips packets, metals and wooden pallets;
- Sustainability Team increased to 13 staff with a Transport Team of 22;
- Solar panels and heat pumps installed;
- Switch from disposable surgical hats to washable saved 25,000 hast in first year;
- Awarded £17.6million of heat decarbonisation funding and successfully delivered projects;
- Reduced greenhouse gases from anaesthetics equivalent to 50 cars off the road;
- Improved 4 outdoor spaces for wellbeing and nature;
- Increased fleet to 7 electric vans and 8 new electric bikes.

At UHBW, we aim to be one of the most sustainable healthcare providers in the world. Since declaring a climate emergency in 2019 we have made progress but there are many opportunities to do things better, smarter and more effectively – for the good of patients, staff and our communities in Bristol and Weston.

As one of the largest organisations in the South West, we have a significant role to play to help protect the environment. We have begun to implement our Sustainable Development Strategy (NHS Green Plan) which sets out how we will manage and reduce our environmental impact, improve efficiency and resilience, and control the cost of delivering our services. Our specific goals are:

- Carbon neutral by 2030- achieving net zero carbon across all our activity;
- Contributing to all the UN Sustainable Development Goals – Benchmarked by achieving 70% rating in our Sustainable Development Assessment tool by 2025;

- Cutting air pollution – Benchmarked by achieving excellent rating on the Clean Air Hospital Framework by 2025;
- Resource efficiency – Zero waste to landfill by 2025 and reducing our consumption of energy and water.

We are committed to embedding sustainability across our own organisation, leading by example in our sector and improving the health and wellbeing of the communities we serve. Following the merger with Weston, we are applying the strategy Trust wide. We have made progress in the past year, bringing together energy, waste, transport staff and establishing a dedicated Sustainability Team to support our staff in delivery of our goals.

We collaborate with our healthcare partners and key stakeholders to ensure that our work is aligned to and have contributed to development of the first ICS Green Plan for 2022/23 and we remain committed to working in partnership to deliver Bristol's One City Plan and the vision for a "fair, healthy and sustainable city".

3.2 Policies

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

Table 10: Sustainability Policy Table

Area	Is sustainability considered?
Travel	Yes
Business Cases and annual business plans	Sustainability impact is assessed for business cases over £1M. Sustainability impact assessment will be brought into business planning
Procurement (environmental)	All our suppliers have been made aware of the Trust's declaration of a Climate Emergency and our 2030 target for carbon neutrality. We are working with Bristol and Weston Purchasing Consortium and North Bristol Trust to integrate sustainability into decision making at all stages of our procurement process through developing a joint Sustainable Procurement Strategy
Procurement (social impact)	
Suppliers' impact	

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

We measure our corporate social responsibility impact using the Sustainable Development Assessment Tool. Our most recent application of the Sustainable Development Assessment Tool was in September 2021, scoring 59% (up from 2020 score 53%) with plans to improve this further included in the Sustainable Development Strategy.

We have worked closely with partners across our care system to develop a Green Plan for Healthier Together our Integrated Care System. We will update the Trust's Sustainable Development Strategy into the green plan format and ensure it is aligned with the Healthier Together plan to ensure we achieve the sustainability benefits across our system.

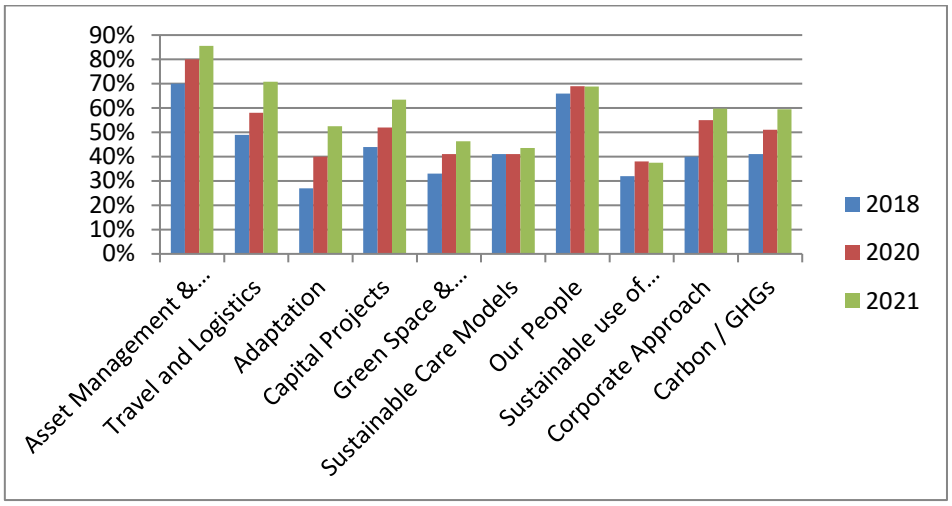
We have updated our Sustainable Development policy and aligning it with the new Green Plans, so we continue to embed sustainability in our processes and procedures.

Climate change brings new challenges both in direct effects to the healthcare estate and to patient health. Examples in recent years include the effects of extreme temperatures and prolonged periods of cold, floods and droughts, which are expected to increase as a result of climate change. The Board has approved plans to address the potential need to adapt the delivery of the

organisation's activities and infrastructure to climate change and adverse weather events. Through our business continuity planning, we have begun to identify the risks we need to consider, and the associated adaptations required. To ensure that our services continue to meet the needs of our local population during such events, we are also developing adaptation plans with health organisations across our region.

We are undertaking climate change risk assessments and reviewed our Sustainable Development Strategy to take account of UK Climate Projections. This ensures the Trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Table 11: September 2021 Sustainable Development Assessment Tool Assessment Score 59% (up from 2020 score 53%)



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

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

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

3.3 Performance

To provide some organisational context, the table below shows how the merger between Bristol and Weston has increased the number of whole-time equivalent staff and floor space within our estate over the past two years.

Table 12: Organisational change

	2017/18	2018/19	2019/20	2020/21	2021/22
Floor Space (m2)	195,044	195,044	195,044	227,565	227,565
No. of Staff	8,677	8,934	9,321	11,037	11,319

3.3.1 Energy

We continue to purchase 100% Renewable Energy Guarantees of Origin (REGO) electricity under our supply contract and have seen drastic reductions in electricity use in this time. Unfortunately, the same combined heat and Power (CHP) technology that has provided savings in electric has also increased our gas consumption, resulting in increased energy-related emissions in 2021/22. This year represents the first full year of our new 3.36MW CHP being in operation. This provides the Trust with financial savings in the form of efficient energy production but has the negative consequence of additional emissions from direct operations.

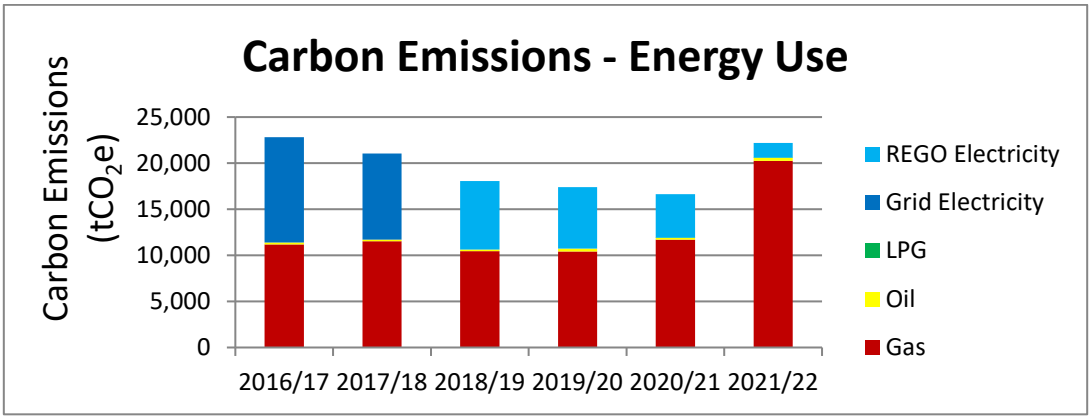


Table 13: Energy use and spend

Resource		2017/18	2018/19	2019/20	2020/21	2021/22
Gas	Use (kWh)	62,552,655	56,729,051	56,625,012	63,745,857	110,466,019
	tCO_2e	11,520	10,438	10,411	11,721	20,233
Oil	Use (kWh)	727,117	737,045	1,143,486	675,780	1,369,885
	tCO_2e	195	198	306	181	367
LPG	Use (kWh)	0	0	0	10,542	3,985
	tCO_2e	0	0	0	2	0.9
Grid Electricity	Use (kWh)	26,547,528	0	0	0	0
	tCO_2e	11,833	0	0	0	0
Grid REGO Electricity	Use (kWh)	42,964	26,223,729	26,189,963	20,366,737	7,555,343
	tCO_2e	0	7,413	6,684	4,748	1,604
Total Energy tCO_2e		21,048	18,049	17,401	16,652	22,205

In the last year the Trust has delivered £17.6 million of projects with Public Sector Decarbonisation Scheme (PSDS) funding to complete the second phase of the CHP project, to maximise the use of heat across the Bristol site. The PSDS funding also included decarbonisation projects at Weston, including upgrades to the heat distribution system and building management system. Solar photovoltaic panels, air source heat pumps and LED lighting replacements have also gone ahead.

These projects will significantly help the Trust meet its ambitious goal to become carbon neutral by 2030.

3.3.2 Travel

The Trust has undertaken a major review and consultation of car parking to support those with the greatest need to travel by car to our hospitals to be able to. The Trust has also been working closely with partner organisations to prepare for the Bristol Clean Air Zone. We can improve local air quality and improve the health of our community by promoting active travel (e.g. walking and cycling) – not only to our staff, but also to the patients and public who use our services. We have a large number of staff walking or cycling to work. We have seen many staff working from home and will seek to maintain the benefits that flexible working arrangements have shown.

We support a culture of active travel to improve staff wellbeing and reduce sickness. We have made improvements to the Trust cycle centres increasing capacity and improving security. Air pollution, accidents and noise, caused by cars as well as other forms of transport, all cause health problems for our local population, patients, staff and visitors.

Table 14: Average travel levels

Category	Mode	2017/18	2018/19	2019/20	2020/21	2021/22
Patient and visitor travel	miles	30,592,210	35,990,587	35,711,130	32,179,499	27,645,892
	tCO_2e	10,994	11,410	11,823	8,876	7,629
Trust fleet travel	miles	136,688	144,000	140,092	139,296	151,544
	tCO_2e	10	10	10	10	10
Staff commute	miles	8,335,279	8,582,157	8,957,481	10,606,557	10,877,559
	tCO_2e	2,299	2,367	2,471	2,926	3,000

We do not currently capture detailed in-year travel data so these figures are based on patient and staff numbers with average travel levels applied. With COVID-19 restrictions we have seen reductions in patient and visitor travel. This reflects a significant increase in non-face to face appointments. Our annual staff travel survey shows that over a quarter of staff travel to work actively (walking or cycling). We have introduced further electrical vans to our fleet for facilities and IT use and have started a trial of electric cargo bikes.

3.3.3 Waste

As with most NHS organisations across the country, the Trust has seen waste levels increasing in the last 12 months. These increases have been due to various Trust activities, including COVID-19 related which directly impacted on waste volumes across the Trust hospital sites. We have seen increased levels of general waste created. Following a safety alert, the Trust is moving away from using food disposal units which has resulted in food wastes being disposed through the general waste compaction process.

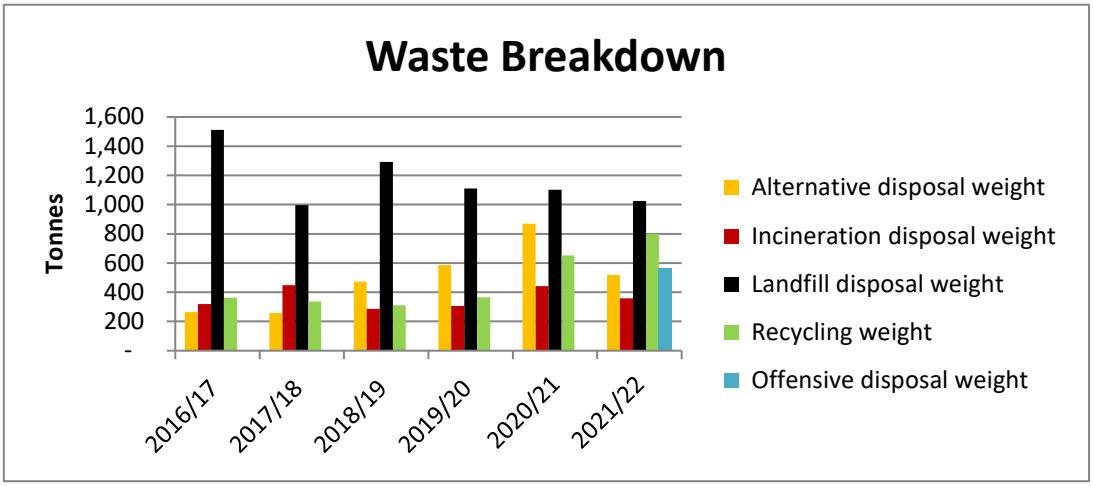
We have been busy developing new approaches to waste, such as the launch of coffee cup recycling stations in cafes across Bristol and Weston. We can also now recycle bread bags and crisp packets from our catering teams, and re-useable metal sharps from our clinical teams in theatres, day care, Endoscopy and Podiatry. We have conducted waste audits to support areas in improving their waste management and we continue to roll out Dry Mixed Recycling.

We have created a re-use storage space and launched Warpit our online re-use hub to coordinate and increase re- use on our sites. The re-use of goods and community equipment in the NHS has several key co-benefits: reducing cost to the NHS, reducing emissions from procuring and delivering new goods and providing social value when items are reused in the community. We are also increasing re-use through partnering with local organisations and will expand reuse to work across our Integrated Care System.

The Trust remains on track to achieve its zero waste to landfill target by 2025 and whilst ensuring the Trust waste resource is disposed sustainably and compliantly.

Table 15: Waste management

Waste		2017/18	2018/19	2019/20	2020/21	2021/22
Recycling	(tonnes)	337	310	365	653	799
	tCO_2e	7	7	8	14	17
Alternative	(tonnes)	258	472	588	869	518
	tCO_2e	5	10	13	19	11
Offensive	(tonnes)					567
	tCO_2e					12
Incineration	(tonnes)	448	286	307	441	358
	tCO_2e	10	6	7	9	8
Landfill	(tonnes)	996	1,293	1,111	1,102	1,024
	tCO_2e	457	592	509	505	478
Total Waste (tonnes)		2,039	2,361	2,371	3065	3267
% Recycled or Re-used		17%	13%	15%	21%	24%
Total Waste tCO_2e		479	615	536	547	526



From 2021/22 we are required to report offensive waste separately to support use of this lower impact waste stream.

The movement to a paperless NHS can be supported by staff reducing the use of paper at all levels; this reduces the environmental impact of paper, reduces the cost of paper to the NHS and can help improve data security. The Trust is continuing to roll out IT programmes to enable paperless working.

3.3.4 Anaesthetic Gases

Building on our previous successes in addressing the climate change impact of anaesthetics, in 2021/22 the Trust saw major strides taken to cut our use of nitrous oxide. The leaking and oversized manifold system in the BRI was decommissioned and nitrous oxide provision has moved to a model of 'local' delivery with canisters on portable trollies. Before introducing this change less than 2% of the nitrous oxide we bought was actually utilised for patient treatment. This extreme wastage has been eliminated for the BRI and as it was so successful, we're looking to roll out this delivery model to the remaining Trust manifolds next year. This is great news for our emissions reduction programme as nitrous oxide has a Global Warming Potential impact 265 times greater than Carbon Dioxide per unit of gas.

3.3.5 Water

With increased activity, we have increased our consumption of water in 2021/22, but the emissions have decreased due to a lowering of the carbon intensity of the water industries.

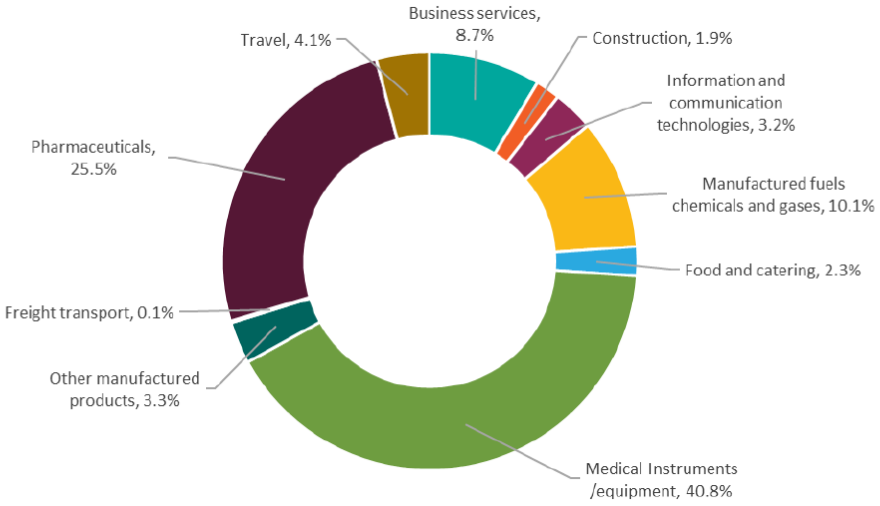
Table 16: Consumption of water

Water		2017/18	2018/19	2019/20	2020/21	2021/22
Mains Use	m^3	233,033	223,504	226,912	272,470	324,452
	tCO_2e	80	77	78	94	48
Waste Treatment	m^3	207,952	199,529	202,218	245,223	305,933
	tCO_2e	147	141	143	174	83

3.4 Modelled Carbon Footprint

The information provided in the previous sections of this report uses the Estates Return Information Collection as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model, based on work performed by Greener NHS/Sustainable Development Unit.

This model indicates an estimated total carbon footprint of 134,690 tonnes of CO_2e for the Trust. Our supply chain is the single largest contributor to our carbon footprint. The data used to calculate the impact of our supply chain is currently based on modelled data from our spend. This modelled data allows us to understand where the greatest impacts in our supply chain lie and therefore where we can focus our efforts to achieve carbon neutrality by 2030. This breakdown is shown below:



A key challenge for us is how we move away from modelled data to more accurate data that reflects the procurement decisions we make and the work our supply chain is doing to reduce carbon emissions. This work will be a key focus for the coming year.

This year we have undertaken a range of projects to help us understand and reduce our supply chain impact.

We have worked closely with our procurement partners, Bristol and Weston Purchasing Consortium and with North Bristol NHS Trust, to create a Sustainable Procurement Strategy that sets out the key actions we will take to achieve our carbon neutral target by 2030.

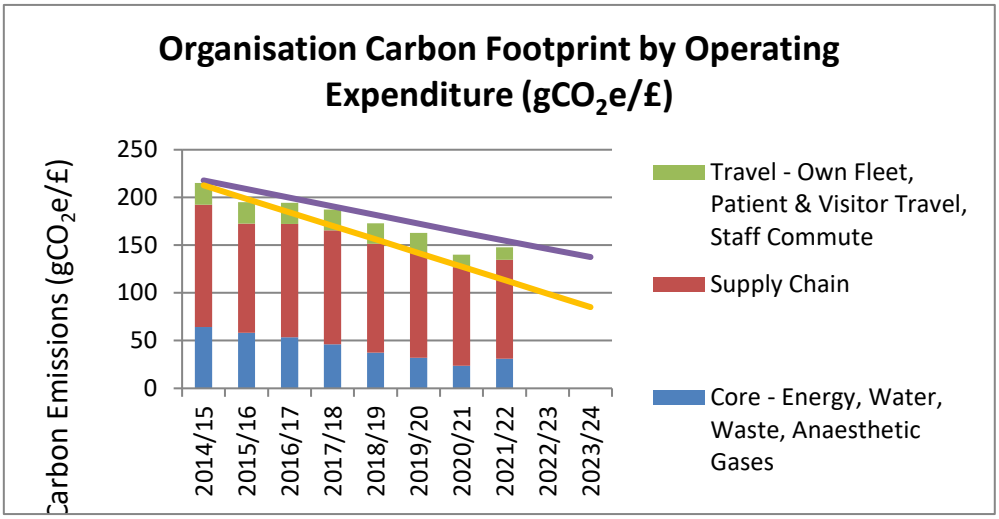
As part of the strategy, a prioritisation exercise was carried out on our spend profile. It assessed the lifecycle environmental, social and governance risks and opportunities of our expenditure, allowing the characterisation of our spend categories into similar routes for action on how we may work with our supply chain to achieve our sustainable procurement outcomes. This will help us to inform our approach with our suppliers over the short, medium and long term.

We have also successfully implemented a number of projects to reduce the carbon impact of our purchasing choices. These have focused on swapping single use items for re-useable and re-manufactured alternatives.

The ideas for these projects come from our clinical staff who are key to identifying areas for improvement and for trialling new products and ways of working. These projects reduce carbon, cost and waste as well as ensuring a more secure source of goods. They also help to build the business case for wider expansion across the Trust to achieve even greater sustainability outcomes.

Table 17: Total carbon footprint

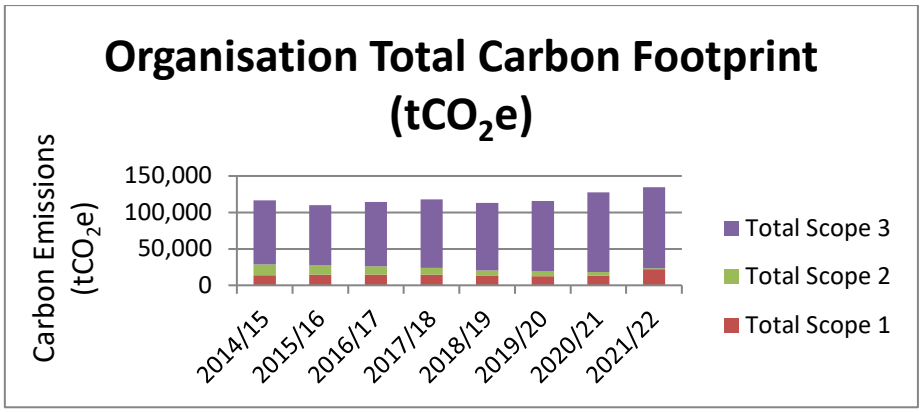
Carbon Footprint Category	% CO_2e
Core – Energy, Water, Waste, Anaesthetic Gases	21%
Supply Chain	70%
Travel - Own Fleet, Patient & Visitor Travel, Staff Commute	9%



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

The above graph shows that the intensity of our emissions has risen, as total emissions have increased and we've spent more capital delivering services.

The below graph shows total Scope 2 (electricity) is slowly decarbonising, driven by wider changes from National Grid. However, total Scope 1 (emissions from direct operations) and total Scope 3 (emissions from our supply chain) are not reducing over time.



4. Accountability Report

4.1 Directors' Report

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

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

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

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

4.1.1 Directors' interests

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

The Director of Corporate Governance maintains a register of interests, which is available to members of the public on the Trust's website: https://www.uhbw.nhs.uk/p/about-us/reports-and-publications

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 made no political donations during 2021/22.

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 18: Board of Directors – Terms of Office

Board Member
Jeff Farrar, Chairman
Appointment 1 December 2017
End of first term 30 November 2020
End of second term 30 November 2021
Jayne Mee, Chair
Appointment
Non-executive Director 1 June 2019
End of first term 8 December 2021
Appointed as Interim Chair 1 April 2021
Appointed to Trust Chair 9 December 2021
End of first term as Trust Chair 31 March 2024
David Armstrong, Non-executive Director
Appointment 28 November 2013
End of first term 27 November 2016
End of second term 27 November 2019
Re-appointed for a third term of three years ending on 26 November 2022
Sue Balcombe, Non-executive Director
Appointment 1 April 2020
End of first term 31 March 2023
Julian Dennis, Non-executive Director and Senior Independent Director
Appointment 1 June 2014
End of first term 31 May 2017
End of second term 30 May 2020
Re-appointed for a third term of three years ending on 30 May 2023
Bernard Galton, Non-executive Director
Appointment 1 July 2019
End of first term 30 June 2022
Jane Norman, Non-executive Director
Appointment 1 March 2021
End of first term 29 February 2024
Martin Sykes, Non-executive Director and Vice-Chair
Appointment 4 September 2017

End of first term 31 August 2020 End of second term 31 August 2023
Steven West, Non-executive Director Appointment 3 July 2017 End of first term 2 July 2020 End of second term 31 March 2022
Eugine Yafele, Chief Executive Appointed 3 May 2022
Paula Clarke, Director of Strategy and Transformation Appointed 4 April 2016
Deirdre Fowler, Chief Nurse Appointed as Interim Chief Nurse 18 January 2021 Appointed as Chief Nurse 29 April 2021
Robert Woolley, Chief Executive Appointed 8 September 2010 End of Term 31 March 2022
Matthew Joint, Director of People Appointed 1 November 2017 End of Term 25 June 2021
Neil Kemsley, Director of Finance and Information Appointed 1 July 2019
William Oldfield, Medical Director Appointed 1 August 2018 End of Term 30 September 2021
Mark Smith, Deputy Chief Executive and Chief Operating Officer Appointed 13 February 2017
Emma Redfern, Interim Medical Director Appointed 16 September 2021 End of Term 18 March 2022
Stuart Walker, Medical Director Appointed 21 February 2022
Alex Nestor, Interim Director of People Appointed 26 June 2021 End of Term 3 January 2022
Emma Wood, Director of People 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 makes a contribution towards funding patient care.

4.1.6 Quality Governance

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

The Trust's quality improvement programme, led by the Chief Nurse, Medical Director and Chief Operating Officer, continues to show us what is possible when we have a relentless focus on quality improvement. In 2020, we published our new four year quality strategy (2021/25), which structures our quality improvement work around four core quality themes:

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

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

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

4.1.7 Better Payment Practice Code

The Better Payment Practice Code 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 19: Performance against Better Payment Practice Code:

	Year ended 31 March 2022			Year ended 31 March 2021		
	NHS Payables	Non-NHS Payables	Total	NHS Payables	Non-NHS Payables	Total
No. invoices paid within 30 days	2,869	145,503	148,372	2,698	131,924	134,622
No. invoices paid	3,743	166,760	170,503	5,370	162,321	167,691
Percentage paid within 30 days - number	76.6%	87.3%	87.0%	50.2%	81.3%	80.3%
Value of invoices paid within 30 days	£46.770m	£299.482m	£346.252m	£46.614m	£251.306m	£297.920m
Value of invoices paid	£68.547m	£364.733m	£433.280m	£79.592m	£327.424m	£407.016m
Percentage paid within 30 days - value	68.2%	82.1%	79.9%	58.6%	76.8%	73.2%

Despite continued challenges of divisional management teams operating within a pandemic environment, performance has improved notably from 2020/21. Although, there remains some difficulty in obtaining authorisation to pay from divisional management staff and engaging with other organisations, there has been a noticeable improvement. The change in conditions and the implementation of an improvement plan have contributed significantly to the improvement in both the volume and value of invoices paid within the 30-day target.

In both years, there was no interest payable arising from claims made under the Late Payment of Commercial Debts (interest) Act 1998 and no other compensation was paid to cover debt recovery cost under this legislation.

4.1.8 Council of Governors

NHS Foundation Trusts are 'public benefit corporations' and are required by the National Health Service Act 2006 to have a Council of Governors, the 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 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 Chair and Directors, and through the forums of Governor Focus Groups (dealing with matters of constitution and membership engagement; strategy and planning; and quality and performance monitoring), 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.

Council of Governor Meetings: The formal meetings of the Council of Governors are usually scheduled to follow some of the Board meetings held in public, and good attendance by governors at both has meant governors are kept up to date on current matters of importance and have the opportunity to follow up on queries in more detail with all members of the Board. All governor and membership activities are formally reported at Council of Governors meetings. Updates from the Chair and Chief Executive 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 2021/22 including the appointment of the Trust Chair, approval of the appointment of the Chief Executive, approval of a business case for a General Intensive Care Unit and re-appointment of Non-Executive Directors.

There were 6 formal Council of Governors meetings in the year (including 2 extraordinary meetings). Due to the COVID-19 pandemic, all were held virtually by videoconference and were livestreamed via YouTube for public viewing.

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

Table 20: Membership and attendance at Council of Governors meetings 2021/22

The figure in brackets denotes the number of meetings an individual could be expected to attend by virtue of their membership of the Council. A figure of zero in brackets (0) indicates that the individual was not a member or that their attendance was not mandatory. ‘C’ denotes the Chair of the meeting. Sickness absence and other reasons for non-attendance are not recorded in the Annual Report.

Number of Council of Governors meetings in the period 1 April 2021 to 31 March 2022		**6**	
Chair: Jayne Mee		**C 5 (6)**	
Governors		**Non-Executive Directors**	
Shabnum Ali	1 (1)	David Armstrong	5 (0)
Hessam Amiri	6 (6)	Sue Balcombe	5 (0)
Ashley Blom	5 (6)	Julian Dennis	4 (0)
Charlie Bolton	5 (5)	Bernard Galton	3 (0)
Graham Briscoe	6 (6)	Jane Norman	5 (0)
John Chablo	5 (6)	Martin Sykes	6 (0)
Sofia Cuevas-Asturias	2 (4)	Steve West	2 (0)
Carole Dacombe	6 (6)	**Executive Directors**	
Khushboo Dixit	3 (5)	Paula Clarke	4 (0)
Aishah Farooq	3 (6)	Deirdre Fowler	3 (0)
Sophie Fernandes	2 (2)	Matt Joint	1 (0)
Tom Frewin	4 (6)	Neil Kemsley	4 (0)
Chrissie Gardner	5 (6)	Alex Nestor	2 (0)

Paul Hopkins	3 (4)	William Oldfield	2 (0)
Jocelyn Hopkins	1 (5)	Emma Redfern	2 (0)
Hannah McNiven	1 (6)	Mark Smith	4 (0)
Sue Milestone	4 (6)	Emma Wood	1 (0)
Sally Moyle	4 (6)	Robert Woolley	5 (0)
Hannah Nicoll	2 (2)		
Debbi Norden	2 (6)		
Graham Papworth	1 (6)		
Barry Parsons	0 (5)		
Penny Parsons	0 (1)		
Mo Philips	6 (6)		
Ray Phipps	6 (6)		
Annabel Plaister	5 (5)		
Mohammad Rashid	5 (5)		
John Rose	6 (6)		
Martin Rose	6 (6)		
Jane Sansom	0 (1)		
John Sibley	5 (6)		
Malcolm Watson	1 (6)		
Mary Whittington	0 (1)		
Audrey Wellman	2 (4)		
Garry Williams	0 (6)		

4.1.9 Governors' Nominations and Appointments Committee

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

The Committee met via videoconference on 4 occasions (May, October, November and February) and in between meetings it conducted business via email. Committee members were involved in all aspects of the recruitment process and appointment of a substantive Trust Chair in October-December 2021, including nominating members to review applications and sit on the interview panel. Towards the end of the year, the Committee started planning for the recruitment of new Non-Executive Directors and Associate Non-Executive Directors in Spring 2022. Other work included reviewing activity records and annual performance appraisal reports for each of the Non-Executive Directors and making recommendation on re-appointments. The Committee reviewed Chair and Non-Executive Director remuneration and recommended no changes this year. In the year the Committee conducted a self-review and review of its terms of reference.

4.1.10 Performance and development of the Council of Governors

As the pandemic continued, governors have been able to carry out all of their necessary formal statutory duties in the year through online meetings. Governors again provided a considerable amount of constructive challenge, questions and feedback on the impact of the pandemic on staff and people accessing our services, the progress of Bristol/Weston merger integration, and many other areas of the Trust's work. A lot of this work was carried out through online meetings of the three governor groups: the Quality Focus Group, Governors' Strategy Group and Membership and Constitution Group.

In terms of formal training, three Governor Development Seminar days took place (in April, June and October, with one planned in January cancelled due to the pandemic). The seminars form an

important part of the programme of development for governors. The programme provided governors with training on their statutory duties including appointing a Chair and holding NEDs to account. The October session included a focus on system-working, with speakers from the Integrated Care System for Bristol, North Somerset and South Gloucestershire, discussing with governors the progress of ICS development and its impact on the Trust. Reflecting their role as representatives of members of staff and members of the public, governors took part in sessions on patient and public involvement and staff culture and values.

The Council of Governors carried out a self-assessment exercise in April 2021 and the results of this led to an action plan for improvements which was monitored by governors throughout the year through their Membership and Constitution Group.

The Lead Governor for 2021-22 was Mo Phillips, Public Governor.

4.1.11 Governor elections

Governor elections are held every two years out of three. They were held in Spring 2021 (postponed from 2020 for 12 months due to the impact of COVID-19 on the Trust and its activity, in line with the measures outlined for local government elections in the Coronavirus Act 2020). In 2021, there were 11 seats up for election across 5 public and staff constituency classes. All seats were contested, with 26 candidates standing altogether. There was good interest from Weston General Hospital staff and the North Somerset public, reflecting the recent Trust merger. The election period consisted of a nomination period (4 March-1 April 2021), during which the seats available were advertised, and a voting period (27 April-21 May 2021) during which voting information was dispatched to public and staff members. New governors took up post on 1 June 2021.

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. Aishah Farooq (reappointed) and Audrey Wellman were appointed in September 2021.

Planning was undertaken in the latter half of the year to support the governor in spring 2022, with 14 seats up for election across five constituencies.

Table 21: Governors by constituency – 1 April 2021 to 31 March 2022

There are 29 governor seats in total. As at 31 March 2022, there were 29 governors in post (17 public, 6 staff and 6 appointed) and 0 vacancies.

Constituency	Name	Tenure	Elected or Appointed
Public Governors			
Public-Bristol	Khushboo Dixit	June 2021 to May 2023	Elected
Public Bristol	John Chablo	June 2019 to May 2022 June 2017 to May 2019	Elected
Public Bristol	Carole Dacombe	June 2019 to May 2022 June 2016 to May 2019	Elected
Public Bristol	Tom Frewin	June 2019 to May 2022 June 2016 to May 2019	Elected
Public Bristol	Sue Milestone	June 2021 to May 2022 June 2019 to May 2020 (extended to May 2021) June 2016 to May 2019 June 2013 to May 2016	Elected
Public Bristol	Graham Papworth	June 2019 to May 2022 June 2017 to May 2019	Elected

Public Bristol	Maureen Phillips	June 2021 to May 2023 June 2017 to May 2020 (extended to May 2021)	Elected
Public Bristol	Martin Rose	June 2019 to May 2022	Elected
Public Bristol	Mohammad Rashid	June 2021 to May 2023	Elected
Public Bristol	Mary Whittington	June 2017 to May 2020 (extended to May 2021)	Elected
Public North Somerset	Graham Briscoe	June 2021 to May 2023 June 2019 to May 2020 (extended to May 2021) June 2014 to May 2017	Elected
Public North Somerset	Annabel Plaister	June 2021 to May 2023	Elected
Public North Somerset	John Rose	June 2021 to May 2023 June 2017 to May 2020 (extended to May 2021)	Elected
Public North Somerset	Penny Parsons	June 2017 to May 2020 (extended to May 2021)	Elected
Public South Gloucestershire	Ray Phipps	June 2019 to May 2022 June 2016 to May 2019 Mar 2015 to May 2016	Elected
Public South Gloucestershire	John Sibley	June 2019 to May 2022 June 2017 to May 2019	Elected
Public South Gloucestershire	Malcolm Watson	June 2019 to May 2022 June 2016 to May 2019	Elected
Public – Rest of England and Wales	Garry Williams	June 2019 to May 2022 June 2016 to May 2019 June 2010 to May 2013	Elected
Public – Rest of England and Wales	Hessam Amiri	June 2019 to May 2022	Elected
Staff Governors			
Medical and Dental	Sofia Cuevas-Asturias	August 2021 to May 2023	Elected
Medical and Dental	Jane Sansom	June 2018 to May 2020 (extended to May 2021)	Elected
Medical and Dental	Shabnum Ali	June 2021 to August 2021	Elected
Non-clinical Staff	Chrissie Gardner	June 2021 to May 2023 June 2019 to May 2020 (extended to May 2021)	Elected
Non-clinical Staff	Charles Bolton	June 2021 to May 2023	Elected
Nursing and Midwifery	Hannah McNiven	June 2019 to May 2022	Elected
Nursing and Midwifery	Debbi Norden	June 2019 to May 2022	Elected
Other Clinical Staff	Jocelyn Hopkins	June 2021 to May 2022	Elected
Appointed Governors			

Bristol City Council	Barry Parsons	June 2021 to May 2023	Appointed
Joint Union Committee	Paul Hopkins	October 2021 to May 2023	Appointed
Joint Union Committee	Sophie Fernandes (nee Jenkins)	June 2020 to October 2021 June 2017 to May 2020	Appointed
University of Bristol	Ashley Blom	June 2020 to March 2022	Appointed
University of the West of England	Sally Moyle	June 2020 to May 2023 June 2017 to May 2020	Appointed
Youth Involvement Group	Aishah Farooq	September 2021 to August 2022 September 2020 to August 2021 September 2019 to August 2020 September 2018 to August 2019	Appointed
Youth Involvement Group	Audrey Wellman	September 2021 to August 2022	Appointed
Youth Involvement Group	Hannah Nicoll	September 2020 to August 2021	Appointed

4.1.12 Foundation Trust Membership

The Trust maintains a broadly representative membership of people from eligible constituencies in keeping with the NHS Foundation Trust governance model of local accountability (see analysis of current membership below). The Trust has two membership constituencies as follows:

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

Staff are automatically registered as members on appointment and may opt out if they wish. Information on opting out of the scheme is included in induction packs and on the intranet.

Public membership is open to members of the public who are not eligible to become a member of the Trust's staff constituency and who are seven years of age and above. Membership is free to join and people can become members by completing a short application form, which is available on the Trust website or in printed form around our hospitals. Public members receive news from our hospitals, invitations to come to events or have their say on our services, and can stand for election as governors and vote for governors to represent them. Members of the Trust can contact the elected governors who represent them by emailing FoundationTrust@uhbw.nhs.uk. This information is available on the Membership page of the Trust website: https://www.uhbw.nhs.uk/p/working-with-us/become-a-member-of-our-trust and is publicised in all communications to members.

Information about the composition of Trust membership is below.

Table 22: Members of the Foundation Trust

Public constituency	
At year start (April 1 2021)	6,441
New members	51
Members leaving	1,882
At year end (March 31 2022)	4,610
Staff constituency	
At year start (April 1 2021)	14,200
At year end (March 31 2022)	14,155

4.1.13 Membership Strategy

Membership Engagement: Despite the pandemic, the Trust continued to implement many of the objectives of its 2020/23 Membership Strategy and to engage with its members as appropriate. Members for whom the Trust had an email address continued to receive regular monthly email newsletters with key messages about the pandemic and other Trust news as well as involvement opportunities from around the Trust and our partners in the wider health system. These newsletters included a report from a different governor each month to enable governor engagement with their constituents. Restrictions on face-to-face events due to the pandemic reduced the number of membership involvement opportunities in this period, but members were invited to the Annual Members' Meeting in September and public events on Stroke Awareness in May 2021, Learning Disabilities Liaison Provision in June 2021, and Cancer Care in November 2021, all of which were held online. A survey of public members was carried out in autumn 2021 and this informed engagement in the second half of the year. Young Members continued to be engaged with the help of the Trust's Youth Involvement Group, and a member of the Trust's Council of Governors, Aishah Farooq, representing young people at a national level on the NHS Youth Forum. Staff governors engaged with their constituents through regular articles in staff newsletters. Social media was used more consistently this year to promote membership and the governor role, and two social media 'takeovers' (campaigns which included posts about membership and governors on all social media channels every day over a week) were held in July 2021 and in February-March 2022 in the run-up to the 2022 governor elections.

Reducing Membership Numbers: Membership numbers have reduced in the year as a result of the Trust's proactive approach to updating its membership records, as set out in its 2020-23 Membership Strategy. The strategy recognised that for some members who joined over a decade ago, Trust membership may no longer be relevant and recommended reviewing membership with a view to ensuring that the data remained robust. The Trust therefore committed to writing to a proportion of members every year over three years to ask them to reconfirm whether they wish to remain members. During 2021/22, the Trust wrote to around 1,600 members who were asked to positively reconfirm whether they wished to remain as members of the Trust, and those who did not confirm continuation of membership were removed from the Trust's register of members in December 2021.

Table 23: Analysis of current membership (those resident 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)
Total	**3,993**	**978,960**
Age (years):		
0-16	41*	190,600
17-21	241	64,492
22+	3,608	723,868
Ethnicity:		
White	3,271	806,242
Mixed	72	21,138
Asian or Asian British	186	32,531
Black or Black British	130	28,584
Socio-economic groupings:		
AB	1,163	101,113
C1	1,190	131,107
C2	779	82,994
DE	851	96,514
Gender analysis		

Male	1,624	486,038
Female	2,225	492,922

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. *Members of UHBW must be at least seven years of age.

4.2 An Overview of Quality

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

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

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

4.2.1 Our Patient Safety Improvement Programme 2019-2021

Our original three-year patient safety improvement programme was paused again for periods during the latter 6 months of 2020/201 as staff who support the programme were necessarily deployed to support patient care and the education of newly appointed nursing staff during the COVID-19 pandemic. However, some improvement work took place to align safety systems for VTE prevention and to support early detection and management of deteriorating patients as detailed in the Trust's Annual Quality Account.

4.2.2 Stakeholder relations

As part of our focus to improve the quality of the care we offer we continue to work in partnership with local Healthwatch organisations. This includes, having an influential voice in setting and reviewing our Quality Objectives on an annual basis, offering additional external scrutiny to our Patient Experience assurance process through the Trust's Patient Experience Group and, by responding to feedback from patients, carers and community groups about our services. Such processes enable us to reflect the needs of the diverse population we serve. In addition, we actively engage with the Bristol Deaf Health Partnership and Bristol Sight Loss Council. These partnerships provide a single forum to foster dialogue; enabling us to work together to understand and improve the experience of Deaf, hard of hearing and visually impaired people across the health community in Bristol.

We also support and participate in engagement exercises that are led by Healthier Together, our local Sustainability and Transformation Partnership, on matters which affect our wider health and care system. There continues to be specific action in relation to Healthy Weston 2 – a programme to join up services for better care in Weston super Mare and the surrounding areas including the future of Weston General Hospital. We have worked in partnership with voluntary sector organisations, service users and health & social care providers to prepare a draft Carer Strategy for the Bristol, North Somerset and South Gloucestershire area. The Trust maintains close relationships with Local Authorities and Joint Health Overview and Scrutiny Committees to support any major changes in services for our patients.

4.2.3 Research and Innovation

The past two years have demonstrated the unique value of research in tackling national and global health challenges, and during 2021-22 our significant contribution to therapeutic and public health COVID-19 research has been a priority. Staff of all professions across our divisions in Bristol and Weston have led and supported this research and continue to embed research as part of the Trust's triumvirate mission alongside clinical care and education. This year 15,416 patients, staff and volunteers have given their time to take part in research that we lead and host.

This year we submitted a successful bid to the National Institute for Health Research (NIHR) to fund the Bristol Clinical Research Facility (CRF), which was awarded in February. This five-year pump priming funding starts in September 2022 and alongside projected commercial early phase trials income will allow us to employ core staff to support the trust strategy of further developing its early phase research capacity and capability.

The NIHR CRF joins NIHR @Bristol infrastructures including the Bristol Biomedical Research Centre (BRC), Applied Research Collaborative West (ARC West), West of England Clinical Research Network (WE CRN), Research Design Service (RDS), which sit under the umbrella of the Bristol Health Partners Academic Health Science Centre (BHP AHSC).

During 2021-22 our NIHR grants comprised 10 NIHR project or programme grants and 4 NIHR fellowships, and our overall grant income from NIHR grants increased by nearly 25% over 20/21 levels.

Four new grants were in set-up, funded by the NIHR's Research for Patient Benefit (RfPB), Programme Development (PDG), and Health and Social Care Delivery Research (H&SDR) funding streams. They were across audiology, neurodegeneration, neonatology and cardiac surgery. Two further NIHR grants started, both in emergency care (paediatric and adult), and included an award from the Health Technology Assessment (HTA) and the Policy Research Programme. There were six NIHR grants awarded during the period, many of which had been worked up and submitted during the previous year.

Our two grants in emergency care commenced and continue to progress to plan. The first, which is an HTA-funded grant called AIRWAYS-3 looking at airway management of patients with cardiac arrest in hospital, builds on the previous grants awarded to Professor Benger and will start recruitment later this year. The second involves evaluating the ICON tool to prevent instances of Abusive head Trauma in infants.

Professor Nicola West's RfPB is a feasibility study to investigate the relationship between Alzheimer's disease progression and dental caries, building on pre-clinical work showing a link between cognitive impairment and oral infection. Patients will be treated in NHS general dental practices (GDP), the region's first piece of large-scale research in this setting.

Results from UHBW's sponsored ComFluCOV trial, which looked at the safety and effectiveness of giving COVID-19 and Flu vaccines at the same time, were published in the Lancet (Safety and immunogenicity of concomitant administration of COVID-19 vaccines (ChAdOx1 or BNT162b2) with seasonal influenza vaccines in adults in the UK (ComFluCOV): a multicentre, randomised, controlled, phase 4 trial). The results of this trial influenced policy around the 'flu' and COVID-19 mass vaccination programme over the winter period. Delivery of the trial was a significant achievement and testament to the excellent collaboration between NHS and our academic partners.

We continued to support COVID-19 vaccine, surveillance and treatment trials throughout the year alongside restarting our research portfolio. The staffing and capacity challenges that the NHS as a whole has been experiencing throughout the pandemic inevitably impacted on our ability to restart research activities during this period. Despite this, the research delivery teams have continued to deliver high quality research and maintain recruitment rates to trials. Commercial research activity recovered well following the pause during the early phase of the pandemic. In 2021/22 we saw a 53% increase in new commercial studies opening at UHBW compared to the previous year, and the doubling of participants recruited to commercial studies compared to 2020/21. Our annual commercial research income doubled in 2021/22 and this is largely due to our success in recruiting to industry-led COVID-19 vaccine trials. We have built on previous successes and recruited the

first UK participants to several commercial trials in Bristol Eye Hospital, Bristol Haematology & Oncology Centre and the UHBW Clinical Research Facility.

COVID-19 vaccine trial activity remained consistently high throughout the year, with UHBW making significant contributions to several adolescent COVID-19 vaccine trials that contributed to policy decisions around vaccination of children. Our paediatric research team recruited and vaccinated the first 16 paediatric participants to a phase III COVID-19 vaccine trial and overall recruited 99 adolescents across the 3 trials assessing the safety, reactogenicity and immunogenicity of various COVID-19 vaccines. This was a significant achievement in the context of the launch of paediatric vaccination with licensed products in the community. Alongside the paediatric work, we recruited pregnant women into Preg-Cov, a phase II, randomised, single-blind, platform trial to assess safety, reactogenicity and immunogenicity of COVID-19 vaccines. The broad range of COVID-19 vaccine trials delivered at UHBW has ensured that a wide demographic (adult, children and pregnant women) have had the opportunity to participate in these vital studies.

The success of the COVID-19 vaccine trials has enabled UHBW to establish a reputation for expertise in delivery of adult vaccine research. As a result, we now have been identified or selected for several vaccine trials in other indications, including for prevention of E.Coli, respiratory syncytial virus, staphylococcus aureus and Ebola.

As a specialist research-active teaching trust that is part of Bristol Health Partners AHSC, our priority has remained to engage and influence at a regional and national level whilst offering patients the best opportunities in research as part of their care locally. We continue to build and develop relationships with NHS and academic partners, with NIHR, with professional bodies and with our industry partners through active membership and participation in groups and workstreams to improve the way we do things.

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 2021 to 31 March 2022.

4.3.1 Annual Statement on Remuneration

The purpose of the Remuneration, Nominations and Appointment Committee is to decide the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors, and to review the suitability of structures of remuneration for senior management. The Committee was chaired by the Trust Chair and all Non-executive Directors were members of the Committee. The Committee was attended by the Chief Executive and Director of People (from July 2021 to December 2021, Interim Director of People) in an advisory capacity when appropriate and supported by the Director of Corporate Governance to ensure it undertook its duties in accordance with applicable regulation, policy and guidance.

The Committee met on 5 occasions in the reporting period to consider the annual review of Executive Directors' performance, the skills and knowledge mix of the Board of Directors, current remuneration levels, and oversaw the appointment of the Medical Director, Director of People and the Chief Nurse and Midwife.

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 Medical Director, Director of People and the Chief Nurse and Midwife.

4.3.3 Senior Manager's Remuneration Policy

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

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

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

The Committee is also cognisant of its responsibilities in relation to addressing the gender pay gap and actively considered during the year how to ensure parity of pay of female and male Executive Directors.

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 2021/22 and 2020/21. There were no exit packages paid to any director in either year. This information has been subject to audit.

Table 24: Remuneration for the senior managers of the Trust 2021/22 (Audited)

Directors' Remuneration for 2021/22 (£'000)	Salary (Bands of £5,000)	Taxable Benefits (to nearest £100)	Annual Performance Related Bonus (Bands of £5,000)	Pension Related Benefits (Bands of £2,500)	Total (Bands of £5,000)
Chair:					
Jayne Mee (Note 1)	60-65	200	n/a	n/a	60-65
Executive Directors:					
Robert Woolley, Chief Executive (Note 2)	240-245	n/a	n/a	n/a	240-245
Mark Smith, Chief Operating Officer	180-185	n/a	n/a	107.5-110	290-295
Paula Clarke, Director of Strategy and Transformation	160-165	n/a	n/a	100-102.5	260-265
Neil Kemsley, Director of Finance and Information (Note 2,3)	175-180	2,300	n/a	n/a	175-180
Deirdre Fowler, Chief Nurse	155-160	n/a	n/a	137.5-140	295-300
Matthew Joint, Director of People	35-40	n/a	n/a	52.5-55	90-95
Alexandra Nestor, Director of People (Interim) (Note 4)	70-75	n/a	n/a	n/a	70-75
Emma Wood, Director of People	35-40	n/a	n/a	55-57.5	95-100
William Oldfield, Medical Director	115-120	n/a	n/a	52.5-55	170-175
Emma Redfern, Medical Director (Interim) (Note 4)	90-95	n/a	n/a	n/a	90-95
Stuart Walker, Medical Director (Note 4)	25-30	n/a	n/a	n/a	25-30
Non-Executive Directors					
David Armstrong	15-20	n/a	n/a	n/a	15-20
Sue Balcombe	10-15	n/a	n/a	n/a	10-15
Julian Dennis	15-20	n/a	n/a	n/a	15-20
Bernard Galton	15-20	n/a	n/a	n/a	15-20
Jane Norman	10-15	n/a	n/a	n/a	10-15
Steven West	10-15	n/a	n/a	n/a	10-15
Martin Sykes (Note 1)	15-20	800	n/a	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 – Neil Kemsley's taxable benefit relates to a lease car
Note 4 – NHS Pensions Online have been unable to provide information for 20/21 and therefore calculation of pensionable benefits in 21/22 is not possible
Note 5 – An error made by Stuart Walker's previous NHS employer when transferring his employment via the national Electronic Staff Records system means NHS Business Services Authority has been unable to provide information relating to his pension benefits.

Table 25: Remuneration for the senior managers of the Trust 2020/21

Directors' remuneration for 2020/21 (£'000)	Salary (bands of £5,000)	Taxable benefits (to nearest £100)	Annual performance related bonus (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chair:					
Jeffrey Farrar	55-60	n/a	n/a	n/a	55-60
Executive Directors:					
Robert Woolley, Chief Executive (Note 1)	235-240	n/a	n/a	n/a	235-240
Mark Smith, Deputy Chief Executive and Chief Operating Officer	175-180	n/a	n/a	55-57.5	230-235
Paula Clarke, Director of Strategy and Transformation	155-160	n/a	n/a	97.5-100	250-255
Neil Kemsley, Director of Finance and Information (Note 1,2)	165-170	6,200	n/a	n/a	170-175
Carolyn Mills, Chief Nurse until 31st January 2021	130-135	n/a	n/a	10-12.5	140-145
Deirdre Fowler, Chief Nurse from 1st February 2021	30-35	n/a	n/a	170-172.5	205-210
Matthew Joint, Director of People	160-165	n/a	n/a	37.5-40	195-200
William Oldfield, Medical Director	240-245	n/a	n/a	82.5-85	325-330
Non-Executive Directors					
David Armstrong	15-20	n/a	n/a	n/a	15-20
Julian Dennis	15-20	n/a	n/a	n/a	15-20
Jane Norman from 1st March 2021	0-5	n/a	n/a	n/a	0-5
Guy Orpen until 31st January 2021	10-15	n/a	n/a	n/a	10-15
Sue Balcombe	10-15	n/a	n/a	n/a	10-15
Bernard Galton	15-20	n/a	n/a	n/a	15-20
Steven West	10-15	n/a	n/a	n/a	10-15
Martin Sykes (Note 3)	15-20	200	n/a	n/a	15-20
Madhu Bhabuta until 2nd July 2020	0-5	n/a	n/a	n/a	0-5
Jayne Mee	10-15	n/a	n/a	n/a	10-15

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

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 2021/22 or 2020/21.

There were no payments to past senior managers in either 2021/22 or 2020/21.

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

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

The following tables show the pension benefits for the senior managers of the Trust for 2021/22 and 2020/21. 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 26: Pension benefits for the year ended 31 March 2022

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 2022	Lump sum at age 60 related to accrued pension at 31 March 2022	Cash Equivalent Transfer Value at 31 March 2022	Cash Equivalent Transfer Value at 31 March 2021	Real Increase in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension
	(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	£000	£000	£000	£000
Robert Woolley (Note 1)	-	-	-	-	-	-	-	-
Mark Smith	5-7.5	7.5-10	50-55	145-150	1,252	1,098	122	0
Paula Clark	5-7.5	7.5-10	65-70	140-145	1,359	1,219	111	0
Neil Kemsley (Note 1)	-	-	-	-	-	-	-	-
Deirdre Fowler	5-7.5	20-22.5	50-55	160-165	1,224	1,036	159	0
Matthew Joint	0-2.5	0	10-15	0	189	142	5	0
Alexandra Nestor (Note 2)	-	-	45-50	95-100	881	-	-	-
Emma Wood	0-2.5	0	20-25	0	254	211	4	0
William Oldfield	0-2.5	0-2.5	65-70	85-90	1,140	1,064	25	0
Emma Redfern (Note 2)	-	-	55-60	60-65	759	-	-	-
Stuart Walker (Note 2)	-	-	-	-	-	-	-	-

Note 1 - Robert Woolley and Neil Kemsley chose not to be covered by the pension arrangements during the reporting year

Note 2 - NHS Pensions Online have been unable to provide information for 20/21 and therefore calculation of pensionable benefits in 21/22 is not possible

Note 3 – An error made by Stuart Walker's previous NHS employer when transferring his employment via the national Electronic Staff Records system means NHS Business Services Authority has been unable to provide information relating to his pension benefits.

This table includes details for the directors who held office at any time in 2021/22.

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 27: Pension benefits for the year ended 31 March 2021

Name	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2021	Lump sum at age 60 related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 31 March 2021	Cash Equivalent Transfer Value at 31 March 2020	Real Increase in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Robert Woolley (Note 1)	-	-	-	-	-	-	-	-
Mark Smith	2.5-5	10-12.5	45-50	135-140	1,098	971	84	0
Paula Clarke	5-7.5	7.5-10	60-65	135-140	1,219	1,075	103	0
Neil Kemsley *(Note 1)*	-	-	-	-	-	-	-	-
Deirdre Fowler	0-2.5	2.5-5	45-50	140-145	1,036	834	31	0
Carolyn Mills	0-2.5	2.5-5	60-65	180-185	1,360	1,279	26	0
Matthew Joint	2.5-5	0	10-15	0	142	97	21	0
William Oldfield	5-7.5	2.5-5	60-65	85-90	1,064	945	81	0

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

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

Table 28: Future Policy Table

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

Note 1 - Where an individual Executive Director is paid more than £150,000, the Trust has taken steps to assure that remuneration is set at a competitive rate in relation to other similar NHS Trusts and that this rate enables the Trust to attract, motivate and retain executive directors with the necessary abilities to manage and develop the Trust's activities fully for the benefits of patients.
Note 2 - The components above apply generally to all Executive Directors in the table and there are no particular arrangements that are specific to an individual director.
Note 3 - The Remuneration, Nominations and Appointments Committee adopts the principle of the Agenda for Change framework when considering Executive Directors pay. However, unlike Agenda for Change, there is no automatic salary progression within the salary scale.

4.3.4 Fair pay multiple (Audited)

The Trust is required to disclose the relationship between the remuneration of the highest-paid director in the organisation 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 £240,000 to £245,000 band (2020/21 £240,000 to £245,000). The relationship to the remuneration of the organisation's workforce is disclosed in the tables below.

Table 29: Highest Paid Director

Year	2021/22	2020/21	Percentage change
Salary and allowances	242,500	242,500	0%
Performance pay and bonuses	0	0	0%

Table 30: Average Employee

Year	2021/22	2020/21	Percentage change
Salary and allowances	41,287	39,787	3.8%
Performance pay and bonuses	0	0	0%

Table 31: Pay Ratio Disclosure and Information

2021-22	25th percentile	Median	75th percentile
Total remuneration (£)	24,805	33,916	46,173
Salary component of total remuneration (£)	24,805	33,916	46,173
Pay ratio information	9.8	7.2	5.3

2020-21	25th percentile	Median	75th percentile
Total remuneration (£)	23,856	32,139	44,503
Salary component of total remuneration (£)	23,856	32,139	44,503
Pay ratio information	10.2	7.5	5.4

Remuneration of the highest paid director was 7.2 times (2020/21, 7.5 times) the median remuneration of the workforce, which was £33,916 (2020/21, £32,139). Remuneration ranged from £18,546 to £242,500 (2020/21, £18,005 to £238,567). The increase in employee remuneration and consequent reduction in the ratio to the highest paid director's remuneration is a result of national pay awards.

In 2021/22, no (2020/21, 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 for 2021/22 in the tables below.

Table 32: Average Employee

Year	2021/22
Salary and allowances	47,234
Performance pay and bonuses	0

Table 33: Pay Ratio Disclosure and Information

2021-22	25th percentile	Median	75th percentile
Total remuneration (£)	26,826	34,503	49,886
Salary component of total remuneration (£)	26,826	34,503	49,886
Pay ratio information	9.0	7.0	4.9

This information has been subject to audit.

4.3.5 Remuneration of Non-Executive Directors

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

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

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

The purpose of the Committee with regard to remuneration is to consider and make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Chair and Non-executive Directors, and, on a regular basis, monitor the performance of the Chair and Non-executive Directors.

4.3.6 Assessment of performance

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

Executive Directors are assessed by the Chief Executive. The Chair undertakes the performance review of the Chief Executive and Non-executive Directors. The Chair is appraised by the Senior Independent Director and rigorous review of this process is undertaken by the Governors' Nominations and Appointments Committee chaired for this purpose by the Senior Independent Director and advised by the Director of Corporate Governance.

4.3.7 Expenses

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

Table 34: Expenses paid to Governors and Directors

Year	Directors			Governors		
	No. in office	No. reimbursed	Amount (£'00)	No. in office	No. reimbursed	Amount (£'00)
2021/22	22	4	23	35	2	1
2020/21	19	8	35	30	3	2

Note 1 - 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.

Eugine Yafele
Chief Executive
22 June 2022

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 35: Analysis of staff costs

	2021/22			2020/21		
	Total £'000	Permanent £'000	Other £'000	Total £'000	Permanent £'000	Other £'000
Salaries and wages	467,400	415,883	51,517	461,805	422,789	39,016
Social security costs	48,124	44,669	3,455	41,054	38,917	2,137
Pension costs*	80,103	76,645	3,458	75,392	72,642	2,750
Apprenticeship levy	2,288	2,288		2,130	2,130	
Termination benefits	77	77		320	320	
Agency/contract staff	28,825		28,825	20,310		20,310
Total Gross Staff Costs	**626,817**	**539,562**	**87,255**	**601,011**	**536,798**	**64,213**
Income in respect of salary recharges netted off expenditure	(3,754)	(3,754)		(3,456)	(3,456)	
Employee expenses capitalised	(1,370)	(1,335)	(35)	(1,784)	(1,742)	(42)
Net employee expenses	**621,693**	**534,473**	**87,220**	**595,771**	**531,600**	**64,171**

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 2021/22 and 2020/21 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 36: Average staff numbers (whole time equivalents)

Staff category	2021/22			2020/21		
	Total	Permanent	Other	Total	Permanent	Other
Medical and dental	1,645	1,544	101	1,629	1,518	111
Administration and estates	2,321	2,246	75	2,227	2,149	78
Healthcare assistant and other support	1,015	892	123	1,036	934	102
Nursing, midwifery & health visitors	4,537	3,943	594	4,551	3,974	577
Scientific, therapeutic and technical	1,514	1,458	56	1,483	1,426	57
Healthcare science staff	209	209	-	197	197	-
Total staff	**11,241**	**10,292**	**949**	**11,123**	**10,198**	**925**

4.4.3 Education, Learning and Development

The Trust's ambition continues to develop as a beacon of outstanding education, supported by the vision of 'developing exceptional people for exceptional careers.' In support of the education strategy and following a period of consultation significant progress was made over the year to merge and re-align education departments within Bristol and Weston to the core work streams within education. Therefore, by March 2021 a revised education structure was in place to progress education and corporate priorities and support emerging priorities within education.

The educational offer includes a diverse range of internal and external provision with the intent of developing, progressing and retaining our people. As a leading university teaching hospital, the Trust has close relationships with local, national and global academic institutions and established partnerships with the University of Bristol and UWE, Bristol to ensure the education and training of the workforce reflect local, regional, national and international priorities. Through Health Education England funding the Trust works collaboratively to develop and co-deliver training programmes that promote multi-disciplinary models of education at both under-graduate and post-graduate education level. Equally, the Trust connects with the local region to develop skills through the West of England Combined Authority in conjunction with further education institutions such as Weston College and the City of Bristol College.

Placements are available to a range of trainees, including clinical students at undergraduate and postgraduate level within medical, dental, nursing, midwifery, allied health professions and healthcare science. The Learning Education Facilitator (LEF) team support pre-registered nurses within the Trust alongside UWE, Bristol staff to ensure the quality and robustness of placement which during the pandemic had the additional challenge of service reconfiguration. The Trust provides educational teaching and clinical based placements for undergraduate medical students on behalf of the University of Bristol, placing students either at the South Bristol Academy and North Somerset Academy.

The clinical education offer is aligned to workforce priorities is supported through several work streams including the trainee nurse associate apprenticeship route which expanded in 21/22 to include 3 additional cohorts. Furthermore, the development of international nurse registered recruitment programme supported by education through the delivery of an international nurse induction programme, development of clinical skills and more readily an OSCE readiness programme to enable international nurses to be NMC registered. Over the year, the Trust continued to deploy national funding for the continuing professional development of nurses, midwives and Allied Health Professionals; with resource also allocated to support the wider partner network. The funding also supported the deployment of practice educator roles, across the Trust, working within clinical areas to provide educational support and teaching to develop skills for safe and high-quality patient care.

Re-organisation of the education department enabled the merger of clinical skills provision across Weston and Bristol into the Practice Development team who through their combined resource has allowed for an expansion of service to train and update clinical staff within

areas such as venepuncture, cannulation, catheterisation, IV additives and nasogastric tube insertion etc. Thereby, ensuring staff are compliant with national and NMC regulations.

The Bristol and Weston Simulation Service continued to provide a valuable clinical and non-clinical multi-disciplinary point of care education programme during the pandemic. The programmes are tailored to the needs of departments and clinical areas and are informed by patient safety and local/national policy. During the year, the service focused upon expanding its current provision into the Weston division to ensure a consistent offer which encompasses all hospital sites and teams. All programmes are accredited by the leading national simulation association (ASPiH). The simulation team and centre were instrumental in supporting the roll-out of the vaccination programme.

Postgraduate Medical Education is responsible for the governance and quality of training provided to all doctors in training in partnership with Health Education England. The team consists of a Director of Medical Education (DME) and an administrative team alongside a broad base of educational faculty including educational and clinical supervisors. In support of students, the department implemented a new governance structure by establishing deputy DME roles: for quality, consultant development, and wellbeing and support.

Within the year, the library service evolved to include the new role of a Knowledge Management Specialist to support Trust wide evidence-based decision making. The Knowledge and Library service undertakes several activities from outreach clinical support work to synthesised literature searches to achieve this intent. The service supports staff and trainees, ensuring the right knowledge and evidence at the right time and in the right place, enabling high quality decision making. There is a physical library space at both the Weston and Bristol sites with access to a wide range of digital and physical resources and a heavily used digital web resource, with a new 'Knowledge Hub' to make accessing all evidence as simple as possible.

The Trust provides a broad range of apprenticeship programmes working in close partnership with independent training providers, local colleges, and universities. The apprenticeship pathways aim to support recruitment of an inclusive and talented workforce from our local communities whilst providing career development pathways for existing staff. The provision of apprenticeship programmes ranges from level 2 through to level 7 within clinical and non-clinical pathways. During the year, the Trust increased its committed levy spend to support in-house apprenticeships and, through the levy transfer scheme, local health and social care partners; therefore, positively contributing to the public sector target for apprentice numbers within the Trust workforce.

The education strategy continues to maximise the opportunities from apprenticeships, as aligned to both workforce and staff priorities. The Trust developed additional resource to support staff at the pre-apprenticeship stage through an English, maths and digital literacy offer aimed at encouraging these skills prior to studying functional skills. Externally, the Trust broadened its wider engagement offer in response to the pandemic through virtual careers fairs and work experience activity. The Trust collaborates with system partners within the BNSSG region to develop a singular health and social care engagement offer and through the development of educational initiatives such as a cross-system T-level strategy.

Throughout the pandemic, the Trust has continued to develop its induction and essential training offer with a greater emphasis upon a blended learning approach to up-skill staff and to ensure essential training compliance. By enhancing the Trust's e-Learning training offer and the on-going work to support the recruitment, accreditation, retention, career development, wellbeing and pastoral support of healthcare support worker staff group.

4.4.4 Diversity and Inclusion

The Trust is committed to inclusion in everything we do because everyone has a right to be treated with dignity and respect. The Trust recognises its legal duties under the Human Rights Act 1998 and the Equality Act 2010, and is committed to undertaking action under the public sector equality duty as defined within the Act. To achieve this, the Trust launched an

ambitious five-year workforce equality, diversity and inclusion strategy with an annual action plan built on four overarching themes with ten objectives.

By 2025 the Trust aims to:

- Be a Trust that continues to see an increase in staff engagement
- Be recognised as an inclusive employer that develops our people at every opportunity, spotting talent in every area of our diverse workforce
- Have leaders that role model our values and create an environment where staff feel safe to raise concerns and challenge where they see something that is not right
- Have an environment where innovation comes naturally – research shows that diversity helps teams to be more effective.

These ambitions will be delivered through an annual action plan underpinning the strategy's objectives. To achieve this, the Trust has established robust equality, diversity and inclusion governance and reporting pathways. The Director of People is the nominated executive lead for equality, diversity and inclusion on the Trust Board with delegated responsibility for the delivery of the programme of work sitting with the Associate Director OD and Wellbeing. Development. The workforce equality, diversity and inclusion steering group is the Trust's key group delivering on the Trust equality, diversity and inclusion strategic objectives and compliance assurance with legislative and regulatory requirements relating to equality, diversity and inclusion. The 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.

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

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

4.4.5 The Workforce Race Equality Standard (WRES)

The NHS Workforce Race Equality Standard (WRES) is designed to ensure employees from Black, Asian, and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Through nine evidence-based measures, the WRES highlights any differences between the experience and treatment of white staff and BAME staff in the NHS with a view to closing those gaps through the development and implementation of action plans focused upon continuous improvement over time. The WRES action plan is integrated into the Trust's yearly equality, diversity and inclusion action plan and progress against plan is reported bi-annually. The Trust's yearly WRES report is also available on its website.

4.4.6 The Workforce Disability Equality Standard (WDES)

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for disabled people working or seeking employment in the NHS. The WDES is a series of evidence-based metrics that provides NHS organisations with comparative data between disabled and non-disabled staff, giving a snapshot of the experiences of their disabled staff in key areas. This information is used to understand where key differences lie and provide the basis for the development of action plans, enabling organisations to track progress on a year-by-year basis. The WDES action plan is integrated into the Trust's yearly equality, diversity and inclusion action plan and progress against plan is reported bi-annually. The Trust's yearly WDES report is also available on its website.

4.4.7 The NHS Equality Delivery System (EDS2)

EDS2, with its four goals and 18 outcomes, is a toolkit that helps NHS organisations identify best practice and potential areas for improvement in relation to the experience of staff and patients from all protected groups. The Trust has completed the work required for the self-assessment of the four goals and 18 outcomes. Identified areas of improvement are incorporated into the Trust's yearly equality, diversity and inclusion action plan and through patient experience and involvement group for the patient outcomes. The Trust is actively involved in the EDS 3 programme pilot aimed at improving the current EDS2 framework and this will be incorporated into future action plans as required.

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 will be 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 developed a cultural awareness training session to support further development in this area alongside recruiting over 60 advocates who will be trained to become experts and support plans being delivered in local areas.

4.4.10 Diversity and Inclusion in the Workplace

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

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

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

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

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

- Equality, diversity and human rights policy: This sets out the Trust's commitments to equality, diversity, inclusion and human rights and its obligations under the Equality Act 2010 and the Human Rights Act 1998. It also describes the roles and responsibilities of individuals and groups in ensuring the Trust fulfils its commitments and obligations to develop and enhance a diverse and inclusive culture.
- Recruitment: This reflects the requirement to advance equality of opportunity, and includes a commitment to interview all applicants with a disability who meet the minimum criteria for a job vacancy.
- Supporting Attendance: This includes guidance on the Trust's duty to provide reasonable workplace adjustments to support the continuing employment of staff who have become disabled.

The Trust is also an accredited Disability Confident Employer, and is a Mindful Employer signatory – an initiative which provides employers with access to information, support and training relating to staff mental health and wellbeing.

4.4.11 Analysis of staff diversity profile

The Trust's annual statutory monitoring of workforce and patient data reflects information as at 31 March 2022. 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 37: Staff with permanent contract	**March 2022**	
Gender – All staff with a substantive employment contract	**Total**	**%**
Male	2,801	23.14%
Female	9,306	76.86%
GRAND TOTAL	12,107	100.00%

Table 38: Directors by gender	**March 2022**	
Gender – Directors (Executive and non-Executive)	**Total**	**%**
Male	9	60.00%
Female	6	40.00%

Table 37: Staff with permanent contract	March 2022	
Gender – All staff with a substantive employment contract	**Total**	**%**
Grand Total	15	100.00%

Table 39: Other Senior Managers by gender	March 2022	
Gender – Other Senior Managers	**Total**	**%**
Male	1	6.67%
Female	14	93.33%
Grand Total	15	100.00%

Note 1 - For the purposes of the Staff section of the report, Senior Managers are defined as Divisional Directors, Clinical Chairs and Heads of Nursing for the Trust's divisions.

Table 40: Ethnicity

	March 2022	
Ethnicity	**Total**	**%**
A - White – British	8,441	69.72%
B - White – Irish	143	1.18%
C - White - Any other White background	955	7.89%
D - Mixed - White & Black Caribbean	68	0.56%
E - Mixed - White & Black African	30	0.25%
F - Mixed - White & Asian	61	0.50%
G - Mixed - Any other mixed background	82	0.68%
H - Asian or Asian British – Indian	647	5.34%
J - Asian or Asian British – Pakistani	66	0.55%
K - Asian or Asian British - Bangladeshi	23	0.19%
L - Asian or Asian British - Any other Asian background	192	1.59%
M - Black or Black British – Caribbean	173	1.43%
N - Black or Black British – African	307	2.54%
P - Black or Black British - Any other Black background	90	0.74%
R – Chinese	55	0.45%
S - Any Other Ethnic Group	240	1.98%
Z - Not Stated	534	4.41%
Grand Total	12,107	100.00%

	March 2022	
Ethnicity	**Total**	**%**

Table 41: Disability	**March 2022**	
Disability	**Total**	**%**
No	10,447	86.29%
Not Declared	1,286	10.62%
Yes	374	3.09%
Grand Total	12,107	100.00%

Table 42: Age profile	**March 2022**	
Age profile	**Total**	**%**
16 – 20	116	0.96%
21 – 25	1,017	8.40%
26 – 30	1,792	14.80%
31 – 35	1,902	15.71%
36 – 40	1,546	12.77%
41 – 45	1,403	11.59%
46 – 50	1,266	10.46%
51 – 55	1,168	9.65%
56 – 60	1,112	9.18%
61 – 65	612	5.05%
66 – 70	134	1.11%
71 – 75	34	0.28%
76 – 80	4	0.03%
Unspecified	1	0.01%
Grand Total	12,107	100.00%

Table 43: Religious belief	March 2022	
Religious belief	**Total**	**%**
Atheism	2,248	18.57%
Buddhism	70	0.58%
Christianity	4,397	36.32%
Hinduism	166	1.37%
Islam	275	2.27%
Jainism	3	0.02%
Judaism	11	0.09%
Sikhism	18	0.15%
Other	806	6.66%
I do not wish to disclose my religion/belief	3,447	28.47%
Undefined	666	5.50%
Grand Total	12,107	100.00%

Table 44: Sexual orientation	March 2022	
Sexual orientation	**Total**	**%**
Bisexual	162	1.34%
Gay or Lesbian	222	1.83%
Heterosexual or Straight	8,645	71.40%
Other sexual orientation not listed	17	0.14%
Not stated (person asked but declined to provide a response)	2,354	19.44%
Undecided	42	0.35%
Undefined	665	5.49%
TOTAL	12,107	100.00%

4.4.12 Occupational Health and Safety and Wellbeing

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

include: new employee surveillance; immunisations; Health at Work Advice and referrals; ill health referrals; and health and wellbeing support.

2021/22 - It has been another challenging year for APOHS, the pandemic has continued to increase demand for occupational health support, this has resulted in a 20% increase in management referrals and an increase in COVID-19 Risk Assessments.

In addition to providing occupational health services to 28,000 health employees across UHBW and NBT, APOHS also delivers occupational health services to over 70 external providers demand from this sector has also increased significantly. This revenue helps improve occupational health services for NHS staff members.

The service has improved delivery against the key performance indicators this is despite high levels of sickness absence, vacancies and COVID-19 restrictions.

APOHS continues to seek opportunities to improve the service and this year we have purchased a new management information system. The new system will be implemented in 2022/23 and will enable the team to provide a more efficient service and improved data analysis and outputs. Other improvement this year include the purchase of new health surveillance equipment, a refresh to the department, including new uniforms for staff members and reception staff and we have also commissioned new automated fire doors for the service, improving accessibility for disabled employees and clients.

The team have implemented a comprehensive training programme which has included clinical supervision for nurses. This has resulted in an improvement in staff morale and staff competency.

APOHS is working closely with the national Growing Occupational Health programme, this was initiated by NHS England and Improvement in response to the People Plan. The aim of the programme is to support occupational health services in the NHS to be integrated, strategic and proactive system partners.

As part of the our system approach, Avon Partnership Occupational Health Service continues to host the Healthier Together Support Network (HTSN), this was initially developed to deliver the nationally funded BNSSG Mental Health and Wellbeing hub. However the remit of the HTSN was extended in 2021/22 to include two additional nationally funded projects; BNSSG Enhanced Health and Wellbeing Pilot and BNSSG Pilot Primary Care. The projects were brought under the HTSN umbrella to ensure the projects could be implemented efficiently, and ensure staff members working in health and social care across BNSSG were supported with work place issues. To support this programme of work the Business Development Manager for APOHS and the Clinical Lead for the UHBW Psychology Service have worked closely together to support the Project Managers to develop a programme of work that complements the UHBW holistic Wellbeing Framework and avoids duplication. This includes developing a service that offers clinical assessments and support, webinars and training. The HTSN has developed a Long COVID-19 pathway for NHS and Social Care employees and has commissioned a number of external support packages including ReACTIV which is a tool that supports manages working in stressful environments or managers/employees that have experienced traumatic events at work.

One of the aims of the service is to provide a levelling up function in community and primary care ensuring employees working in these areas have a support package similar to that available to employees working in UHBW. This system approach to delivery has enabled the team to have a better understanding of the needs of employees working in primary care and community care and to develop a programme of work that addresses the need of all staff and managers working across the BNSSG area.

APOHS intends to build on this model and during 2022/23 will work with the Healthier Together Partnership to explore how we can combine APOHS and HTSN to provide a sustainable, preventative, proactive model of support that can help the system to reduce staff sickness, respond to work place psychological issues in a timely manner and provide a joined up approach to health and wellbeing across the ICS system.

4.4.13 A Safe and Healthy Working Environment

The overall strategy for health and safety in the Trust complies with the Health and Safety Executive guidance document number HSG65: Managing for Health and Safety and also the Care Quality Commission fundamental standards which underpins the legal duty to put suitable arrangements in place to manage health and safety. And, that such arrangements are monitored for effectiveness and regularly reviewed to encourage continuous improvement.

Health and safety and welfare is integral to the Trust's Risk Management Strategy, from which the five-year Health and Safety Action Plan 2018 – 2023 was developed. Progress against this is subject to review by topic Leads and monitored within the Trust Health and Safety Committee with summary reports to the Risk Management Group. In addition, external audits are conducted biennially with internal departmental health and safety audits undertaken annually.

There is an annually reviewed risk management training matrix and prospectus which identifies requirements beyond the essential health and safety training in place for all staff e.g., health and safety training for executives and senior managers, Divisional Health and Safety Leads/Advisors and mandatory departmental risk assessors. Coverage of this is monitored by the Trust Health and Safety Committee for compliance each quarter.

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

The Safety Department encompasses a Manual Handling Team that has enabled the Trust to access the most up to date knowledge and skills to reduce the risk of musculoskeletal disorders to the workforce and deliver efficient service improvement e.g., enhancement to training for Manual Handling Link Practitioners which is anticipated to give clinical staff more responsibilities including local training for hoist and falls equipment.

Changes made within the Safety department in the previous annual period saw the introduction of a central service for FFP3 respirator 'Fit Testing' which was mostly undertaken at department level prior to this. This centralisation of the service has proved to be a significantly positive outcome and the service will continue as a permanent function within the Safety Department making sure fit testing is available to all departments across all Trust sites. The earlier challenges faced in respect to frequently changing makes/models of disposable respirators has settled in 2021/2022 and all 'Fit Testing' is now undertaken using sustainable supplies within the UK. The service lead has attained British Safety Industry Federation (BSIF) Fit2Fit accreditation to ensure the best possible fit test standards are adhered to.

The merger with the Weston General Hospital site saw the introduction of health and safety training for Managers and Risk Assessors plus a welcomed opportunity for additional development of on-site H&S Advisors who have now completed training for Institute of Occupational Safety and Health (IOSH) accreditation. The introduction of a Manual Handling Advisor on-site to assist with both complex patient needs and in-situ training for specialist equipment has been a welcomed addition. Training for hazardous substances risk assessments will commence in July 2022.

4.4.14 Sickness Absence

The Trust's average sickness for 2021/22 was 4.1%.

4.4.15 Staff Turnover

Outturn at the end of 21/22 was 15.1% against a target of 13.1%. Turnover has increased throughout 21/22 peaking at 15.3% in February 2022. The Trust has undertaken a review of leaver and exit interview data and established a range of actions, as part of the new People strategy, that we take through 22/23 and beyond to improve retention. This work will be monitored through the 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 2021/22 the Trust's expenditure on consultancy was £0.475m (2020/21: £0.497m).

4.4.17 Off-payroll engagements

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

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

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

Table 45: Highly paid off-payroll worker engagements as of 31 March 2022, earning £245 per day or greater

No. of existing engagements as of 31 March 2021	-
Of which…	
No. that have existed for less than one year at time of reporting.	-
No. that have existed for between one and two years at time of reporting.	-
No. that have existed for between two and three years at time of reporting.	-
No. that have existed for between three and four years at time of reporting.	-
No. that have existed for four or more years at time of reporting.	-

Table 46: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater

No. of off-payroll workers engaged during the year ended 31 March 2021	3
Of which:	
Not subject to off-payroll legislation	-
Subject to off-payroll legislation and determined as in-scope of IR35	1
Subject to off-payroll legislation and determined as out-of-scope of IR35	2
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 47: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1st April 2021 and 31 March 2022

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.	43

Officers with significant financial responsibility are defined by the Trust as executive directors, divisional directors, clinical chairs, and the Managing and Medical Directors for the Weston site.

4.4.18 Exit packages

The table below shows the number and cost of staff exit packages in 2021/22 with 2020/21 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 48: Exit packages

	2021/22			2020/21		
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	0	3	3	1	8	9
£10,000 - £25,000	0	0	0	1	2	3
£25,001 - £50,000	0	0	0	4	0	4
£50,000 - £75,000	0	1	1	1	2	3
Total number of exit packages by type	**0**	**4**	**4**	**7**	**12**	**19**
Total cost (£'000)	**0**	**82**	**82**	**205**	**166**	**371**

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

Table 49: Analysis of non-compulsory departures

	2021/22		2020/21	
	No.	£'000	No.	£'000
Voluntary redundancies including early retirement contractual costs	1	77	2	115
Mutually agreed resignation contractual costs (MARS)	-	-	-	-
Contractual payments in lieu of notice	3	5	10	51
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**4**	**82**	**12**	**166**
Of which: Non contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

4.4.19 Engaging with staff

The Trust Values provide the foundation for how we are expected to behave towards patients, relatives, carers, visitors and each other. The Trust values and leadership behaviours are integral to the culture of the organisation and set the expectation and accountability across the hospital community.

A revised set of values and behaviours which reflect University Hospital Bristol and Weston have been developed with our people, by our people with over 5,000 staff engaging in the

process of developing our Values and Leadership Behaviours. The new Values have been immersed across the organisation and will be a key cultural component to embed the values in 2022 creating a workplace where the values are illustrated by 'who we are'.

The values launched in November 2021 as:

- **We are supportive**: we are always there for each other We try and do the right thing for patients and colleagues everyday
- **We are Respectful**: we always look for the best in people. We are inclusive welcoming and treat everybody fairly
- **We are Innovative**: We are full of bright ideas. We are open to research, learning and finding news ways of working
- **We are collaborative**: We do things together. We share our experience and expertise for the benefit of the Trust and our communities

The Trust values the role and contribution both Trade Unions and Professional Associations make in supporting and representing the Trust's workforce; and their active participation in partnership working across the Trust. Regular consultation with staff takes place through both informal and formal groups, including the Staff Partnership Forum, Policy Group and the Local Negotiating Committee (for Medical and Dental staff), these groups are being refreshed in light of a deep dive review conducted in the latter part of 2021. 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.

A review of the employee relations commitments at the Trust has been undertaken in 2022 with the intention of delivering consistently on improving a positive Employee Relations culture in the organisation.

4.4.20 NHS staff survey

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

The 2021 National Staff Survey response rate was 47% with over 6000 staff taking time to provide feedback on their experience at work.

Staff engagement with each other, the organisation, and our patients has slightly dropped in the 2021 National Staff survey to 6.9 out of a maximum of 10, however, the engagement score remains above the benchmark group, the acute trust national average score of 6.8.

The pride that staff has in the organisation and their contribution is reflected in the responses to recommending the Trust to receive treatment, which is demonstrated in the results, with 76% of staff confirming that they would recommend University Hospitals Bristol and Weston NHS Foundation Trust as a place to receive treatment. This is further supported and demonstrated by positive improvements in the following questions:

- My immediate manager asks for my opinion before making decisions that affect my work
- Team members often meet to discuss the team's effectiveness
- Opportunities to show initiative in my role

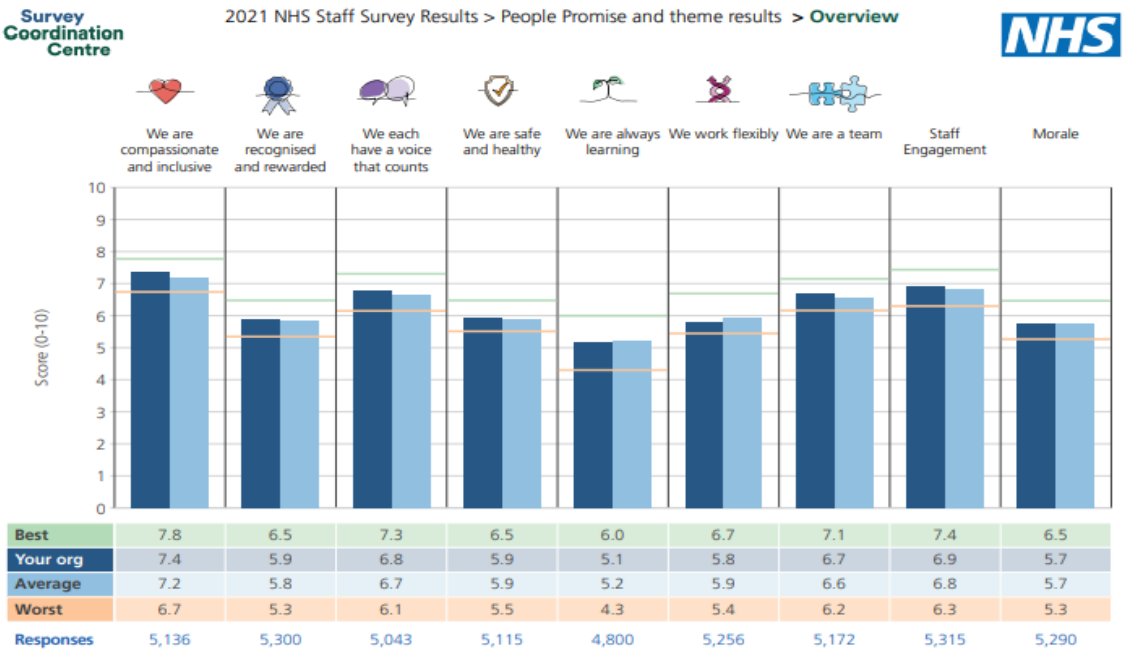
- Would feel secure raising concerns about unsafe clinical practices
- Not experienced harassment bullying or abuse from managers

4.4.21 Staff Survey Reporting

The National Staff Survey has been developed centrally for 2021 and is now aligned to the NHS People Promise. 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 results in relation to the Staff Survey 2021 in line with the nine themes. The national results illustrate that in seven of the nine themes we are the same as or slightly above average in comparison to the benchmark group Acute Trusts.

Table 50: NHS Staff survey Results 2021



	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
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.4	5.9	6.8	5.9	5.1	5.8	6.7	6.9	5.7
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	5,136	5,300	5,043	5,115	4,800	5,256	5,172	5,315	5,290

4.4.22 Key areas for improvement

The Trust recognises that it needs to continuously engage and listen to its workforce and seeks to respond to all suggested areas for improvement.

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

Key areas of focus for 2022/23:

- Following the immersion of new values and leadership behaviours create an organisational culture bringing values to life at work for the benefit of individuals teams and services and ultimately patient care
- Continue to deliver our robust and holistic plan for the wellbeing of our staff at work by providing a comprehensive offer to support physical, healthy lifestyles and psychological wellbeing at work
- Progress our strategic plan for equality, diversity and inclusion- focusing on the cultural influencing priorities including:

- Utilise and develop EDI data to support a culture which recognises and celebrates our differences ensuring equity for all

- Develop and empower the Trust EDI staff networks to give them a strong and effective voice within the organisation
- Develop a culture where we embed our values into policy and practice ensuring fairness transparency and inclusivity

Working in partnership with the business to develop robust culture and people plans in response to the staff survey and staff experience, with an emphasis on listening and responding, and developing conversation frameworks which demonstrate evidenced based 'you said … we did', which have a foundation in creating the space where action is reality.

4.4.23 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:

- Following the successful merger, the TUPE Transfer and the continued integration of services across the Bristol and Weston Trust. Also collaboratively with our Integrated Care System Partners.
- Consultation and implementation of the revised Pay Scales under Agenda for Change (Removal of Band 1)
- Continuing implementation of the electronic document management system as part of an ongoing digitisation programme
- Managing change projects positively, supportively and through partnership working is seen as fundamental to the sustained delivery of responsive services, engaged and motivated staff and excellent patient care (e.g. 7 day working and changes in shift patterns)
- Consultation within Estates and Facilities to ensure beneficial terms and contusions, in order to maximised substantive establishment

4.4.24 Staff policies and actions applied during the financial year

Revisions of policies to include the new Trust values. This includes the probation policy, uniform policy and grievance policy. All our policies are regularly reviewed to ensure that they meet with best practice standards and legislation, and with our corporate objectives.

4.4.25 Tackling Harassment and Bullying

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

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

The Trust is committed to embedding the principles of 'Just Culture' and will focus on developing an integrated approach resolving this issue in partnership with a number of stakeholders. This approach pulls together three key areas:

- Data and Risk;
- Policy and Process;
- Governance.

The Trust recognises that some staff are subjected to unacceptable behaviour from colleagues or service users and this is indicated in responses to questions about bullying and harassment in the National NHS Staff Survey. It is anticipated that this work will improve staff experience and reduce bullying and harassment in the organisation.

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 55 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 51: Relevant union officials

Number of employees who were relevant union officials during 2021/22	Full-time equivalent employee number
55	10440

Table 52: Percentage of time spent on facility time

Percentage of time	No of employees
0%	-
1-50%	53
51%-99%	-
100%	2

Table 53: Percentage of pay bill spent on facility time

The total cost of facility time	£131,845
The total pay bill	£597,992,000
The percentage of the total pay bill spent on facility time	0.022%

Table 54: Paid trade union activities

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

4.4.27 Freedom to Speak Up

The Trust is committed to an open and honest culture to ensure that everyone who works in the organisation feels safe and confident to speak up. We recognise the importance of supporting staff to speak up about any concerns at work to improve services for all patients and the working environment for staff.

In most circumstances, concerns will be raised and resolved through the management structure of the Trust. However, a number of other options are available to staff who do not feel able to raise concerns in this way, including access to the Freedom to Speak Up (FTSU) Guardian. The Director of Corporate Governance is the FTSU Guardian who is supported by a Deputy FTSU Guardian and a network of around 100 voluntary FTSU staff speaking up champions, who work in diverse roles and locations across the Trust. To date, 72 of the champions have received in house training to listen to colleagues experiencing any issues, and to signpost them to further support.

The three objectives of the Trust's Freedom to Speak Up strategy focus on raising awareness of and building confidence in the speaking up programme and ensuring that our leadership and management training is informed by the feedback from the programme. The FTSU Guardian and champions are visible across the Trust by attending key meetings and talking to staff groups to promote speaking up messages. Promotional materials advertising the contact details for the FTSU Guardian (a dedicated phone number and email address) are available across the Trust. There are regular communications about speaking up which are shared in the weekly newsletter to all staff (Newsbeat), including profiles of the champions and case studies on concerns which have been resolved for learning.

The National Guardian's Office/Health Education England's 'Speak Up core training' is mandatory training for staff at UHBW since February 2021 and the 'Listen Up' module also now forms part of a suite of online training for managers in the Trust.

In the year, 102 concerns were raised with the Freedom to Speak Up Guardian (compared to 112 in the last financial year), the majority of concerns raised (54 percent) relate to attitudes and behaviours. There were six quality and safety concerns raised in the year. Where there are concerns relating to quality or safety, these are escalated to the chief nurse/medical director or their deputies to investigate and take appropriate action. Alongside concerns raised around staffing levels, the key themes of concerns related to pay and conditions; working culture; and fairness and transparency in recruitment processes and the management of staff.

The FTSU Guardian reports quarterly to the Board or People Committee on numbers and themes of concerns, feedback from those who have spoken up, and learning.

More details about the Freedom to Speak Up programme can be found in the Freedom to Speak Up annual report 2021/22, which is available on the UHBW website.

Table 55: Number and themes of concerns raised via the FTSU Guardian in 2021/22

	Q1	Q2	Q3	Q4	Total
Number of cases raised with the FTSU Guardian	**30**	**24**	**24**	**24**	**102**
Cases relating to quality / patient safety	1	3	1	1	6
Cases relating to attitudes and behaviours	21	12	9	13	55
Other cases	8	9	14	10	41

4.5 NHS Foundation Trust Code of Governance

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

The Board considers that it was fully compliant with the provisions of the Code in 2021/22, with the exception of paragraph A.5.12. Governors of The Trust are not provided with copies of the minutes of Board meetings held in private due to the confidential nature of business. However, they are provided with a summary of discussion of business at Board meetings held in public and meetings of the Council of Governors, where appropriate. Compliance with the Mandatory Disclosures is available from the Director of Corporate Governance.

The Board is committed to the highest standards of good corporate governance and follows an approach that complies with this Code through the arrangements that it puts in place for our

governance structures, policies and processes and how it will keep them under review. These arrangements are set out in documents that include:

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

All of the Non-executive Directors are considered to be independent in character and in judgement. The Executive Directors undertake an annual appraisal process to ensure that the board remains focused on the patient and delivering safe, high quality, patient centred care. Additional assurance of independence and commitment for those Non-executive Directors serving longer than six years is achieved via a rigorous annual appraisal and review process in line with the recommendations outlined in the Code. A report of the Governors' Nomination and Appointments Committee is detailed further in this report. The composition of the Board over the year is set out in Table 18.

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 2021/22. Good governance is essential if we are to continue providing safe, sustainable and high quality care for patients.

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

The Board also monitors performance of the organisation against the Corporate Objectives set as part of the annual Operating Plan every quarter, 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 Improvement Single Oversight Framework with the focus on four key areas of performance: A&E four hours, 62-day GP cancer, Referral to Treatment times and six week diagnostic waits. The Board does this, plus review of quality and workforce information, via review of the Quality & Performance Report.

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

Following the appointment of Jayne Mee as Chair of the Trust, and as a result of the Board evaluation described above, the Trust has commissioned an external partner to support its ongoing development as a Board. This organisation is undertaking a thorough diagnostic review of the Board in May and June 2022, to inform a series of development seminars to be held with the Board through 2022/23.

4.5.2 Performance of the Board and Board Committees

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

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

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

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

4.5.3 Qualification, Appointment and Removal of Non-executive Directors

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

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

Table 56: Board and Sub-Committee Attendance 2021/22

The Board of Directors discharged its duties during 2021/22 in 12 private and 6 public meetings, and through the work of its committees. The table below shows the membership and attendance of Directors at meetings of the Board of Directors and Board committees. A figure in brackets indicates that the individual was not a member and 'C' denotes the Chair of the Board or committee.

	Board of Directors	Remuneration & Nomination & Appointments Committee	Audit Committee	Quality & Outcomes Committee	People Committee	Finance and Digital Committee
No. of meetings	18	5	5	12	6	8
Chair						
Jayne Mee	18 (C)	5	1	11	5	8
Chief Executive						
Robert Woolley	18	4	3			7
Non-executive Directors						
David Armstrong	16	5	5 (C)			6
Sue Balcombe	17	4		10	6	
Julian Dennis	16	4	5	11 (C)		4
Bernard Galton	14	2	4	1	6 (C)	
Jane Norman	14	4		5		6
Martin Sykes	18	4	5			8 (C)
Steven West	11	1				6
Executive Directors						
Paula Clarke	15			1	3	2
Deidre Fowler	15			7	3	
Matt Joint	4	1		1	1	
Neil Kemsley	18		5			8
Alex Nestor	7	3			3	
William Oldfield	7			4	2	
Emma Redfern	9			2	2	
Mark Smith	17		1	11		7
Stuart Walker	3			2	1	
Emma Wood	5	1			2	

4.5.5 Remuneration and Nomination and Appointments Committees

The purpose of the Directors' Remuneration, Nominations and Appointments Committee is to conduct the formal appointment to, and removal from office, of Executive Directors of the Trust, other than the Chief Executive (who is appointed or removed by the Non-executive Directors subject to approval by the Council of Governors). The Committee also gives consideration to succession planning for Executive Directors, taking into account the challenges and opportunities

facing the Trust, and the skills and expertise that will be needed on the Board of Directors in the future.

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

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

4.5.6 Audit Committee

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

Additional oversight and scrutiny, in particular relating to quality and patient care performance is provided through the Quality and Outcomes Committee, Finance and Digital Committee and People Committee and information is triangulated from all four forums to ensure appropriate oversight and assurance can be provided to the Board in line with the Committee's delegated authority. The Non-Executive members of the Audit Committee also serve as the Chairs of these committees. The day to day performance management of the Trust's activity, risks and controls is however the responsibility of the Trust's Executive.

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

The Committee is responsible for providing the Board with assurance on the adequacy of the Trust's Audit plans and performance against these, and the committee's review of accounting policies and the annual accounts.

During 2021/22, 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 PwC, 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 and Trust wide systems and processes relating to the procurement service.

Additionally during the year, the Audit Committee continued to review the Estates and Fire risks to ensure progress was being made in addressing the issues previously identified in these areas.

4.5.7 Audit Committee Chair's Opinion and Report

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

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

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

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

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

- Releasing revised Terms of Reference, to reflect the Committee's agreed role with respect to Clinical Audit and Operational Continuity in Emergencies.
- Further developed the review process for Internal Audit Reports and the Risk Registers, in partnership with the Executive and with the Chairs of the Quality and Outcomes Committee, Finance and Digital Committee and People Committee.
- Further developed the Estates and Facilities Report.
- Considering how the Standard Operating Policies and Process are owned, maintained, reviewed, and implemented across the organisation
- Informally supported the development of a more robust approach to "Learning from Experience" in partnership with members of the Executive and QOC

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

4.5.8 Quality and Outcomes Committee

The Quality and Outcomes Committee was established by the Board of Directors to support the Board in discharging its responsibilities for monitoring the quality and performance of the Trust's clinical services and patient experience. This includes the fundamental standards of care (as

determined by Care Quality Commission), national targets and indicators and patient reported experience and serious incidents. The Committee is attended by three Non-executive Directors, one of whom is the Chair, and by the Chief Nurse, Medical Director, and Chief Operating Officer/Deputy Chief Executive. The Committee is also supported by the Director of Corporate Governance or Head of Corporate Governance in an advisory role.

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

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

- The 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
- Serious Incident Reports and Never Events.

Ad hoc reports were also requested and received on particular areas of concern to the Committee. During 2021/22, the Committee spent much of its time working closely with Executive members of the Board to monitor and support the Trust's response to the COVID-19 pandemic, and well as continuing to improve the quality of serious incident reporting and how the Trust can demonstrate Trust wide learning from such incidents. Following publication of the Ockenden Report, the Committee also undertook a much more detailed scrutiny of maternity services.

4.5.9 Finance and Digital Committee

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

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

The Committee's membership includes three Non-Executive Directors, and is usually attended by the Director of Finance and Information, Chief Executive, and Chief Operating Officer and Deputy Chief Executive.

The Finance and Digital Committee met on 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 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 Acute Provider Collaborative Board

In 2021 the Trust developed a provider collaborative alongside North Bristol NHS Foundation Trust in light of the development of the Integrated Care System and the progression of the Health and Care Bill through Parliament. The Acute Provider Collaborative Board is a meeting in common of University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust and is a formal sub-committee of the respective Boards.

The purpose of the Board is to provide the following for the Acute Provider Collaborative:

- Strategic leadership and direction
- Non-Executive and Executive oversight
- Agreed scope and phasing of programmes of work,
- Delivery oversight and resourcing agreements of the Executive-led programmes of work (both clinical and corporate)
- A point of escalation for any issues or significant risks that the programmes cannot mitigate

The Committee met on five 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.

4.5.12 NHS Oversight Framework

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

- Quality of care;
- Finance and use of resources;
- Operational performance;
- Strategic change;
- Leadership and improvement capability (well-led).

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

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

Eugine Yafele
Chief Executive
22 June 2022

4.6 Statement of the Chief Executive's Responsibilities as the Accounting Officer of University Hospitals Bristol and Weston NHS Foundation Trust

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

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

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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

Eugine Yafele
Chief Executive
22 June 2022

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 2022 and up to the date of approval of the annual report and accounts.

4.7.3 Capacity to handle risk

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

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

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

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

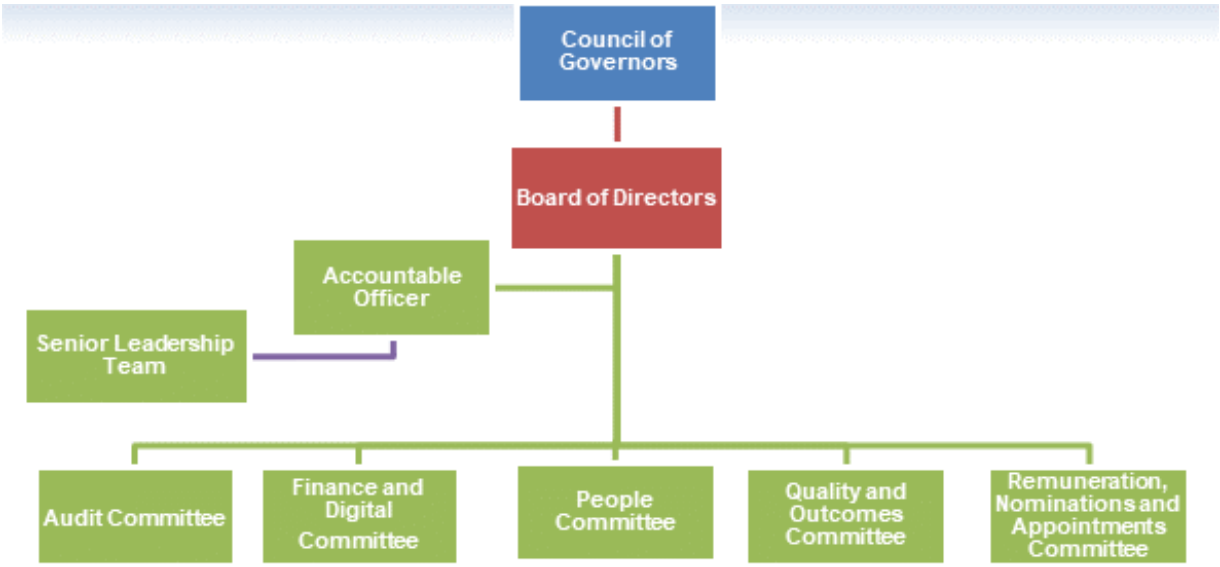
The process of identification, assessment, analysis and management of risks (including incidents) is the responsibility of all staff across the Trust and particularly of all managers.

Staff receive appropriate training to equip themselves to manage the identification, analysis, evaluation and reporting of risk in a way appropriate to their authority and duties. The Trust has an e-learning package on risk management to complement the existing risk assessment training programme. The purpose of this is to raise risk management awareness at Divisional and departmental level and to ensure staff are aware of their responsibilities in relation to risk management. The emphasis of our approach is increasingly on the proactive management of risk and ensuring that risk management plans are in place for all key risks.

Each of the Board Committees (the Finance and Digital Committee, the People Committee, the Quality and Outcomes Committee and the Audit Committee) reviews the risks appropriate to their remit. The Trust's performance information, and the quality of this

information, is also assessed by each of the Board Committees and by the Board as a whole at each meeting.

Table 57: Board Committee Structure



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

Prior to the merger, University Hospitals Bristol NHS Foundation Trust, commissioned an externally facilitated review against the Well-Led Framework in 2019. The conclusions of this review was that there was no reason, in the view of the Good Governance Institute, why the Trust should not maintain its overall rating of 'outstanding'; however, some small areas for improvement were identified, and these were delivered through the Board Development Plan through 2019 and 2020. UHBW will undertake a further external review against the Well-led Framework in 2022/23. The CQC, in its inspection report in 2021 into University Hospitals Bristol NHS Foundation Trust, gave it a rating of Outstanding for the Well-led domain which recognised the strong culture of good governance throughout the organisation.

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

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

The Trust uses the national Electronic Staff Record (ESR) system which is managed by IBM. IBM are responsible for the design, implementation and operation of controls with regard to ESR, producing an annual ISAE 3000 report to provide reasonable assurance that the control objectives are achieved. This is subject to independent audit. For 2021/22 two exceptions were identified during the audit testing of the controls. Having reviewed the control points raised, the Trust does not consider these to have any impact when assessing the risks of material misstatements of the Trust's financial statements.

4.7.4 The risk and control framework

The Trust's risk management policy describes our approach to risk management and outlines the risk architecture in place to support this approach. The policy is reviewed on an ongoing basis as opportunities for improvement are identified, and no less than once every three years. The policy sets out the key responsibilities and accountabilities to ensure that risk is identified, evaluated and controlled. The Board has overall responsibility for the management of risk but it delegates the work to the Senior Leadership Team and Risk Management Group.

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

At The Trust, risk is considered from the perspective of enterprise-wide risk management, with the approach to managing quality, operational, regulatory and financial risk following the same core principles. The management of these risks is approached systematically to identify, analyse, evaluate and ensure control of existing and potential risks posing a threat to our patients, visitors, staff, and reputation of the organisation.

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

Risks are identified through third-party inspections, recommendations, comments and guidelines from external stakeholders and internally through incident forms, complaints, risk assessments, audits (including clinical and internal), claims and national survey results. External stakeholders

include the Care Quality Commission, NHS Improvement, the Health and Safety Executive, NHS Resolution (previously the NHS Litigation Authority), the Medicines and Healthcare Products Regulatory Agency and the Information Commissioner's Office.

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

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

The Trust's Board Assurance Framework is formed of two key documents, the first details the principle strategic risks to the achievement of the Trusts objectives and the second the progress towards the delivery of the objectives.

Responsibility for the controls pertaining to each risk is assigned to an executive director with oversight by a designated Board committee. At year end, the corporate risk registers tracked 12 strategic risks and 37 operational risks.

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

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

- The implementation of a new People Strategy to support the Trust's capacity to deliver staff processes, to ensure the appropriate resources and people systems are in place to support its delivery, and to act as an enabling strategy to the Trust's 2025 Strategy: Embracing Change, Proud to Care. The People Strategy contains a range of workforce-related objectives for the coming 3 years that mitigate major workforce risks.
- The Board receives regular updates on key strategic staffing issues, including staff wellbeing, recruitment and retention, and systems to support staffing processes.
- The Quality and Outcomes Committee of the Board receives Monthly Safe Staffing Reports, as well as a six-monthly review report, to provide assurance that the Trust has discharged its responsibility to ensure safe nurse staffing across key clinical areas. The Chief Nurse also leads an Annual Staffing Review on nurse staffing.
- The People Committee supports the discharge of the Board's strategic priorities and responsibilities relating to its workforce and education. It is intended to focus primarily on all people working within and educated by the Trust, but also take a broader view that encompasses the wider stakeholder base of the Trust.

4.7.5 Quality governance arrangements

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

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

The Trust's annual quality delivery plans and quality objectives set out the actions we will take to ensure that this is achieved.

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

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

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

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

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

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

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

There are no material inconsistencies between the Annual Governance Statement, the annual and board statements required by NHS Improvement, the corporate governance statement and reports arising from Care Quality Commission planned and responsive reviews of the Trust.

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

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

The Trust has undertaken risk assessments and has a Sustainable Development Strategy in place which takes account of UK Climate Projections 2018. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

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

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

4.7.7 Information governance

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

The Trust has an Information Risk Management Group (IRMG) chaired by the Director of Finance and Information, who is the Senior Information Risk Owner for the Trust. IRMG is the principal body overseeing IG compliance and the management of information risks. This group has a reporting line into the Senior Leadership Team, via the Risk Management Group. It also oversees submission of the Trust's Data Security and Protection Toolkit.

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

- The key structures in place, principally Information Asset Owners and Information Asset Administrators who maintain the Trust's systems containing patient and staff personal data
- A trained Caldicott Guardian, a trained Senior Information Risk Owner and a trained Data Protection Officer
- A risk management and incident reporting process
- Staff training
- Information governance risk register
- Review of compliance with the Data Security and Protection Toolkit
- Internal audit review of the evidence provided to comply with the criterion of the Data Security and Protection Toolkit.

Four cases recorded in the Information Governance Incident Reporting Tool were reported to the Information Commissioner's Office in 2021/22. The details are provided in the following table.

Table 58: Incidents reported to the Information Commissioner's Office 2021/22

Date of Incident	Incident description	Number affected	How individuals were informed	Lessons Learned
May 2021	A Cardiotocography (CTG) appeared to be drawn on by hand on two occasions where there had been a loss of contact.	2	Face to face by clinicians involved as per duty of candour	A full root cause analysis investigation was undertaken. The investigation team recommended that the Trust ensure use of the antenatal CTG sticker when interpreting these and that the CTG sticker should

				be revised so that it corresponds to the guideline on Antenatal CTG monitoring.
September 2021	An P45 was posted to the wrong address.	1	The Trust was alerted to the incident by individuals involved.	The Trust has a process in place whereby an employee's address should be checked and documented that it has been checked before a P45/information is posted. The Teams involved have been briefed on this incident and the importance of following the correct process in order to avoid a re-occurrence of this incident.
February 2021	Due to a technical issue within a clinical system some postcodes were incorrectly updated.	100	A subsequent review of the incident indicated that duty of candour was not required.	The system supplier was made aware and worked with the Trust to fix the issue. The Trust then began an auditing process to confirm which patients had been affected by this issue and corrected any mistakes that were identified.
April 2021	A child's clinical letter was sent to a parent who does not have parental responsibility, in error.	2	The Trust was alerted to the incident by individuals involved.	The alerts on the Trust's patient administration system at the time of the incident did not specify what details could be shared with parents. This was subsequently corrected in order to avoid a re-occurrence of this incident.

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. These data are 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. The NHSI's Intensive Support Team (IST) have reviewed our processes and are satisfied with our approach to reporting waiting times.

4.7.9 Significant Internal Control Issues

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

- The impact of the COVID-19 outbreak, and the consequent reduction of elective operating and outpatient activity to allow the release of clinical staff to support wards, had a significant impact on the Trust throughout 2021/22. The key impacts have been on the ability of the Trust to see and treat patients in a timely way resulting in an increase in the number of ambulance delays, an increase in the number of patients waiting for planned care and delays to cancer treatments. These delays and the pressures on services have also had a significant impact on staff wellbeing and the ability of the Trust to retain staff. To support staff, the Trust put in place a significant programme of activities to enhance wellbeing, including psychological therapy support, enhanced counselling, wellness sessions including yoga, and enhanced rest areas for staff across the Trust.
- The Trust had detailed plans in place for the integration of the former Weston Area Health NHS Trust in advance of the merger which took place on 1 April 2020. The impact of the COVID-19 pandemic has resulted in the implementation of these plans being delayed due to a lack of operational capacity within the Trust as it responded to the pandemic. Corporate

services integration is almost complete but the clinical integration schedule has been adjusted and elements of this have been delayed and are now expected to be completed during 2022/23.

4.7.10 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Finance and Digital Committee and the Quality and Outcomes Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the 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 2021/22 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 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 2021/22 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.

Eugine Yafele
Chief Executive
22 June 2022

Appendix A – Biographies of Members of the Board of Directors

Eugine Yafele – Chief Executive

Eugine was appointed chief executive of University Hospitals Bristol NHS Foundation Trust in May 2022. Prior to joining UHBW, Eugine was the chief executive of Dorset HealthCare University Foundation Trust for four years. Under his leadership, the Trust achieved a CQC rating of Outstanding in his first year as chief executive. The Trust was also ranked amongst the top 4 in the annual staff survey for 3 consecutive years – with the best scores nationally for staff engagement and empowerment.

A nurse by background, Eugine brings a wealth of experience across senior clinical and operational roles in the private sector and in acute and mental health organisations in the NHS.

Eugine completed his MBA at Warwick Business School and has broad experience of partnership working and developing new models of care to improve the experience and outcomes for people who use health and social care services.

Mark Smith – Chief Operating Officer & Deputy Chief Executive

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

Mark has held several chief operating officer roles including City Hospitals Foundation Trust, Leeds University Teaching Hospital and Brighton and Sussex University Teaching Hospital.

William Oldfield – Medical Director

After undertaking studies in pharmacology, and subsequently human and applied physiology, Bill studied medicine, before entering the North-West Thames Training Programme in general and respiratory medicine.

During this time, he was awarded a Ph.D. Degree from the National Heart and Lung Institute at Imperial College, London, and gained sub-specialty experience in both allergy and critical care medicine.

He was appointed as consultant in respiratory medicine to St Mary's Hospital, London, and the Royal Brompton Hospital in 2003, and subsequently developed clinical interests in high dependency medicine and pulmonary embolic disease.

Prof Stuart Walker – Medical 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.

He has held a variety of clinical management positions at Imperial College Healthcare NHS Trust including lead clinician, chief of service, deputy medical director and interim medical director before joining University Hospitals Bristol and Weston NHS Foundation Trust in 2018.

Prof 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 has recently began a role as visiting professor at the University of West England.

Paula Clarke – Director of Strategy and Transformation

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 started in the Trust on 1 April 2016

Matthew Joint – Director of People

Matthew previously held senior corporate roles in Human Resources at Centrica and Amey Plc.

Most recently, Matthew held the post of HR director at Royal Mail Group, where he was responsible for more than 40,000 staff. He has extensive experience of implementing major change initiatives in large organisations and has particular expertise in talent management, leadership and development. Matthew trained as a research psychologist and held a Research Fellowship at Leeds University. He also has an MSc in civil engineering.

Neil Kemsley - Director of Finance and Information

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

Neil has over 15 years' experience as a Board director working across the provider, commissioning and regulatory sectors of the NHS.

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

Emma Wood – Director of People

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 has spent more than 30 years in human resources and organisational development, working in executive roles with the Boots Company, Whitbread, Royal Mail, Punch Taverns and Barratt Developments. Until June 2015 she was director of people and organisation development at Imperial College Healthcare NHS Trust. Until June 2021 she was a non-executive director at London Ambulance Service NHS Trust, and a trustee at St John

Ambulance. She joined NHS Charities Together as a Trustee in September 2021. Jayne is also an executive coach where she supports executives and organisations in culture change, engagement and transformation in a wide variety of private and public sector businesses.

Jayne holds an MSc in human resource development from Nottingham Trent University, a certificate in coaching from Henley Management College and is a Fellow of the Institute of Personnel and Development.

Jayne was appointed as Non-Executive 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.

Martin Sykes – Non-executive Director

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

Julian Dennis – Non-executive Director

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

Bernard Galton – Non-executive Director

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

David Armstrong – Non-executive Director

After graduating from Southampton University in 1980 with First Class Honours in Mathematics and its Applications, David initially worked in the banking sector before taking up a position as a systems engineer with GEC-Marconi in 1983. During the early part of his career he worked internationally, both in project management and function management roles. In 1999 he was appointed as business improvement, IT and quality director at Alenia Marconi Systems Ltd and since that time has held Board level positions in a number of GEC-Marconi and BAE Systems businesses, usually with responsibility for governance, risk, assurance and improvement. During his career David has also served on a number of policy making committees including Engineering UK's Business and Industry Panel and as a trustee of the Chartered Quality Institute. In 2014 David left the aerospace and defence sector to pursue interim and Non-executive director roles, including a secondment as ‘head of profession’ at the Chartered Quality Institute, where he was responsible for developing the quality profession, both within industry and the academic sector and also through

development of its individual members. He is a Fellow of the Chartered Quality Institute and a Chartered Quality Professional, and was a Chartered Engineer and Fellow of the Institute of Engineering and Technology from 2005-2019. David is chair of the Audit Committee.

Steven West – Non-executive Director

Steve took up the post of Vice-Chancellor and President of the University of the West of England Bristol in 2008. Steve trained as a podiatrist and podiatric surgeon in London and developed his research interests in lower limb biomechanics and the diabetic foot at King's College London. He worked as a clinician and clinical tutor in the NHS, university sector and undertook research and consultancy in industry and the retail healthcare sectors. He holds a number of national and international advisory appointments in higher education and in his clinical discipline, healthcare policy and practice. He is Non-executive Director for the Office for Students and chair of the UUK Mental Health in Higher Education Working Group. He is also a member of both the Education and the Diversity Honours Committees. He is chair of the West of England Local Enterprise Partnership (LEP) and chair of the West of England Academic Health Science Network (WEAHSN). Steve is a Deputy Lieutenant for the County of Gloucestershire and was awarded a Commander of the Order of the British Empire (CBE) in the New Year's Honours list 2017, for services to higher education.

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.

Appendix B – Contact Details

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

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

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

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

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

Telephone: 0117 34 23764

Email: FoundationTrust@uhbw.nhs.uk

Appendix C – Annual Accounts 2021/22

University Hospitals Bristol and Weston NHS Foundation Trust

Accounts for the year ended 31 March 2022

Neil Kemsley
Director of Finance and Information

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

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

Accounts for the year ended 31 March 2022

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2022 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.

Eugine Yafele
Chief Executive

Date: 22 June 2022

Statement of Comprehensive Income for the year ended 31 March 2022

	Note	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Operating income from patient care activities	3.1	937,560	816,949
Other operating income	4.1	134,259	154,513
Operating expenses	5.1	(1,050,033)	(958,233)
OPERATING SURPLUS		**21,786**	**13,229**
Finance income	8.1	90	-
Finance expenses	8.2	(2,068)	(2,284)
Public dividend capital dividend expense		(11,929)	(9,683)
NET FINANCE COSTS		**(13,907)**	**(11,967)**
Other losses	7	(66)	(74)
Losses / Gains arising from transfer by absorption	2	(100)	16,583
SURPLUS FOR THE YEAR		**7,713**	**17,771**
OTHER COMPREHENSIVE INCOME/(EXPENDITURE)			
Will not be reclassified to income and expenditure			
Impairments	8.3	120	(2,724)
Revaluations	10	15,356	-
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**23,189**	**15,047**

All revenue and income is derived from continuing operations.

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

Statement of Financial Position as at 31 March 2022

	Note	31 March 2022	31 March 2021
		£000	£000
NON CURRENT ASSETS			
Intangible assets	9	10,788	12,617
Property, plant and equipment	10	554,404	514,070
Receivables	12.1	1,906	1,802
TOTAL NON CURRENT ASSETS		**567,098**	**528,489**
CURRENT ASSETS			
Inventories	11	13,562	12,638
Receivables	12.2	33,814	34,815
Other financial assets	13	104	104
Cash and cash equivalents	14	168,091	169,644
TOTAL CURRENT ASSETS		**215,571**	**217,201**
CURRENT LIABILITIES			
Trade and other payables	15	(139,942)	(130,989)
Borrowings	17.1	(6,773)	(6,818)
Provisions	18.1	(370)	(853)
Other liabilities	16	(8,940)	(8,545)
TOTAL CURRENT LIABILITIES		**(156,025)**	**(147,205)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**626,644**	**598,485**
NON CURRENT LIABILITIES			
Borrowings	17.1	(49,832)	(56,097)
Provisions	18.1	(4,537)	(4,325)
TOTAL NON CURRENT LIABILITIES		**(54,369)**	**(60,422)**
TOTAL ASSETS EMPLOYED		**572,275**	**538,063**
EQUITY			
Public dividend capital		323,158	312,135
Revaluation reserve		88,941	75,704
Other reserves		85	85
Income and expenditure reserve		160,091	150,139
TOTAL EQUITY		**572,275**	**538,063**

The accounts on pages 2 to 42 were approved by the Board on 16 June 2022 and signed on its behalf by:

Eugine Yafele, Chief Executive Date: 22 June 2022

Statement of Changes in Equity for the year ended 31 March 2022

Changes in Equity in the current year	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	Total Equity £000
Equity at 1 April 2021	312,135	75,704	85	150,139	538,063
Surplus/(deficit) for the year	-	-	-	7,713	7,713
Net impairments	-	120	-	-	120
Transfers between reserves	-	(2,239)	-	2,239	-
Revaluations - PPE	-	15,356	-	-	15,356
PDC Received	11,023	-	-	-	11,023
Equity at 31 March 2022	**323,158**	**88,941**	**85**	**160,191**	**572,275**

Changes in Equity in the previous year	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	Total Equity £000
Equity at 1 April 2020	216,046	63,753	85	163,626	443,510
Surplus/(deficit) for the year	-	-	-	17,771	17,771
Transfers by absorption – transfers between reserves *	16,583	16,988	-	(33,571)	-
Net impairments	-	(2,724)	-	-	(2,724)
Transfers between reserves	-	(2,313)	-	2,313	-
PDC Received	79,506	-	-	-	79,506
Equity at 31 March 2021	**312,135**	**75,704**	**85**	**150,139**	**538,063**

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

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves

Relates to historical balances and will not move.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows for the year ended 31 March 2022

	Note	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus from continuing operations		21,786	13,229
OPERATING SURPLUS		**21,786**	**13,229**
NON CASH INCOME AND EXPENDITURE			
Amortisation	9	2,898	4,642
Depreciation	10	27,404	26,346
Net impairments	8.3	13,035	2,269
Income recognised in respect of capital donations		(17,179)	(4,093)
(Increase)/decrease in trade and other receivables	12.1 & 12.2	(2,085)	27,728
(Increase)/decrease in inventories	11	(942)	198
Increase/(decrease) in trade and other payables	15	11,495	24,175
Increase/(decrease) in other liabilities	16	395	2,078
Increase/(decrease) in provisions	18	(271)	2,526
Other movements in operating cash flows		5	-
NET CASH GENERATED FROM OPERATIONS		**56,541**	**99,098**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		90	-
Purchase of property, plant and equipment		(66,904)	(66,216)
Purchase of intangible assets		(1,094)	(831)
Receipt of cash donations to purchase capital assets		17,179	1,582
NET CASH USED IN INVESTING ACTIVITIES		**(50,729)**	**(65,465)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received *		11,023	79,506
Loans repaid to DHSC *	17.5	(5,834)	(63,416)
Capital element of finance lease rental payments	17.5	(417)	(369)
Interest paid	17.5	(1,958)	(2,323)
Interest element of finance leases	17.5	(169)	(194)
PDC dividend paid		(10,010)	(11,426)
NET CASH GENERATED/(USED) IN FINANCING ACTIVITIES		**(7,365)**	**1,778**
INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(1,553)**	**35,411**
CASH AND CASH EQUIVALENTS AT START OF YEAR	14	**169,644**	**129,840**
Transfer by absorption		-	4,393
CASH AND CASH EQUIVALENTS AT END OF YEAR	14	**168,091**	**169,644**

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

1. Accounting policies

1.1 Basis of preparation

NHS England and NHS Improvement (NHSEI), in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to NHS foundation trusts, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 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. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

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 Trust's Digital Apprenticeship Service (DAS) 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

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes 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. The scheme is not designed in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it is 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 are 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, e.g., 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 (ie operational assets used to deliver either front line services or corporate functions) are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but 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, 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 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 is shown in the table below:

Asset Type	Minimum Life Years	Maximum Life Years
Buildings excl. dwellings	8	50
Dwellings	15	25
Plant and machinery (incl. medical equipment)	1	34
Transport equipment	1	7
Information technology	1	14
Furniture and fittings	1	29

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 which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised 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.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets 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 is shown in the table below:

Asset Type	Minimum Life Years	Maximum Life Years
Software (purchased)	1	9

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. In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department of Health and Social Care.

1.10 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 by the Office for National Statistics (ONS).

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 finance leases are recognised and measured in accordance with the accounting policy for leases described below.

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

Financial assets 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 exactly 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

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.

The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property, plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating leases payments are recognised on a straight-line basis over the lease term. Lease incentives received are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as lessor

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 2022:

Expected cash outflows	Years	HMT nominal rate	
		2021/22	2020/21
Short-term	Up to 5	0.47%	Minus 0.02%
Medium-term	> 5 to 10	0.70%	0.18%
Long-term	> 10 to 40	0.95%	1.99%
Very long-term	>40	0.66%	1.99%

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 2020~~2~~2:

Year	HMT inflation rate	
	2021/22	2020/21
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution which, in return, settles all clinical negligence claims. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the Trust is disclosed at note 18.2 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 the NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 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 21 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but disclosed in note 21, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 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 public dividend capital 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.
- 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 24 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 handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note 25 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 2021/22.

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

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 *Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the re-measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

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

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of

comprehensive income and capital additions as follows:

Estimated impact on 1 April 2022 statement of financial position	**£000**
Additional right of use assets recognised for existing operating leases	99,088
Additional lease obligations recognised for existing operating leases	(99,088)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**0**
Estimated in-year impact in 2022/23	**£000**
Additional depreciation on right of use assets	(6,525)
Additional finance costs on lease liabilities	(924)
Lease rentals no longer charged to operating expenditure	6,724
Other impact on income / expenditure	(145)
Estimated impact on surplus / deficit in 2022/23	**(870)**
Estimated increase in capital additions for new leases commencing in 2022/23	**4,728**

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 2021/22.

Standards and Interpretations	**Financial year for which the change first applies**
IFRS 17 *Insurance Contracts*	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM which is expected to be from April 2023: early adoption is not therefore permitted.
IAS 21 *The Effects of Changes in Foreign Exchange Rates*	Application to be confirmed - The Financial Reporting Advisory Board (FRAB) is working to understand the potential implications for the UK public sector and plans to publish an exposure draft of proposed amendments in due course.
IAS 37 *Provisions, Contingent Liabilities and Contingent Assets*	Application to be confirmed - FRAB is working to understand the potential implications for the UK public sector and is developing proposals for targeted improvements involving definitions and measurement requirements.

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 49 years by the District Valuer as part of their valuations, depending on their state of repair and intended use. Useful economic life can be adjusted on the Fixed Asset Register if required, for example following an external valuation by the District Valuer. This estimate will take into account past experience. Typically more expensive items have a longer lifespan which reduces the degree of sensitivity of charges.

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.

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

c) Impairment

Impairments are based on the Valuation Office's revaluation, on application of indices or on revaluation of individual assets e.g. when brought into operational use, or identified for disposal. Estimates and judgments are used where the valuations and the assumptions used are applicable to the Trust's circumstances. Additionally, management reviews would identify circumstances which may indicate where an impairment has occurred.

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

d) Annual leave accrual

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

To reasonably estimate the number of days carried forward, the Trust's rostering systems' Healthroster and Softworks are used to provide the data for a sample of a cross section of employees by staff group.

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

The value of the annual leave accrual in the accounts is identified in note 15.

e) Provisions

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

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

The value of provisions in the accounts is identified in note 18.

f) Determining transaction price under IFRS15

The Trust has considered the implications of IFRS 15 in relation to the determination of transaction price and the satisfaction of performance obligations over time. There are no material elements of Trust income that involve assumptions beyond existing transactional estimates.

2 Segmental analysis

The Trust operates only one healthcare segment. The healthcare segment delivers a range of healthcare services, predominantly to Clinical Commissioning Groups and NHS England. The Trust is operationally managed through six clinical divisions and two corporate functions, all of which operate in the healthcare segment. Internally the finance, activity and performance of these areas are reported to the Trust Board. They are consolidated, as permitted by IFRS 8 paragraph 12, into Trust wide figures for these accounts.

Expenditure and non-service agreement income is reported against the operational areas for management information purposes. The out-turn position reported for 2021/22 is shown below with comparator figures for 2020/21.

	Year Ended 31 March 2022 £000	Year Ended 31 March 2021 £000
Corporate income	945,433	867,412
Corporate expenditure*	(26,711)	(71,269)
Divisions/functions net expenditure**		
Division of Diagnostic and Therapies	(76,503)	(71,180)
Division of Medicine	(122,768)	(99,648)
Division of Specialised Services	(147,871)	(131,812)
Division of Surgery	(139,792)	(123,185)
Division of Women's and Children's	(193,471)	(155,975)
Division of Weston	(80,673)	(75,657)
Facilities and Estates	(51,608)	(49,549)
Trust Services	(58,759)	(47,839)
Total division/function net expenditure	(871,445)	(754,845)
Earnings before Interest, Tax, Depreciation & Amortisation	**47,277**	**41,298**
Financing costs	(42,206)	(40,955)
Net surplus before technical adjs reported to NHSEI	**5,071**	**343**
Technical accounting adjustments		
Donations received for Property Plant and Equipment	17,179	4,093
Depreciation on donated assets	(2,254)	(1,998)
Impairment charge when assets brought into use	-	-
Impairment (charge) / reversal from revaluation	(13,035)	(2,269)
Net impact of DHSC donated consumables	(210)	337
Retain impact of DEL I&E (impairments)	1,062	682
Transfer by absorption	(100)	16,583
Total technical accounting adjustments	2,642	17,428
Surplus for the year	**7,713**	**17,771**

* Expenditure is not attributed to a specific division or function. The decrease in 2021/22 is a combination of decreased Covid specific expenditure, a reduction in the cost of annual leave owed to staff, and a large capital grant.

**In the Division of Women's and Children's Services the introduction of a gene therapy drug used to treat Spinal Muscular Atrophy, and an increase in drugs expenditure on Cystic Fibrosis patients, contributed to a marked increase in net expenditure. An increase in patient activity also caused an increase in expenditure on drugs in the Division of Medicine. Increase in expenditure in other divisions were due to the nationally determined pay awards 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 2022 £000	Year ended 31 March 2021 £000
NHS patient activity income	881,399	764,831
Other high cost drug income from commissioners	1,962	861
Other NHS clinical income *(See significant items below)*	10,731	5,530
Private patients *(Note 1)*	758	274
Additional pension contribution central funding *(Note 2)*	24,306	22,938
Other clinical income *(see significant items below)*	9,184	22,515
Elective recovery fund	9,220	-
Total	**937,560**	**816,949**
Other NHS Clinical Income - Significant items include:		
Cross provider charges under maternity pathways	1,723	1,711
Establishment of Adult Critical Care retrieval service	3,216	1,343
Pass through income *(Note 3)*	279	235
Bone Marrow Transplants and CAR- T Therapy	1,021	759
COVID19 Elective plus (H2) - Critical Care	895	-
Adult ECMO Resilience Funding	600	-
Targeted Investment Fund	465	-
NHSX Topcon pilot with BEH	205	-
TTP (Thrombotic Thrombocytopenic Purpura)	181	-
Other Clinical Income - Significant items include:		
Annual leave accrual *(Note 4)*	-	10,963
Genito-urinary medicine (Local Authorities)	8,277	8,301
Corrective payment for claims in respect of holiday pay *(Note 5)*	-	1,663
Injury cost recovery	730	1,045

Note 1 Private patient income was reduced in 2020/21 as a direct result of the COVID-19 pandemic. Private patient activity was not undertaken as part of the national response to the pandemic. The increase in 2021/22 represents a return to more normal levels.

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

Note 3 This pass through income refers to arrangements for the funding of the cost of specified high cost drugs and devices under 'Hub & Spoke' arrangements with other Provider Trusts.

Note 4 In 2020/21 there was an increase in the annual leave accrual due to an increase in leave entitlement earned but not taken at the end of the year. The increase was funded by NHS England in that year.

Note 5 Funding from DHSC to cover the cost of backdated claims for overtime payments and pay accrued during annual leave (Flowers case) was received in 2020/21.

3.2 Income from patient care activities (by source)

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
NHS England	430,757	378,246
Clinical Commissioning Groups	477,230	411,083
NHS Foundation Trusts	251	253
NHS Trusts	2,079	1,795
Local Authorities	8,412	8,301
Non-NHS private patients	758	274
Non-NHS overseas patients	89	810
NHS Injury Scheme	730	1,045
Territorial Bodies	17,254	15,142
Total	**937,560**	**816,949**

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 2022 £000	Year ended 31 March 2021 £000
Income from services designated as commissioner requested services	899,244	767,939
Income from services not designated as commissioner requested services *(Note 1)*	38,316	49,010
Total	**937,560**	**816,949**

Note 1 Funding for annual leave accrual and cost of backdated claims for overtime payments and pay accrued during annual leave (described in Notes 4 & 5 to Table 3.1 Income by Nature) were reflected in 2020/21 only.

3.4 Income from overseas visitors

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Income recognised this year	89	810
For invoices raised in this and previous years;		
Cash payments received	91	155
Increase to credit losses of receivables	13	352
Amounts written off	274	216

4 Other operating income

4.1 Income by type

	Year ended 31 March 2022			Year ended 31 March 2021		
	Contract Income	Non Contract income	Total	Contract Income	Non Contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	23,807	10,984	34,791	18,686	8,243	26,929
Education and training	39,189	754	39,943	40,973	466	41,439
Non-patient care services to other bodies	15,325	-	15,325	11,188	-	11,188
Provider Sustainability Fund and reimbursement and top up funding *(Note 1)*	2,135	-	2,135	41,061	-	41,061
Salary recharges	5,128	-	5,128	4,194	-	4,194
Receipt of capital grants and donations	-	17,179	17,179	-	4,093	4,093
Charitable and other contributions to operating expenditure	-	673	673	-	914	914
Contribution to expenditure – inventory donated by DHSC	-	2,090	2,090	-	13,691	13,691
Rental income from operating leases	-	2,222	2,222	-	1,467	1,467
Other*	14,773	-	14,773	9,537	-	9,537
Total recognised operating income	**100,357**	**33,902**	**134,259**	**125,639**	**28,874**	**154,513**

*Significant items include:	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Clinical excellence awards	3,531	2,840
Trading services - MEMO	459	557
Trading services – Pharmacy	1,437	1,380
Trading services - IT	176	208
Clinical testing	217	168
Catering	962	686
Staff accommodation rentals	163	120
Car park income	512	490
Staff contribution to employee benefit schemes	454	587
Property rentals	388	4
Insurance income	341	-

Note 1 There was a change in the national financial funding regime from 2020/21 to 2021/22. Provider sustainability funding was paid in 2020/21 and was no longer available in 2021/22. Top up funding was received as part of the national Covid-19 response to support providers in 2021/22 and 2020/21. This comprised of £35.026m (£41.1m in total for 2020/21).

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 2022	**£000**	**£000**	**£000**	**£000**
Revenue recognised in reported period that was included within contract liabilities at the previous period end	15	3,883	4,647	8,545
Year ended 31 March 2021	**£000**	**£000**	**£000**	**£000**
Revenue recognised in reported period that was included within contract liabilities at the previous period end	5	2,179	3,914	6,098

4.3 Obligations

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Revenue from contracts entered into but expected to be recognised:		
- within one year	8,940	8,545
- 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 Operating lease income

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

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Rental income – minimum lease receipts	2,222	1,467

Future minimum lease receipts due to the Trust

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
- no later than one year	2,202	1,563
- between one and five years	3,762	2,045
- after five years	3,671	2,527
Total	**9,635**	**6,135**

5. Operating expenses

5.1 Operating expenses by type

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Services from other bodies:		
- NHS & DHSC bodies	11,522	11,436
- non NHS & non DHSC bodies	2,444	2,145
Purchase of healthcare from non NHS bodies	9,929	10,693
Employee expenses excluding Board members	620,013	594,171
Employee expenses – Board members	1,603	1,600
Trust chair and non-executive directors	187	197
Supplies and services: clinical	85,252	85,374
Supplies and services: general	10,222	9,982
Drug costs	166,798	120,852
Inventory write down	-	74
Establishment costs	16,335	16,293
Premises costs – business rates	3,623	4,126
Premises costs - other	13,475	14,368
Transport – business travel	995	543
Transport – other (including patient travel)	2,987	3,306
Depreciation on property plant and equipment	27,404	26,346
Amortisation on intangible assets	2,898	4,642
Net impairments	13,035	2,269
Movement in contract credit loss allowance	474	(675)
Change in provisions discount rate	249	64
Auditor's remuneration - statutory audit	176	203
Internal audit	379	379
Clinical negligence	23,552	20,602
Research and development – other	10,632	7,488
Research and development – hosting payments	9,246	7,281
Rentals under operating leases	8,067	7,201
Other*	8,536	7,273
Total	**1,050,033**	**958,233**

*Significant items include:

	£000	£000
Education and training	4,106	2,530
Legal fees	364	1,094
Parking and security	1,398	1,222
Insurance	559	379

5.2 Other auditor remuneration and limitation of auditor's liability

There is no other non-audit service remuneration in note 5.1 for 2021/22. No other non-audit work at all was undertaken in 2021/22.

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 Nightingale hospital

The following gross costs of supporting the Bristol Nightingale hospital are included in operating expenses (2021/22 £Nil):

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Set up costs		
Staff costs	-	72
Other operating costs	-	424
Running costs		
Staff costs	-	161
Other operating costs	-	-
Total costs	**-**	**657**

5.4 Operating lease expenses

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

Minimum lease payments	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Land	34	34
Buildings	7,026	6,181
Plant and machinery	1,007	986
Total	**8,067**	**7,201**

Future minimum lease payments due under operating leases	**£000**	**£000**
Before one year	7,928	1,716
Between one and five years	26,576	3,503
After five years	83,603	4,433
Total	**118,107**	**9,652**

The Trust leases various equipment and buildings. The most significant was the South Bristol Community Hospital which the Trust leased for a 5 year period from April 2012. We have entered into a new 20 year lease signed in March 2022, which is reflected in the increase to the minimum lease payments above.

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 2022 £000	Year ended 31 March 2021 £000
Salaries and wages	467,400	461,805
Social security costs	48,124	41,054
Apprenticeship levy	2,288	2,130
Pension costs – employer contributions	55,797	52,454
Pension costs – employer contribution funded by NHSE	24,306	22,938
Termination benefits	77	320
Temporary staff - agency/contract staff	28,825	20,310
Gross employee expenses	**626,817**	**601,011**
Income in respect of salary recharges	(3,754)	(3,456)
Employee expenses capitalised	(1,370)	(1,784)
Net employee expenses	**621,693**	**595,771**

6.2 Retirement benefits

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.
The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government closed consultation on the the report of the Government Actuary on the cost control mechanism in June 2021 all three proposed reforms are adopted following this, further detail can be found: Public service pensions: cost control mechanism consultation - GOV.UK (www.gov.uk).

6.3 Retirements due to ill health

During the year ended 31 March 2022 there were 4 (2020/21: 10) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill health retirements are £0.228m (2020/21: £0.311m). 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 £0.066m (2020/21: net loss of £0.074m) 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 2022 £000	Year ended 31 March 2021 £000
Interest on bank account and National Loan Fund Investments	90	-
Total	**90**	**-**

8.2 Finance expenses

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Loan interest on DHSC loans	1,899	2,095
Finance leases	169	194
	2,068	2,289
Unwinding of discount on provision	-	(5)
Total	**2,068**	**2,284**

In both years, there was no interest payable arising from claims made under the Late Payment of Commercial Debts (interest) Act 1998 and no other compensation was paid to cover debt recovery cost under this legislation.

8.3 Impairments

Net impairment charged to operating surplus resulting from:	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Impairment following valuation of assets brought into use	11,939	-
Abandonment of assets in the course of construction	1,062	682
Changes in valuation	326	1,729
Reversal of impairments from change in valuation	(292)	(142)
Total net impairment charged to operating surplus	**13,035**	**2,269**
Net impairments charged to the revaluation reserve	(120)	2,724
Total net impairments	**12,915**	**4,993**

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

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

The impairment losses charged to the Statement of Comprehensive Income relate to the following:

Statement of Comprehensive Income	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Impairment following valuation of assets brought into use		
Combined Heat & Power	3,488	-
British Heart Institute Extension	3,811	-
Bristol Haematology and Oncology Centre Refurbishment	2,572	-
Weston Urgent & Emergency Care	2,068	-
Abandonment of assets in the course of construction		
Clinical Research Unit	1,062	-
Transport Hub	-	682
Change in valuation		
Valuation Office's revaluation of land & buildings	34	1,587
Total	**13,035**	**2,269**

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 2021	30,689	2,641	33,330
Additions – purchased	416	477	893
Additions – donated	-	-	-
Reclassifications with PPE	182	-	182
Disposals	(368)	-	(368)
Cost at 31 March 2022	**30,919**	**3,118**	**34,037**
Accumulated amortisation at 1 April 2021	20,713	-	20,713
Charged during the year – purchased	2,854	-	2,854
Charged during the year – donated	44	-	44
Disposals	(362)	-	(362)
Accumulated amortisation at 31 March 2022	**23,249**	**-**	**23,249**
Net book value at 31 March 2022			
Purchased	7,612	3,118	10,730
Donated	58	-	58
Total net book value at 31 March 2022	**7,670**	**3,118**	**10,788**

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

10. Property, plant and equipment

The Valuation Office undertook a desktop exercise at the 31 March 2022 which valued the Trust's land and buildings on a depreciated replacement cost, Modern Equivalent Asset valuation (MEA). The last full valuation was undertaken at 31 March 2020. The valuation resulted in a net decrease at 31 March 2022 of £11.853m compared to the book values, with £11.973m charged to the Statement of Comprehensive Income as a net impairment and £0.12m movement from 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). The valuations also accord with the requirements of the professional standards of the Royal Institute of Chartered Surveyors: RICS Valuation - Global Standards 2017 and the RICS Valuation – Professional Standards UK (January 2014, revised April 2015), commonly known together as the Red Book, including the International Valuation Standards, in so far as these are consistent with IFRS and the above mentioned guidance; RICS UKVS 1.14 refers.

The following are the agreed departures from the RICS Professional Standards and special assumptions:

- The Instant Building approach has been adopted, as required by the DHSC GAM and HM Treasury for the UK public sector. Therefore, no building periods or consequential finance costs have been reflected in the costs applied when the depreciated replacement cost approach is used.

- It should be noted that the use of the terms 'Existing Use Value', 'Fair Value' and 'Market Value' in regard to the valuation of the NHS estate may be regarded as not inconsistent with that set out in the RICS Professional Standards, subject to the additional special assumption of no adjustment has been made on the grounds of a hypothetical "flooding of the market" if a number of properties were to be marketed simultaneously.

	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 2021	**33,060**	**369,067**	**2,365**	**53,244**	**121,034**	**807**	**33,501**	**2,194**	**615,272**
Transfers by absorption	-	-	-	-	(304)	-	-	-	**(304)**
Additions – purchased	-	4,117	24	35,404	7,850	504	368	180	**48,447**
Additions – donated	-	2	-	16,723	426	-	28	-	**17,179**
Impairments	15	(11,868)	-	(1,062)	-	-	-	-	**(12,915)**
Reclassifications with intangibles	-	-	-	(182)	-	-	-	-	**(182)**
Reclassifications within PPE	-	29,531	-	(42,341)	7,493	-	5,240	77	**-**
Revaluations	1,220	(543)	51	-	-	-	-	-	**728**
Disposals	-	-	-	-	(7,377)	-	(4,566)	(944)	**(12,887)**
Cost or valuation at 31 March 2022	**34,295**	**390,306**	**2,440**	**61,786**	**129,122**	**1,311**	**34,571**	**1,507**	**655,338**
Accumulated depreciation at 1 April 2021	**-**	**-**	**-**	**-**	**75,299**	**548**	**23,286**	**2,069**	**101,202**
Transfers by absorption	-	-	-	-	(222)	-	-	-	**(222)**
Charged during the year – purchased	-	13,732	129	-	7,823	78	3,397	36	**25,195**
Charged during the year – donated	-	767	-	-	1,397	8	37	-	**2,209**
Revaluations	-	(14,499)	(129)	-	-	-	-	-	**(14,628)**
Disposals	-	-	-	-	(7,322)	-	(4,556)	(944)	**(12,822)**
At 31 March 2022	**-**	**-**	**-**	**-**	**76,975**	**634**	**22,164**	**1,161**	**100,934**
Net book value at 31 March 2022									
Purchased	34,295	361,886	2,440	43,839	49,334	661	12,316	342	**505,113**
Donated	-	22,245	-	17,947	2,813	16	91	4	**43,116**
Finance leases	-	6,175	-	-	-	-	-	-	**6,175**
Total at 31 March 2022	**34,295**	**390,306**	**2,440**	**61,786**	**52,147**	**677**	**12,407**	**346**	**554,404**

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

10.1 Donations of property plant and equipment

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

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Ventilators and associated medical equipment	-	1,485
Imaging equipment	-	1,026
Total	**-**	**2,511**

10.2 Net book value of assets held under finance leases

The net book value of assets held under finance leases and hire purchase contracts was:

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Cost or valuation at 1 April	6,246	6,721
Additions	9	11
Revaluation	(9)	(486)
Cost or valuation at 31 March	**6,246**	**6,246**
Accumulated depreciation at 1 April	71	71
Provided during the year	772	740
Revaluation	(772)	(740)
Accumulated depreciation at 31 March	**71**	**71**
Net book value at 31 March	**6,175**	**6,175**

10.3 Net book value of land building and dwellings

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

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Freehold	420,866	398,317
Long leasehold	6,175	6,175
Total	**427,041**	**404,492**

11. Inventories

Year ended 31 March 2022	Drugs	Consumables	Energy	High cost devices	Totals
	£000	£000	£000	£000	£000
Carrying value at 1 April 2021	4,875	5,797	126	1,840	12,638
Transfer by absorption	-	(18)	-	-	(18)
Additions	80,558	58,003	296	-	138,857
Consumed – recognised in expenses	(79,374)	(58,220)	-	(321)	(137,915)
Carrying value at 31 March 2022	**6,059**	**5,562**	**422**	**1,519**	**13,562**

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

In response to the Covid-19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed it to NHS providers free of charge. During 2021/22 the Trust received £2.090m (£13.691m 2020/21) of items purchased by DHSC, consumed £2.300m (£13.280m 2020/21), with a write down of £nil (£0.074m 2020/21). The remaining balance of £0.210m (£0.337m 2020/21) is recorded within the consumables balance. These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of the items is included in the expenses disclosed above.

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 2022 £000	Year ended 31 March 2021 £000
Clinical pension tax provision reimbursement from NHS England	1,906	1,802
Total	**1,906**	**1,802**

12.2 Current Receivables

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
NHS contract receivables	12,820	7,863
Other contract receivables	10,299	11,026
Contract receivable not yet invoiced	10,864	4,573
Annual leave accrual – accrued income	-	6,146
VAT receivable	-	2,663
Allowance for credit losses	(5,064)	(4,880)
Prepayments	4,690	3,761
Clinical pension tax provision reimbursement from NHS England	50	526
Subtotal	**33,659**	**31,678**
Capital receivables	-	1,063
PDC dividend receivable	155	2,074
Total current receivables	**33,814**	**34,815**

12.3 Allowance for credit losses

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Allowance as at 1 April	**4,880**	**5,435**
Transfers by absorption	-	361
New allowances arising	1,251	-
Changes in existing allowances	-	(675)
Reversals of allowances	(777)	-
Utilisation of allowances	(290)	(241)
Balance at 31 March	**5,064**	**4,880**

13. Other financial assets

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £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 2022 £000	Year ended 31 March 2021 £000
At 01 April	169,644	129,840
Transfers by absorption	-	4,393
Net change in year	(1,553)	35,411
At 31 March	**168,091**	**169,644**
Broken down into:		
Cash with the government banking service	167,074	169,342
Commercial bank and cash in hand	1,017	302
Total cash and cash equivalents	**168,091**	**169,644**

15. Trade and other payables

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Current amounts:		
NHS payables – revenue	5,246	13,534
Amounts due to related parties – revenue	7,879	8,070
Other payables – revenue	23,510	20,765
Tax and social security	14,371	11,673
Accruals	70,806	52,878
Annual leave accrual	9,457	12,854
Subtotal	**131,269**	**119,774**
Capital payables	8,673	11,215
Total	**139,942**	**130,989**

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

Outstanding pension contributions of £7.789m (2020/21: £7.427m) to the NHS Pension scheme and £0.017m (2020/21: £0.014m) for National Employment Savings trust (NEST) local pensions are included in amounts due to related parties. PAYE of £6.824m (2020/21: £5.401m) and £7.168m National Insurance (2020/21: £6.236m) are included in tax and social security.

16. Other liabilities

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Current liabilities:		
Deferred income – contract liabilities	8,940	8,545
Total	**8,940**	**8,545**

17 Borrowings

17.1 Borrowings split

Current borrowings:	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Capital loans from Department of Health and Social Care	6,343	6,401
Finance lease obligations	430	417
Total	**6,773**	**6,818**
Non-current borrowings:		
Capital loans from Department of Health and Social Care	47,089	52,923
Finance lease obligations	2,743	3,174
Total	**49,832**	**56,097**

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 2022 £000	Year ended 31 March 2021 £000
Payable:		
Before one year	6,343	6,401
Between one and five years	29,172	23,337
After five years	17,916	29,586
Net obligation	**53,431**	**59,324**

17.3 Finance lease obligations

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

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Payable:		
Before one year	575	575
Between one and five years	2,300	2,300
After five years	815	1,401
Sub-total	**3,690**	**4,276**
Less finance charges allocated to future years	(516)	(685)
Net lease liabilities	**3,174**	**3,591**

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

17.4 Net finance lease obligations

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Payable:		
Before one year	430	417
Between one and five years	1,958	1,862
After five years	786	1,312
Net obligation	**3,174**	**3,591**

17.5 Reconciliation of liabilities arising from financing activities

Year ended 31 March 2022	DHSC Loans	Finance Lease	Total
	£000	£000	£000
Carrying Value at 01 April 2021	59,324	3,591	62,915
Cash Movements			
Principal	(5,834)	(417)	(6,251)
Interest	(1,958)	(169)	(2,127)
Non Cash Movements			
Interest Charge arising in year	1,899	169	2,068
Carrying Value at 31 March 2022	**53,431**	**3,174**	**56,605**

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

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

18. Provisions

18.1 Provision for liabilities:

Year ended 31 March 2022	Clinicians pension tax reimbursement	Pension Injury Benefits	Pensions Early departure	Legal Claims	Total
	£000	£000	£000	£000	£000
At 01 April 2021	2,328	2,343	330	177	5,178
Change in discount rate	-	246	3	-	249
Arising during the year	-	(2)	5	71	74
Utilised during the year	-	(115)	(31)	(43)	(189)
Reversed unused	(372)	-	-	(33)	(405)
At 31 March 2022	**1,956**	**2,472**	**307**	**172**	**4,907**
Timing of economic outflow					
Before one year	50	116	32	172	370
Between one and five years	61	485	134	-	680
After five years	1,845	1,871	141	-	3,857
Total	**1,956**	**2,472**	**307**	**172**	**4,907**

There are no other provisions.

Year ended 31 March 2021	Clinicians pension tax reimbursement	Pension Injury Benefits	Pensions Early departure	Legal Claims	Total
	£000	£000	£000	£000	£000
At 01 April 2020	1,759	211	-	117	2,087
Transfers by absoption	224	144	202	-	570
Change in discount rate	345	36	28	-	409
Arising during the year	-	2,001	133	99	2,233
Utilised during the year	-	(46)	(31)	(21)	(98)
Unwinding of discount rate	-	(3)	(2)	-	(5)
Reversed unused	-	-	-	(18)	(18)
At 31 March 2021	**2,328**	**2,343**	**330**	**177**	**5,178**

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 £531.6m provision in its accounts (2020/21: £384.1m) in respect of clinical negligence liabilities of the Trust.

19. Capital commitments

	Year ended 31 March 2022	Year ended 31 March 2021
	£000	£000
Property, plant and equipment	15,950	17,609
Intangible assets	1,138	1,312
Total	**17,088**	**18,921**

20. Transfer by absorption

Analysis of balances transferred - Year ended 31 March 2022

Amounts transferred from: University Hospitals Bristol and Weston NHS FT	£000	Amounts transferred to: North Bristol NHS Trust	£000
Non-Current Assets	82	Non-Current Assets	82
Current Assets	18	Current Assets	18
Current Liabilities	-	Current Liabilities	-
Non-Current Liabilities	-	Non-Current Liabilities	-
Net Assets	**100**	**Net Assets**	**100**

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

The transfer relates to the transfer of Urology Services from University Bristol and Weston NHS Foundation Trust to North Bristol NHS Trust during the year and includes inventories and assets at book value related to the service.

Analysis of balances transferred - Year ended 31 March 2021

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

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

21. Contingencies

The Trust has no contingent assets at 31 March 2022 (2020/21: £nil).

The Trust has no material contingent liabilities at 31 March 2022. The Trust has contingent liabilities in relation to new claims that may arise from past events under the NHS Resolution “Liability to Third Parties” and “Property Expenses” schemes however the contingent liability will be limited to the Trust’s excess for each new claim.

22. Related party transactions

The University Hospitals Bristol and Weston NHS Foundation Trust is a Public Benefit Corporation authorised under the National Health Service Act 2006.

During the year, none of the Board members or members of the key management staff of the Trust, or parties related to them has undertaken any material transactions with the Trust. Board members have declared interests in a number of bodies. Transactions of more than £0.5m between the Trust and these bodies are shown below.

	31 March 2022 (£m)		31 March 2021 (£m)		2021/22 (£m)		2020/21 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Bristol City Council	1.18	0.52	0.40	0.43	8.37	-	8.57	0.12
Langford Veterinary Services	-	-	-	-	0.01	-	0.01	-
Oxford Health NHS FT	-	-	-	-	-	-	-	0.53
Price Water House Coopers LLP	-	-	-	-	-	0.20	-	0.19
Sirona Care and Health CIC	0.19	0.42	0.25	0.17	0.97	0.21	0.82	0.15
Torbay and South Devon NHS FT	0.32	0.08	0.19	0.04	0.41	0.62	0.43	0.54
University of Bristol	0.41	2.46	0.51	0.03	2.25	10.02	1.92	12.23
University of the West of England	0.04	0.84	0.10	0.12	0.52	0.57	0.46	0.56
Welsh Government	-	-	-	-	14.74	-	12.02	-
West of England Academic Health Service Network	-	-	-	-	0.03	-	0.02	-
Associated Charities	See notes below							
Health Education England	See WGA table below							

All bodies within the scope of Whole of Government Accounting are related parties to the Trust. This includes the Department of Health and Social Care and its associated departments. Such bodies where an income or expenditure, or outstanding balances as at 31 March, exceeds £5m are listed below.

	31 March 2022 (£m)		**31 March 2021 (£m)**		**2021/22 (£m)**		**2020/21 (£m)**	
	Receivables	Payables	Receivables	Income	Income	Expenditure	Income	Expenditure
Bristol City Council	1.18	0.52	0.40	0.43	8.37	-	8.57	0.10
Community Health Partnerships	0.08	0.26	-	0.17	-	6.65	-	6.55
Department of Health and Social Care	0.28	0.24	0.18	-	27.22	-	23.19	-
Health Education England	0.16	0.63	0.23	0.65	39.41	0.27	41.20	0.15
HM Revenue & Customs	-	14.03	-	6.25	-	50.41	-	43.18
NHS Bath and North East Somerset, Swindon and Wiltshire CCG	-	-	-	0.04	15.41	-	14.98	-
NHS Blood and Transplant	-	0.65	0.02	0.68	0.18	7.07	0.16	6.86
NHS Bristol, North Somerset and South Gloucestershire CCG	0.49	1.81	-	14.63	425.46	1.27	362.14	0.44
NHS England - Core (now including expenditure and payables for all regions)	0.82	4.29	8.00	4.45	1.93	-	50.82	-
BNHS England - Central Specialised Commissioning Hub	1.45	-	0.21	-	68.73	-	18.53	-
South West Regional Office (including commissioning hub 14F)	7.76	-	2.59	-	340.02	-	325.05	-
NHS Pension Scheme	-	-	-	-	-	80.00	-	75.08
NHS Resolution	-	-	-	-	-	23.55	-	20.60
NHS Somerset CCG	0.01	0.01	0.14	-	27.47	-	27.05	-
North Bristol NHS Trust	3.49	2.21	1.58	3.43	7.93	14.39	7.81	13.95
Welsh Health Bodies - Cwm Taf Local Health Board	-	-	-	-	0.34	-	0.99	-
Welsh Assembly Government	-	-	-	-	14.74	-	12.02	-

In addition the Trust pays HM Revenue and Customs tax and national insurance on behalf of employees; £98.8m in 2021/22 (£86.5m in 2020/21). The Trust pays the NHS Pension Scheme for employees' contributions which totalled £38.1m in 2021/22 (£35.4m in 2020/21).

The Trust also has transactions with charitable bodies including Bristol & Weston Hospitals Charity (formally Above and Beyond) which is the official charity for all hospitals within the Trust, the Grand Appeal which is the Bristol Children's Hospital Charity, and until cessation the Weston Health General Charitable Fund which was the Weston General Charity. The Weston Health General Charitable Fund and Grand Appeal charities are independently managed by boards of trustees and are not consolidated within the Trust's accounts.

The transactions are as follows:

	31 March 2022 (£m)		31 March 2021 (£m)		2021/22 (£m)		2020/21 (£m)	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Bristol & Weston Hospitals Charity (formally Above and Beyond)	0.27	-	0.23	-	0.66	0.29	0.45	0.30
Grand Appeal	0.04	-	0.07	-	0.13	-	0.39	-
Weston Health General Charitable Fund	-	-	0.30	-	0.01	0.07	0.84	0.30

23. Financial Instruments

23.1 Financial risk management

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

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

a) Market risk and foreign exchange risk

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

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

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

b) Credit risk

Credit risk arises from cash and cash equivalents and deposits with financial institutions, as well as outstanding receivables and committed transactions. The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. This means that there is little risk that one party will fail to discharge its obligation with the other. However disputes can arise, around how amounts are calculated. For financial institutions, only independently rated parties with a minimum rating (Moody) of P-1 and A1 for short-term and long-term respectively are accepted.

c) Liquidity risk

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

23.2 Carrying Value of Financial assets by category

	31 March 2022 £000	31 March 2021 £000
Receivables with DHSC group bodies	20,116	18,276
Receivables with other bodies	10,759	9,651
Other financial assets	104	104
Cash and cash equivalents	168,091	169,644
Total	**199,070**	**197,675**

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

23.3 Carrying Value of Financial liabilities by category

	31 March 2022 £000	31 March 2021 £000
DHSC Loans	53,432	59,324
Obligation under Finance lease	3,174	3,591
Trade and other payables with DHSC group bodies	10,433	22,741
Trade and other payables with other bodies	115,135	96,575
Total	**182,174**	**182,231**

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

Maturity of financial liabilities based on undiscounted cashflows

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Less than one year	133,734	128,247
In more than one year but not more than five years	9,693	31,490
In more than five years	47,572	33,920
Total	**190,999**	**193,657**

23.4 Fair values

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

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

24. Third party assets

At 31 March 2022 the Trust held £nil (31 March 2021: £nil) cash and cash equivalents relating to third parties.

25. Losses and special payments

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

	2021/22		2020/21	
Losses	**No.**	**£000**	**No.**	**£000**
Cash losses	36	30	10	40
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	264	429	285	248
Damage to buildings, property etc.	1	255	3	382
Special payments				
Ex gratia payments	39	1,685	41	12
Total	**340**	**2,399**	**339**	**682**

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

26. Post Statement of Financial Position events

No post statement of financial position events to note.

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 2022 which comprise the Trust Statement of Comprehensive Income, Trust Statement of Financial Position, Trust Statement of Changes in Taxpayers Equity and Trust 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 state of the Trust's affairs as at 31 March 2022 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2021/22.

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 Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to 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 Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified and concur with the Directors' 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 as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", 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 control totals delegated to the Trust by NHS Improvement
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

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 and the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we do not believe there is a fraud risk related to revenue recognition because of the non-complex, fixed nature of the revenue, which limits the opportunities to fraudulently misstate revenue.

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 year-end accruals.

We did not identify any additional fraud risks.

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 pairings, journals containing key words, and material post-closing entries.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspecting transactions in the period prior to 31 March 2022 to verify expenditure had been recognised in the correct accounting period.
- Evaluating accruals posted as at 31 March 2022 and verifying accruals are appropriate and accurately recorded.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.

Identifying and responding to risks of material misstatement related to non-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 directors (as required by auditing standards) and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

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.

The Trust is subject to laws and regulations that directly affect the financial statements, including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

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 these 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 Directors are responsible for the other information presented in the Annual Report together with the financial statements. 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.
- in our opinion those reports have been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 92, 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 dissolve the Trust without the transfer of its services to another public sector entity.

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

The Trust is responsible for putting 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 have undertaken 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 the use of 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 issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the relevant NHS regulatory body 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 Trust incurring unlawful expenditure, or is about to take, or has taken, a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

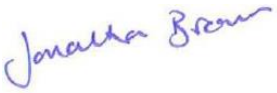
We have nothing to report in this respect.

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 and the terms of our engagement by the Trust. 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 the further matters we are required to state to them in accordance with the terms agreed with the Trust, 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.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of University Hospitals Bristol & Weston NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.



Jonathan Brown
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

22 June 2022