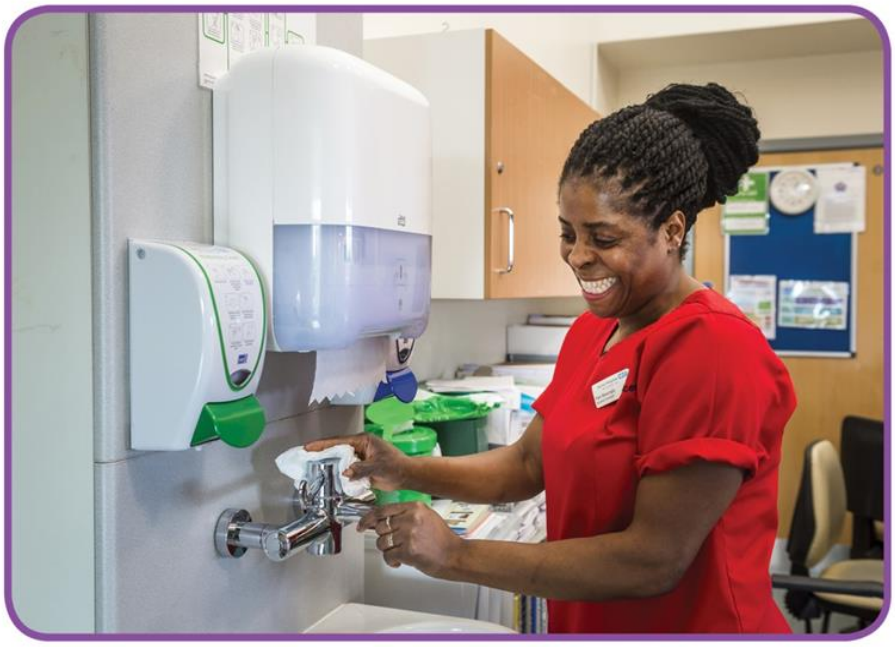
Burton Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 2017 - 2018



SAFE | EFFECTIVE | POSITIVE

Take PRIDE

- Passion
- Respect
- Innovation
- Determination
- Excellence

Burton Hospitals NHS Foundation Trust

Annual Report and Accounts 2017 - 2018

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

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Foreword from the Chairman and Chief Executive

On behalf of the Board of Burton Hospitals NHS Foundation Trust, we are pleased to present the Annual Report and Accounts for the financial year 2017/18.

The past year has seen increasingly closer working with Derby Teaching Hospitals NHS Foundation Trust. The aim of the proposed merger is to help secure general services at Queen's Hospital Burton, including A&E, develop more specialised services at Royal Derby Hospital and make bet use of our Community Hospitals in Derby, Lichfield and Tamworth.

We had initially hoped to merge on 1st April 2018, and a Full Business Case was agreed by both Boards in December 2017. However, while both the Competition and Markets Authority and NHS Improvement were impressed by the strength of the patient benefits case and the strategic rationale for the merger, and acknowledged that the financial case underpinning the proposal had been strengthened, NHS Improvement thought that further work needed to be done to provide greater assurance that the financial plan would be delivered.

We will therefore resubmit our application and assurances to NHS Improvement in June, with the aims of merging on 1st July 2018.

Work has also taken place on a number of other developments within the Trust. A major refurbishment of the Emergency Department at Queen's Hospital in Burton started in November 2017. The work is part of a £1.24m project to modernise the minor injuries area and underlines our commitment to retaining urgent care services in Burton. This has been an extremely exciting development for the Trust as it will help to provide a more modern and spacious area within the Emergency Department to enhance the high-quality care we provide to patients.

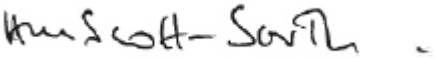
As part of the STRIDE partnership (Strategic Transformation Real Innovation and Delivering Excellence), the Trust has also been working on the development of a Health Village on the Outwoods site. Included in the potential new facilities are a nursery, a primary care hub providing general practice services, a pharmacy, an extra care facility and supported living unit.

Children in Burton and the surrounding areas who require urgent medical care are benefiting from a new assessment unit launched in August 2017. The Paediatric Assessment Unit was piloted in December 2016 as a rapid access unit to assess and monitor children who require medical treatment. Operating 24 hours a day, seven days a week, the unit allows children to be seen by specialist clinical staff sooner so that they can either return home or admitted to a hospital bed. After the successful pilot, the unit was launched on a full time basis.

As part of the wider Staffordshire and Stoke-on-Trent local health system we have continued to play key part in the Sustainability and Transformation Partnership. Our Chief Executive continued to Chair the Emergency Deliver Board for the STP which looks at ways to improve service delivery of emergency care in Staffordshire. The new organisation, should we merger, we will continue to participate in the

Staffordshire STP and will be represented by the Managing Director, Burton on behalf of the Chief Executive.

Finally, we would like to thank the tireless work of our staff and volunteers over the last year, particularly during the winter when pressure on local services was very high. Our staff continue to impress us all with their dedication, respect, and the care they take to ensure that patients and their families receive the best experience possible.



John Rivers
Chairman

Helen Scott-South
Chief Executive

Part 1 - Performance report

1.1 Overview of performance

1.1.1 Statement from the Chief Executive

As has been seen across the NHS, there has been a continued increase in the demand for emergency care this year, with perhaps one of the most challenging winters seen in a long time.

As a result of these 'winter pressures', trusts across the country were given guidance to cease inpatient elective operating for the month of January, so as to ensure that as much bed capacity could be released for patients coming through our Emergency Department.

As part of the regional Winter Plan, the Trust had opened additional beds across our Queen's and Community Hospital sites between January and March. Delays to the discharge of medically fit patients for onward care outside of the Trust were a significant challenge through the course of the year. The trust continues to actively work with our partners across health and social care to improve the discharge pathway, with the commissioning of new services discharge to assess models which will have be benefit in 2018/19.

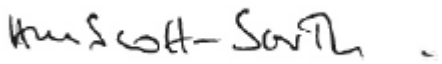
As well as the additional bed capacity a number of new developments were implemented such as our Front Door Frailty Model, which provides a specialised multi-disciplinary service to patients over 75 years of age and aims to reduce the likelihood of a hospital admission with an extended length of stay; the embedding of the Red2Green culture on our inpatient wards to ensure each day of a patients stay in hospital sees minimum delay and maximum value added and contributing to national programmes such as #endpjparalysis, which encourages patients to be dressed and out of bed during the day, which evidences shows, reduces the length of stay and is of benefit to the longer term health of patients.

Despite this pressure, due to the commitment of our dedicated staff and volunteers, the Trust rose to the challenge with great skill and compassion, with emergency 4 hour performance of 91.02%, meaning that over nine out of ten patients presenting to our A&E were seen, treated and transferred or discharged within 4 hours of arrival.

Furthermore despite the pressures on elective activity in winter, the trust met the 92% 18 week referral to treatment standard, in each and every month of the year, which bucked the national trend.

The core values of our staff were further demonstrated by the much improved performance for patients suspected of or diagnosed with cancer. The key performance metric here, is that patients receive diagnosis and definitive treatment within 62 days of referral by their GP. A transformation programme to address a series of capacity and pathway issues underpinned rising performance during the year, culminating in the last two quarters of 2017/18, exceeding the national standard of 85%.

Whilst there have been areas of strong performance, we acknowledge that this is a continuing journey towards our goal of ever-higher standards of quality and care and achieving an Outstanding rating by the Care Quality Commission.



Helen Scott-South
Chief Executive
23 May 2018

1.1.2 Statement of the purpose and activities of the Foundation Trust

The Trust's total bed base is 496 beds over all sites and inclusive of all specialties. The Treatment Centre, acquired in 2011, offers patients the facilities to have some routine operations in a number of specialities such as Gynaecology, Orthopaedic, General Surgery and Eat Nose and Throat as well as the surgical 23-hour stay facility.

Samuel Johnson Community Hospital provides a number of services for the local population of Lichfield including a Minor Injuries Unit, outpatient clinics, rehabilitation beds, a midwife led maternity unit and a Renal Unit together with X-ray and pharmacy services.

The Sir Robert Peel Community Hospital in Tamworth provides the local population with services including a Minor Injuries Unit, outpatient clinics, rehabilitation beds, day case surgery, endoscopy and X-ray and pharmacy services.

The Trust also provides a full complement of Accident and Emergency, outpatient and direct access services. All specialties are supported by a comprehensive range of clinical services in therapies, pharmacy, pathology, and radiology.

In addition, the Trust provides facilities to other NHS providers for specialties such as orthopaedics, phlebotomy and obstetrics. Furthermore, the Trust has a number of partnership agreements and contracts with other healthcare providers to support specialist services.

The Trust's main clinical services are organised and managed by two clinical divisions, Medicine and Surgery; each of which is led by a Divisional Director, a Divisional Medical Director and a Divisional Nurse Director, supported by a dedicated team of General Managers leading their respective clinical Business Units alongside Clinical Directors and Matrons. The clinical divisions meet as part of the Trust Executive Committee on a regular basis in order to review performance and progress service developments.

The Trust has an ambitious plan for achieving high quality care that is safe, effective and ensures a positive patient experience. In our first revision, embodied as the Quality Strategy 2013 – 2015, we stated: "As healthcare providers, we must never forget that patients are at the heart of everything we do. It is our duty to deliver the highest quality service to our patients at all times and to remember that patients have a right to be treated with respect, compassion and dignity."

Our mission today remains the same, because that duty is one we strive to fulfill day in, day out, for the good of our patients and the communities they live in and also to nurture our staff and build a positive working environment; one in which we can all take pride.

The Trust is committed to raise ambitions higher with the launch of the 2016 -2019 Quality Improvement Strategy. The four priority aims for 2016 – 2019 are:

- Aim 1 Eliminate preventable deaths
- Aim 2 Eliminate avoidable harm
- Aim 3 Optimise patient flow
- Aim 4 Optimise our workforce

Our Hospital facilities

The Trust predominantly provides services from Queen's Hospital and the adjacent Outwoods site situated on Belvedere Road in Burton upon Trent. The Trust also provides maternity services, inpatient and outpatient services, surgery and Minor Injuries Units from the Community Hospital facilities in Tamworth and Lichfield. Outreach clinics are also provided in a number of other locations in acute and community settings across a wide range of specialties.

The Trust enhanced its facilities in 2012 by working in partnership with InHealth, a specialist company with experience of working with the NHS on such projects, to open a state of the art cardiac catheterisation laboratory and chest pain unit. This allows local patients to be treated for vital heart procedures on their doorstep, rather than travelling to larger centres for treatment.

Services at a glance:

Anaesthetics	General Surgery (Colorectal / Breast / Upper GI)	Plastic surgery*
Audiology	Gynaecology	Radiology
Cancer services (including oncology and palliative care)	Haematology	Rehabilitation
Cardiology	Intensive care & Critical care	Renal
Care of the elderly	Nephrology*	Rheumatology
Dermatology	Obstetrics	Trauma and Orthopaedics
Diabetes	Ophthalmology	Urology & Urogynaecology
Ear, nose and throat (ENT)	Oral surgery*	* Supported by visiting consultants
Emergency Department	Orthodontics	
Endoscopy	Paediatrics / Neonatal Unit	
General Medicine	Pathology	

Routine maintenance and deep cleaning is undertaken on all sites, in all departments, to ensure that the Trust's facilities provide patients with a modern environment that complies with statutory requirements as a healthcare provider.

1.1.3 History of the Foundation Trust and its statutory background

The Trust was formed in 1993, successfully achieving Foundation Trust status in 2008, and continues to work in partnership with a multitude of different agencies for the benefit of the local population.

1.1.4 Vision, objectives and values

The changing needs of the population and the on-going efficiency gains that the Trust and the wider health economy are tasked with continue to challenge many organisations.

Sustainability and Transformation Partnerships (STPs) are to enable the delivery of a transformed NHS; delivering the "Five Year Forward View" vision of better health, better patient care and improved NHS efficiency. The Trust is a full partner of the Staffordshire and Stoke-on-Trent STP and an Associate Member of the Derbyshire STP.

The STP priorities are:

- Focused prevention
- Enhanced primary and community care
- Effective and efficient planned care
- Simplified urgent and emergency care
- Reduced cost of services.

The STP identifies a clear direction of travel and all organisations involved, including the Trust, will continue to work together in partnership to deliver the STP.

In addition to the STP, the Trust proposes a merger with Derby Teaching Hospitals NHS Foundation Trust. The two Trusts have an overlapping population base, operating 11 miles apart. Along with the rest of the NHS, both the Trust and Derby Teaching Hospitals NHS Foundation Trust are experiencing clinical, operational and financial challenges which are increasing over time. These pressures impact on the annual performance against national quality and operational performance standards.

The **Strategic Outline Case** (SOC) for the merger was agreed by both Boards in October 2016; it sought to answer two key questions:

- Does a form of strategic partnership between the Trust and Derby Teaching Hospitals NHS Foundation Trust improve NHS services resulting in a benefit for the populations served, the combined financial position?
- What form of strategic partnership between the Trust and Derby Teaching Hospitals NHS Foundation Trust is the most appropriate to deliver these improvements?

Both organisations considered the options for securing future sustainability and decided that some form of strategic collaboration between the Trusts would be the best way to address the specific sustainability challenges. Two forms of strategic partnerships were approved by the Boards of Directors to be explored further in the Outline Business Case: a group structure and a merger.

The **Outline Business Case** (OBC) was agreed by both Boards in June 2017. The key questions addressed in the OBC were:

- Which form of strategic partnership between the Trust and Derby Teaching Hospitals NHS Foundation Trust (group structure or merger) most improves NHS services provided by both parties for the benefit of the populations served and the financial positons of both Trusts?
- Are the benefits identified for the preferred organisational form acceptable to both Boards, to proceed with the development of a Full Business Case for the preferred organisational form?

The OBC concluded that a merger was the preferred form of collaboration.

The **Full Business Case** (FBC) developed the vision, approach and plans that will establish the proposed Merged Trust. The key question addressed in the FBC was:

- Are the benefits identified for the merger preferred organisational form acceptable to both Boards to proceed with implementation?

The FBC has concluded, supported by post transaction planning, that the proposed merger remains in the strategic interests of both Trusts allowing them to respond to both internal and external sustainability, quality and viability pressures.

Both Boards considered the FBC and supporting documentation at their meetings in March. The Competition and Markets Authority approved the clinical case for merging the trusts, but NHSI subsequently ruled that further work needed to be done to the financial case.

The governance of the process continues to be managed by the Strategic Collaboration Board and Project Team, together with Patient and Staff Reference Groups.

Strong leadership at all levels will continue to be essential in addressing the challenges that the Trust faces. The Trust will continue to invest and develop leaders both as individuals as well as part of multi-disciplinary teams. Clinical leadership will continue to form a large component of this investment.

The STP and proposed merger with Derby Teaching Hospitals NHS Foundation Trust form the bedrock of the Trust's plans for the years ahead. A "Plan on a Page" for 2017/18, (see diagram below) outlined the key priorities for the Trust, linked to the wider strategy. The ambition ***"To Be The Best, Every Patient, Every Time"*** is at the heart of the Trust's vision, mission and values.

Burton Hospitals: Plan on a Page 2017/18

Burton Hospitals NHS
NHS Foundation Trust

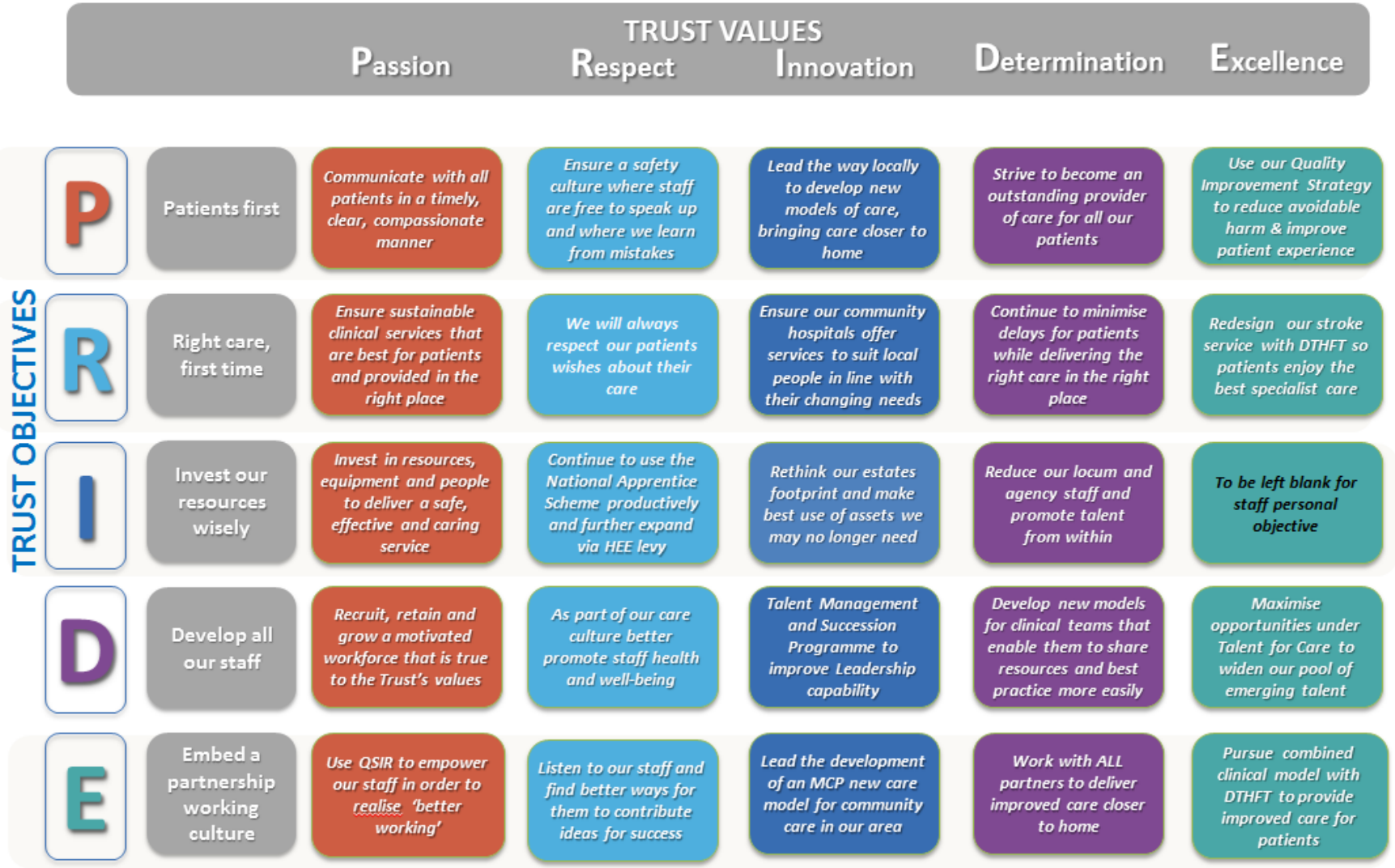
Working Together with PRIDE

Delivering Care Where it Counts: Our Future Plans

- **QUALITY: Getting to Good. Consistently.**
- **EFFICIENCY: Spending Wisely, Saving Safely.**
- **PARTNERS: Clinical and Strategic Collaborations.**
- **TRANSFORMATION: Working Differently for Better Outcomes.**

Burton Hospitals: *Working Together with PRIDE*

Burton Hospitals NHS
NHS Foundation Trust



The Trust's vision has been ***"To support our local communities with excellent healthcare when they need it most"*** and has been delivered through five Trust objectives:

Patients First
Right care, first time
Invest our resources wisely
Develop all our staff
Embed a partnership working culture

Care is delivered compassionately and is underpinned by the Trust's values:

Passion
Respect
Innovation
Determination
Excellence

1.1.5 Principle risks faced by the Trust in delivering its objectives in 2016/17

These are listed in the Annual Governance Statement in Part 2.8.

1.1.6 Going concern disclosure

After making enquiries, the Board of Directors has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts. More information regarding Going Concern can be found in the Notes to the Accounts 1.29.

1.2 Performance analysis

1.2.1 Performance framework

The Trust has a Performance Assurance Framework to both monitor and challenge the overall performance of the Divisions against all national and local targets and planned activity levels and associated income levels: making recommendations for further action in areas of poor performance; requesting and reviewing action plans to address shortfalls and having due regard to the NHS Improvement reporting requirements in terms of potential breaches of targets. As part of the internal performance management framework:

- Key performance measures are adequately reflected in the risk register and related action plans.
- The Trust has adopted a forward looking approach to the review of targets to support the self-certification process and provide appropriate assurance of delivery.

- The Trust provides appropriate reports and briefings to the Board on significant performance monitoring issues, confirming the action taken/proposed to address these.
- The Trust ensures that data quality is complete, accurate and robust and provides adequate assurance to the Board on all targets.

National Targets and Regulatory Requirements	2016/17 Target	2016/17 Actual	2017/18 Target	2017/18 Actual	201718 Performance Against National Target
Compliance with Core Standards as declared to the Care Quality Commission		✓			✓
Clostridium difficile – Number of cases	20	13	20	26	X
MRSA - maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	0	3	0	1	X
Referral to Treatment Waiting Times (RTT) - Incomplete Pathways	92%	94.27%	92%	92.11%	✓
Maximum waiting time of 4-hours from arrival in A&E to admission, transfer or discharge	95%	90.61%	95%	91.02%	X
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93%	95.90%	93%	95.49%	✓
Maximum waiting time of 2 weeks to first outpatient appointment for all suspected Breast Cancer referrals	93%	91.00%	93%	80.32%	X
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96%	99.10%	96%	98.46%	✓
Maximum waiting time of 31 days from diagnosis to subsequent treatment: Surgery	94%	94.50%	94%	95.52%	✓
Maximum waiting time of 31 days from diagnosis to subsequent treatment: Drug Treatments	98%	100%	98%	100%	✓
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	85%	78.90%	85%	80.90%	X
Maximum waiting time of 62 days from urgent referral to treatment for consultant screening service referrals	90%	96.70%	90%	95.16%	✓

Please note Cancer Figures are for April 17 to February 18 only (Latest Available). RTT Incomplete pathways is a snapshot of the waiting list position as at the 31st March 2018.

1.2.2 Analysis of key areas of performance

The Trust has seen strong performance against a number of the key national indicators throughout the course of the year. The 18 week Referral to treatment standard has been met consistently throughout the year, including during the winter months, where the Trust successfully converted operating capacity to focus on treating more daycase procedures, providing increased bed capacity to support emergency admissions. As with the RTT position, the diagnostic waiting time targets, where 99% of patients receive diagnostic tests within 6 weeks, has also sustainably been delivered through the course of the year.

The Trust has seen a significant improvement in Cancer waiting time performance. A national priority for the year, the 62 day Cancer Standard measures the length of time from referral to definitive treatment. The Trust has focussed on the transformation of cancer pathways which cross a range of clinical specialties and teams throughout the year. This hard work and dedication across multiple teams has seen cancer waiting times fall, to the point that the Trust is now in a position where month on month compliance against cancer targets is now being seen.

The other key operational performance standard is the A&E 4 hour target. As with the majority of Trusts across the country this target remains a significant challenge as the volume and complexity of demand rises and the capacity pressures are felt across Health and Social Care. Unfortunately there has been a rise in the number of patients who are Delayed transfers of Care (DTOC), resulting in an increasing volume of patients remaining in hospital beds. This in turn has led to challenges in ensuring timely availability of bed for those patients arriving through A&E which has had a detrimental effect on performance, particular in the winter months. The Trust continues to actively work with partner organisations on 'whole system' solutions to ensuring the right resource and capacity to manage patients across health and social care as effectively as possible. Whilst the compliant A&E performance of March and April 2017 has not been replicated in later months, as a result of these operational challenges, our staff has remained committed to ensuring safe care for our patients has been delivered, with 12 hour breaches avoided.

Patients treated	2016/17	2017/18	Variation
Non-elective patients	35,746	36,272	526
Elective inpatients	4,021	4,134	113
Day case procedures	29,240	28,458	-782
Renal Unit	5,745	5,446	-199
New outpatients	82,599	74,486	-8,113
Follow up outpatients	138,472	137,708	-764
A&E attendances (including Minor Injury Units)	125,023	128,519	3,496
All patients	**421,237**	**415,123**	**5,723**

Notes

- Inpatient figures are based on the number of spells
- Non-electives excluding well babies
- Outpatient figures are based on the number of Consultant attendances
- In 2017/18 the Neurology and Genito-Urinary Medicine services were de-commissioned and accepted no new referrals
- A&E attendances include both planned and unplanned attendances

A comprehensive review of the Trust's clinical performance over the past 12 months, including achievements and issues regarding to the Trust's performance, healthcare associated infections, Accident and Emergency waiting times and cancer targets has been included within the Quality Account, which is contained later within this report.

1.2.3 Transformation

The Transformation team supports improvements in the service delivery of all aspects of the organisation to ensure that our resources are used effectively. The team supports the delivery of a range of projects which fall within three main workstreams;

- **Planned Care**, including Outpatient redesign, improving theatres and elective pathways and developing our diagnostic services. Integral to our work this year has been the establishment of the Joint Transformation Board with our local commissioners, to ensure developments are implemented across primary and secondary care. These include the introduction of electronic referrals, advice and guidance technology, to support GP and specialist consultant communication, cancer pathway developments and developing new models of reviewing follow up patients that do not require unnecessary trips to hospital.
- **Unplanned Care**, focussed on the acute pathway, processes in the Emergency Department, reducing attendances and avoiding admission and supporting early, effective discharge. Particular focus has been given to the implementation of a new information system which provided patient specific details on next steps for each inpatient to support a reduction in delays as well as the development of a Frailty Model to ensure that patients over the age of 75 are assessed by a specialised and multi-disciplinary team to ensure that the care is delivered by the most appropriate team in the most appropriate setting rather than defaulting to acute admission.
- **Community Hospitals,** shaping the vision for the two hospitals to become hubs for their community's has been core to the work of the trust. The drive is to ensure the community hospital site offer an enhanced range of services to the population served.

Alongside these key strands of work, a key element of developing a culture of transformation within the organisation is to ensure all staff have the opportunity to be included. Four cohorts of Trust and wider health community staff, totalling some 80 individuals, undertook training on the newly introduced QSIR (Quality, Service Improvement and Redesign) Programme. This provided an opportunity to learn how to implement, measure and analyse service improvements.

1.2.4 Financial review

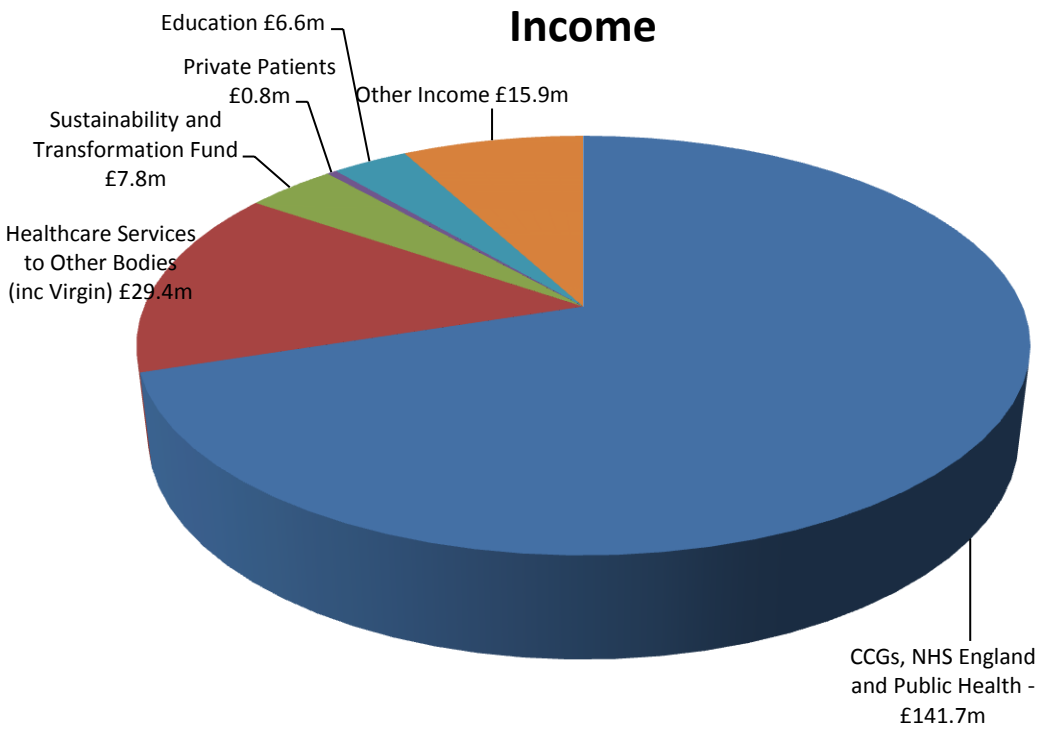
The Trust recorded a deficit of £11.5 million for the year after having received £8.839 million funding from the Sustainability and Transformation Fund for meeting financial targets. Throughout the year the Trust continued to receive financial support in the form of an Interim Working Capital Loan from the Department of Health. As at 31 March 2018 the Trust had received £48.015 million in support loans of which £24.010 is classed as repayable in 2018/19.

Financial performance for year ending 31 March 2018

	£'000
Earnings before Interest, Taxation, Depreciation and Dividends	1,470
Depreciation	(5,841)
Finance Costs and Dividends	(2,385)
Income from Charitable Donations	271
Impairment of Non Current Assets	(5,039)
Loss on Disposal of Assets	(22)
Investment Return	19
Retained Deficit for Year	(11,527)

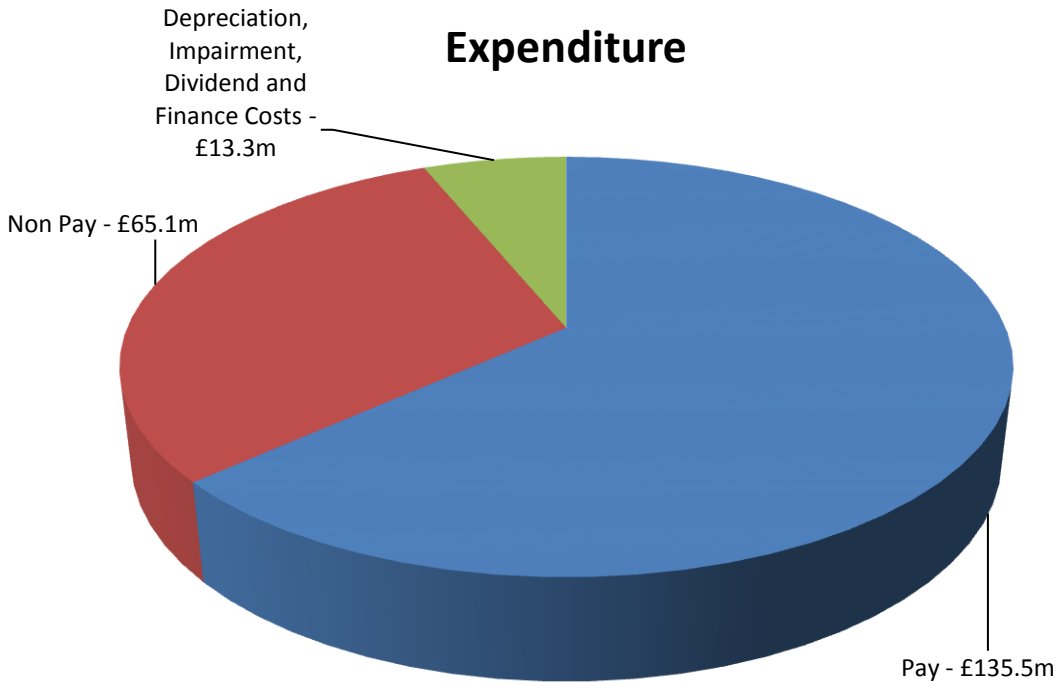
Income

Income for the year amounted to £202.3 million of which £172.9 million was for clinical services and a further £8.8 million from the Sustainability and Transformation Fund. The balance includes income for staff training and services provided.



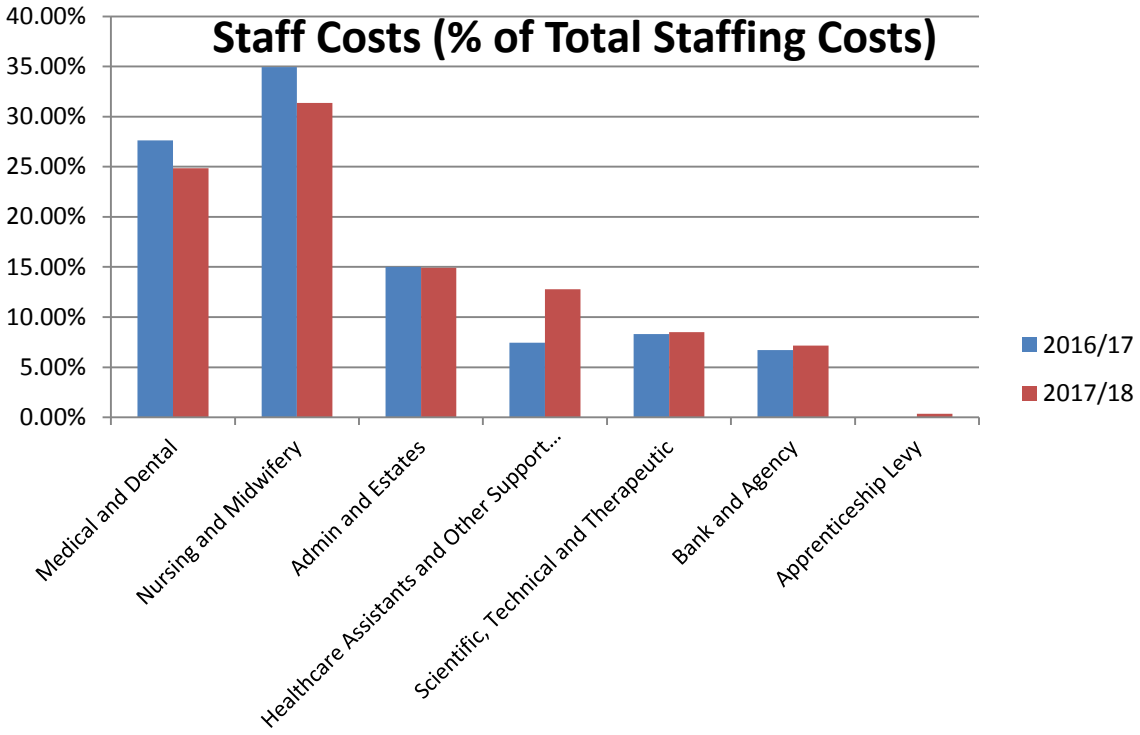
Expenditure

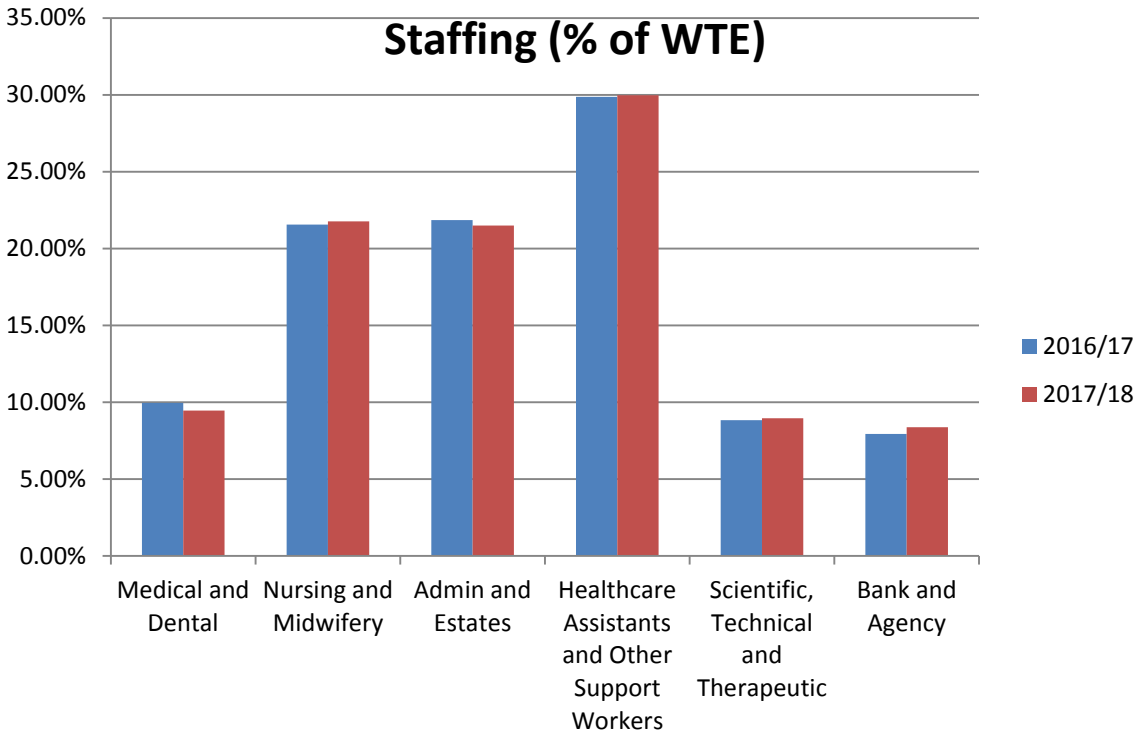
Total costs incurred during the year amounted to £213.8 million.



Pay costs

The Trust spent £135.5 million on pay costs. The breakdown over staff groups is shown below.





1.2.5 Financial disclosures

The Directors have confirmed that they have made available to its External Auditors all necessary and relevant information and disclosures as may be material to the Accounts.

The Directors have confirmed that there is no relevant audit information of which the Auditor is unaware and the Directors have taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Auditor is aware of that information.

As required by Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the Directors confirm that the income from the provision of goods and services for the purpose of the health service in England is greater than the income from the provision of goods and services for any other purpose as seen in Note 6 of the financial statements.

The Directors can confirm that the Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Value for money

The Trust's auditors, based on the work performed to address the significant risks identified and having regard to the AO's Auditor Guidance Note 3 (AGN 03) issued in November 2017, are satisfied that the Trust had proper arrangements in all significant respects to ensure it delivered value for money in its use of resources for the year ended 31 March 2018.

1.2.6 Social, community and human rights issues

Control measures such as policies and procedures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. The effectiveness of these measures is monitored by the People Committee, a sub-committee of the Board.

1.2.7 Important events since the end of the financial year

Appointment of Non-Executive Directors

Following a robust recruitment process the Council of Governors approved the following appointments:

- Joy Street, who has previous Board and senior NHS experience, was appointed from 1 April 2017 to 31 March 2018;
- Steve Hollingsworth, who has a financial background, was appointed from 5 April 2017 to 31 March 2018.

Steve Hollingsworth joined the Board of Directors as a Non-Executive Director Designate until the departure of Dennis Heywood on 31 July 2017.

Council of Governors Elections

The 2017 election process commenced in June 2017 and the process was administered on the Trust's behalf by the independent Electoral Reform Balloting Services Limited. Elections are conducted in accordance with the legislation set out in the NHS Act 2006 (as amended), and also in accordance with the provisions set out in the Trust's Constitution.

1.2.8 Overseas Operations

The Trust has no overseas operations.

1.3 Sustainability and Carbon Reduction

1.3.1 Governance and Leadership

The Trust will, as an integral part of its commitment, ensure the health and wellbeing of its community and ensure that its activities do not adversely impact the environment. The Trust is committed to reduce the environmental impact of its activities, and will comply with all relevant environmental legislation whilst doing so. As such:

"Burton Hospitals NHS Foundation Trust seeks to become an exemplar within the community, by delivering its services in a socially responsible and sustainable manner. The Trust recognises the many health benefits attributed to climate change mitigation, resilience and adaptation, and will foster key partnerships to promote climate action within the services it delivers and the communities it serves."

1.3.2 Management and Responsibilities

The Chief Executive has overall responsibility for ensuring compliance with statutory environmental management, energy consumption and sustainability regulations, through assurance that accountability is devolved to Directors, Managers and Heads of Departments. In addition, the Trust Board has a duty to endorse the Trust Sustainable Development Management Plan (SDMP) and Climate Change Adaptation Plan; and to ensure that any suggested actions progressed to Trust Board conform to current legislation.

The Sustainable Development Group (SDG), reporting into the Finance and Performance Committee, is accountable for the delivery of plans and actions outlined within the SDMP. Membership of the SDG includes Clinical, Estates, Facilities, Human Resources, Communications and Procurement representatives; in addition to the Executive and Non-Executive Directors with responsibility for sustainability.

The Trust also has a designated Waste and Sustainability Officer who has a duty to actively participate in the SDG, provide reports on progress towards targets, oversee the implementation of Trust policy relating to sustainability and to oversee the development of engagement materials to promote sustainability awareness.

1.3.3 Policies

During 2017/18 the Trust Sustainable Development Management Plan (SDMP), Climate Change Adaptation Plan and Sustainable Travel Plan were developed and ratified - to outline the ways in which the Trust will embed sustainability and respond to the challenges that climate change imparts upon our organisation and community. The SDMP dictates that a Sustainability Impact Assessment must be completed prior to the receipt of any new polices or business cases at Board, to ensure that sustainability is considered within all new developments. In addition, the Trust Procurement Policy was updated in 2017/18, to include sustainability considerations.

1.3.4 Sustainable Development Self-Assessment

The NHS Sustainable Development Unit (SDU) self-assessment tool assists organisations in evaluating qualitative and quantitative progress towards sustainable development. To ensure continual progress, the Trust Sustainable Development Group seeks to achieve 20% of the statements each year between 2017/18 and 2021/22. The Trust has achieved 32% of the sustainable development statements (pending final submission of the assessment), exceeding the target for 2017/18, however, significant progress is required within the remit of sustainable resource use and green space and biodiversity.

	2017/18	2018/19	2019/20	2020/21	2021/22
Completion Target	20%	40%	60%	80%	100%

1.3.5 Partnerships

The NHS policy framework sets the scene for commissioners and providers to operate in a sustainable manner. The Trust has not currently established strategic partnerships for carbon reduction but seeks to develop these in the future. For commissioned services, sustainability indicators for our CCGs are as follows:

Organisation Name	SDMP	Sustainable Development Reporting score	
		2016/17	2017/18
Burton Hospitals NHS Foundation Trust	Yes	Poor – 8.2%	Excellent – 59%
NHS East Staffordshire CCG	Yes	Minimum – 19.2%	Good – 33%
NHS South East Staffordshire and Seisdon Peninsula CCG	No	Poor – 5.8%	Minimum – 21%
NHS Southern Derbyshire CCG	Yes	Good – 26.9%	Excellent – 46%

More information on these measures is available here: www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx

1.3.6 Carbon Reduction Targets

Emissions targets:

- 34% reduction in CO_2e emissions by 2020
- 57% reduction in CO_2e emissions by 2030
- 80% reduction in CO_2e emissions by 2050

Building energy targets:

- Achieve a rating of 35-55 GJ/100m^3 for all 'new builds' and an overall rating of less than 65 GJ/100m^3 for the combined BHFT estate

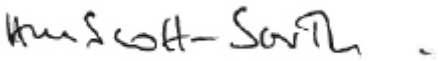
Waste management targets:

- Zero waste to landfill by 2050

Staffs travel targets:

- A 10% decrease in single occupancy car travel and a 10% increase in sustainable transport methods, utilised by staff as a primary means of commute.

Signed



Helen Scott-South
Chief Executive and Accountable Officer
On behalf of the Board of Directors - 23 May 2018

Part 2 Accountability Report

2.1 Directors' Report

The Board of Directors for Burton Hospitals NHS Foundation Trust comprises of Non-Executive Directors and Executive Directors.

The successful management of the Trust is the responsibility of the Board of Directors which maintains a close working relationship with the Council of Governors.

The Non-Executive Directors are appointed by the Council of Governors to provide challenge to the Executive Directors and bring an independent perspective into the Trust.

The composition of the Board of Directors as at 31 March 2018 is made up of the following:

2.1.1 Non-Executive Directors

Mr John Rivers CBE – Chairman
Dr Stephen Goode CBE – Deputy Chairman
Dr John Davies – Senior Independent Director
Mr John Bale
Mr Paul Doona
Mr Steve Hollingsworth
Mrs Joy Street

The Trust considers each of the listed Non-Executive Directors to be independent.

2.1.2 Executive Directors

Ms Helen Scott-South – Chief Executive
Dr Magnus Harrison – Medical Director and Deputy Chief Executive
Mr Duncan Bedford – Chief Operating Officer
Mrs Tosca Fairchild – Director of Governance, Communications & Engagement (non-voting)
Mrs Paula Gardner – Chief Nurse
Mr Jonathan Tringham – Director of Finance, Information, Performance and Estates
Mr Roger Smith – Director of Human Resources (non-voting)
Ms Alison Wynne – Director of Strategy and Partnerships

2.1.3 Management of the Trust

The Board of Directors has responsibility for setting the strategic values, priorities and direction of the Trust. The Board is committed to maintaining high standards of corporate governance by adopting the recommendations contained in NHS Improvement's Code of Governance.

The Trust recognises that the Board should provide a portfolio of skills and expertise to support the delivery of care that is consistently safe, consistently effective and perceived in a positive way by patients. The balance, competence and appropriateness to the requirements of the Trust are met through the composition of the Board. The Director of Strategy and Partnerships leads the collaboration work for both the Trust and Derby Teaching Hospitals NHS Foundation Trust as Programme Director. In order to support capacity within the Executive Team, an Associate Director of Strategy and Partnerships was appointed from January 2017 to January 2018.

Each of the Directors brings a broad range of public healthcare skills, experience, expertise and independent judgement to the Board, to allow productive Board discussions and decisions. These requirements are periodically reviewed.

Each member of the Board undergoes an annual performance assessment, reviewing performance against agreed objectives, personal skills and competencies and progress with personal development plans.

In keeping with the Independent Regulator's Governance Framework and the requirements under the Fit and Proper Persons test, together with best practice in terms of the effective performance of the Board, the Chairman receives an annual performance appraisal. This is led by the Senior Independent Director, taking account of views from the Executive Directors, Non-Executive Directors and the Council of Governors. The appraisal process also involves agreeing and setting the Chairman's objectives for the coming year. The initial reports are considered at the Council of Governors Appointments Committee with the outcomes of the evaluation being agreed by the full Council of Governors.

The Chairman also carries out annual appraisals and objective setting for the Non-Executive Directors with the results being reported to the Appointments Committee and the Council of Governors.

The Board undertakes an annual review of the Terms of Reference of its sub-committees to ensure that committees are effective and remain fit for purpose.

The Board meets monthly in private closed session and bi-monthly, in public, with regular supporting information sessions and ad hoc meetings as necessary. In addition, the Board holds a 'Meet the Board' event where Governors, Members of the Trust and the public are invited to discuss pertinent matters affecting the Trust. There were 17 public and private and one private extra-ordinary Board of Director meetings held in 2017/18.

The Board recognises the importance of staff engagement and communication. Throughout the year, the Trust has used a number of methods of communication to deliver messages to staff, including the Take Pride publication, the weekly newsletter, specific staff briefings and Chief Executive's Brief, a video of which can be viewed by all staff.

The Council of Governors and Board have a constructive relationship, working together to achieve the aims of the Trust. However, there may be circumstances when disagreements could occur between the Council of Governors and the Board

and these are resolved through the Dispute Procedure which can be found in the Trust's Constitution.

During 2017/18 changes to the Board / Senior Management are summarised as:

- Director of Communications role:

  Louise Thompson left the Trust in February 2018. Responsibility for the Communications and Engagement portfolio now sits with the Director of Governance.

2.1.4 Key Responsibilities

The Board has a number of key responsibilities:

- To monitor and oversee all activities undertaken ensuring the provision of safe, effective and positively perceived services for the local population; competent and prudent management; effective planning; maintaining proper procedures for accounting and other records and systems of internal control and for compliance with statutory and regulatory obligations;

- To act as the corporate decision making body, with Non-Executive and Executive Directors being full and equal members of the Board;

- To identify and develop the Trust's vision, values, priorities and objectives and identify and mitigate the key risks facing the Trust in carrying out its statutory and other functions;

- To work with, and have regard to the views of the Council of Governors to produce an Operational Plan and oversee its subsequent submission to NHS Improvement;

- To ensure that the conditions laid out in the Provider Licence as a Foundation Trust are met and where any breaches occur, develop and implement a suitable remedial plan.

2.1.5 Board of Directors as at 31 March 2018 – profiles

For a clear statement regarding the balance, completeness and appropriateness of the Board of Directors please refer to page 25.

Non-Executive Directors

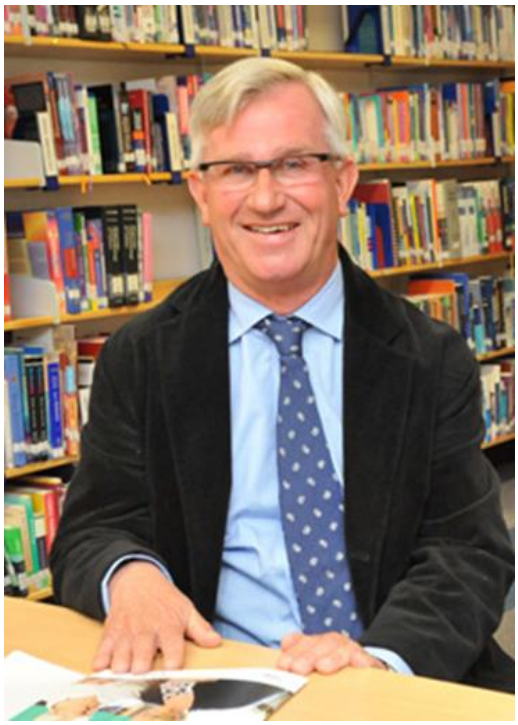
John Rivers CBE – Chairman

John was appointed as Chairman at Burton Hospitals NHS Foundation Trust in March 2016. He is also currently serving a second term as Chairman at Derby Teaching Hospitals NHS Foundation Trust and works on a full-time basis, splitting his time between both Trusts.

John retired from Rolls-Royce plc in 2007 after ten years as Director of Human Resources which was preceded by five years as Personnel Director for the Aerospace Group. For 19 years prior to joining Rolls-Royce, he worked at General Electric Company (GEC) in a number of senior management positions, including Personnel Director at GEC Plessey Telecomms (GPT).

John serves as Chair of the Nominations and Remuneration Committee.

Dr Stephen Goode CBE - Non-Executive Director and Deputy Chairman



Stephen worked in the Criminal and Community Justice System from 1975, retiring from the Ministry of Justice as a Senior Civil Servant in 2013. He undertook international, national and regional roles in his career. He was Chief Probation Officer for Derbyshire between 1997 and 2004, and was awarded a CBE for Services to Probation in 2002. In addition he was a member of the Parole Board from 2000 to 2006 and a Non-Executive Director for the Strategic Health Authority in the Midlands and East between 2006 and 2012.

Stephen is Deputy Chairman, Chair of the Finance and Performance Committee, Chaired the Risk Committee until June 2017. He is also a member of the Nominations and Remuneration Committee, Audit Committee, Quality Committee, and Charitable Funds Committee.

John Bale - Non-Executive Director

John is Managing Director of Bale Crocker, a well-established management consulting practice with a blue chip client base. He advises large organisations, such as law firms, accountancy firms and banks on effective leadership, business development and performance improvement. He spent 12 years with IBM, latterly as Sales Development Director for IBM Global Services Northern Europe. He was then Business Development Director and later Global Lead for Relationship Management with Accenture, the worldwide consulting firm.

John has been a Founding Fellow of the Institute of Professional Sales, an Associate Member of the Chartered Institute of Marketing, a Senior Associate of Judge Business School, University of Cambridge, an adjudicator each year at the UK National Sales Awards and National Business Awards and Chair of the Board of Trustees of Faith in Families, a nationally influential charity.

John is Chair of the People Committee and Chair of the Charitable Funds Committee. He is also a member of the Nominations and Remuneration Committee and the Quality Committee.

Steve Hollingsworth – Non-Executive Director

Steve retired from Rolls-Royce plc in 2012 after a 29 year career with the company. He undertook a variety of commercial and financial roles in the company both in the UK and abroad, culminating as Finance Director – Civil Aerospace from 2002-2012. Steve qualified as a Chartered Accountant with Clark Whitehill in 1982.

Steve is a member of the Nominations and Remuneration Committee and the Finance and Performance Committee.

Joy Street – Non-Executive Director

Joy was until recently a non-executive director at Stafford and Rural Homes and is embarking on a new career in writing. She has had a varied career spanning the public and private sector including being CEO of a Training and Enterprise Council, Chamber of Commerce and Business Link; Chairing a Mental Health Trust for eight years; running her own regeneration consultancy company, owning a restaurant and then working at Board level in the NHS at a specialist hospital.

Joy remains actively engaged in community-based activities including charities and has held several trustee and Chair positions in the voluntary sector and on University boards. Joy recently completed basic training in counselling and is a volunteer Samaritan. Joy is a member of the People Committee and the Nominations and Remuneration Committee.

Dr John Davies - Non-Executive Director and Senior Independent Director

After graduating from St John's College, Cambridge in 1973, John trained in general medicine at the London Hospital before embarking on a career which saw him specialise in Oncology and Haematology. He has also worked as a lecturer and a researcher. From 1980 to 1986, he served on many regional and national scientific societies and committees including the Australian Bone Marrow Transplant Study Group and the Australian / New Zealand Leukaemia & Lymphoma Study Group, and he was National Clinical Lead on the SEHD National Cancer Task Force. From 2000 to 2011 he worked in Edinburgh and has experience as a Regional Medical Director in South East Scotland. He also worked for the Scottish Executive Health Department, specialising in cancer medicines.
John is Chair of the Quality Committee and a member of the Nominations and Remuneration Committee, Audit Committee and People Committee.

Paul Doona - Non-Executive Director

Paul, a chartered accountant, was Finance Director and Company Secretary of St Modwen Properties Plc from 1985 to 1999, managing the flotation and restructure of the company. Following several years as Finance Director, and subsequently Chief Executive of Claims Direct Plc, Paul undertook a number of executive roles in the Internet gaming sector.

Paul's non-executive roles have encompassed various sectors including leisure, property, financial services, recruitment, asset management and natural resources businesses. In addition to the Trust, Paul is currently Vice Chairman and Chair of the Risk Committee at the Dudley Building Society, an independent member of the Audit Committee at Midland Heart Housing Association, and a Director of a number of commercial property businesses.

Paul is Chair of the Audit Committee which includes Risk Management He is also a member of the Nominations and Remuneration Committee.

Executive Directors

Helen Scott-South
Chief Executive

Helen was appointed Chief Executive at Burton Hospitals NHS Foundation Trust in March 2016. Helen joined the Trust with 40 years of NHS experience, having spent almost five years working at Derby Teaching Hospitals NHS Foundation Trust as Chief Operating Officer and then latterly as Interim Chief Executive. Prior to that, Helen had held the role of Director of Operations at Hull and East Yorkshire Hospitals NHS Trust and also served as a Board Director within three other large hospitals. She has extensive experience in change management within teaching, non-teaching and community hospital settings.

Dr Magnus Harrison
Medical Director and Deputy Chief Executive

Magnus is the Executive Medical Director and an Emergency Medicine Consultant. Magnus's role, working with the Chief Nurse, is focused on delivering the highest quality and safest care for all Burton Hospitals NHS Foundation Trust patients. Magnus is the Trust's Caldicott Guardian and oversees all medical revalidation.

Prior to working at the Trust, Magnus was the Clinical Director for Emergency Medicine at University Hospital North Midlands NHS Trust.

Duncan Bedford
Chief Operating Officer

Duncan was appointed as Chief Operating Officer at Burton Hospitals NHS Foundation Trust in May 2016. Duncan joined the Trust with over 25 years' NHS experience at Derby Teaching Hospitals. Prior to that Duncan had worked for local authorities working in both county and district councils.

Duncan has worked in a number of senior management positions, including general management roles in a range of specialties as well as Divisional Director for Medicine and Surgery.

Tosca Fairchild
Director of Governance, Communications & Engagement (non voting)

Tosca joined the Board in September 2014 from Derby Hospitals NHS Foundation Trust where she was the Director of Corporate Affairs, with responsibility for governance, public engagement and risk management as well as being Company Secretary. She has extensive experience in healthcare governance. She commenced her working life in banking and joined the NHS in 2004 at a Primary Care Trust before moving onto Worcestershire Acute Hospitals NHS Trust where she was Company Secretary.

Tosca's role ensures that the Trust meets all its governance, corporate, legal and statutory obligations (NHS Improvement and CQC) and enhances the safety and quality of the services that it provides. Tosca is extremely passionate about governance, public accountability and transparency. Her portfolio includes external and internal communications, stakeholder management, staff engagement, brand management and reputation management, as well as advising on the Trust's broader community relations and partnerships.

Paula Gardner
Chief Nurse

Paula was appointed as the Trust's Chief Nurse in June 2016 after serving the role of deputy Chief Nurse for three and a half years. Paula's role, working alongside the Executive Medical Director, is to ensure patients receive the highest standard of quality care across our three hospitals.

With more than 30 years of nursing experience in the NHS, Paula was previously Head Nurse at Walsall Hospitals NHS Trust before joining Burton Hospitals and holds a Master's Degree in Health and Social Care from the University of Wolverhampton.

Jonathan Tringham
Director of Finance, Information, Performance & Estates

Jonathan was appointed as Director of Finance, Information, Performance and Estates in December 2016. He has worked in the NHS for 24 years starting as a Regional Finance Trainee in Sussex in 1992. Since then he has had roles in a variety of commissioning and provider organisations with 15 years' experience as a Director of Finance across Birmingham and Staffordshire.

Most recently he was Director of Finance at Staffordshire and Stoke on Trent Partnership NHS Trust helping to establish the Trust and integrate Adult Social Care Services with Community Services across the County.

Roger Smith
Director of Human Resources (non voting)

Roger was appointed as Director of Human Resources at Burton Hospitals NHS Foundation Trust in September 2009 having been the Deputy Director of Human Resources for the previous seven years.

Roger joined the Trust with 28 years of experience from the private sector where he undertook a range of Senior Human Resource positions, primarily within the financial services and manufacturing sectors. He has extensive experience of change management and implementation of systems and processes.

Alison Wynne
Director of Strategy and Partnerships

Alison was appointed as Director of Strategy and Partnerships in June 2015. She has been in management in the health service for some 14 years following 2 years as a national management trainee and has a Masters degree. Much of her career has been spent in senior management roles in commissioning, including Head of Planning and Strategy, Director of Commissioning and also Director responsible for setting up a Clinical Commissioning Group.

Alison's focus in the last 18 months has been lead director, on behalf of both Burton and Derby Hospitals, for the proposed merger between the Trusts which is planned for July 2018.

2.1.6 Previous Director Profiles

Dennis Heywood
Non-Executive Director – until July 2017

Dennis enjoyed a successful career with executive leadership role spanning the commercial and retail sectors. His experience lies in finance and sales and marketing, and has included several Chief Executive and Chairman roles.

Dennis had previously worked as Vice Chairman and Non Executive Director at the former Mid Staffordshire NHS Foundation Trust, assisting the trust through its transformation process. He is Chairman of an independent chain of retail stores and a Non Executive Director at the Yorkshire Purchasing Organisation.

Louise Thompson
Director of Communications (non voting) – until February 2018

Louise joined the Trust in January 2015 following an extensive career within the private sector, advising companies on corporate and consumer communications both in the UK and internationally.

2.1.7 Attendance at Board meetings 2017/18

Name and Title	Number of Meetings **	Total No of Attendances
John Rivers Chairman	18	18
John Davies Non Executive Director	18	16
Dennis Heywood [1] Non Executive Director	6	6
Stephen Goode Non Executive Director	18	15
Joy Street [2] Non Executive Director	18	17
Paul Doona Non Executive Director	18	16
John Bale Non Executive Director	18	16
Steve Hollingsworth [3] Non Executive Director	18	16
Helen Scott-South Chief Executive	18	18
Magnus Harrison Medical Director	18	18
Jonathan Tringham Director of Finance, Information, Performance & Estates	18	18
Duncan Bedford Chief Operating Officer	18	18
Paula Gardner Chief Nurse	18	18
Alison Wynne Director of Strategy & Partnerships	18	18
Tosca Fairchild * Director of Governance, Communications & Engagement	18	16
Roger Smith * Director of HR	18	18
Louise Thompson [4]* Director of Communications	18	11

1 Dennis Heywood left the Trust on 31 July 2017
2 Joy Street joined the Trust on 1 April 2017
3 Steve Hollingsworth joined the Trust on 5 April 2017 (non-voting until 1 August 2017)
4 Louise Thompson left the Trust on 28 February 2018

*Non voting members of the Board
**Includes one Extra-ordinary meeting

2.1.8 Meetings of the Non-Executive Directors

In accordance with guidance set out in the Independent Regulator's Foundation Trust Code of Governance, arrangements have continued during the year for the Chairman and Non-Executive Directors to meet outside the normal Board meetings, including undertaking the appraisal of the Chief Executive's performance. These meetings are attended by the Chief Executive at the Chairman and Non-Executive Directors request. The Chairman carries out the Chief Executive's appraisal during the year and delivers a report on this to the Nominations and Remuneration Committee for consideration. The Non-Executive Directors also meet to discuss and appraise the Chairman's performance. The Senior Independent Director conducts the Chairman's appraisal and delivers a

report on this to the Council of Governors for consideration. In addition, the objectives that have been set for the Non-Executive Directors are shared with the Council of Governors, via its Appointments Committee.

2.1.9 Appointment and removal of Non-Executive Directors

Under the Trust's Constitution, the Council of Governors has the power to appoint and remove the Chairman and Non-Executive Directors of the Trust. The termination of an appointment requires the support of three quarters of the Council of Governors, in addition to other requirements of the Constitution being met. Non-Executive Directors are generally appointed on a three year term, which can be renewed. In line with the Code of Governance, any terms beyond six years, e.g. two three year terms would be subject to rigorous review and be on the basis of an annual appointment. At the end of the 2017/18 year there were 22 Governors on the Council with all the seats filled. A resolution for removal would therefore require the approval of 17 Governors.

In accordance with the Constitution a process has been agreed between the Board of Directors and the Council of Governors governing the appointment of the Trust Chair and Non-Executive Directors. In accordance with the Independent Regulator's Foundation Trust Code of Governance, the terms of office of the Non-Executive Directors are set out below:

Non-Executive Director	Appointed	Re-appointed	Expiry of Current Term of Office
John Rivers	14 March 2016	21 March 2018	30 June 2018
John Davies	12 February 2013	12 February 2016	11 February 2019
Paul Doona	1 January 2015	16 November 2017	31 December 2018
Stephen Goode	12 February 2013	12 February 2016	11 February 2019
Joy Street	1 April 2017	21 March 2018	30 June 2018
John Bale	1 March 2015	16 November 2017	28 February 2019
Steve Hollingsworth	5 April 2017	21 March 2018	30 June 2018

2.1.10 Significant commitments of the Trust Chairman

Mr Rivers is also Chairman of Derby Teaching Hospitals NHS Foundation Trust. He has no other significant commitments but has declared involvement in the following organisations:

- Chair – Florence Nightingale Derbyshire Association
- Steering Group Member – Derwent Valley Mills World Heritage Site
- Deputy Lieutenant of Derbyshire.

2.1.11 Risk management

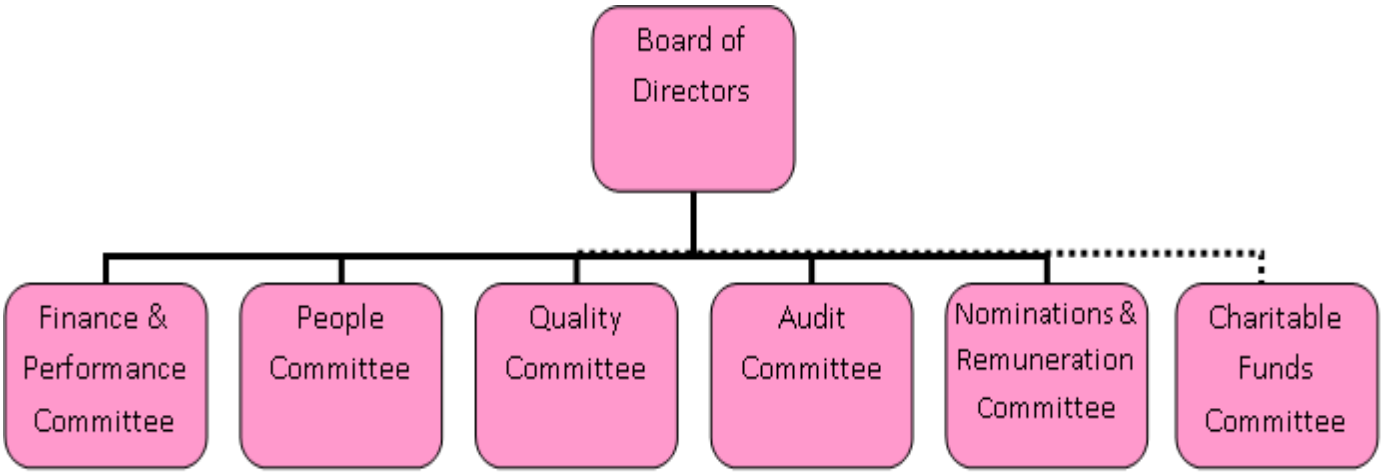
The Trust adopts a robust approach to risk management with the structures and processes in place to successfully deliver the Trust's objectives. The Director of

Governance, Communications & Engagement is the Trust's Chief Risk Officer and provides Board leadership on risk management. Leadership arrangements for clinical, non-clinical, operational, financial and quality risk management are clearly defined and embedded throughout the Trust, supported by a number of appropriate policies and procedures. Further details on the Trust's risk management process can be found in the Annual Governance Statement in Part 2.8 of this report.

2.1.12 Board of Directors committee structure

The Board of Directors is supported by a number of Committees.

All of the Trust's Committees feed directly into the Board, and provide summary reports on the activities of the Committee together with any issues requiring escalation to the Board. The Trust's Committee Structure can be seen below:



2.1.13 Audit Committee

The Audit Committee monitors the effectiveness of the risk management arrangements (clinical, non-clinical, operational, quality and financial), integrated governance and internal control on the Board's behalf. This Committee is a Non-Executive Committee of the Board and has no executive powers.

Further information on the Trust's approach to risk management can be found in the Annual Governance Statement later in Part 2.9 of this report.

Attendance at Audit Committee Meetings

Name and Title	No of Meetings	Total No of Attendances
Paul Doona Non Executive Director and Committee Chair	6	6
Stephen Goode Non Executive Director	6	6
John Davies Non Executive Director	6	6

During 2017/18 the following issues were considered by the Committee as significant in relation to the financial statements, operations and compliance:

Going Concern - International Accounting Standard 1 (IAS 1) requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern.

In preparing the financial statements the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

Action - The Directors consider that there is sufficient evidence that the Trust will continue as a going concern for the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the accounts and has not included the adjustments that would result if it was unable to continue as a going concern. The assessment accords with the statutory guidance contained in the NHS Foundation Trust Annual Reporting Manual.

The Auditor has issued an emphasis of matter paragraph in the course of the audit due to the absence of formal confirmation of the Trust's borrowing requirements. However, the Trust has received significant support in the recent past and has no reason to believe that support will not be provided.

Value for money - The Trust's auditors, based on the work performed to address the significant risks identified and having regard to the AO's Auditor Guidance Note 3 (AGN 03) issued in November 2017, are satisfied that the Trust had proper arrangements in all significant respects to ensure it delivered value for money in its use of resources for the year ended 31 March 2018.

The Trust's Auditors

The Trust's External Auditors for the 12 months ending 31 March 2018 were Grant Thornton. The external audit fee for 2017/18 was £45,000 plus VAT for the Financial Statements Audit and £5,000 plus VAT for the Quality Accounts.

The Internal Audit function provides an independent and objective opinion to the Trust on risk management and control by evaluating the effectiveness of the control framework in place. It also plays a key role in the provision of assurance to the organisation and has counter fraud responsibilities. The Trust's Internal Auditors are KPMG.

Appointment process for the External Auditor

In December 2015 the External Auditors Appointments and Liaison Committee reported to the Council of Governors on the agreed contract specification and procurement process for the tender of External Auditors. The tender process concluded with the recommendation that Grant Thornton should be appointed as the Trust's External Auditors for a three year period commencing on 1 October 2016 with the option to extend for a further two years, depending on performance. This recommendation was approved by the Council of Governors on 20 April 2016.

Provision of non-audit services by the External Auditor

Grant Thornton provided the following non-audit services to the Trust in 2017/18:

- Review of the Trust's Quality Report

2.1.14 Nominations and Remuneration Committee

The Nominations and Remuneration Committee leads the process for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive. In addition, the Committee identifies and appoints candidates to fill other Executive Director roles and leads the process for the removal of any Executive Directors. The Committee establishes appropriate remuneration and terms and conditions of employment for the Executive Directors and oversees the objective setting and performance appraisal of the Chief Executive.

Membership and attendance for this Committee is set out in the Remuneration Report in Part 2.2 of this report.

Terms of Reference – Board Committees

The Trust Board regularly reviews and approves the Terms of Reference for all of its Committees.

2.1.15 Declarations of interests / related party transactions

A Register of Interests is maintained by the Director of Governance, Communications & Engagement. No material conflicts of interest are recorded in the Register. A full Register of the Board of Directors' Interests is available within the FOI Publication Scheme on the Trust's public website:

http://www.burtonhospitals.nhs.uk/foi-results.htm?metadata_field=FOI.ModelPubSchemeHealthBodEng&metadata_value=6+-+d

In addition, the terms and conditions of Non-Executive Director appointments are available from the Trust on request for inspection.

Arrangements are also in place within the Trust to deal with any offers of gifts and/or hospitality and a register is held corporately. Details of this register are available as part of the Trust's Publication Scheme on the public website:
http://www.burtonhospitals.nhs.uk/Publication-scheme.htm

2.1.16 Contact with Directors

Members of the Board can be contacted via 01283 511 511 ext. 5571 or in writing to:

Trust Headquarters
The House
Queen's Hospital
Belvedere Road
Burton on Trent
Staffordshire
DE13 0RB

2.1.17 Disclosures relating to quality governance

The Board is responsible for all aspects of performance and governance of the Trust. The Board should conduct the Trust's affairs effectively and, in so doing, build patient, public and stakeholder confidence that the Trust is providing high quality, sustainable care.

The role of the Board is to set strategy, lead the organisation and oversee operations, and to be accountable to stakeholders in an open and effective manner. The Independent Regulator has developed the Well Led Framework for governance reviews to allow Boards and external organisations to assess Foundation Trust governance. The table below highlights the four domains used to frame governance reviews.

Well Led Framework for Governance Reviews: The four domains of the well-led framework for governance reviews

Strategy and planning	Capability and culture	Process and structures	Measurement
Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver? Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	Does the board have the skills and capability to lead the organisation? Does the board shape an open, transparent and quality-focused culture? Does the board support continuous learning and development across the organisation?	Are there clear roles and accountabilities in relation to board governance (including quality governance?) Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance? Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	Is appropriate information on organisational and operational performance being analysed and challenged? Is the board assured of the robustness of information

Extract from the Well Led Framework for Governance Reviews (April 2015)

As the factors underpinning effective governance can change, for example as people leave or organisations restructure, NHS Improvement requires that trusts undertake regular reviews to ensure that governance remains fit for purpose.

Further information regarding governance can be found in the Annual Governance Statement in Part 2.8 of this report and within the Trust's Quality Report 2017/18 on page 104.

2.1.18 Patient care

The Trust's Quality Improvement priorities for 2017/18, as agreed by the Quality Committee, which is a sub-committee of the Board of Directors are:

- To promote a system of timely identification and proactive management of frailty in the acute setting;
- To review and implement a revised Ward Assurance tool;
- To improve discharge.

The Trust's Quality Account, later within this report, provides greater detail on these priorities, including how they will be implemented and monitored. The Quality Account also provides greater information on the Trust's performance against healthcare targets, complaints handling and Care Quality Commission reviews.

2.1.19 Stakeholder relations and partner working

During 2017/18 the Trust has continued to develop its relationships with key partners and stakeholders.

Proposed Merger with Derby Teaching Hospitals NHS Foundation Trust

Our relationship with Derby has gone from strength to strength, as we have been working towards the proposed merger of the two Trusts. There are many reasons why bringing the two hospital Trusts together is a good idea for patients and staff.

Some services at Burton have a low volume of clinical activity and therefore difficulties in maintaining a stable, experienced multi-professional workforce. An increased population of patients will help to solve this problem. Highly specialised services, such as cancer surgery provided in Derby, require minimum numbers of patients, so increasing the population covered will have a positive effect on this. Bringing teams together to provide care for larger populations will also help with staffing issues such as emergency cover.

A large University Hospital Trust will also be more attractive to new staff and provide more opportunities to existing staff. Merger will improve local access to services, not just in Burton and Derby, but also in Tamworth and Lichfield.

In addition, both Trusts have challenging financial issues as they will be in deficit this year. Merging will provide the opportunity to reduce duplication and make savings.

Merger Milestones

In June 2017 the Outline Business Case for the merger was agreed by both Trust Boards. A Full Business Case (FBC) was then developed, along with details of the patient benefits which a merger would provide. The FBC was approved by both Trust Boards in December 2017, paving the way for further assessments from NHS regulatory bodies.

Work also continued to develop the clinical case for change and potential benefits for patients, with a particular focus on Cardiology, Orthopaedics, Radiology, Renal Medicine, Stroke Services and Cancer Care.

In mid-March 2018, the Competition and Markets Authority (CMA) approved the Burton and Derby Hospitals merger. They were very clear that they expected it to result in substantial patient benefits, and that these outweigh any potential competition concerns that may arise. They also found that the merger would enable the Trusts to use their resources much more effectively for patients across a wide range of specialities.

Following the CMA decision NHSI's Provider Regulatory Committee met to consider the Full Business Case for the merger. They were also impressed by the strength of the clinical argument and the strategic rationale for the merger, and acknowledged that the financial case underpinning the proposal had been strengthened.

However, the NHSI Committee found that further work needs to be done to provide greater assurance that the revised financial plan will be delivered. While this means that the merger will not now go ahead on 1st April 2018, it has allowed us time to do further work which will give greater assurance to our regulators as well as our Boards and Councils of Governors.

We are reviewing the efficiencies identified for the next four years and will provide more detail on Cost Improvement Plans for this year. We are also developing a plan to improve financial governance for the merged Trusts. We will then submit these assurances to NHS Improvement, and are aiming for a new merger date of 1st June or 1st July 2018.

The Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP)

The Trust forms part of the Staffordshire and Stoke-on-Trent local health system and has been a key part of the Sustainability and Transformation Plan. Work on these plans involves closer links with partners in health and social care, and the voluntary sector, bringing these bodies together to shift from reliance on acute hospital care to delivering more care in the place where people live.

Virgin Care

The Trust started working with Virgin Care in 2016, looking at improving pathways for certain long-term conditions as well as supporting projects aimed at reducing unnecessary attendances to the Emergency Department.

Community Matrons from Virgin Care also played a key role in a dedicated Frailty Team working at Queen's Hospital in Burton, supporting the safe and timely discharge of frail patients who present as an emergency admission. A pilot scheme ran until the end of March, involving a multi-disciplinary team who work at the 'front door' of the hospital to quickly identify patients who are aged over 75 and are frail. The team ensures that patients identified as frail receive the right care in the right setting and avoid a stay in a hospital bed where appropriate.

STRIDE Joint Venture

The Trust is part of a joint venture company formed with private sector partner Health Innovations Partners Ltd. The purpose of the STRIDE partnership (Strategic Transformation Real Innovation and Delivering Excellence), is to enable the Trust to draw on private sector expertise as it continues to grow and transform.

In January this year an information evening was held regarding the Trust's proposed development of a Health Village on the Outwoods site, in conjunction with STRIDE. Potential services in the new facilities include a nursery, a primary care hub providing general practice, an extra care facility and supported living unit.

Community Groups and Charities

The Trust's community activities have continued to flourish with staff at the forefront of this support. The Trust has supported the YMCA food bank, donating six large boxes full of non-perishable food, and regular health checks are also given to the YMCA residents by one of our Accident and Emergency Sisters at their premises, Reconnect.

Over the winter months, the Trust's 'SNUG' campaign has been a huge success receiving brand new or as good as new warm clothing to support our frail and vulnerable patients and those in the community who are supported by Age UK Burton and the YMCA.

The Trust has also continued its work in partnership with Burton Albion Community Trust with their National Citizenship Service projects, becoming the first Trust in the country to give the support of memory boxes to young people that have lost a sibling before, during or after birth.

The Burton site of Kerry Foods donates 20 convenience meals every week to the Queen's Hospital Snowdrop suite. This ensures that families can eat at any time, day or night and stay together throughout an incredibly difficult time. The families that have benefited from this support have said how much this kind gesture by the food giant has helped them.

Jyoti Shah and Sarah Minns continue their life-saving community prostate screening. Over the past 12 months they have screened men who work at the Trust, members at Burton Caribbean Association and a series of screenings with the Derbyshire Freemasons. So far they have screened nearly 750 men and diagnosed 36 men with prostate cancer.

The children's ward saw a big refurbishment over the summer which was made possible through two large donations from Daisychain Benevolent Fund and a fundraiser working with the Burton Hospital League of Friends, Brian Storer. The area that once housed an old wooden pirate ship that went mostly un-used now sees a group of large tree like structures to provide shade during the summer months and two play huts connected by a grass covered tunnel.

Ashby based company, Ashfield Healthcare, have supported the Trust throughout the year with donations to purchase two ultrasound scanners, the redevelopment of a ward's un-used side room into a memory room, some new planting at the main entrance to Queen's Hospital and tickets to the theatre in Nottingham for 12 lucky staff members.

2.1.20 Income / financial disclosures

As required by Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the Directors confirm that the income from the provision of goods and services for the purpose of the health service in England is greater than the income from the provision of goods and services for any other purpose as seen in Note 6 of the financial statements.

The Directors confirm that the Trust complies with the public sector Better Payment Practice Code unless other agreements have been reached with Suppliers. A statement on the disclosure of any interest paid under the Late Payment of commercial Debts (Interest) Act 1998 can be found in Note 13 in the Accounts.

The Directors can confirm that the Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

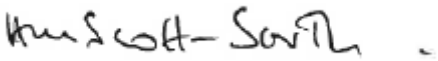
2.1.21 Disclosures to auditors

The Directors have confirmed that they have made available to its External Auditors all necessary and relevant information and disclosures as may be material to the Accounts.

The Directors have confirmed that there is no relevant audit information of which the Auditor is unaware and the Directors have taken all steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Auditor is aware of that information.

2.1.22 Political donations

The Trust has not made any political donations.



Helen Scott-South
Chief Executive
23 May 2018

2.2 Remuneration Report

2.2.1 Annual statement on remuneration

During the course of 2017/18 there were no new appointments made to the Executive Management Team.

The Trust has two roles where Directors are paid in excess of £142,500, the Chief Executive and Medical Director. The Nominations and Remuneration Committee utilised national benchmarking information at the appointment stage of the process and agreed that in each case the individual circumstances warranted setting a level of remuneration that was in excess of the guidance. The Nominations and Remuneration Committee also reviewed the salaries of the Executive Management Team to ensure that these remained competitive and in line with market forces. No substantial changes were made during this process.

2.2.2 Senior manager remuneration policy

The Nominations and Remuneration Committee, in respect of the Chief Executive and other Executive Directors, and the Appointments Committee, in respect of the Chairman and other Non-Executive Directors, are responsible for determining the remuneration policies and practices of the Trust, with the aim of attracting, motivating and retaining high calibre Directors who will deliver the Trust's strategic objectives.

In considering the Executive Directors' remuneration, the Committee takes into account the national inflationary uplifts recommended for other NHS staff, any variation in, or change to, the responsibility of Executive Directors and relevant benchmarking with other public sector posts and the external Capita report. The Committee did receive the NHS Providers benchmarking report on Directors' remuneration and this was used as the main benchmarking report to assess remuneration.

In relation to the policy on payments for loss of office for Executive Directors, any payments would be in accordance with their terms and conditions of employment. No other payments have been made outside the agreed contractual arrangements. The accounting policies for pensions and other retirement and details of senior managers' remuneration can be found in the following tables.

In considering the Non-Executive Directors' remuneration, the Appointments Committee complies with the 'Non-Executive Director Terms and Conditions of Service Policy'.

Future Policy Table

Executive Directors Component	The Nomination & Remuneration Committee is responsible for considering Executive Directors' pay. Pay points are benchmarked against other public sector posts and national inflationary uplifts are in line with other NHS staff.
Non-Executive Directors Component	The Appointments Committee is responsible for considering Non-Executive Directors' pay. The remuneration is fixed with a higher rate for the Chairman of the Trust.
How this supports the short and long term strategic objectives of the foundation trust	The Trust's strategy includes a number of objectives and individual objectives are linked to the Trust's Plan on a Page Strategy. The remuneration ensures the recruitment / retention of Directors with sufficient calibre to deliver the Trust's objectives.
Maximum that could be paid in respect of that component	These are set out in the following Remuneration tables.
How the component Operates	Paid monthly with pension contributions paid by both employee and employer, except where any employee has opted out of the scheme.
Framework used to assess performance	The Trust's appraisal process is used to assess performance see section 2.1.3.
Performance measures	Objectives are agreed during the appraisal which is conducted annually.
Amount paid for minimum level of performance and any further levels of performance	No performance related payment arrangements.
Explanation of whether there are any provisions for recovery of sums paid to directors or provisions for withholding payments	Any sums paid in error may be recovered.

Sections 2.2.3, 2.2.4 and 2.2.5 of the Remuneration Report are subject to audit by the External Auditors.

2.2.3 Senior manager disclosure A - remuneration

		1 April 2017 to 31 March 2018							1 April 2016 to 31 March 2017						
Name and Title	Note	Salary (Bands of £5,000) £000	Other Remuneration (Bands of £5000) £000	Taxable Benefits (to nearest £100) £00	Annual Performance Bonuses (Bands of £5,000) £000	Long Term Performance Bonuses (Bands of £5,000) £000	Pension Related Benefits (Bands of £2,500) £000	Total Remuneration (Bands of £5,000) £000	Salary (Bands of £5,000) £000	Other Remuneration (Bands of £5000) £000	Taxable Benefits (to nearest £100) £00	Annual Performance Bonuses (Bands of £5,000) £000	Long Term Performance Bonuses (Bands of £5,000) £000	Pension Related Benefits (Bands of £2,500) £000	Total Remuneration (Bands of £5,000) £000
John Rivers Chairman/Non-Executive Director		40 to 45	0	0	0	0	0	40 to 45	40 to 45	0	0	0	0	0	40 to 45
John Davies Non-Executive Director		10 to 15	0	0	0	0	0	10 to 15	10 to 15	0	0	0	0	0	10 to 15
Stephen Goode Non-Executive Director		10 to 15	0	0	0	0	0	10 to 15	10 to 15	0	0	0	0	0	10 to 15
Dennis Heywood Non-Executive Director	1	0 to 5	0	0	0	0	0	0 to 5	10 to 15	0	0	0	0	0	10 to 15
Paul Doona Non-Executive Director		10 to 15	0	0	0	0	0	10 to 15	10 to 15	0	0	0	0	0	10 to 15
John Bale Non-Executive Director		10 to 15	0	0	0	0	0	10 to 15	10 to 15	0	0	0	0	0	10 to 15
Steve Hollingsworth Non-Executive Director	2	5 to 10	0 to 5	0	0	0	0	5 to 10	0	0	0	0	0	0	0
Joy Street Non-Executive Director	3	10 to 15	0	0	0	0	0	0 to 5	0	0	0	0	0	0	0
Helen Scott-South Chief Executive		170 to 175	0	0	0	0	0	170 to 175	170 to 175	0	0	0	0	0	185 - 190
Magnus Harrison Medical Director		45 to 50	150 to 155	0	0	0	Not Applicable	200 to 205	40 to 45	150 to 155	0	0	0	47.5 to 50	250 to 255

		1 April 2017 to 31 March 2018							1 April 2016 to 31 March 2017						
Name and Title	Note	Salary (Bands of £5,000) £000	Other Remuneration (Bands of £5000) £000	Taxable Benefits (to nearest £100) £00	Annual Performance Bonuses (Bands of £5,000) £000	Long Term Performance Bonuses (Bands of £5,000) £000	Pension Related Benefits (Bands of £2,500) £000	Total Remuneration (Bands of £5,000) £000	Salary (Bands of £5,000) £000	Other Remuneration (Bands of £5000) £000	Taxable Benefits (to nearest £100) £00	Annual Performance Bonuses (Bands of £5,000) £000	Long Term Performance Bonuses (Bands of £5,000) £000	Pension Related Benefits (Bands of £2,500) £000	Total Remuneration (Bands of £5,000) £000
Tosca Fairchild Director of Governance, Communications & Engagement		90 to 95	0	0	0	0	Not Applicable	90 to 95	90 to 95	0	0	0	0	Not Applicable	90 to 95
Roger Smith Director of Human Resources		95 to 100	0	0	0	0	37.5 to 40	130 to 135	90 to 95	0	0	0	0	12.5 to 15	100 to 105
Alison Wynne Director of Strategy & Partnerships		110 to 115	0	0	0	0	22.5 to 25	135 to 140	110 to 115	0	0	0	0	0	110 to 115
Louise Thompson Director of Communications	5	70 to 75	0	0	0	0	17.5 to 20	85 to 90	75 to 80	0	0	0	0	22.5 to 25	95 to 100
Jonathan Tringham Director of Finance, Information, Performance & Estates	6	125 to 130	0	0	0	0	80 to 82.5	205 to 210	50 to 55	0	0	0	0	65 to 67.5	120 to 125
Duncan Bedford Chief Operating Officer		105 to 110	0	0	0	0	Not Applicable	105 to 110	105 to 110	0	0	0	0	Not Applicable	105 to 110
Paula Gardner Chief Nurse	11	105 to 110	0	0	0	0	Not Applicable	105 to 110	80 to 85	10 to 15	0	0	0	35 to 37.5	135 to 137.5
Steve Fowkes Acting Director of Finance	12	0	0	0	0	0	0	0	5 to 10	75 to 80	0	0	0	Not Available	80 to 85

2.2.4 Senior manager disclosure B - pension benefits

Name	Note	Real increase in pension at age 60 (Bands of £2500) £000	Real increase in lump Sum at age 60 (Bands of £2500) £000	Total accrued pension at age 60 at 31 March 2018 (Bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2018 (Bands of £5000) £000	Cash Equivalent Transfer value at 31 March 2018 £000	Cash Equivalent Transfer value at 31 March 2017 £000	Real Increase in Cash Equivalent Transfer Value £000	Personal Contribution (Bands of £2500) £000
Helen Scott-South Chief Executive		Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Magnus Harrison Medical Director		Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Roger Smith Director of Human Resources		0 to 2.5	5 to 7.5	15 to 20	55 to 60	Not Applicable	Not Applicable	Not Applicable	12.5 to 15
Tosca Fairchild Director of Governance, Communications & Engagement		Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Louise Thompson Director of Communications		0 to 2.5	0	0 to 5	0 to 5	34	21	13	7.5 to 10
Alison Wynne Director of Strategy & Partnerships		0 to 2.5	0	20 to 25	45 to 50	299	277	22	15 to 17.5
Jonathan Tringham Director of Finance, Information, Performance & Estates		2.5 to 5	7.5 to 10	40 to 45	105 to 110	702	594	108	15 to 17.5
Duncan Bedford Chief Operating Officer		Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Paula Gardner Chief Nurse		Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable

All Executive Directors are members of the NHS Pension Scheme, unless otherwise stated in the above Senior Managers Disclosure B this entitles members to a pension based on their service and final pensionable salary (subject to Inland Revenue limits). The scheme also offers life assurance cover. None of the Non-Executive Directors are members of the NHS Pension Scheme and Non-Executive members of the Board do not receive pensionable remuneration. Non-Executive members of the Board do not receive pensionable remuneration

Notes to previous tables

Non-Executive members of the Board do not receive pensionable remuneration

Notes

1 Dennis Heywood left the Trust on 31.7.17

2 Stephen Hollingsworth joined the Trust on 5.4.17
3 Joy Street joined the Trust on 1.4.17
5 Louise Thompson left the Trust on 28.2.18
6 Jonathan Tringham joined the Trust on 1.12.16
11 Paula Gardner was appointed Chief Nurse on 15.6.16 and left the Trust on 31.3.18
12 Steve Fowkes was Acting Director of Finance from 1.11.16 to 30.11.16

"Other" Remuneration paid to Magnus Harrison relates to clinical sessions worked.

“Other” Remuneration paid to Paula Gardner and Steve Fowkes relates to work carried out in another role.

“Not Available” – Pensions information listed above as “Not Available” is because either the named individual was not employed directly by the Trust for the full financial year or the information was not requested from the Pensions Agency.

“Not Applicable” – Pensions information listed above as “Not Applicable” is because the employee was not a member of the NHS Pension scheme, is already in receipt of pension or does not have a CETV due to being of pensionable age.

The Chief Executive and Chief Operating Officer are employed by Derby Teaching Hospitals NHS Foundation Trust whilst the Director of Finance is employed by Staffordshire and Stroke on Trent Partnership Trust. However as they are seconded to Burton Hospitals NHS Foundation Trust their costs are shown in these accounts.

2.2.5 Senior manager disclosure C - highest paid Director in relation to the median remuneration

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation’s workforce. The total remuneration included salary, non-consolidated pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

	2017/18 £'000	2016/17 £'000
Total pay costs	104,391	101,119
Average number employed* (per Note to Accounts 9.2)	3,067	3,011
Median salary within the Trust	23,597	22,458
Highest Paid Director	**Magnus Harrison ****	**Magnus Harrison ****
Mid Point of Salary Banding	202,500	202,500
Ratio to Median	8.58	9.02

* Including Bank and Agency

** The salary figure given combines the remuneration for both the Medical Director role and their clinical role.

2.2.6 Annual report on remuneration

- **Service contracts**

All Executive Director appointments are permanent, unless agreed otherwise, and will only be terminated on resignation of the individual or in the event of a fundamental breach of their employment contract. With regard to notice periods, the Chief Executive has a six month notice period, with all other Executive Directors having a three month notice period. None of the contracts have any provision for compensation in the event of early termination of contract.

- **Non-Executive Directors**

Non-Executive Directors, including the Trust Chairman, are appointed for a set term of office, generally three years. They have a notice period of three months.

- **Remuneration**

The Trust has two Committees that deal with remuneration:

The Nominations and Remuneration Committee

The Nomination and Remuneration Committee is a Board Committee that comprises of all the Non-Executive Directors. One of this Committee's key responsibilities is to decide the remuneration, allowances and other terms and conditions of the Chief Executive and all other Executive Directors.

The Committee receives advice from the Director of Human Resources.

The Appointments Committee

The Appointments Committee is a Sub-Committee of the Council of Governors. The purpose of this Committee is to make recommendations to the Council of

Governors on the appointment of, and salaries payable to the Trust Chairman and Non-Executive Directors. In addition, the Committee periodically reviews the balance of skills, knowledge and diversity of the Non-Executive Directors and reviews the performance of the Chairman and Non-Executive Directors agreeing the final assessment for approval by the Council of Governors, which would include the objectives for the forthcoming year.

The Committee receives advice from the Director of Governance and the Director of Human Resources.

Attendance at Nominations and Remuneration Committee meetings

Name and Title	No of Meetings	Total No of Attendances
John Rivers Chairman and Committee Chair	6	6
Steve Goode Non Executive Director	6	6
John Davies Non Executive Director	6	4
Dennis Heywood Non Executive Director	3	3
Paul Doona Non Executive Director	6	6
John Bale Non Executive Director	6	6
Joy Street Non Executive Director	6	6
Steve Hollingsworth Non Executive Director	6	6
Helen Scott-South Chief Executive	6	4

Attendance at Appointments Committee meetings

Name and Title	No of Meetings	Total No of Attendances
David Rogers [1] Lead Governor and Committee Chair	2	2
Elly Briggs [2] Governor	1	1
John Anderson Governor	2	0
Phil Hodson-Walker [3] Governor	1	1
Cathy Brown	2	1
Kim Coe Governor	2	0

Name and Title	No of Meetings	Total No of Attendances
Deneice Florence-Jukes [4]	1	1
Sheila Jackson Governor	2	0

1 David Rogers became Lead Governor and Committee Chair on 15 August 2017
2 Elly Briggs term of office ended on 25 September 2017
3 Phil Hodson-Walker term of office ended on 25 September 2017
4 Deneice Florence-Jukes was removed from the Council of Governors on 7 February 2018

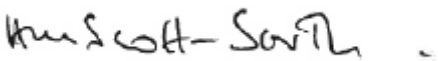
2.2.7 Expenses paid to Governors and Directors

Directors	2016 / 17	2017 / 18
Total Number of Directors in office during the year	19	17
Number to whom expenses were paid	10	12
Total value of expenses paid	£17,797	£12,019

Governors	2016 / 17	2017 / 18
Total Number of Governors in office during the year	25	26
Number to whom expenses were paid	9	8
Total value of expenses paid	£2,792	£2,376

The following elements are included in the expenses:

Business Miles, PSA Members Mileage, Miscellaneous Travel, Parking Costs, Course Expenses, Expenses, Passenger Allowance, Subsistence and Public Transport Rate.



Helen Scott-South
Chief Executive
23 May 2018

2.3 Staff report

2.3.1 Analysis of staff costs

	2016/17			2017/18		
	Permanently employed total £000	Other £000	Total £000	Permanently employed total £000	Other £000	Total £000
Salaries and wages	101,119	0	101,119	104,687	0	104,687
Social security costs	9,139	0	9,139	9,576	0	9,576
Apprenticeship levy	0	0	0	508	0	508
Pension costs – defined contribution plans employer's contribution to NHS pensions	11,953	0	11,953	12,046	0	12,046
Pension costs – other	0	0	0	15	0	15
Other post employment benefits	0	0	0	434	0	434
Other employment benefits	0	0	0	0	0	0
Termination benefits	0	0	0	18	0	18
Temporary staff – external bank	0	0	0	0	0	0
Temporary staff – agency /contract staff	0	8,785	8,785	0	8,839	8,839
NHS charitable funds staff	0	0	0	0	0	0
Total	**122,211**	**8,785**	**130,997**	**127,284**	**8,839**	**136,123**

2.3.2 Analysis of average staff numbers

	2016/17			2017/18		
	Permanent	Other	Total	Permanent	Other	Total
Medical and Dental	300	26	326	288	42	326
Ambulance staff	0	0	0	0	0	0
Administration & estates	649	42	691	663	2	691
Healthcare assistants and other support staff	658	48	706	655	63	706

	2016/17			2017/18		
	Permanent	Other	Total	Permanent	Other	Total
Nursing, midwifery and health visiting staff	899	107	1,006	912	139	1006
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	266	16	282	273	9	282
Healthcare science staff	0	0	0	0	0	0
Social care staff	0	0	0	0	0	0
Agency and contract staff	0	0	0	0	0	0
Bank staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
Total average numbers	**2,772**	**239**	**3,012**	**2792**	**255**	**3011**

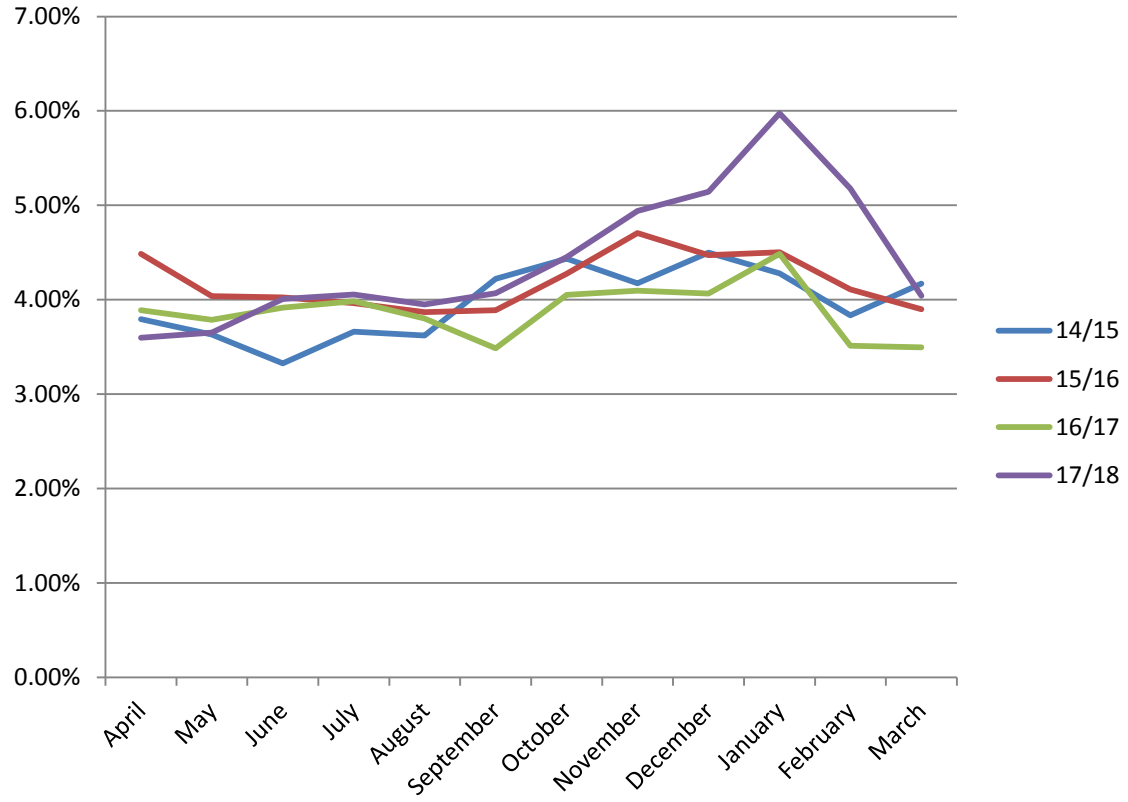
As at 31 March 2017, a breakdown of the average number of Trust employees can be seen in the following table:

	Male	Female	Total
Total Number of Trust Employees	591	2,663	3,254
Of which:			
Senior Managers (Band 8C and above)	8	7	15
Board Directors	10	5	15

2.3.3 Managing sickness absence

Sickness absence is monitored by the Board of Directors on a monthly basis and is also submitted to the Trust's Commissioners as part of monthly monitoring. The following graph demonstrates that in 2017/18, average sickness absence has increased to 4.42% in comparison to the 3.88% reported in 2016/17.

Trust Sickness in 2017 / 18



2.3.4 Staff policies

The Trust is progressively implementing the Equality Delivery System and this is monitored through the People Committee, which is a sub-committee of the Board. As part of this the Trust ensures compliance with the Disability Discrimination in Employment Policy by adopting procedures that do not allow discrimination against future or current employees in all aspects of the recruitment process or their employment. The Trust takes all reasonable steps to make adjustments and remove barriers that put disabled workers at a disadvantage including ensuring that training, career development, and promotion opportunities are equally available to the Trust's disabled employees. The Trust has an Equal Opportunities Policy that is formally agreed and implemented in conjunction with our staff side colleagues.

The Trust has a key responsibility to ensure that promoting equality and valuing diversity is central to all Trust policy making, service delivery, employment practices and community involvement. All levels of staff are required to undertake training in Equality and Diversity, and thus understand the principles of this. Staff receive training on Equality and Diversity every three years and the overall compliance rate currently stands at 99%.

During the year the Trust has worked closely with staff and their representatives to ensure that they are able to contribute to key decisions that are taken within the Trust. There is a monthly Joint Staff partnership which is supplemented with weekly informal meetings with the main staff side officials. Through this mechanism staff are able to influence the development of Trust policies and they are also able to contribute towards improving the overall performance of the Trust. The results of the Staff Survey can be seen in Section 2.3.9 later in this report.

2.3.5 Slavery Act

Introduction
The Modern Slavery Act was passed in March 2015 with the aim of addressing slavery and human trafficking in the 21st century.

Although the Act focuses on victim identification and prosecutions it also highlights the role of business in tackling the global problem of slavery, forced labour and human trafficking through the 'transparency in supply chains' provision.

Obligations of the Act take effect from October 2015 when commercial organisations with a turnover above £36million a year must publish a 'Slavery and Human Trafficking Statement.' The statement must disclose what an organisation is doing to tackle modern slavery in their organisation and their supply chain.

As Burton Hospitals is an organisation that spends in excess of £60m per annum on a wide range of goods and services, we need to ensure that we are appropriately managing the risk of potential modern slavery within our supply chains.

Spend Categories
Due to the Trust having many supply routes, from national contracts through to low value orders with local companies, it is important to categorise this spend based on the risk of impact to modern slavery, and also to ensure there is no duplication with work that is going on nationally.

For example it is through national and collaborative agreements, with bodies such as NHS Supply Chain, where the majority of our medical and non-medical consumables are purchased, which would be the most likely areas for the potential of modern slavery further down the supply chain. Within this spend it is anticipated that work will be undertaken nationally with these suppliers, and the Trust can therefore rely on this work rather than have to make a plan for any suppliers through these routes. Currently spend on these agreements amounts to around 50%.

An explanation of the main areas is provided below, along with a high level explanation of actions taken:

- For all collaborative / national arrangements (circa 50% of all our spend):
  - NHS Supply Chain – provide the Trust with the majority of our frequently used medical consumable items. NHSSC have confirmed that they have written to all suppliers on their frameworks asking them to disclose their statements, as well as communicating with the Medical Supplier Board and relevant Trade Associations on future actions.
  - HealthTrust Europe – from whom the Trust procures the majority of our agency staffing contracts – have issued a Human Trafficking Policy making explicit the standards expected of all suppliers on their frameworks.
  - Commercial Procurement Collaborative – have been asked to comment but are yet to respond

- Crown Commercial Service – have been asked to comment but are yet to respond

For all the above areas the Trust will not take further action, except to ask for regular updates, as this would unnecessarily duplicate work already being undertaken at a national level.

- For all locally tendered projects (over £25k and advertised nationally or in the EU) there is a pass/fail question within the pre-qualification documentation that asks potential suppliers to confirm that they comply with the Modern Slavery Act. Should a supplier not comply, this would be reviewed and it is likely they would be removed from the procurement process.

- For all local spend that is not related to collaborative arrangements or local tender exercises the Trust places a purchase order that refers suppliers to our Supplier Code of Conduct on our website. This document has a statement outlining our expectation that suppliers (and their supply chains) comply with Modern Slavery legislation.

- Agency staffing arrangements, seen to be a high risk area, are purchased through national framework agreements, with these bodies undertaking full compliance checks on suppliers.

Future Actions
Key actions over the next twelve months to improve transparency in supply chains will be to:

- Develop list of potentially highest risk suppliers
- Develop due diligence approach for where modern slavery is identified

Considerations

- The Trust is currently going through a merger process and as such it would not be sensible to conduct a large exercise in this area prior to the conclusion of this process.
- It should be considered that we do not have the resources or skills to fully investigate supply chains of suppliers – i.e. reviews / visits to sites / other countries for assurance etc. – as may be possible in large private sector firms
- We do not have the resource to contact all 1,500 suppliers and request they sign a code of conduct, monitoring and addressing responses. The code of conduct is available on the website and referred to in our purchase orders.
- It would make sense for the larger suppliers who supply to the whole NHS to be managed at a national level – and we will continue to review whether this work is taking place

2.3.6 Health and Safety

The Trust is supported by the Head of Health and Safety and a Fire Officer who provide professional advice, guidance and training to managers with the aim of ensuring that safe working practices are adopted and legal obligations met.

Under the Health and Safety at Work Act 1974 the Trust aims to protect, so far as is reasonably practicable, the health, safety and welfare of our staff, patients, visitors and others that are effected by our work activities.

The main focus is to manage health and safety risks effectively through the Health and Safety Strategy together with supporting policies, working procedures and practical risk assessments to ensure high standards. Key performance indicators identified in the Trust's Health and Safety Policy measure the effectiveness of the measures taken via annual departmental Health and Safety Inspections which are audited for verification. The Departmental Manager also conducts quarterly safety checks. To ensure that staff are safe in the workplace a 24/7 security provision has been developed at the Queen's Hospital site in Burton on Trent. In addition, a police base has been introduced at the Sir Robert Peel site in Tamworth.

Health and Safety performance is monitored by the Trust's Health and Safety Group, which reports to the Quality Committee, a Committee of the Board. This Group analyses the incidents reported to identify trends and emerging risks and considered appropriate actions to mitigate risks.

2.3.7 Occupational Health

The Trust provides Occupational Health Services for all staff with an on-site Occupational Health Department. As of the 1st of January 2018, the Occupational Health Department was TUPE transferred to Derby Teaching Hospitals, but remains on-site and available to all staff.

The Occupational Health Department is concerned with all aspects of health related to work and the working environment and therefore undertakes assessments of how the work employees undertake affects their health as well as how their health may impact on their ability to work.

The Trust recognises its legal responsibilities to safeguard employees' health and safety at work; the Occupational Health Department helps the Trust achieve this.

The Trust's Occupational Health service is key to the success of the health and wellbeing programme for staff. The Trust is currently considering ways to develop links with a number of organisations that can help the Trust to achieve its goals. As part of the collaboration with Derby Teaching Hospitals, the Trust now has access to CiC, an independent, free and confidential advice service to help support staff. This service is available 24 hours a day and can be accessed by any staff in a variety of methods.

2.3.8 Counter Fraud and Corruption

The Trust has in place effective arrangements to ensure a strong counter fraud and corruption culture exists across the organisation and to enable any concerns to be raised and appropriately investigated. These arrangements are underpinned by a dedicated Local Counter Fraud Specialist and a programme of counter fraud education and promotion. The fitness for purpose of these arrangements is overseen by the Audit Committee which has confirmed them as being effective and proportionate to the assessed risk of fraud.

During 2017/18 the Trust received eight counter fraud referrals. None of these referrals resulted in confirmed instances of fraud or corruption. However, one case is on-going.

The key principles of The Bribery Act 2010 are now embedded in the Trust and our Director of Finance is the Executive Lead on behalf of the Board. Training on this important subject is provided to all appropriate staff as part of the Trust Induction programme.

For the avoidance of doubt this means that the expectation of each employee, contractor and agent of the Trust at all times and in all business dealings is as follows:

- To uphold the public sector values of honesty, openness and accountability;
- To uphold the highest standards of probity and stewardship in the use of public money;
- To uphold compliance with Trust policies and standards of business conduct.

On behalf of the Trust, the Chief Executive is able to confirm the Trust's commitment to ensuring that all staff are aware of their responsibilities in relation to the prevention of bribery and corruption.

2.3.9 Staff attitude and opinion survey results

The Trust's overall response rate declined by 3.5% from the previous year, although the Trust remained above the national average for Acute Trusts.

	2016 (previous year)	2017 (current year)		Trust Improvement / Deterioration
	Trust	Trust	Acute Benchmarking Group Average	
Response rate	**43.5%**	**47.0%**	**44.0%**	**3.5%**

The Staff Engagement score from the 2017 Annual Staff Survey Results has slightly decreased in the year.

	2016 (previous year)	2017 (current year)		Trust Improvement / Deterioration
	Trust	Trust	Acute Benchmarking Group Average	
Staff Engagement Score*	**3.80**	**3.78**	**3.79**	**0.01**

**scale from 1 to 5 with 1 being the poorest engagement and 5 the highest*

Staff Engagement has continued to be a key priority throughout the year as part of the Trust's continuing improvement journey and in order to more fully involve staff

in discussions on various strategic partnerships, including the planned collaboration with Derby Teaching Hospitals and the Staffordshire and Stoke-on-Trent STP. The Human Resources and Communications teams have worked together to develop programmes of engagement that seek honest feedback from staff about how they are feeling, and that encourage two-way conversations about ideas for improvement.

For each of the 32 key findings from the 2017 National Staff Survey, the acute trusts in England were placed in order from 1 (top ranking score) to 99 (bottom ranking score). The Trust's five highest and five lowest ranking scores are presented in the following tables:

Top 5 Ranking Scores	2016 (previous year)	2017 (current year)		Trust Improvement / Deterioration
	Trust	Trust	Acute Benchmarking Group Average	
Key Finding 11 Percentage of staff appraised in last 12 months	96%	93%	86%	-3%
Key Finding 28 Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	26%	24%	28%	-2%
Key Finding 25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	24%	23%	28%	-1%
Key finding 22 Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	13%	12%	15%	-1%
Key Finding 20 Percentage of staff experiencing discrimination at work in the last 12 months	9%	9%	12%	0%

(lower scores better except for key findings 11)

Bottom 5 Ranking Scores	2016 (previous year)	2017 (current year)		Trust Improvement / Deterioration
	Trust	Trust	Acute Benchmarking Group Average	
Key Finding 18 Percentage of staff attending work in the last 3 months despite feeling unwell because the felt pressure from their manager, colleagues or themselves	54%	55%	52%	+1%
Key Finding 27 Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	41%	43%	45%	+2%
Key Finding 3 Percentage of staff agreeing that their role makes a difference to patients / service users	89%	88%	90%	-1%
Key Finding 15 Percentage of staff satisfied with the opportunities for flexible working patterns	48%	47%	51%	-1%
Key Finding 19 Organisation and management interest in and action on health and wellbeing (1-5 scale)	3.53	3.54	3.62	0.01

(lower scores better)

It is clear from these results that staff awareness regarding whistleblowing and reporting of incidents of bullying and harassment or incidents of violence have significantly increased. The results for bullying and harassment incidents will be explored further with detailed analysis being undertaken prior to consideration and challenge by the People Committee, a sub-committee of the Board of Directors. In response to the quality of appraisals, an audit of appraisals will be completed in June 2018 following completion of the annual appraisal process. The appraisal training will be developed and based on best practice.

The increase in staff attending work despite feeling unwell has begun to be addressed as well as the increase in sickness overall and this is being supported further with the help of the Human Resources Department to assist staff to return to work after sickness and improve staff well-being in general.

As mentioned previously, Staff Engagement has continued to be a key priority throughout the year. Engagement will be developed further with the implementation of a Staff Engagement Strategy. In addition, the Trust monitors the relevant indicators within the Friends and Family Test as an barometer of staff morale.

2.3.10 Expenditure on consultancy

Expenditure on Consultancy is disclosed in Note 7 in the accounts.

2.3.11 Off-pay-roll arrangements

Table 1: For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2018	0
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

The Trust confirms that all existing off-payroll engagements would be subject to a risk based assessment and assurance would be sought that the individual was paying the right amount of tax.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months.

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	0
No. for whom assurance has been requested	0
Of which...	
No. for whom assurance has been received	0
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received.	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

Number of off-payroll engagements of Board members and / or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed Board members, and / or senior officials with significant financial responsibility during the financial year. This figure **must** include both off- payroll and on-payroll engagements	10

The Trust monitors the number of staff on off-payroll arrangements on a daily basis and will only authorise these when exceptional circumstances exist. Where we do need to resort to off payroll arrangements we endeavour to seek alternative arrangements at the earliest opportunity.

2.3.12 Staff exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	0	0
£10,000 - £25,000	1	0	1
£25,001 - £50,000	0	1	1
£50,001 - £100,000	0	0	0
£100,000 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
Total number of exit packages by type	0	0	0
Total resource cost	0	0	0

2.3.13 Exit packages; non-compulsory departure payments

	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	1	30
Non-contractual payments requiring HMT approval	0	0
Total	0	0
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0

2.4 Disclosures - NHS Foundation Trust Code of Governance

The 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 Code of Governance issued in 2012.

The Board of Directors confirms that the Annual Report and Accounts, on the whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy as required in the NHS Foundation Trust Code of Governance.

Areas of Non-Compliance

There were no areas of Non-Compliance.

2.4.1 NHS England EPRR Core Standards Performance

Each year the Trust is required by NHS England to undertake an Emergency Preparedness, Resilience & Response (EPRR) self-audit to ensure that it has robust plans, procedures and policies in place to address emergency and unforeseen incidents. This takes the form of a comprehensive excel spread-sheet questionnaire which is populated with evidence of compliance and a RAG rating.

Each year there is a slightly different emphasis, called a 'Deep Dive' this year's EPRR assurance deep dive topic was organisational governance, to ensure that EPRR is secured appropriately within the trust including internal organisational EPRR accountability, regular reports to public Board meetings, a work program and a training and exercise program.

The audit was presented to the Trust Executive Committee (TEC) in August 2017 by the Emergency Preparedness Manager. The report was then subsequently submitted to NHS England and South Staffordshire CCG for appraisal.

Following self-audit, on 19th October 2017, the Chief Operating Officer who is also the Accountable Emergency Officer (AEO) and the Emergency Preparedness Manager represented the Trust at a Confirm & Challenge session with representatives of NHS England and East Staffordshire CCG, where EPRR evidence was again assessed.

Trusts are then graded for compliance as below:

- Full – All standards met.
- Substantial – 1 to 5 standards require attention.
- Partial – BHFT – 6 to 10 standards require attention.
- None Compliant – 11 or more standards are not compliant.

The Trust was graded as **'Partially Compliant'** last year (2016/17) with eight areas requiring attention.

This year the trust was graded as **'Substantially Compliant'** with four areas requiring attention:

1. More effective Security Lockdown Policies & Procedures in place.
2. Greater training of On-Call Staff in EPRR.
3. Continuous Personal Development in EPRR could not be evidenced.
4. Governance – More frequent Exec attendance at LHRP.

Three of the above areas have already been addressed and the remaining area, CPD is in the process of being addressed.

The Accountable Officer for East Staffordshire CCG has written to the Chief Operating Officer and asked that the trust continues to keep the CCG updated with progress on achieving full compliance.

The Trust will continue to liaise with East Staffordshire CCG to achieve full compliance.

2.5 Council of Governors

The Council of Governors is made up of 13 publicly elected Governors, five staff elected Governors, and four appointed Governors. The Governors meet on a regular basis and are actively involved in various Trust activities. The elected Governors, as at 31 March 2018, and the appointed Governors during 2017/18 can be seen in the following tables:

2.5.1 Elected Governors as at 31 March 2018

Type and Area	Name	Term of Office
Public Governor, East Staffordshire	John Anderson	3 years ending Sept 2018
Public Governor, East Staffordshire	Adriana Bailey	3 years ending Sept 2020
Public Governor, East Staffordshire	Graham Lamb	3 years ending Sept 2019
Public Governor, East Staffordshire	Philippa Saddington	3 years ending Sept 2020
Public Governor, East Staffordshire [1]	Bernard Peters	3 years ending Sept 2018
Public Governor, East Staffordshire [2]	David Rogers	3 years ending Sept 2018
Public Governor, South Derbyshire	Sheila Jackson	3 years ending Sept 2018
Public Governor, South Derbyshire	Gemma Price	3 years ending Sept 2019
Public Governor, Lichfield & Tamworth	Navinder Dhillon	3 years ending Sept 2018
Public Governor, Lichfield & Tamworth	Pam Dhanda	3 years ending Sept 2018
Public Governor, Lichfield & Tamworth	Denise Baker	3 years ending Sept 2020
Public Governor, Lichfield & Tamworth	David Dundas	3 years ending Sept 2020
Public Governor, North West Leicestershire and the Rest of England	Merryl Patrick	3 years ending Sept 2019
Staff Governor, Other - Non-clinical	Amanda Scott	3 years ending Sept 2020
Staff Governor, Nursing & Midwifery	Cathy Brown	3 years ending Sept 2018
Staff Governor, Volunteers	Elaine Day	3 years ending Sept 2018
Staff Governor, Other Clinical	Allison Dean	3 years ending Sept 2019
Staff Governor, Medical & Dental	Susan Williams-Jones	3 years ending Sept 2018

[1] Resigned as Lead Governor on 23 May 2017 and resigned as Public Governor on 20 February 2018
[2] Lead Governor appointed on 15 August 2017

2.5.2 Appointed Governors during 2017/18

Name	Appointed Governor	Term of Office
Susan McGarry[1]	Local Authority – East Staffordshire Borough Council	Term of Office ends May 2018
Deneice Florence-Jukes [2]	Local Authority – East Staffordshire Borough Council	Term of Office ends September 2020
Bernard Peters[3]	Local Authority – Staffordshire County Council	Term of Office ends February 2021
Kim Coe	Local Authority – South Derbyshire District Council	Term of Office ends May 2020
Garry Jones	Voluntary Sector	Term of Office ends June 2019
David Hanson	Higher Education Representative	Term of Office ends June 2019

[1] Resigned from Council of Governors 22 June 2017
[2] Resigned from Council of Governors 7 February 2018
[3] Appointed on 20 February 2018

2.5.3 Terms of office of Governors

An elected Governor may hold office for a period of three years commencing immediately after the Annual Members Meeting at which the appointment is announced. For elections held at other times of the year, Governors will take office following the general Council of Governors meeting at which the election is announced. Appointed Governors may also hold office for up to three years but a shorter term may be determined by the appointing organisation.

2.5.4 Elections held in 2017/18

The annual Governor elections took place in September 2017 with a total of five seats being contested (two seats in East Staffordshire, two seats in Lichfield & Tamworth and one Staff Governor seat for Other Staff). All seats were filled during the election, resulting in a full complement of Governors.

The Trust can confirm that all elections to the Council of Governors were held in accordance with the election rules set out in the Trust's Constitution. During 2015 / 16, the Board and Council of Governors agreed to adopt the revised Model Election Rules allowing the Trust to utilise electronic voting in forthcoming elections.
The results of these elections can be seen in the following table:

Governor elections held during 2017/18

Date of election results	Constituency	No. of Eligible Voters	No of seats	No. of Candidates	Election Turnout	Elected Governor(s)
13.9.2017	Staff – Other Non-Clinical	Unknown	1	1	Unopposed	Amanda Scott
13.9.2017	Lichfield & Tamworth	1475	2	4	19.9%	Denise Baker David Dundas
13.9.2018	East Staffordshire	Unknown	2	2	Unopposed	Adriana Bailey Philippa Saddington

2.5.5 Governor roles and responsibilities

The over-riding role of the Council of Governors is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the Members and of the public.

In addition, Governors also have other required duties, which include:

- To appoint and, if appropriate, remove the Chair;
- To appoint and, if appropriate, remove other Non-Executive Directors;
- To invite members of the Board to meetings of the Council of Governors to answer questions;
- To represent the interests of Members and the public;
- To amend the Constitution, following approval by the Board;
- To approve the appointment of the Chief Executive;
- To appoint and, if appropriate, remove the Trust's External Auditor;
- To receive the Trust's Annual Accounts, any report of the Auditor on them, and the Annual Report;
- To be involved in the preparation of the Operational Plan by canvassing and feeding back the views of Members and the public to the Board;
- To approve significant transactions, as defined in the Trust's Constitution;
- To approve changes to the proportion of income derived from non-NHS sources as detailed in the Trust's Constitution.

The Health and Social Care Act 2012 also gave Governors the right to refer a question to an Independent Panel for advising Governors. The role of the panel is to answer questions raised by Governors as to whether a Trust has failed or is failing to act in accordance with its Constitution, or to act in accordance with Chapter 5 of the NHS Act 2006. A question can only be referred to the panel if more than half of the members of the Council of Governors voting approve the referral.

2.5.6 Contact procedure for the Council of Governors

Members may contact Governors via the following:

Email: membership@burtonft.nhs.uk

Post: FREEPOST RRJK-LJEL-UYUL
Burton Hospitals NHS Foundation Trust
Queen's Hospital
The House (Membership)
Belvedere Road
Burton on Trent
Staffordshire
DE13 0RB

2.5.7 Register of Governors' interests

A Register of Governors' Interests is available on the Trust's website;
http://www.burtonhospitals.nhs.uk/Membership/Updated%20Register%20of%20Interest.pdf

2.5.8 Governor developments

During the previous 12 months, the majority of new Governors have attended the NHS Providers GovernWell Core Skills training package with one Governor attending the Accountability Specialist Skills Module. This training, aimed at new Governors and existing Governors who require a refresh of skills, covers pertinent topics such as Governors roles and responsibilities, effective questioning and challenge, quality and NHS finances.

The Trust's Council of Governors was represented at the first NHS Providers Governor Focus Conference held on 20 April 2016. The conference provided a good opportunity for Governors to share their experiences and ideas with their peers as well as listen to experienced professionals from across the health sector and beyond.

The Trust is committed to ensuring that Governors have access to the required training, both at a national and local level to ensure that they are capable of discharging their duties.

In line with the Governors duty to represent the interests of Members of the Trust as a whole and the interests of the public views, Governors have received training on the following topics:

- Plan on a Page Strategy session
- Governance & Risk Management
- Staff Survey Results

In order to ensure that Governors receive timely information, Governors are invited to attend the public Board of Directors meetings. In addition, Governors are invited to attend a bi monthly Governor Briefing following the Closed Board of Directors meetings where the Chairman and Chief Executive, supported by the Executive Directors when required, brief the Governors following discussions at the Board meeting.

As a result of the collaboration work with Derby Teaching Hospitals NHS Foundation Trust, in January 2017 monthly Governor Workshops were established to ensure that Governors continue to be fully briefed and have an opportunity to consider the progression of work and seek clarification where required. The Chairman, Chief Executive, Non-Executive Directors and members of the Executive Team attend the Workshops to hold two way discussions with the Governors on topics such as; the collaboration process and timescale, the clinical case for change and governance arrangements.

2.5.9 Council of Governors reporting committees

There are currently three reporting Committees of the Council of Governors. These are:

- **Membership and Communications Committee**

The Membership and Communications Committee supports the recruitment of

public Members, reflecting the demographics of the community served by the Trust. In addition, the Committee identifies and effectively communicates opportunities for membership events and works with partners, voluntary and community groups to increase awareness of membership opportunities and on joint ventures aimed at reaching "hard to reach" groups. The Membership and Communications Committee reviews the Trust's Membership Strategy, for approval by the Council of Governors.

- **External Auditors Appointments and Liaison Committee**

The External Auditors Appointments and Liaison Committee has responsibility for the process of appointing, removing or re-appointing the Trust's External Auditors. The process is formal, rigorous and transparent and completed in conjunction with the Board of Directors Audit Committee. The Committee's recommendation must be considered and approved by the full Council of Governors.

- **Appointments Committee**

Chaired by the Lead Governor, the Appointments Committee makes recommendations to the Council of Governors on the appointment of the Chairman and the Non-Executive Directors. The Committee also provides advice to the Council of Governors on levels of remuneration for the Chairman and other Non-Executive Directors, for approval by the Council of Governors. The Committee receives reports on the process and outcome of the appraisal for the Chairman and the Non-Executive Directors.

To support the Operational Plan process and to formalise the systems in place to ensure that the Trust had regard to the views of the Council of Governors, the Council of Governors established an Operational Plan Task Group which provided regular feedback to the Council of Governors.

2.5.10 Informal Governors meetings

The Governors continued to meet to consider and discuss the information received at the previous meeting and receive feedback from those Governors attending the Board's Committee meetings. These meeting feed into the agenda setting process.

2.5.11 Public meetings

Council of Governors meetings are held bi-monthly and in public. Attendance is shown in the following table. They provide a forum for engaging with the Governors and gaining important views and opinions which will help shape the future direction of local health services. At these meetings the Council of Governors have continued to receive and welcome questions from Members and members of the public covering topics such as the collaboration work with Derby Teaching Hospitals NHS Foundation Trust, services at Sir Robert Peel Hospital in Tamworth and Samuel Johnson Community Hospital in Lichfield and car parking.

Attendance at Council of Governor meetings 2017/18

All Public and Staff Governors are elected by the Membership of the constituency that they represent. Partner Governors are appointed by the appointing organisation. An elected Governor may hold office for a period of three years commencing immediately after the Annual Members Meeting at which the appointment is announced.

Name and Title	Number of Meetings *	Total Number of Attendances
John Rivers Chairman	15	15
Graham Lamb Public Governor – East Staffordshire	15	14
John Carr [1] Public Governor – East Staffordshire	8	8
Adriana Bailey [2] Public Governor – East Staffordshire	4	2
John Anderson Public Governor – East Staffordshire	15	9
David Rogers Public Governor – East Staffordshire Lead Governor from 15.8.17	15	13
Roger Lewis [3] Public Governor – East Staffordshire	8	3
Bernard Peters [4] Public Governor – East Staffordshire and Lead Governor until 14.8.17	12	6
Philippa Saddington [5] Public Governor – East Staffordshire	7	3
Navinder Dhillon Public Governor – Lichfield & Tamworth	15	4
Pam Dhanda Public Governor – Lichfield & Tamworth	15	10
Phil Hodson-Walker [6] Public Governor – Lichfield & Tamworth	8	6
Malcolm Pearson [7] Public Governor – Lichfield & Tamworth	8	8
David Dundas [8] Public Governor – Lichfield & Tamworth	7	5
Denise Baker [9] Public Governor – Lichfield & Tamworth	7	7
Merryl Patrick Public Governor – NW Leicestershire and the Rest of England	15	4
Sheila Jackson Public Governor – South Derbyshire	15	10
Gemma Price Public Governor – South Derbyshire	15	10
David Hanson Partner Governor – Higher Education	15	9
Garry Jones Partner Governor – Support Staffordshire	15	11
Susan McGarry [10] Partner Governor – East Staffordshire Borough Council	3	0
Deneice Florence-Jukes 11 Partner Governor – East Staffordshire Borough Council	6	5

Name and Title	Number of Meetings *	Total Number of Attendances
Bernard Peters[12] Partner Governor – Staffordshire County Council	3	0
Amy Plenderleith [13] Partner Governor – South Derbyshire District Council	1	1
Kim Coe [14] Partner Governor – South Derbyshire District Council	14	5
Susan Williams-Jones Staff Governor – Medical & Dental Staff	15	12
Cathy Brown Staff Governor – Nursing & Midwifery Staff	15	14
Allison Dean Staff Governor – Other Clinical Staff	15	14
Elaine Day Staff Governor – Volunteers	15	13
Elly Briggs [15] Staff Governor – Other Staff	8	6
Amanda Scott [16] Staff Governor – Other Staff	7	5

Notes

1 John Carr term of office ended 25 September 2017
2 Adriana Bailey term of office began 25 September 2017
3 Roger Lewis term of office ended 25 September 2017
4 Bernard Peters term of office as Public Governor ended 19 February 2018
5 Philippa Saddington term of office began 25 September 2017
6 Phil Hodson-Walker term of office ended 25 September 2017
7 Malcolm Pearson term of office ended 25 September 2017
8 David Dundas term of office began 25 September 2017
9 Denise Baker term of office began 25 September 2017
10 Sue McGarry resigned from the Council of Governors 22 June 2017
11 Deneice Florence-Jukes term of office began 7 September 2017. Removed from Council of Governors 7 February 2018
12 Bernard Peters term of office as Appointed Governor began 20 February 2018
13 Amy Plenderleith resigned from the Council of Governors 5 April 2017
14 Kim Coe term of office began 6 April 2017
15 Elly Briggs term of office ended 25 September 2017
16 Amanda Scott Term of office began 25 September 2017

* Including three Extra Ordinary Council of Governors meeting.

The Non-Executive Directors, the Chief Executive and the Executive Directors regularly attend Council of Governors meetings.

Director attendance at Council of Governor meetings 2017/18

Name and Title	Dates Attended *
John Davies Non-Executive Director and Senior Independent Director	17 May 2017; 23 January 2018; 14 March 2018; 21 March 2018
Joy Street [1] Non-Executive Director	17 August 2017; September 2017; 16 November 2017; 23 January 2018; 14 March 2018
Steve Hollingsworth[2] Non-Executive Director	17 August 2017; 16 November 2017; 14 March 2018; 21 March 2018

Name and Title	Dates Attended *
Stephen Goode Non-Executive Director and Deputy Chair	17 May 2017; 20 July 2017; 17 August 2017; September 2017; 16 November 2017; 23 January 2018; 14 March 2018; 21 March 2018
Paul Doona Non-Executive Director	17 May 2017; September 2017; 16 November 2017; 23 January 2018; 14 March 2018. 21 March 2018
John Bale Non-Executive Director	17 May 2017; 20 July 2017; 17 August 2017; 21 September 2017; 16 November 2017; 23 January 2018; 14 March 2018
Helen Scott-South Chief Executive	17 May 2017; 20 July 2017; 17 August 2017; September 2017; 16 November 2017; 23 January 2018; 14 March 2018; 21 March 2018
Magnus Harrison Medical Director	20 July 2017; September 2017; 16 November 2017; 23 January 2018;14 March 2018; 21 March 2018
Jonathan Tringham Director of Finance, Information, Performance and Estates	17 May 2017; 14 March 2018; 21 March 2018
Paula Gardner Chief Nurse	17 May 2017; 20 July 2017; September 2017; 23 January 2018; 14 March 2018; 21 March 2018
Duncan Bedford Chief Operating Officer	20 July 2017; 23 January 2018; 14 March 2018
Tosca Fairchild Director of Governance, Communications & Engagement	4 April 2017; 17 May 2017; 20 July 2017; 17 August 2017; September 2017; 16 November 2017; 23 January 2018; 14 March 2018; 21 March 2018
Alison Wynne Director of Strategy and Partnerships	17 May 2017; 20 July 2017; September 2017; 16 November 2017; 23 January 2018;14 March 2018; 21 March 2018
Louise Thompson[3] Director of Communications	17 May 2017; 20 July 2017; 16 November 2017;
Roger Smith Director of Human Resources	17 May 2017; 20 July 2017; 16 November 2017; 21 March 2018

1 Joy Street joined the Trust on 1 April 2017
2 Steve Hollingsworth joined the Trust on 5 April 2017
3 Louise Thompson left the Trust on 28 February 2018

* Includes one Extra Ordinary Council of Governors meeting.

2.5.12 Trust membership

The Trust encourages as many local residents as possible to register as Members to show support for the Trust. The Membership Strategy sets out how the Board of Directors has monitored the representativeness of the Trust's membership and the level and effectiveness of the member engagement. The Trust wants to ensure that the services fully represent the needs of the entire local population to be confident that the Trust takes account of the views of everyone in the area, without prejudice to any part of the community as stipulated within the Equality Act 2010. In order to ensure that patients who live on the fringe of the Trust's catchment areas are eligible to become Members, the Trust amended its Constitution in 2012 to rename the North West Leicestershire constituency North West Leicestershire and the Rest of England, excluding the Trust's other public constituencies.

The Foundation Trust Members are grouped into two Constituencies; Public and Staff.

Public Constituencies

Anyone aged 16 or over can register for Membership. This is provided they are not eligible to become a Member of the Staff Constituency or otherwise disqualified for Membership as described in the Constitution.

Staff Constituencies

Members of staff are individuals who are employed by the Trust with a contract of employment which does not have a fixed term, or with a fixed term of at least 12 months. The Staff Constituency also includes individuals who have been employed continuously by the Trust for 12 months. All staff employed by the Trust who are eligible automatically become Members on appointment, although they can decide to opt out if desired.

There are five representatives from the Staff Constituency representing:

- Medical and Dental staff
- Nursing and Midwifery staff
- Other clinical staff
- Other staff - non-clinical
- Volunteers

The total numbers of Members for both Public Constituencies and Staff Constituencies are shown in the following tables:

Membership numbers for the Trust

Public Constituency Members Constituency	Figures as at 31 March 2017	Figures as at 31 March 2018
East Staffordshire	2,983	2,963
South Derbyshire	1,335	1,311
Lichfield & Tamworth	1,484	1,457
North West Leicestershire & the Rest of England	627	616
Total Membership	**6,429**	**6,355**

Staff Constituency Members Constituency	Figures as at 31 March 2017	Figures as at 31 March 2018
Medical & Dental	206	205
Nursing & Midwifery	910	900
Other Clinical	731	761
Other	925	898
Volunteers	171	226
Total Membership	**2,943**	**2,990**

The total number of Members for the Trust, detailed in the above tables, as at 31 March 2018 equals 9,345.

2.5.13 Membership Strategy

The Trust is committed to being a successful Membership organisation and strengthening its links with the local community. A number of objectives have been set out in a Membership Strategy that aims to work towards Membership recruitment, managing Membership, effectively communicating with Members, and active engagement.

Membership is open to all persons able to use the Trust's services and willing to accept the responsibilities of Membership, without prejudice to any part of the community as stipulated within the Equality Act 2010.

By working hard with these different groups and working in a consultative fashion, the Trust believes that the Members and Governors can positively influence the planning and delivery of the Trust's services.

The Trust recognises that building a representative Membership body is a great opportunity to learn from, respond to and work more closely with patients, public, staff, volunteers and stakeholders. Members are able to advise whether they would wish to take a more active role. The Membership Strategy allows the Member to identify two different levels of involvement – an informed Member and an involved Member.

Both types of Member have equal rights, have the opportunity to vote in Governor elections and may put their views forward if they wish to do so. An informed Member will be advised of public meetings and membership events, along with being communicated with regularly via a newsletter on current issues and developments. However, an involved Member will in addition have the opportunity to take part in surveys, questionnaires, consultations, focus or advisory groups and attend open days or educational events. All Members have the opportunity to stand for election as a Governor.

The Membership Strategy also very clearly allows for Members to change their level of involvement at any time, and become involved in a wider range of activities, as they choose.

The Membership Strategy is available to view on the Trust's public website at;
http://www.burtonhospitals.nhs.uk/membership/What-is-Foundation-Trust-Membership.htm

2.5.14 Membership development and engagement

It is a constant challenge to develop and engage with a truly representative Membership and the Trust continues to work with its partners in the community to reach all diverse groups in an effort to strengthen its representation.

Derby Teaching Hospitals NHS Foundation Trust Collaboration Work

Both the Trust and Derby Teaching Hospitals NHS Foundation Trust have provided regular communications to Members regarding the collaboration process, which has included a specific and regular newsletter providing updates.

It is also important to ensure that staff, patients, their families and carers are involved in the development of the potential partnership. In order to support the work to be undertaken a Patient Reference Group has been established, with Governor involvement from both trusts. In order to ensure that staff from both organisations are engaged, a Staff Reference Group has been developed to support the process with the involvement of Staff Governors from both trusts.

The Council of Governors monitors the effectiveness of the Strategy through the delivery of its objectives which is reported back through the Membership and Communications Committee. This Committee will ensure that the Strategy remains a meaningful and relevant document. The Membership Strategy is reviewed annually and the Committee will continue to develop Membership through a recruitment, communications and engagement action plan.

A number of mechanisms have been developed to allow the Board, and in particular the Non-Executive Directors, to develop an understanding of the views of Governors and Members, including a 'Meet the Board' session bi monthly allowing Governors, Members and members of the public to informally ask the Board of Directors questions about pertinent issues.
Board of Directors and Council of Governors meetings are held in public, with the date, time and venue publicised on the Trust website and in the local media allowing stakeholders to meet Board members and Governors. Members meetings were held in September 2017 and in March 2018.

2.6 Regulatory Ratings

2.6.1 Single Oversight Framework

NHS Improvement's Single Oversight Framework came into force on 1 October 2016 and replaced the Risk Assessment Framework. It provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

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

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

Segmentation

Burton Hospitals NHS Foundation Trust is in Segment 3.

This segmentation information is the Trust's position as at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website. The following table describes the four segments:

Segment	Description
1	**Providers with maximum autonomy** – no potential support needs identified across our five themes – lowest level of oversight and expectation that provider will support providers in other segments
2	**Providers offered targeted support** – potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not needed
3	**Providers receiving mandated support for significant concerns** – the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)
4	**Special measures** – the provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean that they are in special measures

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2017/18 Q3 Score	2017/18 Q4 Score
Financial Sustainability	Capital Service Capacity	4	4
	Liquidity	4	3
Financial Efficiency	I&E Margin	4	4
Financial Controls	Distance from Financial Plan	2	1
	Agency Spend	3	3
Overall Scoring		**3**	**3**

2.6.2 Care Quality Commission Inspection

Burton Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully compliant. Burton Hospitals NHS Foundation Trust has no conditions. The Care Quality Commission has not taken enforcement action against Burton Hospitals NHS Foundation Trust during 2017/18.

Over the course of the last 12 months, the CQC has not undertaken a full inspection at any of the Trust's three locations; Queen's Hospital in Burton, Samuel Johnson Community Hospital in Lichfield and Sir Robert Peel Hospital in Tamworth. The last planned visit took place on the 7, 8 and 9 July 2015 and the subsequent report was received in October 2015.

Burton Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

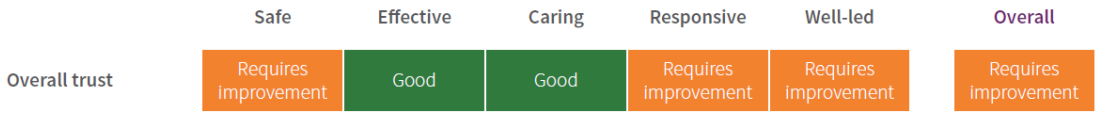
CQC inspectors use professional judgement, supported by objective measures and evidence, to assess services against five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs
- Are they well-led?

Following the inspection, the CQC gave the Trust an overall rating for the Trust as 'Requires Improvement', which was split by the three locations as follows:

- Queen's Hospital - Requires Improvement
- Sir Robert Peel Community Hospital - Good
- Samuel Johnson Community Hospital – Good.

The overall rating in respect of the CQC's five key questions was assessed as follows:



Extract from Burton Hospitals NHS Foundation Trust Quality Report dated 22 October 2015

The inspection highlighted improvements in safety and leadership, caring and compassionate staff and a strong, responsive, open culture. Across the Trust, more than 80% of the Trust's core services were rated "Good" by the Inspection team, with notable improvements including Urgent and Emergency Services at Queen's Hospital, Medical Care across the Trust, End of Life and Services for Children and Young People. Both Sir Robert Peel Community Hospital and Samuel Johnson Community Hospital were given a "Good" rating overall which is a great reflection on the quality of care that is offered to the Trust's wider community.

The report identified many diverse examples of "Outstanding Practice", in particular innovative approaches to improving patient outcomes and increasing patient and carer engagement.

The inspection identified that there was still further work to do, particularly regarding delays in the outpatient department, the lack of a clear pathway for patients needing emergency gynaecological treatment and concerns regarding patient flow throughout services. The actions identified were incorporated into the detailed action plan to monitor progress in delivering and embedding the actions and this work continues.

As a result of the sufficient progress made, and the Trust's continuing commitment to ongoing quality improvements, the CQC made its recommendation to the Independent Regulator that the Trust should be removed from special measures status in October 2015.

In 2016/17 the CQC did, however, undertake a Review of Health Services for Children Looked After and Safeguarding in Staffordshire. The review was undertaken between 4 to 9 April 2016 and explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.

The focus was on the experiences of looked after children and their families who receive safeguarding services.

The CQC reviewed:

- The role of healthcare providers and commissioners;
- The role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews;
- The contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

The CQC also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004, which included the statutory guidance, Working Together to Safeguard Children 2015.

The final report was published in October 2016 with actions identified for the Trust being incorporated into the Trust's Consolidated Action Plan. Monitoring delivery of actions is set out in the Annual Governance Statement in Part 2.8 of this report.

2.7 Emergency Preparedness, Resilience & Response (EPRR) Core Standard Performance

Each year the Trust is required by NHS England to undertake an Emergency Preparedness, Resilience & Response (EPRR) self-audit to ensure that it has robust plans, procedures and policies in place to address emergency and unforeseen incidents. This takes the form of a comprehensive excel spread-sheet questionnaire which is populated with evidence of compliance and a RAG rating.

Each year there is a slightly different emphasis, called a 'Deep Dive' this year's EPRR assurance deep dive topic was organisational governance, to ensure that EPRR is secured appropriately within the Trust including internal organisational EPRR accountability, regular reports to public Board meetings, a work program and a training and exercise program.

The audit was presented to the Trust Executive Committee (TEC) in August 2017 by the Emergency Preparedness Manager. The report was then subsequently submitted to NHS England and South Staffordshire CCG for appraisal.

Following self-audit, on 19th October 2017, the Chief Operating Officer who is also the Accountable Emergency Officer (AEO) and the Emergency Preparedness Manager represented the Trust at a Confirm & Challenge session with representatives of NHS England and East Staffordshire CCG, where EPRR evidence was again assessed.

Trusts are then graded for compliance as below:

- Full – All standards met.
- Substantial – 1 to 5 standards require attention.
- Partial – BHFT – 6 to 10 standards require attention.
- None Compliant – 11 or more standards are not compliant.

The Trust was graded as **'Partially Compliant'** last year (2016/17) with eight areas requiring attention.

This year the Trust was graded as **'Substantially Compliant'** with four areas requiring attention:

- More effective Security Lockdown Policies & Procedures in place.
- Greater training of On-Call Staff in EPRR.
- Continuous Personal Development in EPRR could not be evidenced.
- Governance – More frequent Exec attendance at LHRP.

Three of the above areas have already been addressed and the remaining area, CPD is in the process of being addressed.

The Accountable Officer for East Staffordshire CCG has written to the Chief Operating Officer and asked that the Trust continues to keep the CCG updated with progress on achieving full compliance.

The Trust will continue to liaise with East Staffordshire CCG to achieve full compliance.

2.8 Statement of Accounting Officers Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Burton Hospitals 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.

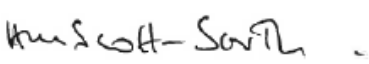
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Direction which requires Burton Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Burton Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health 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 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; and
- Prepare the financial statements on a going concern basis.

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

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



Helen Scott-South
Chief Executive
23 May 2018

2.9 Annual Governance Statement for the Period 1 April 2017 to 31 March 2018

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*.

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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Burton Hospitals 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 Burton Hospitals NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust has adopted a comprehensive approach to Risk Management with structures and processes in place to successfully deliver its risk management objectives.

Following the appointment of the Director of Governance, Communications & Engagement in 2014, leadership arrangements for risk have continued to be strengthened. The Director of Governance, Communications & Engagement post incorporates the Chief Risk Officer duties and is responsible for providing an overview of governance, including risk management, to ensure that processes are fit for purpose using expert knowledge and skills in governance. Other roles and responsibilities are clearly defined in the Risk Management Strategy and Policy, supported by job descriptions and individual objectives.

The Trust's Divisional structure has been in place since September 2016. It has two Divisions, with supporting Business Units to assist the delivery of the Trust's objectives. In addition, the senior leadership of the Divisions was reviewed with the Divisional Director being accountable for the division, supported by a Divisional Medical Director and Divisional Nurse Director. This has allowed leadership to be further embedded at Divisional level where managers have responsibility for risk identification, assessment and recording within the appropriate risk register.

All new members of staff are required to attend a mandatory induction training that includes an introduction to incident reporting and risk management. Existing members of staff are required to refresh their training every three years. Staff training covers key elements of risk management including adverse incident reporting using the Trust's integrated risk management system, the definition of a serious incident, and the importance of learning from adverse incident reporting at both national and local level. In addition, some members of staff have attended root cause analysis (RCA) investigation training which incorporates best practice techniques from the National Patient Safety Agency (NPSA).

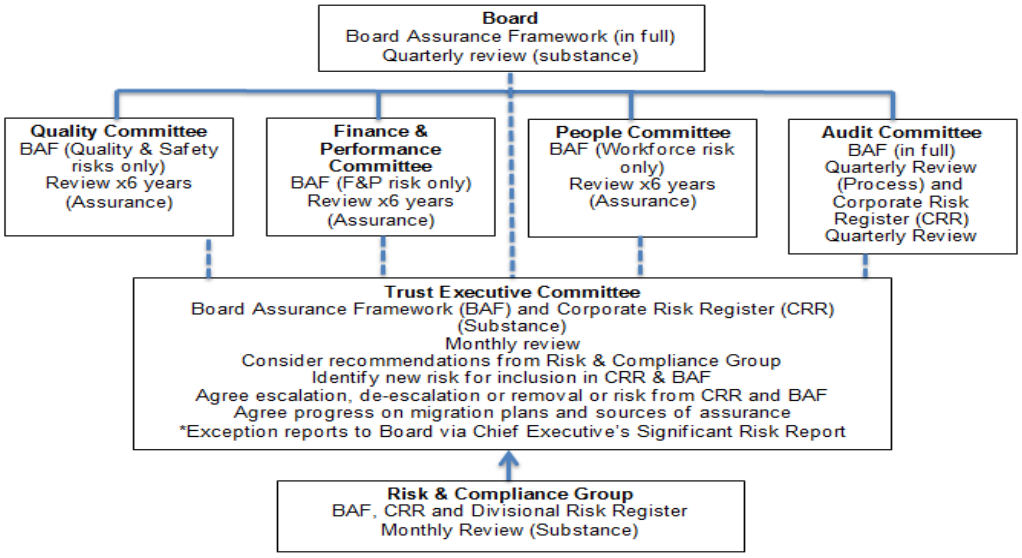
Responsibility and accountability arrangements for risk management are seen in the table below:

Chief Executive	The Chief Executive is accountable for ensuring an effective risk management system is in place in order to meet the statutory requirements relevant to the Trust. As Accountable Officer, the Chief Executive is accountable to the Chairman and the Board of Directors for ensuring there is an effective system of risk management and internal control in place, and for meeting all statutory and corporate governance requirements. The Chief Executive delegates responsibility for the maintenance of the system of internal control to the Executive and Divisional Management Teams (Divisional Directors / Divisional Medical Directors and Divisional Nurse Director).
Director of Governance, Communications & Engagement	The Director of Governance, Communications & Engagement is the Trust's Chief Risk Officer and is responsible for developing and implementing systems of internal control. She is responsible for the development and implementation of the Trust Risk Management Strategy and Risk Management Policy. The Director of Governance, Communications & Engagement is responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet its requirements in relation to risk management and is also responsible for ensuring risk registers are reviewed on a monthly basis. She has responsibility to ensure that Trust has a robust Board Assurance Framework.
Director of Finance, Information, Performance & Estates	The Director of Finance, Information, Performance & Estates has delegated responsibility for managing the strategic development and implementation of financial risk management and is responsible for implementing financial systems of internal control including the reporting of fraud to NHS Protect. The Director of Finance, Information, Performance & Estates is responsible for informing the Board of Directors of the key financial risks within the Trust, the actions being taken to control them, and provides written

	advice to the Accountable Officer on the content of the Annual Governance Statement regarding financial risk. The Director of Finance, Information, Performance & Estates is also the Trust Senior Information Risk Owner (SIRO) with ownership of the Trust's Information Risk Policy. The Director of Finance, Information, Performance & Estates provides written advice on information risks to the Accountable Officer for the Annual Governance Statement.
Executive Directors	Executive Directors have delegated responsibility for governance and risk management arrangements within their areas of control. All Executive Directors are accountable to the Chief Executive and the Board of Directors for the maintenance of effective systems of internal control within their areas of responsibility. Executive Directors are responsible for reporting on controls and assurances of the highest risks to the Trust objectives through the Board Assurance Framework (BAF). Each Director is responsible for risk management leadership including the implementation of, and compliance with, current Trust policies and for ensuring sufficient resources have been allocated to undertake effective risk management. Leading by example, Executive Directors are fundamental in establishing and sustaining an environment of openness on risk management within their Divisions.
Board of Directors	The Board of Directors is responsible for endorsing the organisation's system of internal control, including risk management as identified in the Risk Management Strategy and has collective responsibility for: ➢ Providing leadership on the management of risk; ➢ Agreeing the Trust Objectives and developing the Board Assurance Framework; ➢ Reducing, eliminating and exploiting risk in order to increase resilience; ➢ Determining and communicating the risk appetite for the Trust; ➢ Ensuring the approach to risk management is consistently applied; ➢ Making sure assurances are available to demonstrate that risks have been identified; assessed and all reasonable steps have been taken to manage them effectively and appropriately; ➢ Ensuring appropriate resources are available to support the risk management system and to manage risk within the agreed risk appetite; ➢ Protecting the reputation of the Trust; ➢ Correctly identifying risk, the scoring of risk and compliance with Trust controls.

4. The risk and control framework

The Trust has adopted an integrated framework for risk management that is described in its Risk Management Strategy, supported by a set of policies and procedures. The Board Assurance Framework (BAF) provides a comprehensive framework for the management of principal risks that may threaten achievement of the Trust's strategic objectives, taking account of the existing and required control measures and assurances. The Risk Management Strategy is delivered through an integrated risk management process which puts line management at the centre of the risk management process as follows;



Key – CRR – Corporate Risk Register

The Board of Directors approved the revised Risk Management Strategy in December 2017 taking account of structural changes. All risks are managed and mitigated in accordance with the approach outlined above. Future risks that may impact the Trust's ability to deliver the Operational Plan have been identified. Action plans to manage and mitigate these are being prepared in accordance with the process identified above and the impact of mitigating actions will be closely monitored by the appropriate Board Committee. The Board of Directors receives a regular summary report from each of its Committees providing both assurance and, by exception, escalation of those items the Board should be made aware of.

The Trust is committed to providing high quality patient services and securing a safe environment for patients, staff and the public, taking every opportunity to learn from adverse incidents. It is the policy of the Trust to ensure that all incidents (clinical and non-clinical) are managed so that the impact is minimised and harm to patients, staff and visitors limited.

The Trust has developed and implemented an integrated policy for the management of all internally and externally reportable incidents, including Serious Incidents (SIs) and Internal Safety Alerts (ISAs) requiring investigation. The policy reflects national changes in the Serious Incident Framework, which was published in March 2015, to support and enable improved learning from adverse events and near misses as part of the Trust's drive to continuously improve the quality of the

care and treatment it provides to its patients. The Serious Incident Group meets twice monthly to monitor the investigation and lessons learnt following SIs.

The Trust is dedicated to promoting and nurturing a just or 'no blame' culture to promote open and honest processes for reporting incidents and raising concerns. The Trust has the 'Policy for Being Open and Duty of Candour' which was reviewed and approved in January 2018.

This policy describes how the Trust demonstrates its openness with service users and relatives when mistakes are made. Being Open is a set of principles that healthcare staff should use when communicating with service users, their families and carers following an incident in which the service user was harmed. The specific delivery of Being Open communications will vary according to the severity grading, clinical outcome and family arrangements of each specific event. The Duty of Candour applies to all patient safety incidents regardless of the level of harm where moderate, severe harm or death has occurred as a result of an incident.

The Trust aims to promote a culture of openness, which it sees as a prerequisite to improving patient safety and the quality of service user experience.

Being Open relies initially on staff and the rigorous reporting of patient safety incidents. The Trust endorses the Francis Report Recommendation 173:

'Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be open, honest and truthful.'

Therefore, staff who are concerned about the non-reporting or concealment of incidents, or about on-going practices which present a serious risk to patient safety, are encouraged to raise their concerns under the Trust's Whistleblowing Policy [No: 115].

In addition, the Trust has appointed a Freedom to Speak Up Guardian which is a newly created role for every Trust in England. It follows the publication of the Freedom to Speak Up Review which was commissioned by the Secretary of State in February 2015, chaired by Sir Robert Francis QC. This role supports the profile of raising concerns in the organisation and provides challenge to staff and the Board if the culture does not provide the appropriate atmosphere to allow concerns to be raised. The Freedom To Speak Up Guardian also provides confidential advice and support to all staff in relation to concerns regarding patient safety and / or the way their concern has been handled.

<u>The Board Assurance Framework</u>

During the past year, the Board of Directors continued to monitor and review the risks within its Board Assurance Framework (BAF). The risks within the BAF were collectively agreed as the areas that would have a direct impact on the Trust's ability to deliver its priorities and objectives. Strategic risks were reviewed and reassessed with Board Committees considering the strategic risks relevant to

them as well as the high scoring operational risks that may pose a threat to strategic objectives, challenging and monitoring the risk mitigation actions in place. The highest scoring BAF risks at 31 March 2018 were:

- **Failure to achieve and maintain national performance targets due to increased demand on services and capacity impacting on reputation, performance and quality – Risk Score 16.**

- **Delivery of 2017/18 Operational Plan may not result in the level of financial savings planned for; resulting in the trust being unable to develop or maintain standards of services for patients – Risk Score 16.**

- **Pressure on management capacity due to the volume of working STP's and strategic planning processes could lead to failure to implement strategic changes whilst delivering effective day-to-day management – Risk Score 16.**

- **Failure to maintain robust cyber security creating a risk of theft of personal identifiable data and the potential to cause substantial IT systems related problems resulting in the Trust being unable to provide services and/or providing limited services – Risk score 15.**

Corporate Governance Statement

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence. On an annual basis the Trust utilises NHS Improvement Self Certification templates to consider compliance against Condition FT4, training of Governors and Condition G6 and make the appropriate declarations. The templates, together with the supporting reports, identifies whether the Trust confirms compliance against the corporate governance statements and details the risks and mitigating actions where appropriate. This is considered and challenged by the Board of Directors prior to approval.

The Board has worked with NHS Improvement and key stakeholders to understand its future pressures for clinical, operational and financial sustainability. Sustainability and Transformation Partnership (STPs) have been drawn up in every part of England to enable the delivery of a transformed NHS; delivering the "Five Year Forward View" vision of better health, better patient care and improved NHS efficiency. The Trust is a full member of the Staffordshire and Stoke-on-Trent Sustainability & Transformation Partnership. If the merger with Derby Teaching Hospitals NHS Foundation Trust complete, the Trust will be a member of the Derbyshire STP.

In addition, the Trust has continued to explore collaborative working with Derby Teaching Hospitals NHS Foundation Trust during 2017/18. The two trusts have an overlapping population base, operating 11 miles apart with respect to the Queen's Site. Along with the rest of the NHS, both Trusts are experiencing clinical, operational and financial challenges which are increasing over time. These

pressures impact on the annual performance against national quality and operational performance standards.

Both Boards approved a Strategic Outline Case in October 2016 and agreed that some form of strategic collaboration was likely to be the best way to address the specific sustainability challenges. The Outline Business Case was considered in June 2017 and the Full Business Case in December 2017. The Patients Benefit Case submitted to the Competitions & Markets Authority (CMA) in December 2017. The positive outcome of the CMA decision was received on 15th March 2018 advising that the patient benefits from the merger significantly outweighed any lessening of competition and choice.

Members of the Executive team are invited to attend the Staffordshire County Council Joint Health Scrutiny Accountability Sessions where any risks that have significant impact on public stakeholders would be highlighted and discussed. Any potential changes to service provision that would have a greater impact on the public at large would be subject to public consultation, via the commissioners. The Council of Governors also has a role to play with respect to the management of risks affecting public stakeholders as their duties include representing the interests of the Members of the Trust as a whole and the interests of the public.

Information Risks

The Information Governance Steering Group has responsibility for overseeing day-to-day information governance issues; developing and maintaining policies, standards and procedures and guidance and raising awareness of Information Governance requirements. The Medical Director as Caldicott Guardian, supported by the Information Governance Lead, is responsible for the establishment of policies for the control and appropriate sharing of patient information with other agencies. The Director of Finance, Performance, Information and Estates is the Senior Information Risk Owner.

The Information Governance Policy has undergone its annual review and was ratified by the Trust Executive Committee in January 2018. The Policy sets out the overall framework for information governance arrangements at the Trust, supported by additional documents such as the Information Risk Management Programme.

A systematic review of risks relating to information systems and data flows has also been carried out and corrective actions identified when required. An incident reporting system is in place to capture, record and analyse reported issues relating to information systems and confidential data.

The Trust is required to undertake a self-assessment against the Information Governance Toolkit on an annual basis. As at 31 March 2018, the Trust achieved an overall score of 83% and is satisfied that the Information Governance assessment is adequate. The score is the same as last year's performance.

The number of Requirements Level 1 or below remains at zero. The number reaching the maximum attainment of Level 3 remains the same as the previous

year, 23 in total. NHS Digital continue to rate the Trust as “Satisfactory” for the period 2017/18.

Trust Score for Attaining Information Governance Standards

Year	Level 0	Level 1	Level 2	Level 3	Overall score	Self-assessed Grade
2017/18	0	0	22	23	83%	Satisfactory
2016/17	0	0	22	23	83%	Satisfactory
2015/16	0	0	24	21	82%	Satisfactory
2014/15	0	0	27	18	80%	Satisfactory

Trust has maintained Level 3 (the highest level) compliance for the FoI standard for the 2017/18 IG Toolkit submission

There were no serious incidents relating to confidentiality breaches, cyber-security or data loss during the reporting period.

Information Governance training compliance is 96% which is a 1% decrease on last year’s performance but is 1% over the national target.

Policies

All policies throughout the organisation are required to be Equality and Diversity Impact Assessed (EIA) and must include both a statement on the front index sheet, and an EIA number confirming that an Equality and Diversity Impact Assessment has been completed. The Equality and Diversity Impact Assessment documentation is embedded within the Policy Framework that provides authors with a corporate guide to the way in which Trust policies need to be written and how they can be approved.

Care Quality Commission (CQC)

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

Care Quality Commission Inspection – July 2015

The CQC inspection teams are formed from a national team of clinical and other experts, including people with experience of receiving care. Intelligent monitoring helps the CQC to decide when, where and what to inspect, including listening better to people's experiences of care and using the best information across the system.

The CQC inspectors use professional judgement, supported by objective measures and evidence, to assess services against five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs
- Are they well-led?

By well-led, it is meant that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

The Trust received notification that the CQC would undertake a full re-inspection during July 2015 across all three sites following the same methodology as used during the Inspection in 2014. The purpose of the visit was to evaluate the Trust against the CQC standards across five key domains: Safe, Caring, Effective, Responsive to Patient's Needs and Well Led. This Inspection was an opportunity to highlight the progress that the Trust had made since the last visit, and to showcase the work that the Trust was proud of, as well as to gain constructive feedback that would support improvements in the quality of the services that the Trust offers to its patients.

Following the inspection, the CQC gave the Trust an overall rating for the Trust as 'Requires Improvement', which was split by the three locations as follows:

- Queen's Hospital - Requires Improvement
- Sir Robert Peel Community Hospital – Good.
- Samuel Johnson Community Hospital – Good.

As a result of the significant progress made from the 2014 inspection, the Trust was officially taken out of Special Measures in October 2015.

The Chief Nurse arranged a Trust-wide Mock CQC Inspection in October 2017 in order to benchmark the Trust against the previous Key Lines of Enquiry. A number of areas were identified that had demonstrated significant improvements and there were some areas where further actions were required. The Trust has in place a well embedded evidence based process for action monitoring of all recommendations from external reviews called the Consolidated Action Plan (CAP) which was developed and implemented by the Director of Governance, Communications & Engagement in 2014 as part of the work to exit Special Measures. The results of the Mock CQC in October 2017 were used to further support the achievement of delivery against actions in the CAP and as a consequence a significant number of actions were closed down with only 6 actions remaining as at 31 March 2018 from a total of 33 which were in the CQC Report 2015.

Previously, the Finance & Performance Committee received quarterly self-assessment compliance reports against the Care Quality Commission (CQC) regulations for each of the Trust's registered locations following review by the responsible Executive Director. This supported the quarterly monitoring

submission as previously required by the Independent Regulator, Monitor. Since the implementation of the Single Oversight Framework by NHS Improvement the requirement to provide this quarterly monitoring has ceased. Therefore, the Quality Committee receives the quarterly self-assessments against the CQC regulations. Where any shortfall in compliance is identified, an action plan is developed, received and monitored by the relevant Board committee.

Other

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

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

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

4. Review of economy, efficiency and effectiveness of the use of resources

4.1. Capacity

The Trust has reviewed the arrangements for the monitoring of performance against financial and operational targets and the Trust objectives. The Integrated Performance Report that is received monthly by the Board of Directors and the Finance & Performance Committee ensures that financial reports are considered alongside performance reports to provide the wider picture in relation to cost, performance, quality and risk. The Quality Committee and People Committee also consider Quality and Workforce dashboards which are part of the Performance Report. Both internal audit and external expertise has been used over the past year to review organisational process and policy to ensure the Trust manages the challenges faced with capacity.

4.2. Finance

The Finance and Performance Committee continued to provide challenge and focus on the delivery of the Trust's financial targets. The Committee met monthly through the year to fulfil its remit.

4.3. Cost Improvement Schemes

The Trust's Cost Improvement Programme (CIP) continues to include a number of workstreams which are monitored on a weekly basis. This regular monitoring informs the Finance and Performance Committee, a formal Committee of the Board.

4.4. Performance

The Board provides a formal arena for the consideration of key performance information and the management of action plans. Procedures are in place to ensure that all strategic decisions are considered at Executive and Board level. The Board approved the Performance Assurance Framework in September 2014 following recommendations from a task and finish group that carried out a review of performance at the Trust. This was further reviewed and approved in March 2017.

4.5. Internal Controls

Additionally, Internal Audit provides independent assurance on internal controls, risk management and governance systems to the Audit Committee and to the Board. Where there is scope for improvement, appropriate recommendations are agreed with management for implementation, with regular updates on progress reported via the Audit Committee.

4.6. Regulators

The Trust had Enforcement Undertakings to rectify the breach of the Provider Licence in relation to financial planning and governance applied in April 2013. As a result the Trust strengthened governance arrangements with the appointment of the Director of Governance, Communications & Engagement in 2014 to provide strong leadership for governance and risk. In December 2017, the Trust was issued with a Certificate of Compliance and a Discontinuation Certificate for Section 106 and Removal of Section 111 of the Enforcement Undertakings. New Enforcement Undertakings were applied February 2018 relating to financial and clinical sustainability.

In addition to the external reviews commissioned previously, Deloitte undertook a Board Capacity Review in March 2017. The report concluded that there were no material concerns in relating to capability and effectiveness of the Board of Directors and the Trust is noted to have strong governance arrangements in place for risk management. The independent regulator undertook a sustainability review in 2015 which covered clinical sustainability and drivers of the deficit. The Trust continues to address issues within its control and work with Derby Teaching Hospitals NHS Foundation Trust and the Staffordshire and Stoke-on-Trent Sustainability and Transformation Planning to support this work.

On 1 October 2016 NHS Improvement published the Single Oversight Framework which replaced the Risk Assessment Framework for foundation trusts. This framework provides an integrated approach for NHS Improvement to oversee both foundation trusts and trusts and identify the support needed to deliver high quality, sustainable healthcare services aiming to help providers attain and maintain CQC ratings of "good" or "outstanding".

The framework assesses providers' performance against five themes:

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

Dependent on the extent of support required, NHS Improvement placed providers in one of four segments as seen in the following table:

Segment	Description
1	**Providers with maximum autonomy** – no potential support needs identified across our five themes – lowest level of oversight and expectation that provider will support providers in other segments
2	**Providers offered targeted support** – potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not needed
3	**Providers receiving mandated support for significant concerns** – the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)
4	**Special measures** – the provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean that they are in special measures

Extract from NHS Improvement Single Oversight Framework – September 2016

5. Information Governance

The Information Governance Steering Group reports to the Finance and Performance Committee which reports to the Board of Directors. The Information Governance Steering Group is chaired by the Chief Information Officer, who reports to the Director of Finance as Senior Information Risk Owner, and monitors the overall arrangements for data quality including the implementation and review of the Data Quality Policy. The Information department undertakes routine validation checks and report on completeness of key data items. There were no serious incidents relating to confidentiality breaches, cyber-security or data loss during the reporting period.

6. Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Trust has adopted a comprehensive approach to the development of the Quality Report that provides information and assurance on the quality of services

for local people, patients and their families, stakeholders and staff and demonstrates that, from the ward to the Board, the Trust is committed to improving services further.

The Trust has implemented a number of measures throughout the year across the organisation to provide further assurance. These include (but are not limited to):

- Internal Quality Compliance Inspections have been reinvigorated and pertinent questions have been included in the Board To Ward process to ensure that further assurance is received from Ward and Departmental level. A pilot of the new Quality Toolkit is being undertaken from January to March 2018.
- A Trust wide Mock CQC Inspection was undertaken in October 2017 to provide a benchmark in preparation for future CQC inspections.
- The Trust's Quality Improvement Strategy identifies quality improvement priorities for 2016-19. It has been developed in consultation with patients and staff and aims to further progress the Trust's ambitions identified within the 2013-15 Quality Strategy; continuing to ensure that our patients receive services that are consistently safe and effective with a focus on improving the experiences of our patients.
- A Quality Stocktake has been developed to encompass all quality improvements under one umbrella.
- Regular Trust wide Quality Summits have been held during 2017/18.

6.1. Governance and Leadership

Executive Directors are responsible for Quality within the Trust both as individuals in specific areas, and collectively for ensuring that the Quality Account presents a balanced view, supported by appropriate controls and accurate data.

The Quality Committee is the principal delegated sub Committee of the Board with responsibility for quality. The Committee has a cyclical plan of work that allows it to receive assurance from its sub groups that focus on specialist risk issues including: the Infection Prevention Board, Health & Safety Group and the Safeguarding Steering Groups (Adults and Children). In addition, a Quality Review Group has been established, chaired by the Medical Director, which reports to Quality Committee, with a core focus to monitor service quality. The Quality Review Group obtains assurance from its sub-committees, Divisional clinical quality dashboards and trust-wide quality indicators and provides assurance to Quality Committee.

6.2. Policies

The Trust has a number of clinical and non-clinical policies which incorporate the quality requirements at an operational and strategic level. Robust development and approval processes ensure that quality assurance is considered throughout the drafting and approval stages. Key policies support the Information Governance arrangements for data collection, security, reporting and quality. The Data Quality Policy provides clarity on staff responsibilities, procedures and training requirements and references to the Information Governance and Health Record

keeping data requirements. Policies are subject to regular review (defined on each document) and are available to all staff via the Trust intranet.

6.3 Systems and Processes

The Information department and clinical coding team have a key role in maintaining data quality. They extract data from the Electronic Patient Record (EPR) system to produce a wide range of reports for internal and external purposes. Data checking and validation is integral to this process and is detailed in departmental procedures.

6.4 People and Skills

Comprehensive training programmes are available for clinical and non-clinical staff and competency is monitored as part of the Trusts appraisal system.

External reviewers provide independent opinions on the appropriateness and adequacy of training. Staff receive training on data quality and refresher courses and update training is available at regular intervals. Locum and agency staff receive the same training.

The Board of Directors ensures that quality improvement is central to all activities. This is achieved by routine monitoring, participation in national improvement campaigns, celebrating success with our staff awards and proactively seeking patient views on our services. A recent development is the establishment of regular Quality Summits where learning is shared across the organisation.

6.5 Data use and Reporting

The Trust collects and uses information on a daily basis to support decision making by clinicians and managers. The collection of high quality information is essential for transparency, accountability and to support quality improvement within the organisation.

The Trust has reviewed the Performance Assurance Framework and is developing a range of revised scorecards for use throughout the organisation. The scorecards record performance against a number of quality indicators across all the services that the Trust provides. The indicators include national performance measures, local performance indicators and internal areas that the Trust has chosen to focus on.

The Performance Assurance Framework and scorecards engages the Board of Directors to regularly review the performance and data requirements of the Trust. The data within the scorecards is signed off by the Executive Director for the associated area creating the strong foundations for data quality ownership. The scorecards are actively used at different levels within the organisation on a monthly basis and are available to all members of staff on the Trust intranet. Every quality indicator includes a forecast in order to identify step change in performance and when remedial action in required. The scorecards are routinely reviewed to ensure that they remain fit for purpose.

7. Review of effectiveness

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

Board of Directors	The Board receives regular reports on all risk areas and reports from the relevant reporting committees and working groups.
Audit Committee	The Audit Committee has adopted a holistic approach to risk management and considers clinical, financial, quality and organisational matters. The Finance & Performance Committee, Quality Committee and People Committee report into the Audit Committee for risk management.
Quality Committee	The Quality Committee receive reports on quality and safety, clinical audit, infection prevention and safeguarding issues. Divisions provide regular update reports to the Risk and Compliance Group, Quality Review Group, Infection Prevention Board, Health & Safety Group and the Safeguarding Steering Groups (Adults and Children) which report to the Quality Committee.
People Committee	The People Committee obtains assurance that all workforce risks are being managed effectively.
Finance and Performance Committee	The Finance and Performance Committee focuses on the financial and performance position of the Trust and related risks.
Clinical Audit	The Trust uses clinical audit to measure and assess quality of care. The Clinical Audit Annual Plan reflects both national and local priorities. It has been developed in line with guidance from national bodies and also includes local projects prompted by local issues. Project results are used to inform action planning and monitoring. Regular audit meetings provide clinicians with the opportunity to hear and respond to audit results. The Trust is a leader in the provision of training in clinical audit principles and methods to junior doctors.

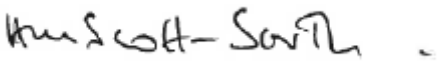
Internal Audit	Internal Audit provides an independent and objective opinion to the Trust on risk management and control by evaluating the effectiveness of the control framework in place. It also plays a key role in the provision of assurance to the organisation and have counter fraud responsibilities.

The Head of Internal Audit Opinion has confirmed that "Our overall opinion for the period 1 April 2017 to 31 March 2018 is that Significant Assurance with minor improvement opportunities can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control."

8. Conclusion

As Accountable Officer I am confident that no significant internal control issues have been identified.

Signed



Helen Scott-South
Chief Executive
23 May 2018

Quality Report 2017 - 2018

Contents

Part 1:

Statement on Quality from the Chief Executive

Our aim is to provide outstanding healthcare to all of our patients so that when people in our community need healthcare they will look to Burton Hospitals NHS Foundation Trust first. We want to put our patients at the very heart of everything we do at Burton Hospitals, and this Quality Report sets out the quality of care we provide to the public. It explains the Trust's progress over the past year against the priorities identified within last year's Report.

In September 2016, we launched our new Quality Strategy for 2016/19 which set out a structure for us to all work together to maintain sustainable, high quality care for our patients, their families and carers. The key aims of our strategy are to eliminate preventable deaths, eliminate avoidable harm, optimise patient flow and optimise our workforce.

To further develop our strategy, an engagement programme and analysis of patient feedback took place in 2017/2018 to gauge what is important to our patients and local community and identify the areas that they think we should improve upon.

Our ambition is to be rated as an outstanding healthcare provider by the Care Quality Commission (CQC). The Trust was given an overall rating of 'Requires Improvement' at its last inspection in 2015 and the Trust has not participated in any special reviews or investigations by the CQC during the past year. However, we remain committed to ensuring that, when the CQC next visits, we can demonstrate all the improvements we have made to patient care.

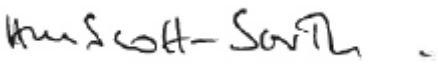
In 2017/18 we identified the following three improvement priorities, agreed by the Board of Directors following consultation with patients, staff, stakeholders and members of the public:

1) Frailty
2) The implementation of an adapted Ward Assurance Tool.
3) Improving Discharge

Having reviewed our progress, as set out in this Report, we have decided to continue our focus on them for 2018/19 too.

All of our staff continue to strive for the very best possible care and outcomes for our patients on a daily basis. This Quality Report recognises their many achievements and, I hope, provides assurance of the quality of the care we provide for the people of Burton, Tamworth and Lichfield.

I am happy to confirm that, to the best of my knowledge, the information contained within this document is accurate. The Board of Directors at Burton Hospitals NHS Foundation Trust has agreed the content of this Quality Report and approved the document for publication.



Helen Scott-South
Chief Executive
23 May 2018

Part 2:

2.1 Priorities for improvement

Developing the Quality Report

The Quality Report reports annually on the quality of services delivered by NHS healthcare providers to the public. The primary purpose of this document is to allow the Trust to demonstrate commitment to the delivery of continuous, evidence-based quality care, and to explain the Trust's progress over the past year against the priorities identified within the Trust's 2017/18 Quality Report.

A variety of engagement events took place during 2017/18 with both external stakeholders and internal staff groups to provide feedback on the Trust's services.

Summary of Quality Accounts Engagement 2017-18

An engagement programme and analysis of patient feedback took place in 2017-2018 to gauge what is important to our patients and local community and identify the areas that they think we should improve upon.

Your Hospital Survey

The survey asked respondents to rate the Trust in the domains of Safety, Communication, Kindness and Compassion and Clinical Care. The survey was conducted at a wide range of engagement activities which took place throughout the year; and promoted at all three hospital sites. The scores for Safety, Kindness and Compassion and Clinical Care remained the same as the previous year. The highest priority for improvement, for those patients and members of the public who took part in the survey, continues to be Communication, although this score reflects sustained improvement when compared to previous years.

There were a similar number of respondents to the previous year. However, the survey was completed by a more diverse range of respondents than in previous years, in terms of age range and ethnicity, which reflects the broader range of engagement activities which took place during the year. Our aim is to continue to build on this over the coming year to ensure we are receiving representative feedback from the communities we serve.

The majority of respondents based their answers on their own experience or on the experience of friends, family, colleagues or neighbours. Most respondents indicated that this experience took place within the last six to twelve months.

Overall survey scores 2014-15, 2015-16, 2016-17 and 2017-18

	2014/15	2015/16	2016/17	2017/18
Safety	80	81	84	85
Kindness and Compassion	81	85	88	88
Communication	65	68	76	79
Clinical Care	80	86	84	84

Negative comments regarding to communication related to: doctors' communication; information around appointment changes and cancellations; more information following diagnosis; clearer communication, not using jargon; text appointment reminders; information regarding waiting times.

The Trust also received positive comments regarding communication including:

Additional comments made in response to the question *"What could we do to improve our hospital?"* related to: car parking; improvements in lighting and condition of the pavements (Queen's Hospital); waiting times; weekend and evening appointments; additional lighting in Reception A waiting areas; food/more variety on menu; quicker triage process.

In response to the question *"Tell us what you think Burton Hospitals NHS Trust does well and should do more of?"* comments included:

- *Gathering community feedback*
- *Courtesy, advice and assistance given by professionals and volunteers*
- *Really good compassion and care. Friendly staff*

- *The hospital is well kept, clean & pleasant and the staff are friendly & helpful.*
- *Staff were extremely caring. I have stayed here with mum 3 times this year and all the staff have been very caring to myself as a relative and my mum as a patient.*

Engagement Events linked to the SSTP and Burton & Derby Collaboration

A communications and engagement plan has been developed to engage with our patients and public to understand their ideas, thoughts and concerns about future partnership work with Derby Teaching Hospitals, Staffordshire Sustainability and Transformation Plan (SSTP), Virgin Care and STRIDE (joint venture).

Engaging with our communities continues to be a priority for the Trust and is an important strand of the Quality Improvement Plan.

The main focus for the Trust during 2017-18 has been the Burton and Derby Collaboration and a number of engagement events have taken place including: the Annual General Members' meeting and public meetings held at Queen's Hospital in September and October. Staff and Public Listening events were held at Samuel Johnson Community Hospital, Lichfield and Sir Robert Peel Community Hospital, Tamworth in December.

Members of the Senior Executive Team also attended the Healthwatch Staffordshire AGM in July to give a presentation and to take part in a panel discussion and Q&A session. They have also attended Patient Participation Group meetings and community group meetings such as the Uttoxeter 50+ Forum.

These events gave members of the public, representatives of patient and community groups and staff the opportunity to raise any issues they had regarding the collaboration and to ask questions.

We have worked closely with the Senior Executive Team and colleagues at Derby Teaching Hospitals Foundation Trust who have also been involved in these events and developed a similar engagement programme with their communities. A number of joint events have been held including events for Southern Derbyshire Patient Participation Groups held at Royal Derby Hospital on 7th December and at Sharpe's Pottery Museum, Swadlincote on 14th February.
Over the last six months members of the PALS and PPE Team have attended a number of community events:

- Let's Talk Mental Health at the Pirelli Stadium on 25th May
- Play Day 2nd August, at Meadowside Leisure Centre; along with colleagues from the Children's Ward
- Eid Celebrations at the Pakistani Community Centre, Uxbridge Street on 10th September. Approximately 10 new members were recruited at the event and two new members of the Youth Forum
- Support Staffordshire Forum at the Voluntary Services Centre, Union Street Car Park, on 18th September
- Diabetes UK annual event at the Pirelli Stadium on 19th September; along with colleagues from the Diabetes Centre

- Improving Lives – Virgin care event at Burton Town Hall on 10th October
- Shobnall Family Engagement Event at Princess Street Community Centre on 26th October
- Step into the NHS Careers event at Stafford County Showground on 22nd November
- 25th March 2018 Nowruz - Persian New Year Celebration Burton Afghan Community Centre

The opportunity was taken to engage with attendees regarding their experiences as patients of the Trust; and to raise awareness of the Burton Derby Collaboration. Meetings have also taken place with members of the LGBT, Polish and Muslim communities to discuss further ways of engaging with members of those communities; and with Staffordshire ASSIST who support people with sensory impairments. Meetings have also taken place with Carers Hub groups in Burton, Tamworth, Lichfield and Uttoxeter; and with the Burton Caribbean Association Luncheon Clubs.

Moving forward we are keen to continue to build and further develop these links which have enabled us to gain feedback from a wider cross section of people who use our services. The majority of feedback has been very positive with people commenting on the high quality treatment and care they have received and the friendliness and kindness of staff. Members of the groups have appreciated being given the opportunity to meet to discuss their experiences and are keen to keep in contact in the future.

Engaging Communities Staffordshire were commissioned to support engagement with harder to reach groups, on behalf of both Trusts; and to support patient involvement in the six clinical reviews being undertaken as part of the collaboration.
To date twenty patient representatives have been recruited to contribute their views on the development of care pathways for a number of specialities: A&E/Acute Medicine; Cancer (Urology); Cardiology; Orthopaedics; Radiology; Renal and Stroke. Workshop events were held with the patient representatives in September, November and January which gave them the opportunity to meet with clinicians; to gain an overview of each clinical area; to discuss their role as patient representatives; to identify any training/support they require; and to give an overview of the NHS. Feedback from the patient representatives has been very positive and plans are in place to support their ongoing involvement in the clinical reviews.
Individual departments, such as Rheumatology, held meetings with patients to give an update on the collaboration plans and to hear their views.

A Burton Derby Collaboration Awareness Survey was undertaken during July to October with 667 people completing the survey. 68% of respondents were aware of the collaboration and had received information about it through a number of different channels including through the collaboration newsletter, local media, staff and public meetings, social media and word of mouth. Key themes have been analysed and fed into the planning process; and answers to questions included in the FAQs (Frequently Asked Questions) document published on the collaboration website.

Eight further editions of the Burton & Derby Collaboration Update, launched in February 2017, were published during 2017-18 to keep our local communities and stakeholders informed about how Burton Hospitals and Derby Teaching Hospitals are planning to work more closely together. The circulation list continued to grow throughout the year with the newsletter being sent to Members, volunteers, Patient Participation Groups, key stakeholders and a wide range of community groups and organisations.

The Trust is also committed to engaging with staff and in addition to the public meetings previously mentioned 40 Staff Listening events; informal briefing sessions and Senior Executive briefings took place throughout the year.

The STRIDE team held a public meeting on 17th January at Queen's Hospital, Burton to give an update on the plans for the development of the Outwoods site and to give people an opportunity to ask questions.

Review of the priorities for 2016/17

Priority 1- Frailty

How does this link to our Quality Improvement Strategy?
Strategic Aim 1 Eliminate preventable deaths
Strategic aim 2 Eliminate avoidable harm
Strategic aim 3 Optimise patient flow

Why is this a priority area?
The Trust is increasingly seeing more frail older people, particularly as an emergency admission. Once a frail older person is admitted to hospital it is likely that they will have a prolonged length of stay and require a higher level of care on discharge than they required pre admission. This leads to patients suffering harm as a consequence of a hospital acquired infection, pressure ulcer, acute kidney injury or a fall amongst others. There has been significant National work relating to this and involvement of the third sector such as Age UK. Enhanced community nursing enhancement proposed could have an indirect impact on improving the discharge of eligible patients into their own home and reducing length of stay for your patients with right nursing care packages in place Consultation with the older population has been an integral part of the National picture.

The evidence suggests that once a frail patient is admitted to hospital they are entering the last 12 months of their lives and for many end of life will occur during the hospital stay or soon after discharge. This highlights the importance of this being a priority area linking back to strategic aim one two and three

What did the Trust do?
Burton Hospitals NHS Foundation Trust established its Frailty Service in 2014. The multi-disciplinary team are: 3 WTE Advanced Clinical Practitioners, 3 Occupational Therapists, 3 Physiotherapists and a Consultant Geriatrician who started in November 2017. It is an 8am to 7pm, 7 days a week service.

In November 2017, the AMBER care bundle was included in a frailty pathway pilot. All patients aged 75 and over who scored 0-4 on NEWS (National Early Warning Score) were screened using the Edmonton Frailty Scale. (The Rockwood scale is used following the completion of a comprehensive geriatric assessment to share with GP and community teams as this scale is used in the community.) The pilot also included testing electronic CGA,(Comprehensive Geriatric Assessment) alert systems for the community interventions and fortnightly virtual wards. A clinical facilitator provided training about the AMBER care bundle and supported practice development in this area. In parallel to this pilot, the clinical facilitator was leading a refresh of the AMBER care bundle across the Trust.

Acute frailty interface with the AMBER care bundle

If a patient had an Edmonton score 12-17 the clinical teams are prompted to:

- Refer to Frailty team to assess and discharge to the appropriate setting with support. Liaise with community teams to initiate advanced care planning.
- Consider if a patient has clinical uncertainty of recovery

Acute frailty interface with the AMBER care bundle

If a patient had an Edmonton score 12-17 the clinical teams are prompted to:

- Refer to Frailty team to assess and discharge to the appropriate setting with support. Liaise with community teams to initiate advanced care planning.
- Consider if a patient has clinical uncertainty of recovery.

Early results: first 2.5 months of the pilot

16 patients were recognised as having clinical uncertainty of recovery and received care supported by the AMBER care bundle.

Two of the 16 had an Edmonton score of less than 12 (range 5-11). 14 had a score greater than 12 (range 12-16).

Initial outcomes were:

- 2 patients were discharged back to preferred place of care
- 10 died in hospital following an average LOS (Length of Stay) 8.5 days (range 2-20)
- 4 still in hospital – waiting for complex discharge planning or continuing with treatment

Results were:

- 15 of 16 patients received all four components of the AMBER care bundle

The majority of the conversations about what was important to the patient was held with families as patients were either too unwell or had advanced dementia. The family were concerned that patients are kept comfortable, clarity over discharge planning and clarity about when and how to contact the family.

Learning

The AMBER care bundle was a useful refocus of care in the unit. It worked well as a prompt to initiate discussions with the patient's family to understand what is important to the patient and regarding future admissions, care and recognition of deterioration. It supports good team working and enhanced community links important to ensure good care.

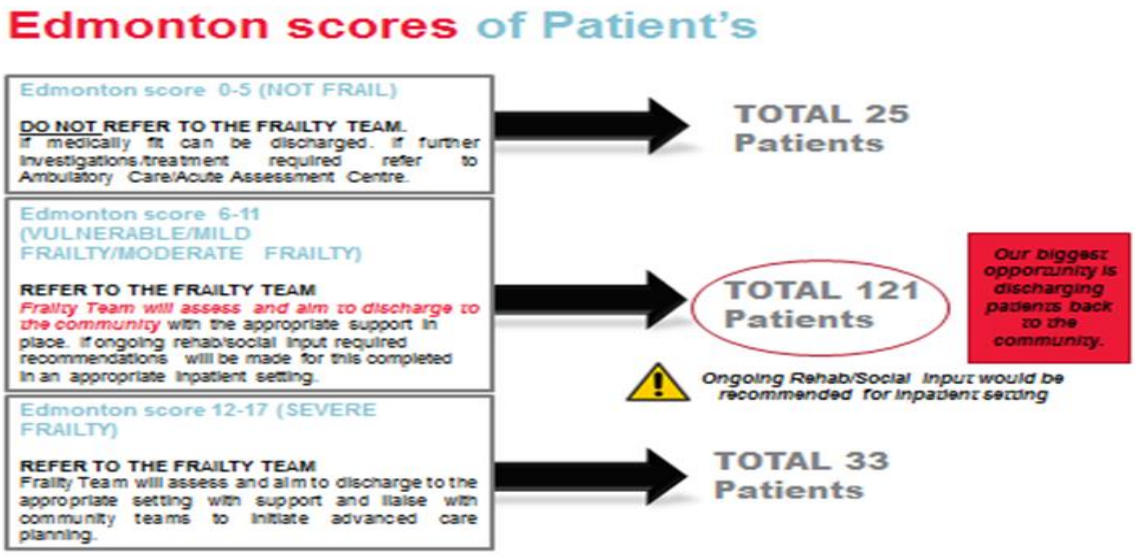
Burton Hospitals are planning further developments to improve electronic systems and ensuring the approach to care is continued by ward teams when patients are admitted.

Implementing the Edmonton Score
All pts aged 75 and over acutely admitted to the Emergency at Queens Burton Hospital NHS Trust were assessed in order to determine who would be classified as frail and were assessed with Edmonton Frailty Score (EFS) in order to stratify them for frailty and address them to the right team for the appropriate level of care.

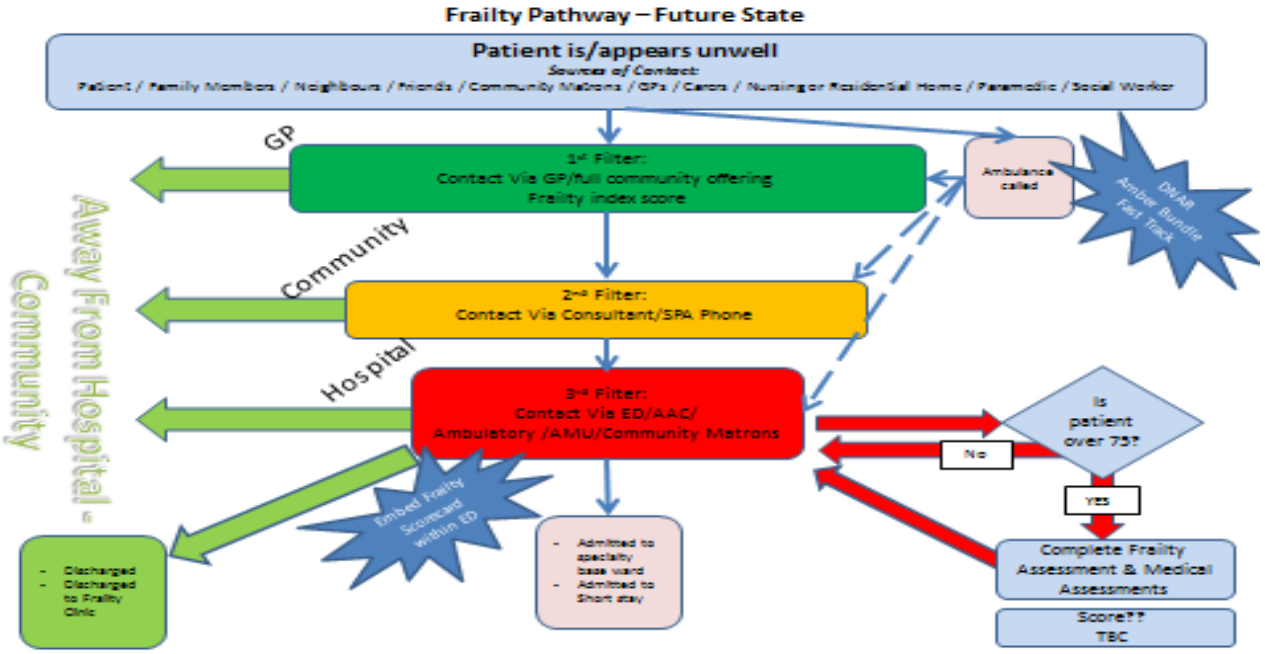
Patients were stratified accordingly with the score as not frail, mild/moderate and severe frail.

Each group were address to a different pathway of care and a patient centred care plan was put in place.

All patients' data were processed and analyzed using statistical package for data analysis.



Edmonton Score used by the Trust.



Identified pathway and future work.

Priority 2: The implementation of an adapted Ward Assurance tool

How does this link to our Quality Improvement Strategy?

Strategic Aim 1 Eliminate preventable deaths
Strategic Aim 2 Eliminate avoidable harm
Strategic Aim 3 Optimise patient flow
Strategic Aim 4 Optimise our workforce

Why is this a priority area?
In January 2013 the Director of Nursing, commissioned work on a review of the nursing metrics in line with best current practice. Following the review the ward assurance tool was developed. The monthly audit is carried out on all in-patient areas within the Trust, and samples 50% of all patients who are in patients on the day of the unannounced visit.

The nursing care indicators cover essential elements of care, which are both important to patients/carers and are identified as risks to the Trust if there is a failure to meet the Trust minimum standard. The data collected through ward assurance audit provides an understanding of potential areas for improvement and development, this helping leadership teams to focus not only local actions but identify opportunities for organisational learning and the sharing of best practice.

Maternity, Paediatrics, Critical Care and the Emergency Department have adapted some of the criteria of the adult ward assurance standards to meet the needs of their specific patient groups.

As a Trust we had consistently achieved the Trust target of 95%, for 32 consecutive months. The previous tool was therefore no longer providing us with the necessary assurance, and was no longer meaningful in identifying areas for

quality and safety improvements. We have adapted the tool to focus on areas we have identified we need to further improve, such as pressure prevention. In addition we wanted the tool to encourage the auditors to involve our patients and provide real time patient feedback to questions, rather than reliance on documentation. The monthly results of the audits will provide our patients, staff and the Trust Board with assurance that our core care delivery meets the Trust standards, and improve patient experience.

What did the Trust do?
The new ward assurance tool has been in use within the organisation since April 2017. There have been some issues with completion compliance and this has been regularly monitored and senior teams have been engaged and challenged as required. A process to support the teams in completing ward assurance has also been put in place; this involves escalation for support if completion of ward assurance audit is unlikely in certain and exceptional circumstances. The corporate nursing team will then identify whether support can be offered to ensure the audits are completed thus providing the continuous flow of data for each area, thus supporting the teams to improve quality through the information collected and themes identified.

Prior to launching the new ward assurance tool it was initially used in conjunction with the previous tool over a four month period (January 2017-April 2017). During which time, regular meetings with the senior team were held to discuss and identify any changes required to the new tool, and what the ward assurance scores would have been if utilising the adapted tool. An initial dip in the ward assurance scores was expected giving drive and focus for quality improvement and improved patient experience. As a result we expected to see a gradual reduction in harm free care and an improvement in patient experience results. The Divisional Nurse Directors and Head of Midwifery provide assurance to the Divisional Boards and the Quality Review Group that standards are being met by each area and where there is failure to meet the standard, there is an agreed framework for improvement which will be monitored within the Divisions and reported to the Chief Nurse.

What has been achieved so far?
New ward assurance tool implemented as planned including roll out to areas that had not been audited previously.

Overall ward assurance audit scores consistently above 95%.

Six monthly rotation of auditors, to reduce risk of complacency as auditors become familiar with their areas and the teams they audit.

Support has been provided from the Corporate Nursing team for auditors that encounter difficulties collecting ward assurance data.

Corporate nursing team available to support with quality improvements and actions arising from ward assurance data and action plans.

Escalation process in place to ensure ward assurance data is submitted for all the required areas.

Review of data collected with the new tool to ascertain if changes are required to ensure data captured is valuable and supports understanding of care experiences and quality – over the course of the year from April 2017 updates have been added as identified to improve data quality.

Trust wide development opportunities identified within the ward assurance data collected are being undertaken including, review and adaptation of fluid balance charts to support clinical teams in managing fluid overloads and deficits – links to management of deteriorating patient.

Table 1 shows the overall ward assurance scores for inpatient areas from April 2017- March 2018 – this showing a score above 95% for all months since the new ward assurance tool was implemented.

Table 1

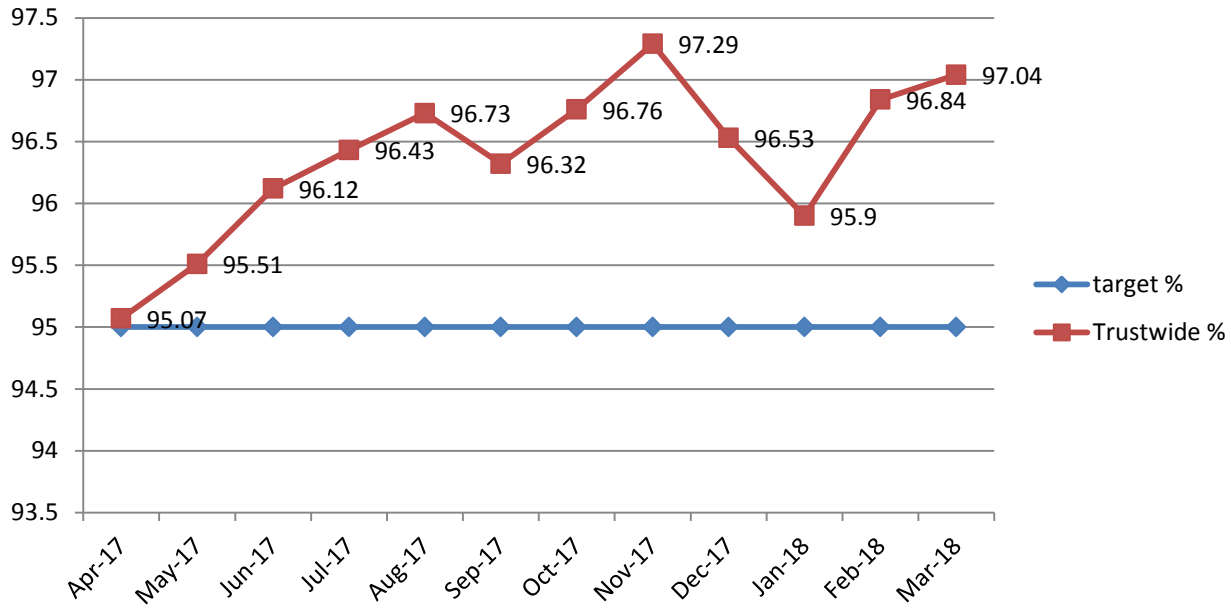


Table 2- shows areas where ward assurance is collected and submitted – this is RAG rated with associated percentage scores for each ward/clinical area in that month.

Table 2 also identifies areas where there have been non submissions over the period April 2017- March 2018. Table 3 shows submission percentages per month from April 2017.

Table 2

Ward	Mar 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17	Aug 17	Jul 17	Jun 17	May 17	Apr 17
BH01	95.75 %	98.47 %	97.42 %	93.70 %	98.13 %	97.98 %	97.98 %	98.35 %	96.99 %	98.61 %	94.99 %	95.66 %

Ward	Mar 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17	Aug 17	Jul 17	Jun 17	May 17	Apr 17
BH03	96.67 %	95.40 %	92.71 %	95.51 %	95.26 %	96.95 %	97.74 %	95.14 %	96.68 %	97.52 %	93.81 %	92.37 %
BH04	97.32 %	96.69 %	96.09 %		98.03 %	97.64 %	97.88 %	98.82 %	97.06 %	98.02 %	98.51 %	98.01 %
BH05	94.28 %	95.01 %	90.30 %	91.29 %	95.73 %	88.94 %	92.60 %	94.52 %	91.03 %	92.08 %	88.30 %	90.43 %
BH06	98.52 %	95.79 %	96.67 %	96.65 %	96.34 %	98.07 %	85.07 %	94.93 %	93.62 %	94.18 %	94.54 %	95.03 %
BH06CCU	98.94 %	98.99 %	98.06 %	97.07 %	98.24 %	98.77 %	99.71 %	98.34 %	99.12 %	97.71 %	99.09 %	98.85 %
BH07	93.80 %	93.41 %	95.60 %	93.59 %	95.73 %	97.81 %	96.62 %	94.20 %	96.63 %	94.80 %	93.44 %	94.84 %
BH08	97.78 %	94.72 %	96.04 %	96.14 %	96.71 %	93.25 %	96.59 %	96.59 %	97.05 %	96.98 %	93.81 %	92.29 %
BH11	99.32 %	98.75 %	98.61 %	99.07 %	97.88 %	98.35 %	98.40 %	96.52 %	97.90 %	99.35 %	98.07 %	99.03 %
BH12	98.26 %	99.03 %	98.78 %		96.95 %	100%	99.38 %	97.06 %	98.82 %			
BH14	95.66 %	97.38 %	97.73 %	97.32 %	98.02 %	99.75 %	97.32 %	98.95 %	97.48 %	96.37 %	98.47 %	96.08 %
BH15	93.52 %	97.92 %	87.68 %	94.62 %	96.15 %	91.31 %	92.94 %	92.11 %	94.70 %	88.92 %	89.08 %	83.24 %
BH16	95.02 %	90.83 %	94.70 %	95.52 %	97.83 %			92.65 %	85.24 %	84.62 %	95.49 %	
BH19	92.15 %	97.97 %	90.73 %	81.77 %	82.45 %	93.51 %	86.60 %	95.39 %	91.54 %	99.22 %		
BH20	93.01 %	94.76 %	92.06 %		94.99 %	95.74 %	95.43 %	95.50 %	94.40 %	93.95 %	89.66 %	91.60 %
BH30	97.18 %	96.88 %	97.05 %	95.91 %	98.46 %	92.00 %	93.60 %	97.54 %	94.49 %	91.11 %	91.50 %	89.95 %
BHAE	96.17 %	96.06 %	88.84 %	98.57 %		91.89 %		90.43 %		94.40 %	97.39 %	97.42 %
BHAEAAC	98.84 %	100.00%	98.58 %	99.47 %	99.15 %	99.39 %	98.40 %	99.14 %	100.00%	96.80 %	100.00%	96.51 %
BHITU	98.68 %	100.00%	99.61 %	99.07 %	100.00%	98.39 %	99.53 %	99.52 %	99.42 %	95.43 %	95.61 %	93.38 %
BHMEDDC	100.00%	95.63 %				100.00%	100.00%	100.00%				
BHNNU	96.97 %	91.21 %	100.00%		97.81 %			99.09 %	98.61 %	95.65 %	96.67 %	

Ward	Mar 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17	Aug 17	Jul 17	Jun 17	May 17	Apr 17
BHONCU	100.00%	93.78%				100.00%	100.00%	96.23%		94.07%	92.59%	
BHSRPMI		98.18%	97.16%	98.83%	99.42%		87.03%					
BHTC05	97.50%	99.47%	100.00%	100.00%	96.58%	97.85%	99.07%	98.37%	94.49%	97.46%	92.95%	98.70%
SJH – Anna	98.34%	98.72%	96.97%	98.06%		98.29%	98.47%	97.97%	99.15%	97.40%	97.63%	98.45%
SJH – Darwin	97.87%	97.57%	98.93%	98.37%	98.40%	97.11%	97.91%	97.91%	97.50%	99.27%	99.02%	99.42%
SJH - Maternity	100.00%	100.00%	99.37%	99.36%	99.38%	100.00%	97.87%	98.74%	99.39%	100.00%	100.00%	99.24%
SJHRENAL	100.00%	99.66%	99.32%	98.47%	100.00%	100.00%	99.70%	98.84%	100.00%	100.00%	100.00%	100.00%
SRPH – Philip	99.52%	99.28%	99.27%	99.52%	99.51%		99.52%	99.27%	99.76%	99.52%	99.00%	98.06%
Total	97.04%	96.84%	95.90%	96.53%	97.29%	96.76%	96.32%	96.73%	96.43%	96.12%	95.51%	95.07%

Table 3

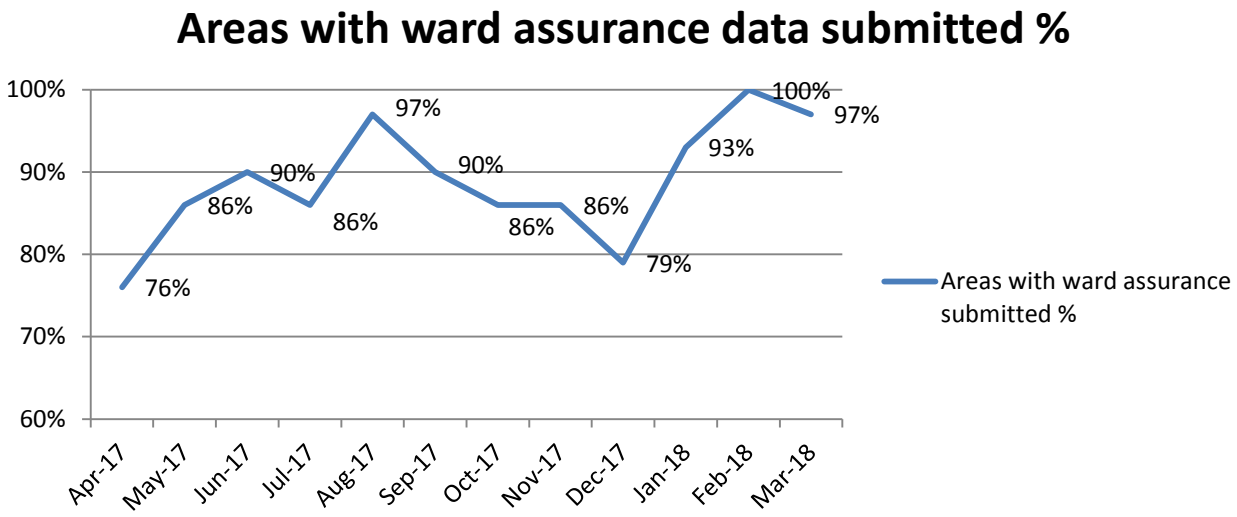


Table 3 (above) shows the completion percentage for ward assurance from April 2017. A process for escalation was introduced in January 2018. February 2018 was the first month of all areas submitting ward assurance data as shown in tables 2 & 3. The process introduced aims to ensure that ward assurance data is collected for the required areas every month.

Priority 3 - Improving Discharge

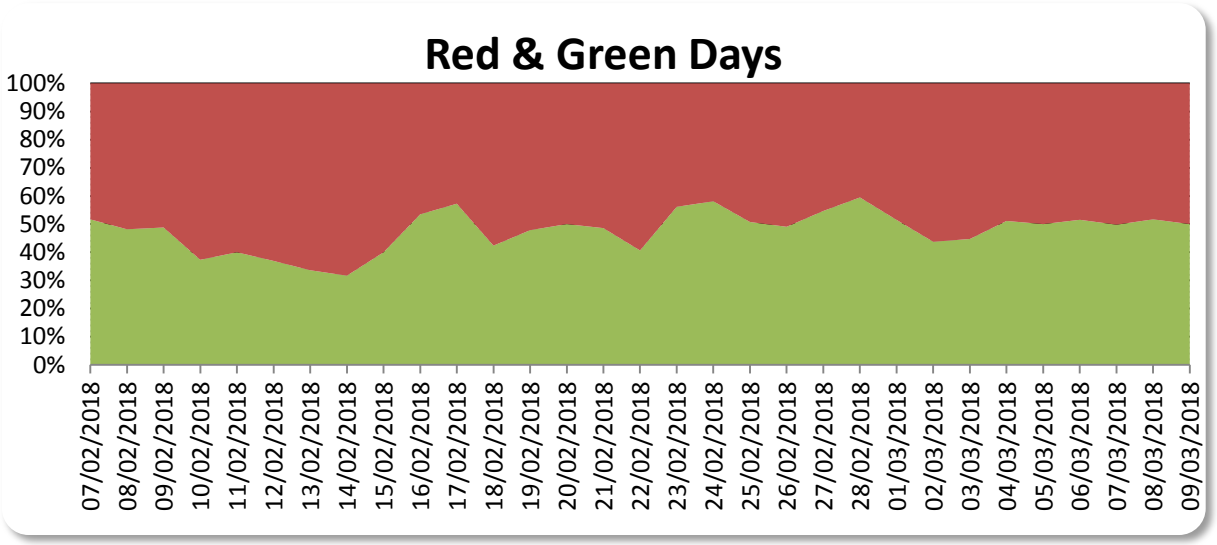
How does this link to our Quality Improvement Strategy?
Strategic aim 2 Eliminate avoidable harm
Strategic aim 3 Optimise patient flow

Why is this a priority area?
It is acknowledged that many of the patients we care for are in their last 1000 days and due to this Time is the most important currency. Every day an older patient spends in hospital is a day we are stealing from their '1000 remaining days.'
"Reducing unnecessary waiting for patients and unnecessary chasing up by staff has to be a win win for everyone working in and using our health and care systems. The risks for our patients are well documented and significant. (Dr Ian Sturgess)

Patient Delays
As well as the nationally reported DTOC position, BHFT currently measures other categories of patient delay as part of the patient pathway. Medworxx reports are used by the operational teams to identify where blocks are in the patients journey, and allows them to unblock these by progressing the outstanding issues for the delay.

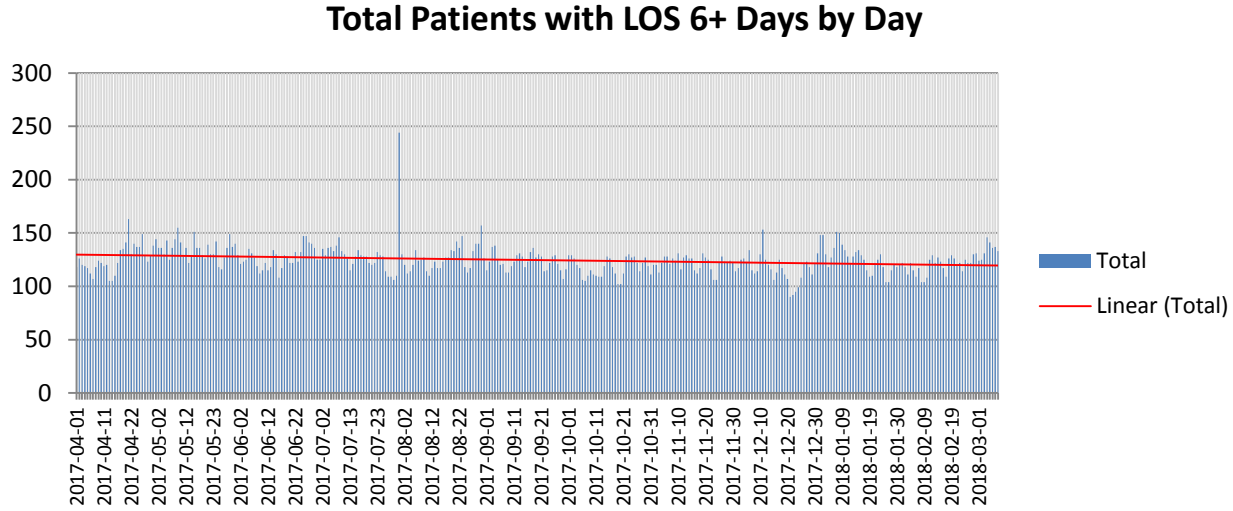
Internal/External Delays
Medworxx is utilised to monitor what the primary reason for the patient delay is on any particular day. This could be due to an internal factor or an external factor. An internal factor could be for example be that the patient is awaiting an MRI and an external could be that the patient is awaiting for a community OT assessment of their property to allow them to go home. BHFT are working with Medworxx to further develop the system in the proactive escalation of patient delays. EMR is a new module that has been purchased which will escalate through automated email specific delays to the relevant General Managers, Head of Departments, Divisional Directors and ultimately the COO and CEO.

Red and Green Days
Red and Green days are a service improvement technique that determines whether a patient has had "Value" added to their day on that particular day. The ward board is undertaken in the morning and all the patients are classified as RED. In the afternoon the ward team reconvene for a "huddle" and discuss whether all the actions that support the patients to progress towards their discharge have been undertaken on that day. If the answer is YES then the day is classified as a GREEN, and if the answer in NO it is a RED day. Medworxx has the capability of collecting this through a new module that has been purchased and the medical wards are working towards populating this data. Dedicated work with support from ECIP (Emergency Care Improvement Programme) on the Medical Wards is ongoing and there are fully established afternoon "huddles" to support deliver of agreed actions of the day and the planning for patients for the next day.



Patients Under Assessment

DTOC (Delayed Transfers of Care) only becomes reportable once the Discharge Notification has been submitted. There are a number of patients on any one day that are under assessment notifications (previously known as a Section 2) that could potentially have their assessment undertaken elsewhere if there were alternative models of care in place. These are models such as a fully functional Discharge to Assess model where patients could have their assessments carried out for example in a Nursing Home or their own home with appropriate domiciliary care. Currently data regarding patients under assessment is not reported on at national or local level.



Discharge to Assess

To deliver services more efficiently and achieve the strategic intention to move care closer to home requires different models of care in the community. BHFT have been working with partners on a revised Home First Discharge to Assess Model. There is now agreement on a system wide model and pathways are in place with SSOTP **(***Staffordshire and Stoke-on-Trent Partnership* NHS Trust) and the County Council, 59% of the required hours are commissioned. Recruitment to

the Domiciliary Care hours required to support the model continues to be challenging and currently only 23% of those hours are being delivered.

A model of D2A (Discharge to assess) bed pathway has been implemented at the community hospital and although we have seen a reduction on in the length of time taken to assess a patient by social services we have seen an increase in the numbers of patients who are delayed in the system waiting for either a nursing home placement or a package of care following their assessment. The out of hospital capacity continues to be challenging and the market exercise by the county council to increase the Dom Care hours is taking longer to realise than originally planned.

Update on Sign up to Safety Initiatives

NEWS and NEWS2

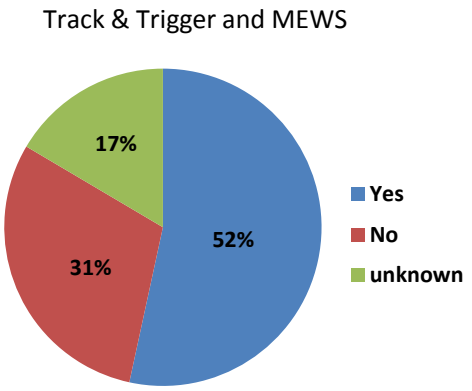
The NEWS (National Early Warning Score) observation charts were implemented on all wards and clinics, using observation charts at Queen's Hospital site by the end of 2017 to assist in the recognition of the deteriorating patient. NEWS2 was released by the Royal College of Physicians just before Christmas 2017 and plans are now in place to implement the NEWS2 chart in April 2017 at Queen's Hospital Burton and then implement at the Community Hospitals in May/June. In addition to staff working in areas where observation charts are used, staff from other teams who will be looking at the charts as part of patient care have also been trained, i.e.

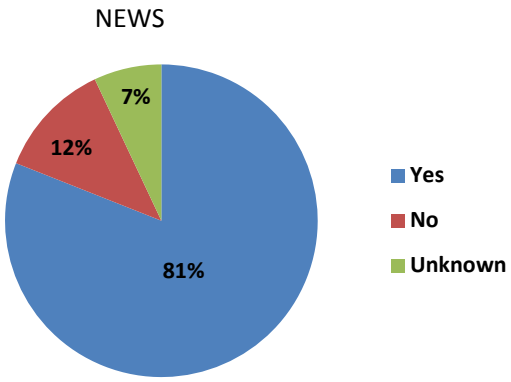
- Respiratory Team
- Diabetes Team
- Physios
- OT's etc.
- Training has also been delivered to some student nurses at Wolverhampton University and some newly qualified nurses through the Learning & Development Department.
- There is a new policy is in the process of being written, which will be the "Deteriorating Patient" policy which includes NEWS2, Recognition, Escalation of the deteriorating patient but will still include Track & Trigger Charts for Maternity as NEWS is not for pregnant women.
- Competencies for champions (NEWS2 trainers based on wards) are in the process of being developed.

Following implementation, the team will then go back to ward areas to do audits and carry out any further training that is required in order for the NEWS2 obs chart to be embedded in practice.

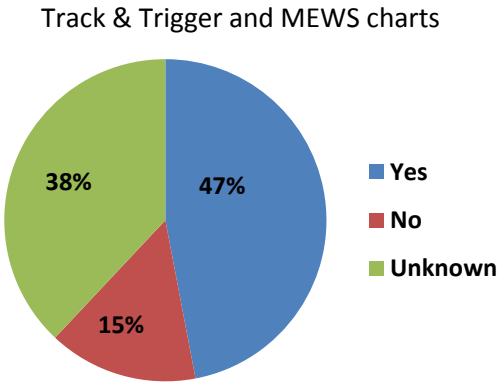
Track & Trigger and MEWS versus NEWS audit

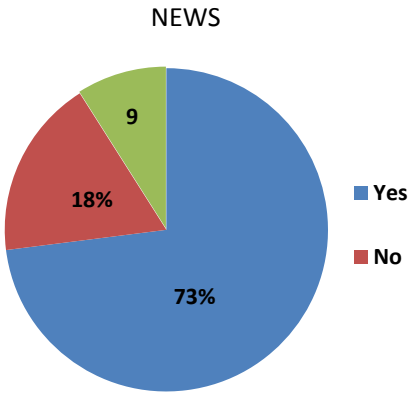
Was the patient escalated as per the clinical response on the front of the chart?



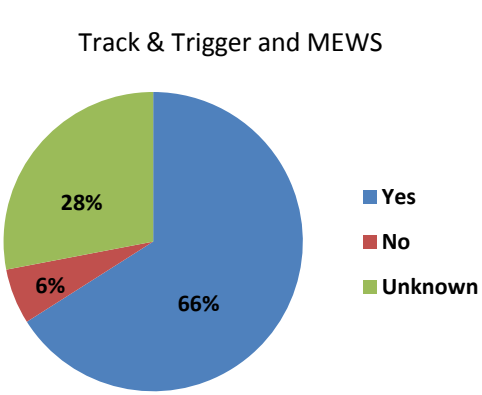


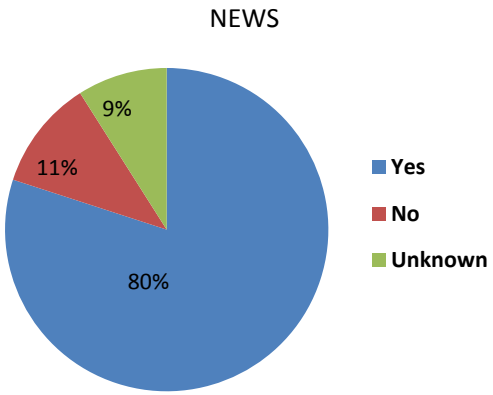
Was this documented on the back of the chart?



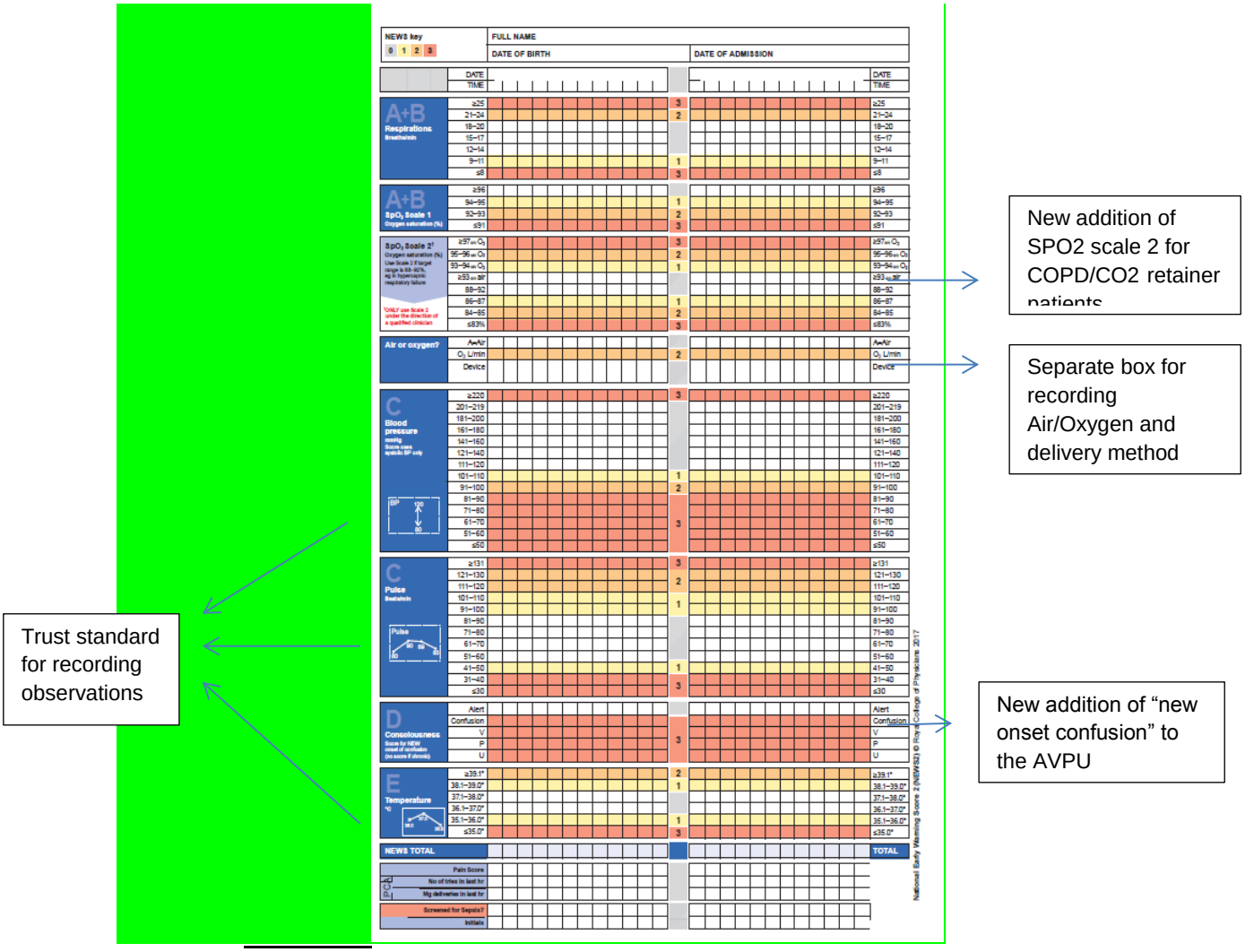


Was a treatment plan put in place?





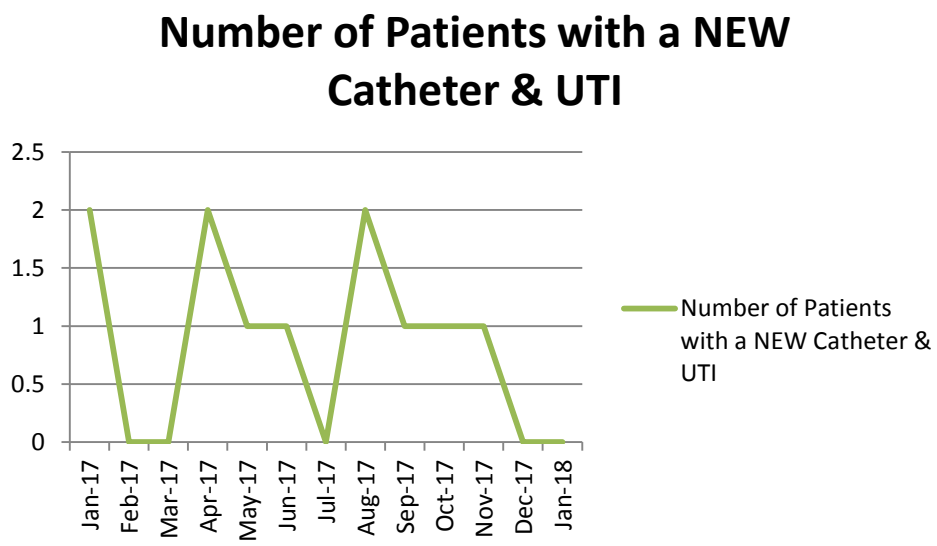
NEWS2 Observation Chart – Royal College of Physicians 2017



CAUTI (Catheter Acquired Urinary Tract Infection)

- Infection Prevention and Control have devised a Surveillance tool which provides information on what patient has a catheter on what ward. Infection Prevention and Control are then able to do a "confirm and challenge" with the ward staff around those catheters.
- Houdini posters "Stop and Think" for catheters have been placed with catheter supplies.
- Ongoing education on CAUTI's which is being led by ward staff.
- Agency nurse's paper documentation has been updated to include HOUDINI in the structure.
- There is now a CAUTI catheter record form in use.
- Training continues to be delivered to junior doctors and student nurses

The graph below shows the number of new catheters and UTI's from January 2017 to December 2017.



AKI (Acute Kidney Injury)

The Corporate Nursing Team have been working with the Renal Physicians in Derby to:-

- Update the AKI guidelines at Burton Hospitals NHS Foundation Trust
- Looking into introducing an AKI Risk Score for all emergency admission patients who do not have an AKI on admission. This will indicate to the staff whether the patient is at risk of an AKI and enable measures to be put in place to prevent the patient developing an AKI.
- There is going to be a planned audit of AKI patients for the time period of January –December 2017. To see where we are with the care of patients with an AKI.

In addition to our QIS, The Trust has '***Signed up to Safety'***.

Sign up to Safety is a national initiative, from NHS England to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible.

The Trust will continue with the Sign up to Safety Pledges from 2017/2018 to ensure all are embedded.

The five Sign up to Safety pledges:

Put safety first. Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.

- *Early Warning Score and Response*

Further improve all aspects of patient escalation from accurate recording of observations through to timely senior medical review.

Implement a single chart system for recognition of the deteriorating patient, namely NEWS.

- *Acute Kidney Injury*
- Optimise our detection and management of AKI. Follow 'Safe Kidney' *Safe Surgery*
- Sustain our active use of the WHO checklist & briefings. Embed this and de briefings.
- *Falls*
- Further reduce falls and improve our initial falls assessment and post falls process
- *Pressure Ulcers*

Reduce the incidence of avoidable pressure ulcers across the organization. A focus on high risk areas (based on hotspot DATIX data). Deliver on our pressure reduction plan as outlined in our Pressure Ulcer Improvement plan submitted to NHSI as part of the re-launch of the 'stop the pressure' campaign.

- *Catheter associated urinary tract infections*

The most common hospital acquired infection is urinary tract infection and many of these are linked to the patient having a catheter. We aim to reduce the number of inappropriate catheters in the hospital by making sure they are removed when they have served their purpose or are only put in for the right clinical reasons. If we can reduce the number of inappropriately used catheters we can have a real impact on the number of infections as a result.

Continually learn. Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.

- Empower and educate patients and staff around their safety through safety leaflets.
- Sharing learning from complaints publically – including via our website & public Trust Board meetings
- Implement the new ward assurance tool which focuses on 'talking' to the patient to gain answers, feedback and quality and safety assurance rather than sole reliance on charts and documentation.

Honesty. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

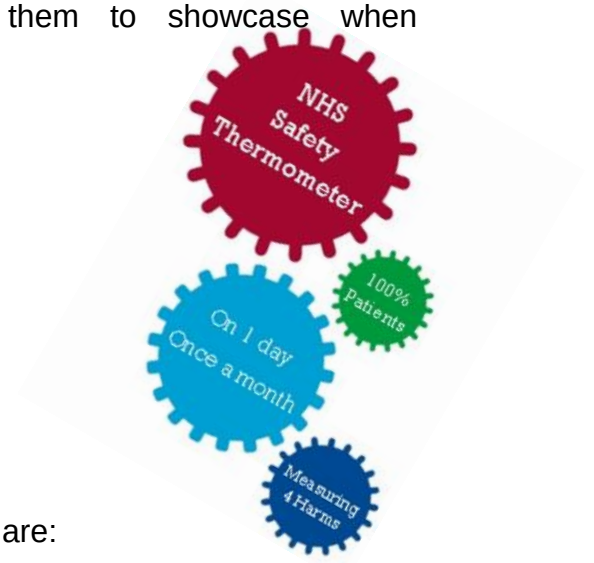
- 100% adherence to DOC
- Support our staff and students via the RCN campaign to speak out safely with each other, patients and their families/carers.
- Offer a face to face meeting with patients and families where the patient has come to harm under our care.

Collaborate. *Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.*

- We are committed to working across healthcare via our transformation programmes. We will focus on joining up care for the frail elderly through our comprehensive geriatric assessment and use of the frailty score which will provide a management plan that “moves” with the patient back to primary care.
- Build upon our collaboration/partnership with DTH and share practice, learning and successes.

Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

- Increase shared learning when things go wrong through local ward/departmental level feedback in teams.
- Share learning and offer support through quarterly quality summits
- Adopt Schwartz round principles as a method of supporting all grades and groups of staff, introduce ‘coffee with compassion’
- Celebrate staff successes and support them to showcase when improvements to processes are made.



Our three Quality Improvement Priorities for 2018/19 are:

Taking the information above, re 2017/18 priorities, into consideration the Trust has elected to continue with developing and embedding them in 2018/19.

Priority 1: Frailty

How does this link to our Quality Improvement Strategy?
Strategic Aim 1 Eliminate preventable deaths
Strategic aim 2 Eliminate avoidable harm
Strategic aim 3 Optimise patient flow

Why is this a priority area?
The Trust is increasingly seeing more frail older people, particularly as an emergency admission. Once a frail older person is admitted to hospital it is likely that they will have a prolonged length of stay and require a higher level of care on discharge than they required pre admission. This leads to patients suffering harm as a consequence of a hospital acquired infection, pressure ulcer, acute kidney injury or a fall amongst others. There has been significant National work relating to this and involvement of the third sector such as Age UK. Enhanced community

nursing enhancement proposed could have an indirect impact on improving the discharge of eligible patients into their own home and reducing length of stay for your patients with right nursing care packages in place Consultation with the older population has been an integral part of the National picture.

The evidence suggests that once a frail patient is admitted to hospital they are entering the last 12 months of their lives and for many end of life will occur during the hospital stay or soon after discharge. This highlights the importance of this being a priority area linking back to strategic aim one two and three eliminating preventable deaths, avoidable harm and optimisation of patient flow.

What does the Trust plan to do?
Frailty care should commence within the community and the aim is to work further with community teams to achieve this. The Comprehensive geriatric assessment should commence in primary care and the use of the electronic frailty index by GPs should support this. In the acute setting once a frail older person attends the ED they will be stratified in relation to their degree of frailty and comprehensive geriatric assessment will take place by the multidisciplinary team led by the frailty consultant and team. The aim will be to ensure as many patients as possible return to their own home without becoming a deep admission, secondly that all severely frail patients are not over medicalised and a clear plan is in place in terms of their care. We have commenced work utilising the amber care bundle and this work will continue in conjunction with the severely frail.

Target for 2018/19	We will be able to measure: The number of people over 75 seen by the frailty team; Those that were stratified and the degree of frailty; Numbers of those discharged back home from ED; Numbers that were severely frail and commenced on amber. This will allow for targets to then be set
Director Leads	Jim Murray
Monitored by	Quality Review Group
Reported to Board of Directors via	Quality Committee

Priority 2: The implementation and embedding of an adapted Ward Assurance tool

How does this link to our Quality Improvement Strategy?
Strategic Aim 1 Eliminate preventable deaths
Strategic Aim 2 Eliminate avoidable harm
Strategic Aim 3 Optimise patient flow
Strategic Aim 4 Optimise our workforce

Why is this a priority area?

The new ward assurance tool has been in use within the organisation since April 2017. We have adapted the tool to focus on areas we have identified we need to further improve, such as pressure prevention. In addition we wanted the tool to encourage the auditors to involve our patients and provide real time patient feedback to questions, rather than reliance on documentation. The monthly results of the audits will provide our patients, staff and the Trust Board with assurance that our core care delivery meets the Trust standards, and improve patient experience.

There have been some issues with completion compliance and this has been regularly monitored and senior teams have been engaged and challenged as required. A process to support the teams in completing ward assurance has also been put in place; this involves escalation for support if completion of ward assurance audit is unlikely in certain and exceptional circumstances. The corporate nursing team will then identify whether support can be offered to ensure the audits are completed this providing the continuous flow of data for each area, this supporting the teams to improve quality through the information collected and themes identified.

What does the Trust plan to do?

Though the new ward assurance audit tool has been successfully implemented as planned, there is further work to be undertaken. The aim of this to ensure the processes are embedded and the tool remains functional and supports quality improvements and service developments.

- Continue to embed the new ward assurance tool and process – including shared learning and undertaking actions to improve quality
- Having consistently achieved 95% overall. Work with ward and department teams to support all areas to achieve 95% and over
- Continue to support ward and department teams to ensure ward assurance data is submitted every month
- Review year one data to identify any learning points or further changes required to the tool.

Undertake further engagement events with teams to support further.

Target for 2018/19	• Achieve >95% overall for the Trust, consistently • Achieve > 95% in all clinical areas • Achieve all wards to be audited each month
Director Leads	Jim Murray, Chief Nurse
Monitored by	Quality Review Group
Reported to Board of Directors via	Quality Committee

Priority 3: Improving Discharge

How does this link to our Quality Improvement Strategy?

Strategic aim 2 Eliminate avoidable harm
Strategic aim 3 Optimise patient flow

Why is this priority area?

It is acknowledged that many of the patients we care for are in their last 1000 days and due to this Time is the most important currency. Every day an older patient spends in hospital is a day we are stealing from their '1000 remaining days.'
"Reducing unnecessary waiting for patients and unnecessary chasing up by staff has to be a win win for everyone working in and using our health and care systems. The risks for our patients are well documented and significant. (Dr Ian Sturgess)

What will the Trust do?

The Trust has identified the following areas for focus in 2018/19

- Implement with Health Economy Partners full Discharge to Assess model for Home and Bed based Services
- Improve the education programme regarding Complex Discharge and Patient Choice
- Reduction in the numbers of Stranded and Super Stranded Patients through focus on reduction on internal and external delays

Target for 2018/19	• Reduction in the numbers of patients waiting 6 days or more in Hospital (Stranded Patient Metric) • Reduction in the numbers of patients waiting over 21 days • Reduce the numbers of Health and Social Care Assessments undertaken in Hospital (Discharge to Assess model)
Director Leads	Duncan Bedford
Monitored by	Performance Reviews A&E Delivery Board
Reported to Board of Directors via	Trust Executive Committee

2.2 Statements of Assurance from the Board

Income and contracts

During 2017/18 Burton Hospitals NHS Foundation Trust provided all of the Commissioner Requested Services identified within the NHS standard contract.

Burton Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in seven of these relevant health services: General Medicine (including Cardiology), T&O, General Surgery, Urology, Gynaecology and Paediatrics.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2017/18.

Participation in Clinical Audit and Clinical Outcome Review

Clinical audit is a quality improvement process that is defined in full in “Principles for Best Practice in Clinical Audit” (HQIP 2011). It allows clinicians and organisations to assess practice against evidence and to identify opportunities for improvement. At a national level, it provides organisations with information that enables them to measure the effectiveness of their own organisation and practice against national benchmarks.

During 2017/18, 38 national clinical audits and 7 national confidential enquiries covered relevant health services that Burton Hospitals NHS Foundation Trust provides.

During that period, Burton Hospitals NHS Foundation Trust participated in 92% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Burton Hospitals NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

National Clinical Audit and Clinical Outcome Review	Host Organisation
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)
BAUS Urology Audits: Female stress urinary incontinence	British Association of Urological Surgeons
Bowel Cancer (NBOCAP)	Royal College of Surgeons
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)
Child Health Clinical Outcome Review Programme - Chronic Neurodisability	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Child Health Clinical Outcome Review Programme - Young People's Mental Health	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health
Elective Surgery (National PROMs Programme)	NHS Digital
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons
Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database	Royal College of Physicians
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database	Royal College of Physicians
Falls and Fragility Fractures Audit Programme (FFFAP) – Inpatient falls	Royal College of Physicians
Fractured Neck of Femur	Royal College of Emergency Medicine
Head and Neck Cancer	Saving Faces – The Facial Surgery Research Foundation
Inflammatory Bowel Disease (IBD) programme	Inflammatory Bowel Disease Registry
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol
Maternal, Newborn and Infant Clinical Audit Programme – maternal morbidity and mortality confidential enquiries	MBRRACE - UK – National Perinatal Epidemiology Unit

National Clinical Audit and Clinical Outcome Review	Host Organisation
Maternal, Newborn and Infant Clinical Audit Programme – maternal mortality surveillance	MBRRACE - UK – National Perinatal Epidemiology Unit
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal Mortality Surveillance	MBRRACE - UK – National Perinatal Epidemiology Unit
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal mortality and morbidity confidential enquiries	MBRRACE - UK – National Perinatal Epidemiology Unit
Medical & Surgical Clinical Outcome Review Programme - Acute Heart Failure	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Medical & Surgical Clinical Outcome Review Programme - Perioperative Diabetes	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
National Audit of Breast Cancer in Older Patients	Royal College of Surgeons
National Audit of Dementia	Royal College of Psychiatrists
National Audit of Intermediate Care	NHS Benchmarking Network
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Royal College of Physicians
National Comparative Audit of Blood Transfusion – Red cell and platelet transfusion in adult haematology patients	NHS Blood and Transplant
National Diabetes Audit – Adult Inpatients	NHS Digital
National Diabetes Audit – Adults (Core)	NHS Digital
National Diabetes Audit – Pregnancy in Diabetes	NHS Digital
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)
National Lung Cancer Audit (NLCA)	Royal College of Physicians
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Royal College of Paediatrics and Child Health
National Ophthalmology Audit	Royal College of Ophthalmologists
Oesophago-gastric Cancer (NAOGC)	Royal College of Surgeons
Pain in Children	Royal College of Emergency Medicine
Procedural Sedation in Adults	Royal College of Emergency Medicine
Prostate Cancer	Royal College of Surgeons

National Clinical Audit and Clinical Outcome Review	Host Organisation
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians
Serious Hazards of Transfusion (SHOT)	NHS Blood and Transplant

The national clinical audits and national confidential enquiries that Burton Hospitals NHS Foundation Trust participated in during 2017/18 are as follows:

National Clinical Audit and Clinical Outcome Review
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
BAUS Urology Audits: Female stress urinary incontinence
Bowel Cancer (NBOCAP)
Cardiac Rhythm Management (CRM)
Case Mix Programme (CMP)
Child Health Clinical Outcome Review Programme - Chronic Neurodisability
Child Health Clinical Outcome Review Programme - Young People's Mental Health
Diabetes (Paediatric) (NPDA)
Elective Surgery (National PROMs Programme)
Endocrine and Thyroid National Audit
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database
Falls and Fragility Fractures Audit Programme (FFFAP) – Inpatient falls
Fractured Neck of Femur
Head and Neck Cancer
Learning Disability Mortality Review Programme (LeDeR)
Maternal, Newborn and Infant Clinical Audit Programme – maternal morbidity and mortality confidential enquiries
Maternal, Newborn and Infant Clinical Audit Programme – maternal mortality surveillance
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal Mortality Surveillance
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal mortality and morbidity confidential enquiries
Medical & Surgical Clinical Outcome Review Programme - Acute Heart Failure
Medical & Surgical Clinical Outcome Review Programme - Perioperative Diabetes
National Audit of Breast Cancer in Older Patients
National Audit of Dementia
National Audit of Intermediate Care
National Cardiac Arrest Audit (NCAA)
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
National Comparative Audit of Blood Transfusion – Red cell and platelet transfusion in adult haematology patients
National Diabetes Audit – Adult Inpatients
National Diabetes Audit – Adults (Core)
National Diabetes Audit – Pregnancy in Diabetes
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit
National Joint Registry (NJR)

National Clinical Audit and Clinical Outcome Review
National Lung Cancer Audit (NLCA)
National Maternity and Perinatal Audit
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)
Oesophago-gastric Cancer (NAOGC)
Pain in Children
Procedural Sedation in Adults
Prostate Cancer
Sentinel Stroke National Audit programme (SSNAP)
Serious Hazards of Transfusion (SHOT)

The national clinical audits and national confidential enquiries that Burton Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit and Clinical Outcome Review	% of cases
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	100
BAUS Urology Audits: Female stress urinary incontinence	100
Bowel Cancer (NBOCAP)	100
Cardiac Rhythm Management (CRM)	100
Case Mix Programme (CMP)	100
Child Health Clinical Outcome Review Programme - Chronic Neurodisability	100
Child Health Clinical Outcome Review Programme - Young People's Mental Health	100
Diabetes (Paediatric) (NPDA)	100
Elective Surgery (National PROMs Programme)	81 of HES
Endocrine and Thyroid National Audit	100
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database	92
Falls and Fragility Fractures Audit Programme (FFFAP) – Inpatient falls	100
Fractured Neck of Femur	80
Head and Neck Cancer	100
Learning Disability Mortality Review Programme (LeDeR)	100
Maternal, Newborn and Infant Clinical Audit Programme – maternal morbidity and mortality confidential enquiries	100
Maternal, Newborn and Infant Clinical Audit Programme – maternal mortality surveillance	100
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal Mortality Surveillance	100
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal mortality and morbidity confidential enquiries	100
Medical & Surgical Clinical Outcome Review Programme - Acute Heart Failure	67
Medical & Surgical Clinical Outcome Review Programme - Perioperative Diabetes	88

National Clinical Audit and Clinical Outcome Review	% of cases
National Audit of Breast Cancer in Older Patients	100
National Audit of Dementia	65
National Audit of Intermediate Care	100
National Cardiac Arrest Audit (NCAA)	100
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	100
National Comparative Audit of Blood Transfusion – Red cell and platelet transfusion in adult haematology patients	100
National Diabetes Audit – Adult Inpatients	100
National Diabetes Audit – Adults (Core)	60
National Diabetes Audit – Pregnancy in Diabetes	100
National Emergency Laparotomy Audit (NELA)	70
National Heart Failure Audit	100
National Joint Registry (NJR)	99
National Lung Cancer Audit (NLCA)	100
National Maternity and Perinatal Audit	100
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	100
Oesophago-gastric Cancer (NAOGC)	100
Pain in Children	100
Procedural Sedation in Adults	68
Prostate Cancer	100
Sentinel Stroke National Audit programme (SSNAP)	100
Serious Hazards of Transfusion (SHOT)	100

The reports of 31 national audits were reviewed by the provider in 2017/18 and Burton Hospitals Foundation Trust intends to take the following actions to improve the quality of healthcare:

National Clinical Audit and Clinical Outcome Review	Actions being taken to improve quality
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	The report was reviewed by the audit lead and no actions were required.
Adult Asthma (BTS)	The report was reviewed by the audit lead and some of the resulting actions are: • Educate clinical staff in Emergency Department and Acute Wards on steroid use and peak flow measurement pre and post bronchodilator • Introduce the Asthma Care Bundle and Asthma Discharge Bundle to the hospital information system to prompt steroid prescribing • Carry out a local audit of steroid use for patients with acute asthma

National Clinical Audit and Clinical Outcome Review	Actions being taken to improve quality
Bowel Cancer (NBOCAP)	The report was reviewed by the audit lead and some of the resulting actions are: • A case review for all deceased patients highlighted in the report is being undertaken • Discussions regarding the histopathology service, with reference to resection specimens, are underway with the service provider
Case Mix Programme (CMP)	The report was reviewed by the audit lead and no actions were required.
Elective Surgery (National PROMs Programme)	The data was reviewed by the audit lead and some of the resulting actions are: • Data to be presented to all relevant clinicians • Data for femoral hernias to be investigated as the total number of procedures does not match expected values
National Hip Fracture Database	The report was reviewed by the audit lead and some of the resulting actions are: • A case review is to be undertaken for the patients who did not have surgery • Matrons are to be contacted regarding reporting of pressure ulcers • Investigate recent data for perioperative medical assessment, time to surgery and proportion of patients who mobilised the day after surgery • Put in place a process to collect and submit re-operation and follow up data
Inpatient falls	The report was reviewed by the audit lead and some of the resulting actions are: • The hospital information system has been amended to flag high risk medication to the prescriber for review • A guideline and pathway is being developed for delirium screening for all patients with delirium symptoms. A screening tool has been agreed. • A joint project is being undertaken by physiotherapy and occupational therapy to ensure the accessibility of mobility aids. Once embedded a local audit will be carried out
Maternal mortality surveillance	The report was reviewed by the audit lead and no actions were required.

National Clinical Audit and Clinical Outcome Review	Actions being taken to improve quality
Acute Non Invasive Ventilation (NCEPOD)	The report was reviewed by the audit lead and some of the resulting actions are: • Ensure that continuous ECG monitoring is available on wards for patients having acute non-invasive ventilation (NIV) • Ensure that nurse to patient staffing levels of one to two are maintained for patients on NIV • Ensure that all patients have an escalation plan prior to starting treatment • Carry out an annual local audit of NIV provision
Moderate and Acute Severe Asthma (RCEM)	The report was reviewed by the audit lead and some of the resulting actions are: • Add the Asthma Care Bundle to the hospital information system in ED • Review the results for the same patient cohort to check for any missing data
Perinatal mortality and morbidity confidential enquiries	The reports were reviewed by the audit lead and some of the resulting actions are: • To use the national tool for review of stillbirths and neonatal deaths when it is available
National Audit of Breast Cancer in Older Patients	The report was reviewed by the audit lead and some of the resulting actions are: • To ensure that all the correct data is submitted for the next round of the audit
National Audit of Dementia	The report was reviewed by the audit lead and some of the resulting actions are: • Introduce and embed the '4AT' screen in ED • Results of the '4AT' to be appropriately documented at discharge • Investigate ways of improving the completion rate for the 'This is me' document • Liaise with the catering manager to ensure that the nutritional needs of patients with dementia are met • Investigate ways of increasing the number of dementia champions
National Audit of Intermediate Care	The report was reviewed by the audit lead and the resulting action was: • Review the provision of care on wards at Queen's Hospital as it may not meet the definition of intermediate care

National Clinical Audit and Clinical Outcome Review	Actions being taken to improve quality
National Cardiac Arrest Audit (NCAA)	The report was reviewed by the audit lead and some of the resulting actions are: • Carry out a case review of the unexpected non-survivors identified in the report • Investigate ways of improving data quality • Ensure that cerebral performance category is assessed and recorded at discharge
National Diabetes Audit – Adult Inpatients	The report was reviewed by the audit lead and some of the resulting actions are: • Produce a business case for a specialist diabetes nurse for inpatients • Ensure that insulin errors are recorded and monitored, and appropriately actioned • Carry out a local audit of diabetic ketoacidosis • Investigate the option of changing to electronic prescribing of insulin • Review the paper form used for monitoring of administration of insulin on wards
National Diabetes Audit – Adults (Core)	The report was reviewed by the audit lead and some of the resulting actions are: • Ensure that all staff have appropriate access to the hospital information system to ensure that urine albumin/creatinine ratio is recorded • Ensure that patient education is recorded appropriately, including any education that has taken place elsewhere • Ensure that patients with high HbA1C levels at transition are highlighted and resources are targeted at them appropriately
National Diabetes Adult – Foot care	The report was reviewed by the audit lead and some of the resulting actions are: • Data was not submitted for the report due to technical issues with data uploading by the service provider. These have now been resolved.
National Diabetes Audit – Pregnancy in Diabetes	The report was reviewed by the audit lead and some of the resulting actions are: • A local audit is to be carried out to include a larger cohort of patients a numbers were too small to support action planning
National Diabetes Audit - Transition	The report was reviewed by the audit leads and no actions were required.

National Clinical Audit and Clinical Outcome Review	Actions being taken to improve quality
National Emergency Laparotomy Audit (NELA)	The report was reviewed by the audit lead and some of the resulting actions are • More clinicians are being given access to the database and encouraged to input data so that case ascertainment can be improved • An audit of delays to theatre has been carried out to identify the causes. Significant delays will be reported as incidents • Emergency care guidelines have been revised and the pathways revisited to improve lengths of stay • Elderly patients to be seen by the geriatricians together with the acute frailty team. Vulnerable patients will receive regular reviews.
National Heart Failure Audit	The report was reviewed by the audit lead and some of the resulting actions are: • Results show better than national average performance, and the challenge is to maintain these results by ensuring there is access to a heart failure nurse • Increase the number of referrals to the cardiac rehabilitation team • Ensure there is access to BNP testing to streamline heart failure diagnosis • Work with commissioners to improve access for patients in Lichfield and Tamworth to heart failure specialist follow up
National Joint Registry (NJR)	The report was reviewed by the audit lead and some of the resulting actions are: • Put in place a process to identify any unmatched records to ensure that all patients are included on the registry
National Lung Cancer Audit (NLCA) Outcomes	The report was reviewed by the audit lead and some of the resulting actions are: • Resection rates were good, better than the national average • Survival rates were as expected • Timing of clinics to be optimised to improve the pathway for patients requiring transfer to a tertiary centre for treatment
National Lung Cancer Audit	The report was reviewed by the audit lead and no actions were required.

National Clinical Audit and Clinical Outcome Review	Actions being taken to improve quality
National Maternity and Perinatal Audit (Patient data and organisational)	The reports were reviewed by the audit lead and some of the resulting actions are: • Ensure that all the required data is submitted • Ensure that the relevant HES data is appropriately processed and submitted
National Neonatal Audit Programme (NNAP)	The report was reviewed by the audit lead and some of the resulting actions are: • Data entry training for the neonatal database to be given at induction • Case reporting to the obstetrics team of all eligible mothers who do not receive steroids or magnesium sulphate • Local audit of temperature measurement to be carried out
Prostate Cancer	The report was reviewed by the audit lead and some of the resulting actions are: • Data to be checked to see whether all patients who should have had a Gleason score had one recorded and produce an accurate % completion • Carry out a local audit of MRI scanning to determine whether tumour node metastasis (TNM) staging and prostate imaging score is completed for all patients.
Sentinel Stroke National Audit programme (SSNAP)	The report was reviewed by the audit lead and some of the resulting actions are: • The four hour target for transfer to a stroke ward is being breached due to outliers. Beds on the stroke ward are to be ring fenced • The national average for proportion of patients having thrombolysis within one hour was not met. Registrars are to have thrombolysis teaching • More training is required for staff to carry out swallow assessments so that the four hour target can be achieved • A seven day service for therapies is being developed • A daily review of mood and cognition is to be carried out by occupational therapists
Serious Hazards of Transfusion (SHOT)	The report was reviewed by the audit lead and no actions were required.

National Clinical Audit and Clinical Outcome Review	Actions being taken to improve quality
Severe Sepsis and Septic Shock	The reports were reviewed by the audit lead and some of the resulting actions are: • The lack of a complete set of observations being carried out is to be discussed with nursing staff

The reports of 152 local clinical audits were reviewed by the provider in 2017-18 and Burton Hospitals NHS Foundation Trust intends to take the actions to improve the quality of healthcare provided;

Local Clinical Audit Topic	Actions to improve quality
Dignified Throne Audit	An audit was carried out to assess the toilet and bathroom facilities throughout the hospital to see whether they were contributing to falls. Data was collected by lay representatives. Actions taken: Work is underway with the Estates department to address the issues found – extra support rails, additional raised toilet seats and increased lighting in areas
Venous Thromboembolism (VTE) Assessment	NICE guidelines recommend that all patients are assessed to identify all those with increased risk of venous thromboembolism (VTE), and prophylaxis given if appropriate. A prospective audit was carried on medical wards, which showed that not all risk assessments were documented within 48 hours of admission. Actions taken: Recording of VTE assessment has been made compulsory in the hospital information system, and all ward staff were made aware of the need for a completed risk assessment form.
Urology documentation	A new process for assessing documentation was piloted in the Urology department. Based on Royal College guidelines, the new process can incorporate both paper and electronic notes. Actions taken: Results were good and no actions were required. The process is being rolled out to other specialties.
'Amber' Care	A baseline audit was carried out of the provision of 'Amber' care across the Trust. Areas where further training was required were identified. Actions taken Training has taken place on wards, and for junior doctors. Patient care charts were amended to include a section on Amber care.

Local Clinical Audit Topic	Actions to improve quality
Neonatal follow up	A new NICE guideline for neonatal follow up was audited to assess compliance. Where the guideline was not being followed, changes to practice were made to ensure that all babies are followed up appropriately. Actions taken: Babies born at 31 to 34 weeks gestation and babies born small for gestational age (SGA) are now routinely followed up. Teaching was carried out to ensure that patient data is recorded correctly to prompt the correct follow up.
Intra operative cholangiography (Re audit)	An audit was carried out of the use of intra operative cholangiography (IOC) for laparoscopic cholecystectomy. It was found that in some cases IOC was being used inappropriately. Changes to practice were made to ensure that all required testing including imaging was carried out pre-operatively to reduce the need for IOC, and a re-audit was carried out. This showed that the process was safe and that the new guidelines were being followed. Actions taken: No further actions required. The re-audit showed that the changes made were effective
Anaesthetic Staff Knowledge of Emergency Drugs and Equipment	A staff survey was carried out to ascertain the level of awareness of the location of the emergency drugs and equipment for use in theatres. Not all staff members were aware of the use of yellow bags for emergency drugs, and where they were located. Actions taken Specific teaching for emergency drugs and equipment has been included in induction teaching, and prominent signs have been placed to show the location of the emergency equipment and yellow bags.
Follow up of Stable Forearm Fractures	NICE guidance for non-complex fractures indicates that children with torus fractures should not need rigid cast or further review. It was noted that some patients were receiving a rigid cast and at least one follow up appointment. An audit was carried out, and the following actions were agreed. Actions taken: On first follow up in fracture clinic all those with a confirmed stable fracture on x-rays will have back slab changed to wrist splint and discharged with an information leaflet. A flowchart with the new guidelines was placed in the fracture clinic to raise awareness. More paediatric wrist splints were sourced.

Participation in clinical research

The Trust is committed to clinical research as a driver for improving the quality of care and patient experience. Research also provides an opportunity for staff to

develop their own skills and knowledge. Engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques. This is further evidenced by engagement with the Primary Care Research Network in an effort to co-ordinate research activity between primary and secondary care, in order to offer research participation to as wide a population as possible.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered and to make a contribution to wider health improvement. Furthermore, it allows clinical staff to stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The number of patients receiving relevant health services provided or sub-contracted by Burton Hospitals Foundation Trust in 2017/18, who were recruited during that period to participate in research approved by the Ethics Committee through the Health Research Authority (HRA), was 953.

During the year the Trust were involved in conducting 131 clinical research studies in:

- Anaesthetics
- Cancer
- Stroke
- Paediatrics
- Dermatology
- Respiratory medicine
- Gastroenterology
- Musculo-skeletal disorders
- Ophthalmology
- Diabetes
- Cardiology
- Reproductive health
- Haematology
- Metabolic and endocrine disorders
- Cardiovascular/Lipids
- General Surgery

In 2017/18 the National Institute for Health Research (NIHR) supported 126 of these studies through its research networks.

The Trust aims to complete 100% of these studies as designed within the agreed time and to the agreed recruitment target. However, recruitment targets and completion dates are commonly adjusted as research studies progress to take into account, for instance, slower than expected recruitment which may result in extension of the end date. Conversely, some studies complete early in the light of conclusive findings at an earlier than expected stage. Most of the studies undertaken at the Trust are hosted as part of national research and often, recruitment targets and completion dates are influenced at a national level.

A wide range of clinical and non-clinical staff, within the various specialities, were involved in participating in and supporting research approved by the HRA at the Trust during 2017/18.

Of the 17 studies given permission to start, 53% were given permission by an authorised person less than 40 days from receipt of a valid completed application. 95% of the studies were established and managed under national model agreements. Out of the 17 studies permitted to start, one was eligible to use a 'research passport'. The research passport scheme is a nationally adopted

process coordinating and streamlining pre-engagement checks for external staff entering NHS premises to conduct research activities.

In the last year, 2 publications have directly resulted from the Trust's involvement with the NIHR. However, the Trust is mainly a host site for studies initiated by trial centres elsewhere, and it is these centres that have responsibility for publishing and disseminating their results.

Use of the CQUIN payment framework

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.

A proportion of the Trust's income in 2017/18 is conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The monetary total for income in 2017/18 conditional upon achieving quality improvement and innovation goals was £3.5m.

A summary of developments and achievements and specific performance achieved against each CQUIN scheme in 2017/18 is detailed in the tables below.

Summary of developments and achievements against the Year 1 2017/19 CQUIN schemes

Topic and Rationale	Achievement
NHS e- Referrals (National CQUIN) As technology is becoming embedded in everyday life, an e referral system can provide patients with an instant referral into secondary care.	Achieved
NHS Advice and Guidance (National CQUIN) The CQUIN sets out to improve the GP access to consultant advice on potential referrals into secondary care.	Partial achievement
Transformation CQUIN – reduction in follow up outpatient activity. To align the work with the Sustainability and Transformation Plan(STP) for Staffordshire	Partial achievement
NHS Improving services for people with mental health needs who present to A&E Patients with a known mental ill health are 5 times more likely to present to an acute hospital. The Trust and the mental health trust are incentivised to work together to improve the patient outcomes and patient experience.	Achieved

Topic and Rationale	Achievement
Specialist CQUIN – hospital medicine optimisation This CQUIN aims to support the procedural and cultural changes required to fully optimise use of medicines commissioned by specialised services,	Achieved

The CQUIN schemes for 2018/19 have been determined following discussions with Commissioners and reflect the National guidance on continuing with the improvement ambitions for a second year.

Areas for CQUIN payment framework in 2018/19

Topic	Rationale
NHS Advice and Guidance	The CQUIN sets out to improve the GP access to consultant advice on potential referrals into secondary care.
Transformation CQUIN – reduction in follow up outpatient activity.	To align the work with the Sustainability and Transformation Plan(STP) for Staffordshire
NHS Improving services for people with mental health needs who present to A&E	Patients with a known mental ill health are 5 times more likely to present to an acute hospital. The Trust and the mental health trust are incentivised to work together to improve the patient outcomes and patient experience.
Specialist CQUIN – hospital medicine optimisation	This CQUIN aims to support the procedural and cultural changes required to fully optimise use of medicines commissioned by specialised services,

Statements from the Care Quality Commission (CQC)

Burton Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully compliant. Burton Hospitals NHS Foundation Trust has no conditions. The Care Quality Commission has not taken enforcement action against Burton Hospitals NHS Foundation Trust during 2017/18.

Over the course of the last 12 months, the CQC has not undertaken a full inspection at any of the Trust's three locations; Queen's Hospital in Burton, Samuel Johnson Community Hospital in Lichfield and Sir Robert Peel Hospital in Tamworth. The last planned visit took place on the 7, 8 and 9 July 2015 and the subsequent report was received in October 2015.

Burton Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

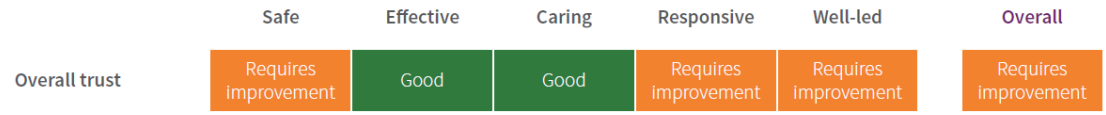
CQC inspectors use professional judgement, supported by objective measures and evidence, to assess services against five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

Following the inspection, the CQC gave the Trust an overall rating for the Trust as 'Requires Improvement', which was split by the three locations as follows:

- Queen's Hospital - Requires Improvement
- Sir Robert Peel Community Hospital - Good
- Samuel Johnson Community Hospital – Good.

The overall rating in respect of the CQC's five key questions was assessed as follows:



Extract from Burton Hospitals NHS Foundation Trust Quality Report dated 22 October 2015

The inspection highlighted improvements in safety and leadership, caring and compassionate staff and a strong, responsive, open culture. Across the Trust, more than 80% of the Trust's core services were rated "Good" by the Inspection team, with notable improvements including Urgent and Emergency Services at Queen's Hospital, Medical Care across the Trust, End of Life and Services for Children and Young People. Both Sir Robert Peel Community Hospital and Samuel Johnson Community Hospital were given a "Good" rating overall which is a great reflection on the quality of care that is offered to the Trust's wider community.

The report identified many diverse examples of "Outstanding Practice", in particular innovative approaches to improving patient outcomes and increasing patient and carer engagement.

The Inspection identified that there was still further work to do, particularly regarding delays in the outpatient department, the lack of a clear pathway for patients needing emergency gynecological treatment and concerns regarding patient flow throughout services. The actions identified were incorporated into the detailed action plan to monitor progress in delivering and embedded the actions and this work continues.

As a result of the sufficient progress made, and the Trust's continuing commitment to ongoing quality improvements, the CQC made its recommendation to the Independent Regulator that the Trust should be removed from special measures status in October 2015.

The CQC did, however, undertake a Review of Health Services for Children Looked After and Safeguarding in Staffordshire. The review was undertaken from the 4th to the 9th April 2016 and explored the effectiveness of health services for

looked after children and the effectiveness of safeguarding arrangements within health for all children.

The focus was on the experiences of looked after children and their families who receive safeguarding services.

The CQC reviewed:

- The role of healthcare providers and commissioners.
- The role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
- The contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

The CQC also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2015.

This report was published in October 2016 with any actions identified being incorporated into the Trust's Consolidated Action Plan.

Data Quality

The Trust collects and uses information on a daily basis which is used to support decision making by clinicians and managers and for monitoring and research purposes by a range of external organisations. It is essential that the data is accurate, relevant, reliable, timely, complete and valid to produce information that is fit for purpose. Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made.

The Data Quality Group plays a key role in ensuring good Data Quality; its key functions are to:

- Raise awareness about the impact of Data Quality and share best practice
- Contribute to the design of quality systems and processes
- Support frontline data capture teams to improve Data Quality
- Ensure compliance with Secondary Use Assurance section of the Information Governance Management Framework.

The Data Quality Group provides a regular report to the Information Governance Steering Group which in turn reports to the Finance and Performance Committee. During 2017/18 the following actions to improve Data Quality were carried out:

- A work plan to improve Data Quality was implemented and monitored by the Data Quality Group.
- Overall data quality was monitored via The Data Quality Maturity Index (DQMI) to highlight areas for improvement so action could be taken to improve.

- To supplement the DQMI indicators the Data Quality Group also monitored key indicators based on data extracted by the Information Department and the Human Resources team.
- An audit of key data items in Trust systems was carried out as well as a completeness and validity check as part of the annual IG Toolkit process
- Standard Operating Procedures for report production have been reviewed and updated.

The Trust has improved its position in NHS Digital's Data Quality Index (DQMI) over the last 12 months. NHS Digital introduced the Index in November 2016 to measure the quality of patient related data in seven nationally mandated data sets. The index takes into account key data items such as the recording of a patient's GP, Postcode, and NHS number. These are essential items to ensure that the correct patient is clearly identified and so that clinical communications, (eg discharge letters) are sent to the right GP. They are also important in ensuring that the Trust receives income for the services that it provides. The Trust's DQMI score is 99.9% for July to September 2017 (the latest figures available) and is ranked first out of 227 NHS Trusts.

It is essential that Data Quality is not only maintained but improved upon; therefore the Trust will be taking the following actions to improve data quality in 2018/19:

- Re-write of the data quality strategy to provide a clear focus for the data quality steering group and direction of travel for the data quality improvement work programme
- Data Quality Risk assessment of the Trust Key Performance Indicators to assess validity of data, governance of processes to inform the improvement work programme
- Continue to target key areas such as outpatients, wards, secretarial support to ensure demographic data is accurate and kept up to date.
- Continue to monitor compliance with Data Quality standards

NHS number and General Medical Practice Code

Improving the quality of NHS number data (i.e. correctly recording the number for every patient) has a direct impact on improving clinical safety as the NHS number is the key identifier for patient records, regardless of how or where a patient accesses care. Accurate information about the patient is required in all healthcare settings to support clinical care. The consistent use of the NHS number supports this by linking up elements of a patient's record across healthcare organisations providing a way of checking the information is about the right patient.

Accurate recording of the patient's general medical practice code is essential to enable the transfer of clinical information about the patient between healthcare providers thus helping to deliver seamless care for patients. This is particularly important when coming to discharge patients from hospital.
The Trust submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records in the data for the period April to December 2017, the latest data available, which included the patient's valid NHS number was:

	Trust %	National %
For admitted patient care;	99.8	99.4
For outpatient care; and	99.9	99.5
For accident and emergency care	99.0	97.1

The percentage that included a valid General Medical Practice Code was:

	Trust %	National %
For admitted patient care;	100	99.9
For outpatient care; and	100	99.8
For accident and emergency care	100	99.3

Clinical Coding

Burton Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is highly important as the data is used for a range of purposes including:

- Monitoring provision of health services across the UK
- Research and monitoring of health trends
- NHS financial planning and Payment by Results (PbR)
- Clinical governance

During 2017/18 the Trust implemented the following to improve the Clinical Coding service. This comprised of:

- The monitoring of Key Performance Indicators (KPIs) using the internal Coding Dashboard and the external reports supplied by CHKS.
- The department continues to use the DQA tool within the Medicode functionality.
- Individual Coder Audits are carried out on a regular basis. Any training or problem areas are identified from the Audits and the improvements are monitored.

The impact on the quality of Coding is being monitored via an internal Coding Dashboard and external comparison with peers.

The Trust commissioned an audit of Clinical Coding to assess compliance with Information Governance standards. The audit reviewed 200 sets of case notes from Paediatrics, General Surgery, Gynaecology, Urology and General Medicine. The audit demonstrated that the accuracy level required to comply with Level 2 of the Information Governance Coding standard was achieved.

Level of Attainment Achieved			
% Diagnoses Coded Correctly		% Procedures Coded Correctly	
Primary	Secondary	Primary	Secondary
93.0	91.37	92.31	88.88

Level of Attainment Required		
	Level 2	Level 3
Primary Diagnosis	>=90%	>=95%
Secondary Diagnosis	>=80%	>=90%
Primary Procedure	>=90%	>=95%
Secondary Procedure	>=80%	>=90%

Information Governance Assessment Report

Information Governance provides a single framework of requirements, standards, and best practice covering confidentiality and data protection, corporate information, clinical information, information governance management, information quality and information security.

Burton Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 83% and was graded green. The score is the same as last year's performance. A full breakdown of the position is as follows:

Trust Score for Attaining Information Governance Standards

Year	Level 0	Level 1	Level 2	Level 3	Overall score	Self-assessed Grade
2017/18	0	0	22	23	83%	Satisfactory
2016/17	0	0	22	23	83%	Satisfactory
2015/16	0	0	24	21	82%	Satisfactory
2014/15	0	0	27	18	80%	Satisfactory

Trust performance is rated as Satisfactory by NHS Digital.

Grade Key

Not Satisfactory	Not evidenced Attainment Level 2 or above on all requirements (IGT Version 8 or after)
Satisfactory with Improvement Plan	Not evidenced Attainment Level 2 or above on all requirements but improvement actions provided (IGT Version 8 or after)
Satisfactory	Evidenced Attainment Level 2 or above on all requirements (IGT Version 8 or after)

2.3 Reporting against core indicators

The Burton Hospitals Foundation Trust considers that this data is as described for the following reasons; as it is nationally standardised data which allows us to draw comparisons against the NHS as a whole. The tables below highlight the Trust's performance and allow direct comparison of key performance indicators against national targets.

2017/18 performance against key national indicators, including comparison against target and previous year's performance

Performance against National indicators: Apr'17 - Mar'18

Performance Indicator	Target 2017/18	2017/18 Actual (Apr-Mar)	2016/17 Actual (Apr-Mar)	2017/18 Performance Against Target	2017/18 National** Actual	
Waiting Times in A&E (% under 4 hours)	95%	91.0%	90.6%	Red	88.4%	
Referral to Treatment Waiting Times - Incomplete Pathways ***	92%	92.1%	94.3%	Green	87.9%	National Figures - February position latest available
Cancer target - Urgent referral to treatment of all cancers in 62 days^	85%	80.9%	78.9%	Red	82.0%	April – February latest available
Cancer target - 62 day wait for first treatment from consultant screening service referral^	90%	95.2%	96.7%	Green	90.9%	April – February latest available
Cancer target - 31 day wait for second or subsequent treatment: Surgery^	94%	95.5%	94.5%	Green	95.5%	April – February latest available

Performance Indicator	Target 2017/18	2017/18 Actual (Apr-Mar)	2016/17 Actual (Apr-Mar)	2017/18 Performance Against Target	2017/18 National** Actual	
Cancer target - 31 day wait for second or subsequent treatment: Drug Treatments^	98%	100.0%	100.0%	Green	99.4%	April – February latest available
Cancer target - Urgent referral for suspected cancers in two weeks^	93%	95.5%	95.9%	Green	94.2%	April – February latest available
Cancer target - Two week wait for patients referred with breast symptoms^	93%	80.3%	91.0%	Red	93.0%	April – February latest available
Cancer target - Diagnosis to treatment of cancer in 31 days^	96%	98.5%	99.1%	Green	97.5%	April – February latest available
Clostridium Difficile - No. of Cases	<= 20	26	13	Red		

** National 2017/18 Actual Data (Apr - Mar)
> Figures cover England only not UK
^ Cancer figures are Apr-Feb (latest available)
*** RTT Incomplete Pathways are snapshot of patients waiting as at end of March 2018

Performance Indicator Patient Safety Measures	2017/18 Actual (Apr-Mar)	2016/17 Actual (Apr-Mar)	
Mortality (CHKS RAMI)	84.1*	95.09*	*April - February only, as March coding is incomplete
Mortality (SHMI) - Oct 2016 - Sep 2017	0.99	1.01	
Mortality (SHMI) Banding	NA	NA	

Performance Indicator	2017/18 Actual (Apr-Mar)		2016/17 Actual (Apr-Mar)	
Mortality (SHMI) % of pts admitted to a hospital within the trust whose deaths were included in the SHMI and whose treatment included palliative care. - Oct 2016 - Sep 2017	31.19		29.82	
Patients with MRSA infection (rate per 1000 bed days)	0.006		0.018	
Patients with C.Difficile infection (rate per 100,000 bed days)	16.07		7.99	
Medication errors (per 1000 inpatient admissions exc. neonates)	8.12		7.75	
Clinical Effectiveness Measures				
Re-admission rate by Age: 2017/18 within 28 days of discharge *	0-15	12.6%	0-15	12.1%
	16+	12.6%	16+	11.1%
Re-admission rate overall: 2017/18 within 28 days of discharge *	12.6%		11.4%	
Cancelled Operations	278		271	
% of patients waiting less than 4 hours in A&E	91.0%		90.6%	
Patient Experience Measures				
Treated with Kindness & Compassion	98.0%		98.0%	
Overall Patient Experience Score	97.0%		97.0%	
Handover times between ambulance crews and A&E staff (% within 15 minutes)	76.4%		76.1%	

*Apr-Feb only as the patients discharged in March can readmit until end of April

*Apr-Feb only as the patients discharged in March can readmit until end of April

Local Indicators

	Target Defined By	Report name	March 18	Year to Date Average	Year to Date Total
16	L	PXC1 - Trustwide Complaints	24	22	268
257	L	PXC1 - Complaints Acknowledged within 3 Days	100.00 %	100.00 %	
140	L	PXC2 - Compliments	93	66	788
64	L	PXC3 - Emergency Readmissions	10.50%	11.26%	
65	L	PXC3 - Patients with Ward Moves Over 3 (Not Clinically Indicated)	7	5	63
83	L	PXC3 - Patient Moves after 10pm	52	67	809
62	L	PXC4 - Discharge Summaries	68.08%	66.53%	
63	L	PXC4 - Outpatient Clinic Letters Sent Out in 5 Days	88.12%	95.43%	
13	L	PSM1 - Occurance of Serious Incidents - for Last 1 year	4	5	67
12	L	PSM2 - Never Events by reported dates - Current Financial Year	0	0.25	3
135	L	PSM3 - Trustwide Serious Incidents Rate per 100 Bed Days - for Last 1 year	0.03	0	
264	L	PSM4 - Patient Falls - Category 5 (Death)	0	0	0
152, 153	L	PSM5 - Pressure Ulcers Grade 3 & 4 by Month	5	4	49
81	L	PSM7 - All Reported Incidents	671	687	8,241
8	L	PSM7 - Patient Falls All Severities (excluding accidents)	102	79	947
262	L	PSM7 - Patient Falls - Category 3 (Moderate Harm)	2	1	16
263	L	PSM7 - Patient Falls - Category 4 (Severe Harm)	0	0	0
	L	POM1 - Raw Mortality - Emergency Patients	3.55%	3.19%	
131	L	POM2 - Total Numbers of Deaths/ Beddays	0.70%	0.61%	
88	L	QAS1 - Resus Training Compliance - Adult	80.37%	80.37%	
89	L	QAS1 - Resus Training Compliance - Paeds	76.18%	78.49%	
17	L	QAS2 - Ward Assurance	97.04%	96.49%	
90	L	QAS3 - QIA CIP Approved Workbooks		92.31%	
80	L	QAS2 - TP Prescribed Within 1 Day of Admission	77.24%	68.07%	

Part 3: Overview of Quality

Patient Safety Indicators:

Mortality

There are a number of metrics used to monitor hospital mortality across England. The predominant measures are SHMI – Standardised Hospital Mortality Index (issued by the Department of Health) and HSMR – Hospital Standardised Mortality Ratio (issued by Dr Foster, based at the Imperial College, London). The reason for the variation between HSMR and SHMI is that they measure slightly different things. There are 3 main differences:

- SHMI measures inpatient and day case deaths, within 30 days of discharge whether in the hospital or the community. HSMR measures a selected group of inpatient and day case deaths within 56 diagnostic groups. This accounts for approximately 80% of deaths in hospital
- HSMR makes adjustments, based on factors such as deprivation and palliative care, where SHMI does not
- SHMI attributes death to the hospital at which the patient was last seen, whilst HSMR divides the number between the Trusts that the patient has attended.

The Trust has actively been using the CHKS database since 2017. This system supports a range of reports, which enable individual doctors to receive feedback on their mortality ratio and overall clinical performance.

<u>Current Situation</u>
A SHMI or HSMR index score of 100 means that there have been the same number of deaths as would be expected according to the model. The index is calculated as ('number of actual deaths' / 'number of expected deaths') x 100. The peer comparison aspect is important because as time goes on all models will gradually fall from 100 due to changes in coding and practice, so the index could be below 100, but could be unfavourable compared to other trusts.

The Trust's SHMI for the period July 16 to June 2017 rate was 90.66. A 'higher than expected SHMI should not immediately be interpreted as indicating bad performance and instead should be viewed as a 'smoke alarm' which requires further investigation by the Trust.

The Trust's HSMR rate for the period March 2016 to February 2018 was 94.44. HSMR also allows the Trust to scrutinise mortality ratios at specialty level, for specific diagnostic groups. If a hospital has an unexpected high score, then an alert is sent to the hospital.

HSMR and SHMI alerts are taken to the Trust Mortality Assurance Group on a monthly basis. This information is then reported to a number of groups including the Trust Executive Committee, Board of Directors, Quality Review Group and Quality Committee.

There has been a great deal of work by the coding team to improve accuracy of the data. The Trust has in place an experienced mortality coding lead to undertake the coding of all deaths, accredited by IHRIM (The institute of Health Records Information Management). The Trust has focused on coding co-morbidities and palliative care accurately, so that the expected morbidity rate correctly reflects our patient case mix.

During the reporting period, a total of 31.65% of patient deaths had palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.

Learning from Deaths

During 2017/18 1076 Burton Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 227 in the first quarter; 215 in the second quarter; 266 in the third quarter; 368 in the fourth quarter.

By 31/03/18, 98 case record reviews (Level 2) and 1 investigations (SI) have been carried out in relation to 1076 of the deaths included in item 27.1.

In 1 case, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review (Level 2) or an investigation was carried out was:

25 in the first quarter;
21 in the second quarter;
21 in the third quarter;
31 in the fourth quarter.

0.4% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 0 (representing 0%) for the first quarter; 0 (representing 0%) for the second quarter; 4 (representing1.5%) for the third quarter, 0 (representing 0%) for the fourth quarter.

The Burton Hospitals Foundation Trust has taken the following actions to improve the mortality indicators and so the quality of its services by:

The Trust holds a regular (monthly) Mortality Assurance Group (MAG), that is multi-disciplinary including palliative care and all business units are represented via the clinical divisions. The CCG is represented at the meetings. MAG reports to the Trust's Quality Committee. The clinical divisions report at the meeting in relation to mortality reviews, and Trust wide benchmarked data such as SHMI and HSMR are reported. In addition, any trends of higher than expected mortality in specific patient groups are highlighted and MAG discusses whether there should be any further actions or specific mortality reviews. MAG also reviews any Mortality Outlier alert that the Trust receives and any reports that are generated. In addition MAG will review and comment on any SI reports that have been undertaken in which there was a patient death.

Since October 2017, MAG has also discussed as a standing item the LeDeR mortality programme that is specifically reviewing all deaths in people with a Learning Disability. This is a national programme and involves all deaths wherever they occur and is not related solely to hospital mortality. The Trust is represented at the regional steering group for this review and there has been 7 Trust staff trained as LeDeR reviewers. This national audit was set up to investigate and outline the causes for the increased mortality and decreased life expectancy for people with Learning Disability. The Trust also takes part in other National Audits that benchmark outcomes including mortality – these include paediatric and neonatal mortality, emergency laparotomy, intensive care, heart attack and hip fracture.

The Trust is strengthening its reporting systems by integrating its mortality review tool within its Datix Governance System. Currently business units use the Trust's electronic review tool to different extents with some business units using a paper based proforma and discussing cases at minuted meetings. There has been increased challenge of the divisions and business units to report cases and to provide an assessment of whether there are any aspects of care that would lead to a view that the death was preventable.

There has been set criteria for deaths to be escalated to more formal review such as those following an unexpected cardiac arrest or elective / emergency surgery. Cases are discussed at MAG if there have been issues raised during the mortality review. Cases are referred to the SI group for more formal investigation if there is felt to be a preventable aspect for the death. There has been increased focus on the Neck of Femur care pathway to ensure that patients are operated on within a specified time following admission, access to theatre over the weekend and increased medical input from the orthogeriatricians.

A case had a formal SI undertaken in which it was felt that the use of contrast had contributed to an acute kidney injury. This patient was known to have significant co-morbidities and following the SI review and discussion with a Renal physician, it was felt that use of contrast was clinically justified in the case.

During the next period it is the intent to have a fully integrated mortality review tool within the governance database which will allow for a consistent, rigorous approach that all business units will follow.

A large piece of work has been undertaken in conjunction with the Coding Department to ensure that all patients with a Learning Disability are coded correctly within the system. On the back of this an educational piece of work will be carried out to ensure that this is done at the point of contact as opposed to post visit.

As and when alerts are notified to the Trust, the Coding department is now routinely used as a sense check. All the records within the alert are investigated by a dedicated coding expert who then discusses the findings at MAG. Based on this expert advice, recommendations are reached – sometimes this can be education around a specific aspect of coding or the suggestion that a clinical deep dive is required into the case notes. The presence of the coding expert at MAG is therefore a key element within this process.

The mortality review process is becoming more rigorous although the Trust accepts that the review process needs to be better integrated within its governance system to ensure that there is continual monitoring of mortality reviews and outcomes.

0 case record reviews and 0 investigations completed after September 2017 which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Trust's Mortality Review Tool.

0 representing 0% of the patient deaths during [2016/17 reporting period] are judged to be more likely than not to have been due to problems in the care provided to the patient.

Healthcare Associated Infection

Publicly available "fingertips" data shows that the Trust in the main is performing well in relation to healthcare associated infection. The main challenges this year were the number of *C.difficile* cases, which exceeded the target set for the year and seasonal influenza affecting the Trust over the winter months. Unusually there was very little Norovirus which occurs seasonally between October and March, peaking during the winter months.

The Burton Hospitals Foundation Trust has taken the following actions to improve number of patients with C.Difficile infection and so the quality of its services through the following actions: Major changes to the management of *C.difficile* saw the introduction of formal reviews on wards of all patients by the Medical Microbiologist, Antimicrobial Pharmacist and Infection Prevention and Control Team members. This activity ensured that patients were treated proactively allowing adjustment to treatment where applicable and also actively promoting knowledge and support at ward level. Local measures to reduce the incidence of Gram negative blood stream infections have been embedded in the Trust's Quality Improvement Plan. There was active participation in two key events namely, World Hand Hygiene day and World Antimicrobial Stewardship day. Three of the team are undertaking professional development activity so as to further equip themselves to improve the service offered to patients. In addition there were a number of collaborations with our colleagues at Derby Teaching Hospitals NHS Foundation Trust. More intense preparation is now under way for service provision post-merger, focusing on aligning the service between the two sites and preparing for day one following the merger.

Meticillin-resistant Staphylococcus Aureus (MRSA) blood stream infections
There was a single case of a Trust attributable MRSA blood stream infection during the year. A robust post infection review is undertaken for all cases where MRSA is identified in the blood stream of patients. The technical definition applying to initial attribution of cases is a case which emerges after the day of or the day following the day of admission.

***Clostridium difficile* (*C. difficile*) infection**

The Trust is subject to an externally set target in relation to the maximum permissible number of this infection. The target for the year 2017/18 remained unchanged from the previous year of no more than twenty cases. The circumstances surrounding each case are subject to rigorous examination both internally by the Trust and by Commissioners. This scrutiny provides assurance concerning those cases that are regarded as being unavoidable. Where lapses in care have been identified cases are defined as being avoidable. Plans are then formulated to ensure that those lapses in care have been addressed thus reducing the risks to other patients. . There have been twenty six cases in the Trust this year and of these only ten have been due to lapses in care. This is a significant increase compared to performance last year. This is probably due to two main factors as described below:-

- Changes to the Trust antimicrobial prescribing policy
- Shortages in supply of relevant antibiotics

The number of lapses in care has remained similar to last year despite the overall increase in cases. Work will continue in the coming year to further reduce lapses in care that may contribute to the development of *C.difficile* infections.

Carbapenemase Resistant Enterobacteriaceae

The numbers of patients who are identified as carriers or are infected of these highly resistant bacteria remain extremely low. No infections were identified as being acquired in this Trust during this year. Screening is currently compliant with national guidance. Plans are being developed to expand screening to include admissions and transfers from more local hospitals where this bacterium has been known to have caused problems.

Meticillin-sensitive Staphylococcus Aureus (MSSA) bacteraemia

The presence of this bacterium in the blood stream of patients is reported to Public Health England (PHE) by all Trusts as part of national surveillance and data collection. No national targets have been set for the number of these cases. Using the same technical definition as that defined for MRSA the number of cases that could be described as attributable to the Trust amount to nine for the year 2017/18 which is a small increase compared to last year.

Gram negative organisms giving rise to blood stream infections

Additional national surveillance was implemented in April 2017 concerning certain organisms which give rise to blood stream infections. These are:

- Escherichia coli (E.coli)
- *Pseudomonas aeruginosa*
- *Klebsiella* spp

Infections with these bacteria have increased significantly over the past few years and there is now a national ambition to reduce Gram-negative Blood Stream Infection (BSI) by 50% by the year 2021. The main concern is *E.coli* blood steam infections which represent 55% of all BSI with wide variation of rates across the

country. These infections have increased by 20% in the last five years with a continuing upward trend

Escherichia coli (E.coli) bacteraemia
The numbers of Trust acquired cases of this infection have significantly reduced this year and amounts to a reduction of 42% compared to 2016/17. Once again the vast majority of these infection originated in the community prior to admission.

Pseudomonas aeruginosa bacteraemia
Numbers of Trust acquired cases are being reported under PHE surveillance arrangements. There have been six cases originating in Trust but as this is a new data reporting stream there is no comparable data from previous years.

Klebsiella spp bacteraemia
Numbers of Trust acquired cases are being reported under PHE surveillance arrangements. There have been thirteen cases originating in Trust but as this is a new data reporting stream there is no comparable data from previous years.

Hand hygiene
The Team were fully involved with World hand Hygiene day held in May 2017. Novel approaches were taken to ensure that the important messages around this most basic of practices were emphasised. Observational audit of practice continues to be the standard by which practice is measured in this Trust and most other Trusts in the UK. This continues to show compliance in excess of 90% in almost all areas of the Trust.

The technical challenges of an alternative electronic data collection method have now been overcome. The decision whether to invest in this system is now deferred until the outcome of the merger proposal is determined.

Antibiotic Stewardship
There were major improvements to Antimicrobial Stewardship this year. The mobile telephone “APP” was completed allowing easier access to the Trust antimicrobial prescribing guidelines. Formal ward rounds were implemented to specifically review patients with *Clostridium difficile* infection. This involved considerable collaborative work between the Consultant Medical Microbiologist, The Antibiotic Pharmacist and the Infection Prevention and Control Team. There were national shortages of some antibiotics during the year leading to short term changes in prescribing guidelines. These changes may also have adversely affected rates of infection in the Trust. There was further collaboration with Commissioners to make most effective use of the World Antimicrobial awareness day in November 2017.

Infection prevention and control audit, surveillance and monitoring projects
Formal continual surveillance of certain orthopaedic operations has been maintained during the year. The implementation of actions following a rise in infections in this class of surgery appears to have been successful with rates having fallen back to levels just slightly above the national average. If maintained the improvements will result in rates less than the national average within twelve months. The general range of audit is unchanged from last year and is listed below.

- Ward and departmental environment – IPCT and by Matrons
- MRSA screening
- MRSA decolonisation treatment
- *Clostridium difficile*
- Commode cleaning
- Additional audits in "hotspot" areas, particularly those areas where sporadic cases of *Clostridium difficile* infection have occurred
- Audit of endoscopy decontamination using nationally approved audit tools and in conjunction with Trust decontamination lead.
- Contract monitoring of the pressure relieving mattress decontamination provider.

Screening patients on admission to determine whether they are colonised with MRSA continues in line with national guidance as issued in August 2014.

Infection Prevention Metrics
Key components of the metrics are in the process of being updated following the publication of updated High Impact Interventions by NHS improvement and the Infection Prevention Society. In keeping with previous editions most of the interventions involve the use of devices in patient care. The use of devices significantly increases the risk of patients acquiring infection. Another key area included in the metrics is the assurance that clinical environments are appropriately maintained. Audit results are analysed and compared to the number and rate of infections that have occurred in ward areas thus triangulating data from several sources. These data are reported to the Infection Prevention Board (IPB) and to the Quality Review Group.

Outcome Monitoring
In addition to reports to the Infection Prevention Board and Quality Review Group other reports are produced for the individual Divisions with attendance at meetings by the Infection Prevention and Control Team. Weekly and monthly reports are also generated for Commissioners in accordance with contractual obligations. By these means date is widely disseminated, improvement plans shared and progress against internal and external measures monitored.

Challenges for 2018/19
The Infection Prevention and Control Team will continue to strive to reduce healthcare associated infection to irreducible minimum levels by proactive strategies and local support to all wards. The other major challenge will be to ensure that the merger Derby Teaching Hospitals NHS Foundation Trust is successful and provides excellent services for patients in each of the five sites that will be covered by the new organisation.

Medication Errors

Medication safety is a hugely important aspect of healthcare delivery with medicines being the most common therapeutic intervention in healthcare. The process of medicines delivery – from prescribing to supply to administration – is complex. An error at any stage may result in actual or potential harm to the patient.

Consequently, ensuring patients receive the right medicine, at the right dose and at the right time is a key priority for all health care professionals.
The 3rd WHO Global Patient Safety Challenge: Medication Without Harm aims to "reduce severe avoidable medication related harm globally by 50% in the next 5 years". The campaign recognises the part that patients, their carers and healthcare professionals all have to play in reducing risks to patients.

In the last 12 months, medication incidents accounted for 7.5% of all total incidents reported at the Trust. On average, 51 medication incidents were reported each month. Of those which have been graded, 89% resulted in no harm/near miss and 0.5% resulted in moderate harm to a patient. No severe harm from medication incidents has been reported. 3% of reports have not been graded at the present time.

By encouraging continued dialogue and discussion about medication safety, promoting medication incident reporting and sharing the outcomes and learning, Burton Hospitals continues to work to minimise the risk to patients from medication errors.

The Burton Hospitals Foundation Trust has taken the following actions to improve the number of medication errors and so the quality of its services by:

Error reporting and medicines management:

- The Datix incident reporting system is now embedded within the Trust. Optimising the local system – making it easier to report and utilising the data reporting functionality - is an ongoing process. The Trust appointed MSO works with the Governance team on this for medication incidents.
- The importance of reporting medication incidents is emphasised within the induction process for clinical staff, and is part of the Medication Safety Study days which have run quarterly during the last 12 months.

- Work is ongoing to ensure medicines management training is a formal aspect of induction for all clinical staff
- Lead Divisional Pharmacists and Specialist pharmacists review medication Datix reports for their areas, provide support for medication related issues and raise the profile of safe medicines management.
- Lead Divisional Pharmacists attend Divisional governance meetings where Datix trend and other medicines concerns are discussed
- The Safe Medication Practice Group also reviews medication incidents and identifies any trends and themes.
- Senior staff reviewing medication incidents may request escalation to "internal safety alerts" (ISAs), thus ensuring that deeper investigation takes place, recommended changes are implemented and the outcomes are shared.
- Medication related guidelines and policies are reviewed by senior pharmacists prior to ratification by the Trust Drugs and Therapeutics Group.

Feedback and learning:

- The Governance team use Datix to share outcomes and learning with a monthly message on the access page. This is seen every time the system is accessed to report or review an incident. Learning from medication incidents is included in these messages.
- The MSO publishes regular newsletters, providing feedback and sharing of learning from medication safety incidents reported locally, regionally and nationally.
- Medication related ISA action plans and outcomes are shared within and across Divisional teams
- Monthly "Druggles" - safety huddles about drugs - are held in paediatric areas. These multi-disciplinary sessions provide learning and sharing forums for all things medicine related, including medication error reports. They are now being rolled out to other areas such as ICU, Theatres and AAC.
- Controlled Drug related medication incidents are shared at the Local Intelligence Network meetings, in addition to localised sharing within the Trust
- The Trust appointed MSO is a member of the regional MSO group, which aims to promote a minimum standard for safe working practices across the West Midlands Region. The MSO is also attends quarterly meetings with MSO colleagues within the local healthcare economy, working towards a joined up approach to medication safety.

- The Antibiotic Stewardship Group is working to improve antibiotic prescribing across the Trust

Pharmacy:

- A dispensing robot was installed in the pharmacy department at Queens Hospital, Burton in August 2017. This has significantly reduced the number of picking errors reviewed by the pharmacy Error Reduction Group (ERG).

- An Omnicell system is now in place for storage of Controlled Drugs in the pharmacy department. This ensures a robust audit trail of pharmacy staff involved on CD dispensing.

- The arrival of the robot has released members of the pharmacy technician team to increase clinical pharmacy presence on the wards. This helps to raise the profile of safe medicines management on the wards and supports early medicines reconciliation for new patients

- Early medicines reconciliation reduce the chances of omitted doses and can detect or prevent prescribing errors. Data now available shows that pharmacy currently complete medicines reconciliation for, on average, 87% of patients, with 79% of patients having medicines reconciliation completed within 24 hours of admission.

- The Trust has an electronic prescribing and medicines administration system which allows the implementation of a variety of error-reduction strategies. These include warnings associated with high-risk drugs, dose calculators, drug monographs, interaction warnings, and the restriction of prescribing by individual password. The system is under constant review and improvement, in association with feedback from users, national safety alerts and updates, local and regional incident reports. The pharmacy IT team work very closely with pharmacists and others to optimise the system.

Falls

Patient safety is a key focus, especially when providing care and services to older and vulnerable persons. With people over the age of 65 making up 16% of the population it is not surprising that they occupy 65% of acute hospital beds. Patient falls account for approximately 40% of patient safety incidents reported to the National Patient Safety Agency (NPSA, 2007) and may result in injury that can lead to an increased length of stay, additional medical costs and ultimately a loss of confidence and independence for the patient. 10% of all patients aged over 65 who fracture their hips will die within 30 days. 50% of fragility fractures go onto fracture their hips and 50% never regain their previous level of mobility. The aging population means that incidence will increase by 50% by 2030.

The Burton Hospitals Foundation Trust has taken the following actions to improve the number of falls and so the quality of its services by:

In keeping with the above, the NHS Litigation Authority requires evidence of organisational use of risk assessments, monitoring, implementation and evaluation of appropriate actions in relation to slips, trips and falls.

The Trust, in accordance with the NICE quality standard Falls in Older People (2017), has been working to ensure that all patients at risk of falling are identified with the use of multifactorial falls assessment. A particular focus has been taken regarding the recording of lying and standing blood pressure and medication reviews.
We took part in the National Falls audit which showed a demonstrable improvement in the *areas* which were rag rated red last round of audit. The improvement surrounded lying and standing blood pressure and medication reviews.
We have conducted bed rail audits and a dignified throne audit to determine if we can further reduce falls in bathrooms.
All falls resulting in harm are investigated and discussed at a multidisciplinary meeting to ensure shared learning and appropriate actions are embedded in practice.

Discharge summaries

The Burton Hospitals Foundation Trust has taken the following actions to improve the number of discharge summaries completed and so the quality of its services by:

- A review of the discharge summary template on the version 6;

- The discharge policy has been updated with guidance on completing discharge summaries in a timely manner;
- A list is compiled daily of outstanding discharge summaries which is sent to clinical teams.

Incidents

NHS Trusts are required to submit the details of patient safety incidents to the National Reporting and Learning Service [NRLS]. The NRLS, thereafter, provides comparative feedback to Trusts twice a year. Trusts are able to use this information to identify and tackle areas of low reporting, as high reporting Trusts are considered to have a stronger safety culture; although the NRLS recognise that the use of incident reports should never be used as indicators of actual safety.

It is recognised that, even in organisations with a strong reporting and learning culture, not all patient safety incidents are recognised and reported by staff. In contrast, lower levels of incident reporting than peers should not be seen as positive sign, unless there is sufficient evidence supporting that these lowered rates are as a result of patient safety improvements.

Higher levels of reporting may reflect genuine safety concerns, or may reflect a safer reporting culture. As organisations vary in the services they provide; the location in which they are situated and the size of the organisation, comparative figures should be viewed in context.

Burton Hospitals Foundation Trust has a responsibility to comply with legislation, regulations and standards as well as a common duty of care. The Trust Board promotes and encourages the development of a positive and fair blame incident reporting culture with an emphasis on reporting incidents allowing the Trust to continuously learn from incidents and improve the quality of services to patients, staff and the public.

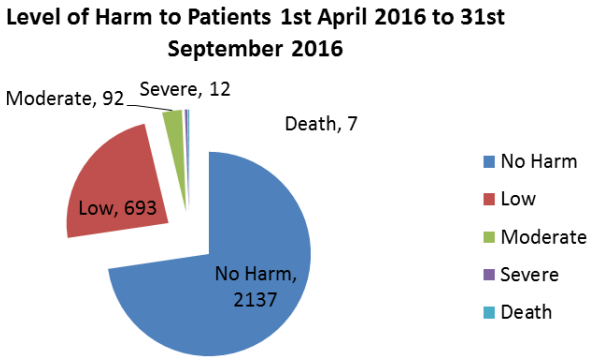
The table below identifies the number of **patient safety incidents** (PSI) reported to the NRLS between 1st April 2014 2016 to 30th September 2017 includes:-

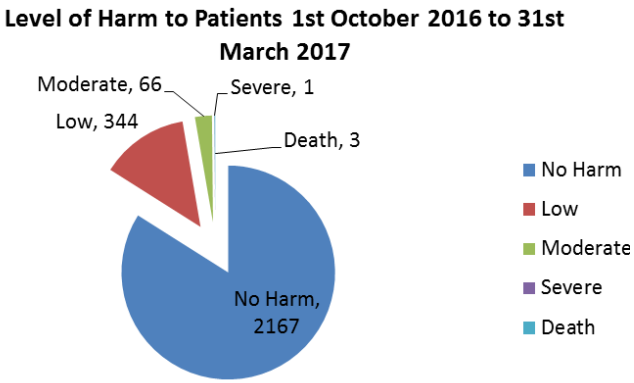
Indicators	1 April 14 to 30 Sept 14	1 Oct14 to 31 March 15	1 April 15 to 30 Sept15	1 Oct15 to 31 March 16	1 April 20 to 31 Sept 16	1 Oct 16 To 31 March 17	1 April 17 to 30 Sept 17
Number of patient safety incidents reported	1574	2280	2872	2916	2941	2581	2739
Incident rate per 1000 bed days	20.95	28.84	38.04	35.84	36.7	31.39	38.83

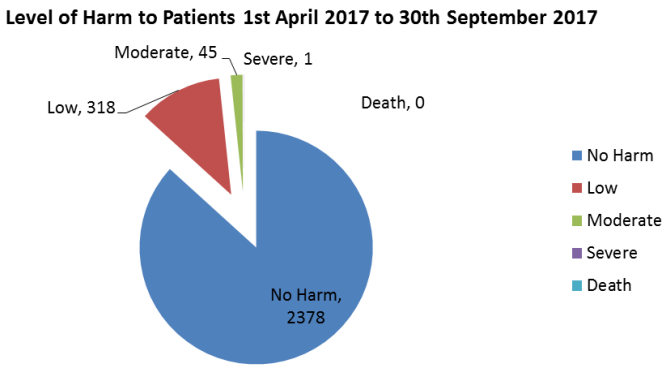
Datix was implemented at the Trust for reporting incidents on 1st August 2016 and this could be a factor in the reason why the number of incidents had declined for the last 6 months within the table above and that there has been change within the organisational structures.

The below table identifies the harm caused to patients from 1st April 2014 to 30th September 2017 as published by the NRLS

	1 April 14 to 30 Sept 14		1 Oct14 to 31 March 15		1 April 15 to 30 Sept15		1 Oct15 to 31 March 16		1 April 20 to 31 Sept 16		1 Oct 16 To 31 March 17		1 April 17 to 30 Sept 17	
Degree of harm	No	%	No	%	No	%	No	%	No	%	No	%	No	%
No Harm	765	48.6	970	42.5	2136	74.1	2139	73.4	2137	72.7	2167	84	2378	86.7
Low	697	44.2	1137	49.9	617	21.5	654	22.4	693	23.6	344	13.3	318	11.6
Moderate	99	6.2	152	6.7	114	4.0	113	3.9	92	3.1	66	2.6	45	1.6
Severe	11	0.7	20	0.9	5	0.2	5	0.2	12	0.4	1	0.0	1	0.0
Death	2	0.1	1	0	0	0.1	5	0.2	7	0.2	3	0.1	0	0.0







The latest data that has been published by the NRLS identifies that Burton Hospitals NHS Foundation Trust continues to stay in the 'Acute (non-specialist) organisation' which now compares 136 organisations compared to the peer group of 'Small Acute Organisation' which had 28 organisations (published data including October 2013 to March 2014), however since the NRLS have removed this category meaning that BHFT is now benchmarked against much larger Trusts.

The latest NRLS data published identifies that the Trust is now sitting at 85th place per 1000 bed days out of the 135 organisations; we have increased by 34 places since the previous NRLS publication in September 2017.

The current median number of incidents per 1000 bed days is 41.99 across the 135 organisations.

Training programmes continue to be developed and delivered by the Governance Department to raise awareness, improve incident reporting and Root Cause Analysis training which continues on a three monthly programme for investigation officers.

Analysis of the data from the different modules on Datix is presented via reports to a wide range of groups and committees within the Trust including Business Unit and Divisional Committees; Patient Experience Group, Medical Devices; and the Risk and Compliance Group (just an example). The Governance framework allows the escalation of information from the subcommittees to Trust Committees which then feed into the Trust Board.

Never Events 2017-2018

The organisation reported 3 No Harm Never Events in 2016-2018, which were reported for the following categories: -

- 1 x Administration of medication by the wrong route
- 2 x Wrong implant/prosthesis
    - Right medial base plate was inserted instead of the right medial base place
    - Prosthesis mismatch noted between two differing manufactures

Following the two 'wrong implant/prosthesis' Never Events the Trust liaised with the Healthcare Safety Investigations Branch (HSIB) to see if they would be interested in the issues raised regarding packaging from the manufacturers. The HSIB is an independent organisation that exists to improve safety at a national level. They undertake investigations where it is felt that there is potential for learning something new that can improve practice across the healthcare system, not just at this hospital.

Data gathered by HSIB from national reporting systems showed that despite published guidance aimed at preventing these events, the frequency of this error has not reduced. Evidence from both research and reporting systems demonstrates that implantation of the wrong prosthesis occurs across the

healthcare system (there are on average 50 incidents a year) and reflects a national, systemic issue.

Learning Potential – What is the potential for an HSIB investigation to lead to positive changes and improvements to patient safety across the healthcare system?

The HSIB investigation will review the safety measures currently in place, seeking to understand why they do not always prevent implantation of the wrong prosthesis from a National level. It will seek to identify strategies and opportunities to reduce the risk of this happening again.

Datix

The Trust has been using Ulysses (Safeguard) at the organisation since approximately 2004 as the software system of choice but following a review of the products available in 2015, Datix was the successor.

The Trust moved from using Ulysses (Safeguard) at the organisation to Datix from 1st August 2016 with a phased implementation plan for the role out and transfer over to the new Software system.

The Trust has implemented following modules within Datix: -

- Incidents
- Risk Register
- PALS
- Complaints
- Claims

The final module to be implemented was the Safety Alerts module. This module was developed in quarter 4 of the previous financial year and has been since 1st April 2017. The Alerts module enables emails and responses through the system which will ensure a more streamlines process and effect audit trails of the alerts received and implemented.

Datix IQ – Mortality Module

In February 2016, the Healthcare Quality Improvement Partnership (HQIP) commissioned the Royal College of Physicians (RCP) to deliver the first ever National Mortality Case Record Review (NMCRR) programme. The aim of the NMCRR project is to establish and roll-out a standardised methodology and process for retrospective case record review of mortalities to support improvement, understanding and learning from problems in care that may have contributed to patients' deaths.

The RCP partnered with Datix to provide the software platform for the system.
In December 2016 the CQC reviewed the way NHS trusts review and investigate deaths. They found that opportunities to learn from patient deaths are being missed and there was no single framework for NHS Trusts to set out what they need to do to maximise learning from deaths. The CQC outlined the obligation for Trusts to know something about every death and to evidence learning and improvements from mortality reviews.

Datix Cloud IQ Mortality Review allows organisations to meet CQC guidelines by enabling them to capture, review and learn from deaths.

The Trust has purchased the Mortality Review module which will allow the organisation to improve the process, information gathering and conduct robust mortality reviews within the Business Units, detail actions to move forward and identify lessons learned, ensuring the Trust is compliant with all of the CQC demands.
The Mortality module is currently being developed within Datix and is envisaged to be rolled out within Quarter 1 2018-2019.

Freedom to Speak Up Guardian

In February 2015 Sir Robert Francis published his review in to Speaking Up in the NHS. One of his recommendations was that every Trust should have a named person who could support all staff to speak up and to raise their concerns—a Freedom to Speak Up Guardian.
Freedom to Speak Up Guardians work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers.

The Governance Department has worked with the Trust Freedom to Speak up Guardian to develop an online form using Datix for any staff member to report a concern. This also enables a smooth extraction of data from the Datix system for any trends/themes internally and for National submission.

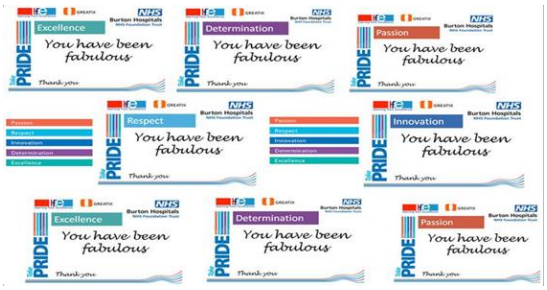
Learning from Excellence

The Trust has joined in the movement to aim to identify, appreciate, study and learn from episodes of excellence in frontline healthcare.

Learning from excellence (LFE) has been launched across the organisation following a successful trial within the Emergency Medicine Pathway. Staff can nominate other staff members when they have observed them performing / demonstrating a specific episode of excellent work. We need to capture the niceties that the staff member displayed to enable the trust to learn from these examples.

We have linked the LFE to the trust PRIDE values

The staff member who has been nominated will receive a gratitude card and their line manager will also receive a copy of the nomination.



The nomination is made via the intranet and is linked to Datix and is fondly known nationally as a GREATIX and can be accessed via the news section on the intranet main page.

Patient Information Leaflets – The Implementation of SharePoint

*Microsoft **SharePoint is** a browser-based collaboration and document management platform from Microsoft. Microsoft's content management system. It allows groups to set up a centralized, password protected space for document sharing'*

Document management controls the life cycle of documents in our organisation — how they are created, reviewed, and published, and how they are ultimately disposed/archived retained. Although the term "management" implies that information is controlled from the top of the organisation, an effective document management system should reflect the culture of the organisation that uses it. The tools that you use for document management have been developed to be flexible enough to enable the Business Units to control a document's life cycle that fits the Trust's culture and goals

The Governance Department have been developing SharePoint over the past 6 months and was able to go live on 7th February 2017. There have been three phases to the implementation of SharePoint at the Trust

The Governance Department has developed SharePoint to manage the Patient Information Leaflets which holds approximately 3000 leaflets through an audit trail and streamlined process. SharePoint was implemented on 7th February 2017 which enables that at 3, 2, and 1 month intervals before the Patient Information leaflet expires, designated staff within the Business Units and the author/reviewer of the leaflet will receive an email to advise that this is 'notice' that the patient information leaflet will be expiring in 3, 2 or 1 months' time.

The final stage was completed on 27th April 2017 where the Trust commenced the 'automatic' archiving of patient information when it is passed its expiry date, so that there will not be any patient information held on SharePoint which has passed their expiry date.

The SharePoint system continues to allow the Governance Department to manage the active Patient Information leaflets within the Trust, within a time efficient process.

Clinical Effectiveness Indicators:

Readmission rates

The NHS Outcomes Framework indicators require Trusts to monitor the number of readmissions within 30 days. There are many reasons why a patient is readmitted into hospital within 30 days of being discharged. Sometimes this can be a planned re-admittance for clinical reasons. However, it can sometimes indicate that there were problems with discharge arrangements; the patient may have been discharged too early or there were insufficient services in place to support the patient when they returned home. The Trust periodically audits notes of patients who have been readmitted within 30 days.

For the purposes of the Quality Account however, Trusts are required to report on the previous indicator of readmissions within 28 days. The percentage of the Trust's readmissions, based on 28 days, is 12.5% (April 2017 – January 2018). This demonstrates a slight increase on the outturn position for 2016/17, which stood at 11.1%. Through the Unplanned Care Transformation Programme, the Trust has worked on timely and safe discharge from hospital which requires support services to be available from the day of discharge. These services are generally provided by a number of other organisations with whom the Trust has continued to work closely with during the year. Equally, the trust has looked to focus on ensuring that, where possible, patients avoid admission to an acute hospital bed as their condition or needs can be managed more effectively elsewhere. Success in this objective does result in a higher average acuity of patient in our beds and as such the likelihood of clinically driven readmission is marginally increased.

The Burton Hospitals Foundation Trust has taken the following actions to improve the 're-admission rate overall' and so the quality of its services by continued focus on improving discharge planning, engaging the multi-disciplinary team to ensure that patients are discharged safely when they are medically fit, linking this with their expected date of discharge (EDD). Through the implementation of Medworxx and the adoption of the national 'Red to Green' concept, the Trust has embedded practice which enables greater insight into the status of each patient and whether they are experiencing any unnecessary delays, both internally within the Trust or awaiting external support. Reducing external delays driven by health and social care capacity constraints has been, and continues to be, a key priority working alongside partner organisations.

Furthermore, the Trust has continued its work with Virgin Healthcare who have been focussing on those patients with long term conditions such as diabetes and chronic obstructive pulmonary disease (COPD) who tend to be the more frequently readmitted patients due to the nature of their disease. Pathways are being developed to proactively manage these patients care without need for acute admission with anticipated commencements dates in 2018/19.

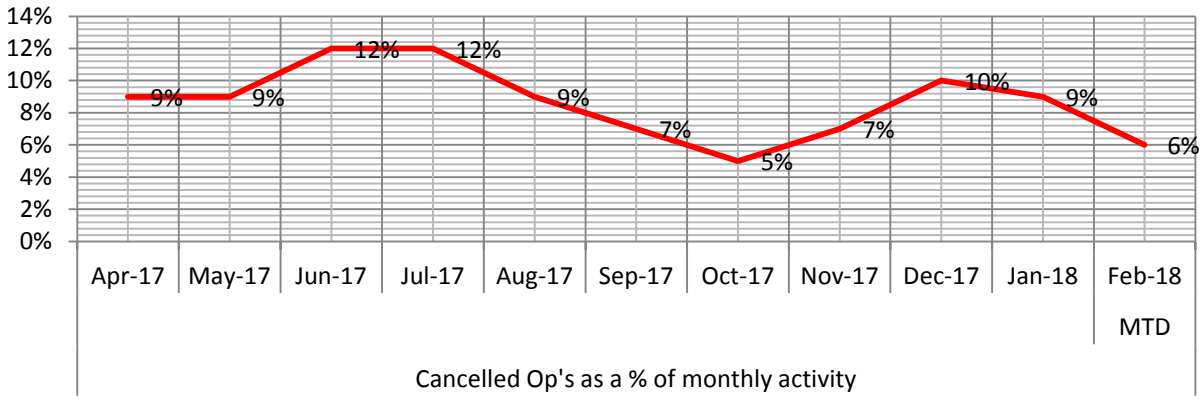
Cancelled Operations

Operations are sometimes cancelled for clinical reasons; the patient may be unwell or their condition may have changed. However, on occasion operations are cancelled for non-clinical reasons; a bed may not be available or there may be theatre scheduling problems or equipment failure. Such cancellations can cause great anxiety, distress and inconvenience for patients and their families.

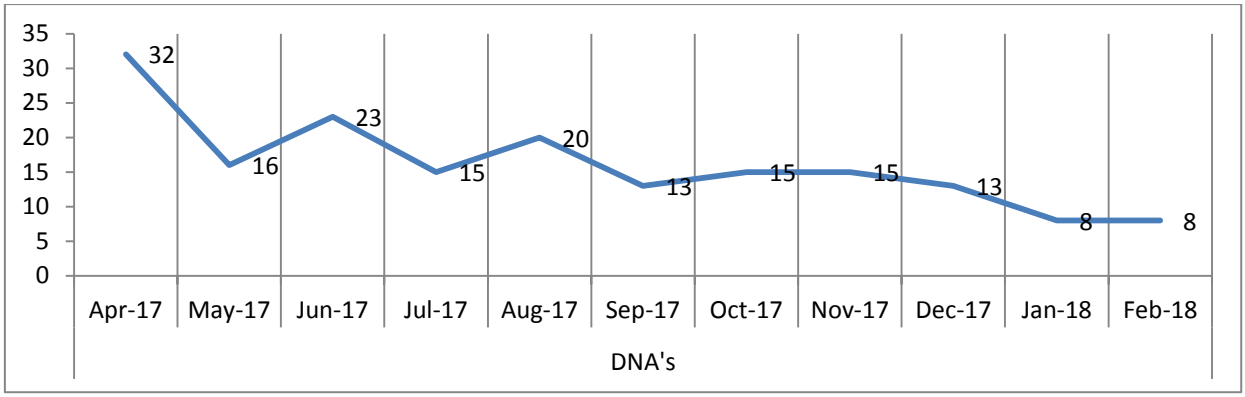
Any non-clinical cancellations are recorded, with key themes presented to the Trust Board. Through the Planned Care Transformation programme focus and attention is given to resolving underlying issues. A key theme nationally is insufficient elective beds as a result of high emergency demand, particularly in winter months.

The Burton Hospitals Foundation Trust has taken the following actions to improve the number of cancelled operations and so the quality of its services by developing a robust Winter Plan, in anticipation of the predicted rise in emergency medical admissions in the winter months with a focus on ensuring sufficient bed capacity for emergency patients as well as ensuring that appropriate levels of elective surgery could proceed without unnecessary cancellations to surgery. The Trust entered the winter months with a stable and compliant routine waiting list position and proactively planned to operate on increased numbers of daycases in January, with fewer elective inpatient cases so as to ensure sufficient beds for emergency patients and to minimise the volume of elective surgery cancellations due to there being no bed. This ensured that elective activity was able to continue, with fewer cancellations seen within the Trust than experienced by many other organisations and also ensure that no urgent or cancer elective cases need to be cancelled.

The Trust is aiming to have no more than 5% of cases cancelled and the chart below shows the month on month progress being made to reduce cancellation rates. A text reminder service has been introduced which ensures all patients awaiting an operation are contacted shortly prior to their procedure to reduce likelihood of cancellation on the day i.e. if they have a cold which would prevent procedure going ahead this can be ascertained before the day, allowing the patient to be rebooked and the operating slot to be given to another patient.



The text reminder service has also had a positive impact on reducing the number of 'Did Not Attends' (DNAs). The table demonstrates the fall in the number of patients not attending for their procedure by month across 2017/18 year to date.



Emergency and Urgent Care

The focus of the national and local healthcare system remains on the length of time people wait to receive treatment within an Emergency Department. It has been shown that patients who are diagnosed and treated within 4 hours have better clinical outcomes and vastly improved patient experience.

The 4 hour ED waiting time standard remains a clear indicator of an effective and joined up emergency and urgent care system care. The Trust and its partners continue to develop systems to improve waiting times and reduce delays both within the Emergency Department and the wider hospital setting.

2017/18 has, as with wider NHS, been a very challenging year in terms on emergency demand. This has been particularly evident over the winter months which have been characterised by a consistently high patient acuity, particularly concerning incidence of respiratory tract infections, including confirmed Flu cases; a requirement to open additional planned bed capacity earlier and at a higher level than anticipated in the Trust Winter Plan and, as a result, compromised patient flow leading to increased 4 hours breaches and delays to patients accessing acute beds. Whilst the Trust has not been able to consistently meet the 95% national standard through the course of the year, 2017/18 will outturn with more than 90% of patients being treated or discharged within four hours of presentation compares favourably with providers nationally.

Through the A&E Delivery Board, the Trust is working with its partners at the Clinical Commissioning Group, Community Trust and Local Authorities to improve the levels and quality of care provided so patients can be safely discharges in a timely manner.

The Burton Hospitals Foundation Trust has taken the following actions to improve the Waiting times in ED (emergency Department) and so the quality of its services through the following actions:

In 2017/18 the transformation programme has focussed on the acute pathway, processes in the Emergency Department, reducing attendances and avoiding admission and supporting early, effective discharge. Particular focus has been given to the implementation of a new information system which provided patient specific details on next steps for each inpatient to support a reduction in delays as well as the development of a Frailty Model to ensure that patients over the age of 75 are assessed by a specialised and multi-disciplinary team to ensure that the care is delivered by the most appropriate team in the most appropriate setting rather than defaulting to acute admission. As we move into 2018/19 the emergency pathway will continue to be the key transformation priority to help drive internal improvements and work with partners to support the development of out of hospital services to improve timely discharge of medically fit patients.

Patient Experience Indicators:

Inpatient Experience

The Trust aims to provide the best possible patient experience.

Being treated with kindness and compassion is a big part of the patient experience, along with ensuring that the Trust is responsive to the needs of inpatients, as it is recognised that often patients can be at their most vulnerable when they have cause to use hospital services.

A variety of methods are used to gain feedback on what patients and their families think about the Trust's services. This includes a number of local surveys that are carried out each month on all wards with a target of 20 patients and relatives responding to surveys. The Trust's monthly inpatient surveys undertaken anonymously by impartial volunteers show that the hospital continues to score well in kindness and compassion and responsiveness to patient needs. All questions relating to this have scored an average of 96% or above over the year. Overall scores have remained consistent over the last 3 years.

Question	Score 2014-15	Score 2015-16	Score 2016-17	Score 2017-18
Did staff welcome you and show you things you needed to know when you arrived on the ward?	94	96	97	97
Have you been treated with kindness and compassion by staff?	96	98	98	98
Do staff explain things to you in ways you understand?	95			
Do Nurses explain things to you in ways you understand?		97	97	97
Do therapists (Physiotherapists, Occupation Therapists, Speech Therapists, Dietitians) explain things to you in ways you understand?			98	98
Do Doctors explain things to you in ways you understand?		93	94	95
Have you been able to get the attention of staff when you needed it?	92	96	97	97
Do you get enough help from staff to eat and drink?	97	98	99	98
If you have had any pain, do you think that staff have done all they can to help control it?	95	97	97	97
Have staff done all they can to help you stay clean?	98	99	99	99
If you need help getting to the toilet or bathroom, do you get it in time?	93	96	96	96

National Inpatient Experience Survey 2016

At the time of writing the 2016 results are the most up to date National Inpatient Experience Survey results available to the Trust.

The Trust performed as well as most other Trusts in the National Inpatient Survey 2016 in all key patient experience domains and is performing better than most other Trusts on two questions. There were no questions where the Trust scored worse than most other Trusts, which is consistent with 2015.

Domain	2016 Better/ Same/ or Worse	Trust Score
Emergency/A&E	Same	8.6
Waiting list and planned admissions	Same	8.6
Wait to get a bed on a ward	Same	7.5
The hospital and ward	Same	8.2
Doctors	Same	8.7
Nurses	Same	8.2
Care and treatment	Same	7.9
Operations and procedures	Same	8.6
Leaving hospital	Same	7.1
Overall views of care and services	Same	5.4
Overall experience	Same	8.2

Indicator	2016 Survey Better / Same/ or Worse	Trust score
Did you feel threatened during your stay in hospital by other patients or visitors?	Better	9.8
Did you have confidence and trust in the nurses treating you?	Better	9.3

Patients' overall experience of their care as reported in the National Inpatient Survey is as good as most other Trusts.

Overall Impression	2016 Survey Better/ Same/ or Worse	Trust Score
Overall, experience on a scale of 0 - very poor to 10 - very good.	Same	8.2

Maternity Services National Patient Survey

The results of the National Maternity Survey undertaken in 2017 show that the Trust is performing as well as most other Trusts who undertook the survey in the 3 domains measured.

Domain	2017 Survey	
	Better/ About the Same/ or or Worse	Trust Score
Labour and Birth	Same	9.0
Staff during labour and birth	Same	9.0
Care in hospital after the birth	Same	8.0

Children and Young People's National Patient Survey

The results of the National Children and Young People's Survey undertaken in 2016 show that the Trust's score was significantly better for three questions in comparison with the previous survey undertaken in 2014. There were no questions which showed a significant worsening of score. In comparison with the other 137 Trusts surveyed the Trust performs well and sits within the expected range for the majority of areas – for 43 questions. The Trust scored in the top 20% of Trusts for 12 questions; and in the bottom 20% of Trusts on 7 questions.

The general consensus was that of a very positive patient experience which is reflected in the score of 8.6/10 for the question asking parents/carers for their view of their child's overall experience.

Emergency Department National Patient Survey

The results of the Emergency Department National Patient Survey undertaken in 2016 show that the Trust is performing as well as most other Trusts who undertook the survey in the 9 domains measured.

Domain	2016 Survey	
	Better/ Same/ or Worse	Trust Score
Arrival at the emergency department	Same	7.9
Waiting times	Same	5.8
Doctors and nurses	Same	8.4
Care and treatment	Same	7.6
Tests (answered by those who had tests only)	Same	8.6
Hospital environment and facilities	Same	8.6
Leaving the emergency department	Same	6.3
Respect & dignity	Same	9.1
Experience Overall	Same	8.0

Friends and Family Test 2017-18

All NHS Trusts in England and Wales are expected to ask all patients the Friends and Family Question. The Friends and Family Test is not intended to provide comparisons between Trusts or against national scores but as a local indicator of satisfaction. This is presented as the percentage of patients asked who would recommend their care in this hospital to family and friends.

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Inpatient & Daycase	97	97	96	97	97	96	98	97	98	97	96	97
A&E/MIU	93	89	90	87	88	87	84	86	86	88	87	90
Maternity	99	99	98	97	97	98	98	98	98	99	94	98
Outpatients	91	90	93	91	94	95	96	95	98	96	89	95

Delivering Same Sex Accommodation

The Trust has continued to work hard through the year with the Estates, Facilities and operational teams with the aim of complying with same sex accommodation standards and improving the environment. The Trust continues to declare compliance with the Government's requirement to eliminate mixed sex accommodation.

Patient Reported Outcome Measures (PROMs)

The Trust has a requirement to provide details on PROMs for 4 different surgical procedures. These 4 procedures are unilateral hip replacements, unilateral knee replacements, groin hernia surgery and varicose vein surgery.

All patients undergoing surgery at the Trust that fall under one of the identified procedures are asked at pre-operative assessment to complete a questionnaire. All forms that are completed by patients are returned to Quality Health who are the Department of Health approved contractor. All consent forms that are completed with regard to a patient's procedure are held within their notes.

Staff who are involved with the PROMs programme encourage participation in the questionnaires at every available opportunity and reiterate the importance to patients of capturing their feedback. Staff report good rates of participation and willingness by patients to take part in the survey.

All figures are derived from the Health Episode Statistics (HES) website. The data relating to the Trust, and nationally, for all procedures in terms of participation at pre-operative and the response rates of post-operative stages are shown in the tables on the following page. The EQ-5D scores and condition specific scores for each procedure are also shown in the following tables. The EQ-5D score identifies the percentage of respondents who recorded an increase in their general health following their operation, based on a combination of five key criteria concerning their general health for each procedure.

The data below is taken from the from the Health Episode Statistics (HES) website for the reporting period April 2016 – March 2017.

April 2016 to March 2017, provisional data

Adjusted average health gain for Provider - BURTON HOSPITALS NHS FOUNDATION TRUST (RJF)

NOTE: Table 1 and Table 2 only display data at England and Provider level

Table 1: Pre-operative participation and linkage

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	651	677	104.0%	469	69.3%
Hip Replacement	311	301	96.8%	230	76.4%
of which *					
Primary	*	*	*	*	*
Revision	*	*	*	*	*
Knee Replacement	340	376	110.6%	239	63.6%
of which *					
Primary	*	239	70.9%	*	100.0%
Revision	*	0	*	0	0.0%

Table 2: Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate
All Procedures	677	676	99.9%	499	73.8%
Hip Replacement	301	301	100.0%	238	79.1%
of which *					
Primary	*	*	*	*	*
Revision	*	*	*	*	*
Knee Replacement	376	375	99.7%	261	69.6%
of which *					
Primary	239	238	99.6%	187	78.6%
Revision	0	0	0.0%	0	0.0%

April 2016 to March 2017, finalised data - groin hernia and varicose vein procedures

Adjusted average health gain for Provider - BURTON HOSPITALS NHS FOUNDATION TRUST (RJF)

NOTE: Table 1 and Table 2 only display data at England and Provider level

Table 1: Pre-operative participation and linkage

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	452	231	51.1%	193	83.5%
Groin Hernia	417	231	55.4%	193	83.5%
Varicose Vein	35	*	*	*	*

Table 2: Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate
All Procedures	231	230	99.6%	153	66.5%
Groin Hernia	231	230	99.6%	153	66.5%
Varicose Vein	*	*	*	*	*

Complaints

The focus for all health providers is on listening to, acting upon and learning from feedback from service users because of the importance placed on the values of prioritising the patient voice. This includes ensuring that feedback from the Friends and Family Test, audits, surveys and complaints feeds into Trusts' learning and quality assurance and improvement processes. Complaint management has in recent years, received significant attention from Government ministers, the media and the public, and major reports (Clwyd-Hart, Berwick and Francis) have shaped and influenced policy across the NHS landscape.
In September 2017, Robert Behrens of the Parliamentary and Health Service Ombudsman stated that:

'*The NHS provides high-quality care to millions of people every year, but unfortunately we still see a wide variation in the quality of complaint handling. Far too many complaints come to us that could have been resolved by the NHS, leaving people waiting too long for answers and delaying important improvements'*

As well as being committed to providing high quality care, the Executive board and all staff at Burton Hospitals NHS Foundation Trust are committed to ensuring all feedback that is received is responded to effectively. For the past 4 years the Trust has seen improvements in the timeliness of complaint responses, as well as a significant reduction in the number of complaints received.

	2015/16	2016/17	2017/18
Number of Complaints	239	239	237
Number of PALS contacts, including compliments	3064	3390	3663

To ensure that the Trust provides a robust complaints handling service, the team are performance managed against a set number of key performance indicators.
Complaint KPI's

To maintain numbers in line with 2015/16 (baseline Apr '15- Mar '16)
90% of written complaints responded to within initial timescale agreed with complainant (monthly trajectory to be established 15/16)
100% of complaints acknowledged within 3 days
Reduce % of complaints that are either ongoing/reopened

In addition to considering the performance of the complaint team which is underpinned by agreed KPI's, in 2017 the Corporate Trust team made a commitment to the Trust's ambitious Quality Improvement Plan (QIP) and the complaint function for the Trust was set some dynamic and innovative actions to achieve.

Core indicator	Quality Improvement strategy	CQC 5 Questions	National Driver	Actions Ambition
Complaints	Positive Patient Experience	Are they responsive to People's needs? Are they caring? Are they well-led?	Leading Change- Adding value (ILVAC) 4. We will be centred on individuals experiencing high value care; 5. We will work in partnership	Scope the engagement of the community with PALS, and Complaints Team – working with the PPE Lead to reach out to communities. Review signage and literature in other formats and languages Strengthen the soft intelligence process working more closely with primary care to address themes and trends Learning from trends and themes

		with individuals, their families, carers and other important people to them	To further develop and promote workshops to support staff on the local resolution of concerns; holding a complaint meeting; the role of the Investigating Officer and writing complaint responses

In support of these objectives during 2017/18, members of the Complaints, PALS, Volunteer and PPE Teams' have attended a number of community events:

- Let's Talk Mental Health at the Pirelli Stadium
- Play Day at Meadowside Leisure Centre; along with colleagues from the Children's Ward
- Eid Celebrations at the Pakistani Community Centre, Uxbridge Street, where approximately 10 new members were recruited at the event and two new members of the Youth Forum
- Support Staffordshire Forum at the Voluntary Services Centre, Union Street Car Park
- Diabetes UK annual event at the Pirelli Stadium; along with colleagues from the Diabetes Centre along with the Trust's Volunteer Coordinator
- Improving Lives – Virgin care event at Burton Town Hall
- Shobnall Family Engagement Event at Princess Street Community Centre
- Step into the NHS Careers event at Stafford County Showground

Along with the Trust's PPE Lead, the Complaints Manager has used these events to engage with representatives of our local community to gauge awareness of both the PALS service and the complaint function within the Trust. Meetings have been held with representatives of the local LGBT community, the Polish and Muslim communities with plans to develop improved links with some harder to reach groups and to arrange some wider engagement sessions. Links with Stafford ASSIST have resulted in complaint documentation being translated into an easier to use format for those with a sensory impairment. Regular catch ups with local Healthwatch representatives have also provided invaluable opportunities to learn more about why people complain and more importantly what stops people from complaining. Feedback, via Healthwatch for both Derbyshire and Staffordshire, has been strengthened with agreed routes for learning more about how patient's experience our Trust, the services it provides and its staff. Healthwatch now provide two reports, one detailing comments and feedback to share within the organisation and another with specific details for further investigation. Additionally, Healthwatch Derbyshire will review feedback about the Trust on a regular basis and then provide feedback for us to consider on recurring themes or issues.

Soft intelligence feedback continues to be received and following recent changes within the CCG, this feedback is now received in a more timely way. Agreement on the process for investigation has been confirmed also, with issues being either logged, investigated or referred for clinical risk investigation.

Trends and themes of feedback are shared at a number of Trust forums, including Quality committee, Board meetings and the Patient Experience and Staff Wellbeing Group. Additionally, themes of feedback and complaints are discussed at a number of senior nursing forums, as well as divisional performance reviews and divisional governance reviews, as well as with our local Commissioners at the Trust's monthly quality review group meeting.

The Complaints and PALS team have had a busy year delivering 'BLAST' training throughout the organisation to wards and departments. In total approximately 120 staff of differing grades and disciplines on our wards have attended sessions and the feedback has been positive. Staff have reported feeling more engaged, confident and empowered to address concerns or complaints and this often leads to speedier local resolution. Following on from BLAST training session on the Children's ward, the Ward Play Activity Coordinators assisted the team with a poster competition; children on the ward were asked to design posters advertising the PALS service. The posters have been used around the hospital sites to encourage patient feedback and the all the children received a small gift and certificate from the Trust for their efforts. To aid more effective complaint investigating, the Complaints Lead and Deputy have also delivered dedicated complaint investigation training for staff that have been identified as Investigating Officers.

The Burton Hospitals Foundation Trust has taken the following actions to improve the number of complaints and complaint response times and so the quality of its services by:

Some other initiatives this year for the complaint service include

- Consolidating and embedding the use of Datix after the implementation in October 2016. This system supports effective complaint reporting and analysis of trends and themes across complaints, PALS and serious incidents
- Bespoke training sessions have been held to support Investigating Officers to improve complaint investigations to underpin the quality of the responses
- Sessions at the Trust's Induction Market Place sessions with representatives from the PPE team to inform new starters about the importance of both services and feedback to the organisation
- Joined up working with the Patient Experience Team and the Complaints/PALS team to ensure trends and themes of feedback are monitored and shared widely in the organisation
- Matron Quality Ward rounds refreshed in 2017/18 with a focus for the rounds reflecting the CQC key lines of enquiry
- In support of the proposed Trust merger, strong links have also been made with the Complaints & PALS teams at our neighbouring Trust.

Complaints referred for investigation by the Parliamentary and Health Service Ombudsman (PHSO)

To ensure openness and in line with good complaint handling guidance, the team at BHFT ensure all complainants are provided with information about how to refer

any unresolved complaints to the PHSO which is an independent body who can review all aspects of a complaint, including how the Trust has investigated a formal complaint and responded. The Complaints Team work in a supportive and collaborative way with colleagues in the PHSO to ensure any independent reviews are thorough and completed in a timely manner. Additionally, the Trust will offer to refer itself if local resolution has stalled and a complainant is still unhappy with the outcome of the Trust's complaint investigation.

- In 2015/16 there were 9 new referrals to the PHSO
- In 2016/17 there were 11 new referrals to the PHSO
- In 2017/18 there were new referrals to the PHSO *72% reduction on the previous year

Of the three cases investigated by the PHSO this year, 2 were not upheld and one was partially upheld.

Compliments

Compliments to the Trust provide a rich source of feedback on how a patient/relative has found the services provided by the Trust. This feedback is diverse and will reflect both an experience in the ward or outpatients, but also provide commentary on the other Trust services which support the function of the Trust, including Portering, administration staff, volunteers, catering and cleanliness. Additionally, compliments provide an invaluable boost to moral for staff who work hard to provide good care delivery, sometimes in challenging circumstances.

Compliments received across all 3 sites	2015/16	2016/17	2017/18
Total received	667	725	747

A&E: I was well looked after. I found everything streamlined and felt supported and updated throughout my stay. I was offered sandwiches and coffee…wow!! Thank you so much everyone. Impressive organisation.

Oncology/Ward 30: I found all staff helpful and supportive with any queries I had regarding my care and treatment. Nothing seemed to be too much trouble, people were professional in the way they dealt with me.

Maternity: Excellent care and support given by all on the maternity wards throughout my pregnancy and labour.

Ward 19 : I have been very satisfied with the care I have received during my stay. Thank you to all the staff.

Ward 30: I thank you all for the kindness and care you have given me without exception and wish you all love and luck for the future.

MIU @ SRPH: I felt like a real person, they took the time to care and listen to me. From the person in reception, to the nurse I saw, excellent service

Part 3: Additional Quality Overview

Implementing guidance from the National Institute for Health and Care Excellence (NICE)

NICE was established as a Special Health Authority to make recommendations to the NHS on new and existing medicines, treatments and procedures. NICE guidance is published monthly.

The Trust maintains a Policy which is accessible to all employees, outlining the core principles for a collective approach to planning and enabling the consistent dissemination, implementation and evaluation of NICE guidance. It is recognised that adequate implementation of NICE guidelines requires a robust process that involves all Trust staff. Therefore, the Trust has a NICE Working Group that meets monthly to consider each individual guideline and agree on a dissemination pathway and develop a system in which to receive a coherent response to the guideline from the named responsible individual informing of current Trust compliance. The NICE Working Group maintain up to date records of NICE compliance and identify and enable resolution of any issues that the Trust may have with implementation; this includes re-visiting any guideline that is being updated or developed.
The NICE Working Group membership consists of:

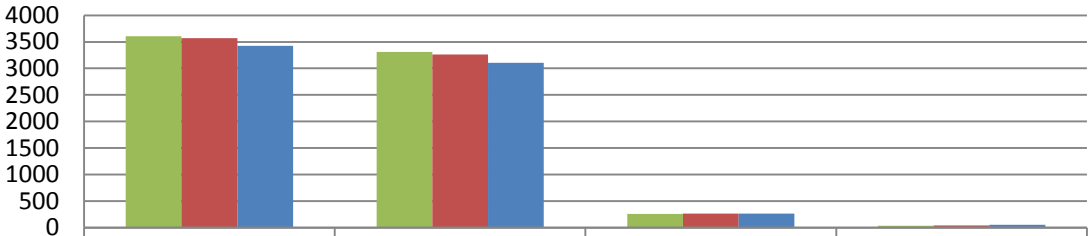
- Deputy Medical Director
- Associate Director (Medical Directors Office) – Chair
- Divisional Medical Director Medicine
- Divisional Medical Director Surgery
- Head of Pharmacy or nominated representative
- Clinical Audit Manager or nominated representative
- Corporate Nursing representative

The NICE Working Group reports into the Trust Quality Review Group, which in turn reports to the Quality Committee which is a sub-Committee of the Board of Directors.

Overview of Maternity Services

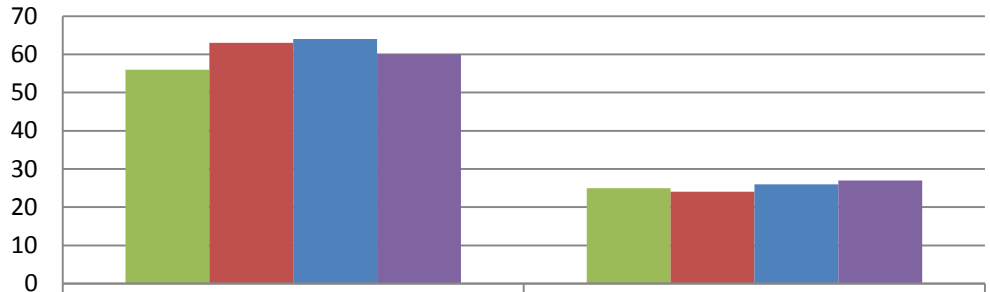
Maternity provision within Burton Hospitals Foundation Trust is an integrated service, with care being provided at Queens Hospital, the Midwifery Led Unit (MLU) at Samuel Johnson Hospital in Lichfield and in the Community. A multidisciplinary team provided care for 3423 births in 2017-18; the graphs below compare 2015-16, 2016-17and 2017-18 performance against the national average for 2017:

Comparison of Birth Data



	Total Births inc SJH/HB	QHB births	SJH births	Home/BBA
2015/16	3603	3309	258	36
2016/17	3571	3264	264	43
2017/18	3423	3103	266	54

Comparison of Data C/S and Normality Rates



	Normality Rate %	C/S Rate%
2015/16	56	25
2016/17	63	24
2017/18	64	26
Nat.Aver (2017)	60	27

The multidisciplinary team work in close cooperation to provide a seamless journey throughout pregnancy. Antenatal and postnatal care is delivered across a wide geographical area by the community midwifery services, who also undertake a small number of home births per year. Approximately 22% of women who birth with the Trust will have a midwife as their lead professional; initiatives are in place to increase these numbers.

The Consultant led unit is based at Queens Hospital and compromises of an ante natal clinic, maternity assessment unit, which includes a 24 hour triage facility, a combined ante natal/ post-natal ward and a central delivery suite. The majority of Midwifery staff rotate on a daily basis to all areas; this includes Ante-Natal Clinic, Maternity assessment, Delivery Suite, the provision of caesarean section cover, and the Ante-Natal / Post Natal Wards. The Service is covered by all Obstetric Consultants, with a designated Service Consultant covering the unit during the week, with an on call service for the evening and weekends. There is also a dedicated team of Obstetric Anaesthetic consultants, ensuring senior cover and leading the evolution within this discipline. Senior Midwifery cover is also provided

by both an on call manager and Supervisor of Midwives. This close working relationship of the multidisciplinary team ensures the service has a continuum for evolving and ensuring the best journey for all women choosing to birth at the Trust.

The Trust's Central Delivery Suite compromises of 7 delivery rooms, each with en-suite facilities. These rooms are adaptable to deliver both high risk and low risk midwifery-led care. Two of these are set up specifically to deliver midwifery led care, one with a couch instead of the bed and birthing stool (bed available). This includes a birthing pool suite, which is inclusive of women who are classed as higher risk, as telemetry is available to monitor fetal well-being (wireless, waterproof CTG) which has been well received by our women and families.

There is a dedicated Obstetric theatre and recovery area within the footprint of delivery suite, enabling provision for timely emergencies and elective caesarean sections. Women having an elective caesarean section are on the enhanced recovery programme, which is a bundle of 'best evidence based practices' with the intention of helping patients recover faster after surgery with better clinical outcomes and fewer complications. This includes key steps in the patient's journey from decision to care in the community following discharge. The key components to its success are reinforcing the women's expectations around an early return to '*normal'* in all aspect of recovery and the collaboration between the woman and the multidisciplinary team. Those parents who suffer a pregnancy loss are cared for in a dedicated bereavement suite and supported by a bereavement team. Attached to the footprint of the central delivery suite is also a level 1 neonatal facility, which is part of the central new born network.

The Midwifery led unit at the Samuel Johnson Community Hospital in Lichfield provides an alternative model of maternity care to the community of South Staffordshire and beyond. The unit has 2 pool rooms, 3 delivery rooms, triage facility and a 3 bedded ward. Alternative therapies are also delivered including aromatherapy and reflexology. Risk assessment clinics are run, to ensure all women booked are appropriate and fully aware of the service, this robust assessment has led to a lower than national average transfer rate. This site has gained real momentum for since the transformation into a community hub, extending the provision of care and offer to our women.

Community midwifery is provided across the Burton area to all women living in that geographical area irrespective of where they choose to deliver their baby. Community midwives employed by the Trust provide care to women in South Staffordshire, South Derbyshire and North West Leicestershire, and women may choose to birth at any of the cross border hospitals. This year community midwifery has transformed the model of care to provide enhanced care for an increased time, based on the exemplar model at Portsmouth, work which forms part of the transformation programme for the Pan Staffordshire local maternity service.

High quality, safe, effective care that is responsive to our women and families is reflected in the high performance of the Quality key performance indicators across the service.

Maternity services remain in the spotlight, with the National ambitions time frame to reduce Stillbirth, Neonatal deaths and brain injuries brought forward. We continue on our mission for this, with a continued reduction in still births and sustained implementation of the saving babies lives care bundle for the third consecutive year. We were exceptionally proud for Dr Wendy Oakley, consultant obstetrician to be asked to lead on a chapter of the MBRRACE report and to be asked to pilot the new perinatal mortality review tool. We are working closely with both our commissioners, users and local maternity system to ensure real change comes to fruition, ensuring outcomes and service provision across the whole of Staffordshire and health economy continues to excel.

2017/18 has seen changes that have benefits for both maternity service users and the wider Trust.

Shortlisted for RCM Award

Sands Award for Bereavement Care
Introducing EMDR to bereavement services
Samantha Evans
Burton Hospitals Foundation Trust

Bereavement care for women experiencing a pregnancy related loss has changed significantly in recent years and opportunities to build positive memories around sad events are widely offered, but when negative and/or traumatic memories begin to interfere with daily life and add anxiety to future pregnancies, how can this be addressed? A proactive approach in helping women in cases of complex grieving has now been introduced in the form of Eye Movement Desensitisation and Reprocessing (EMDR) and this invaluable approach is now available to women who have suffered a pregnancy loss within Burton Hospitals Foundation Trust and is delivered by Bereavement Midwife Sam Evans.

EMDR therapy is an integrative psychotherapeutic approach developed by Dr Francine Shapiro in the 1980's based on the theory of reprocessing traumatic memories to reduce their validity within the present moment. Today, the therapy is commonly used to treat a wide range of psychological difficulties that typically originate in trauma, such as direct or indirect experiences of violence, accidents or natural disasters. EMDR is also used to treat more prolonged distress that originates in shock or loss in adult life or issues experienced during childhood.

We all have the ability to process and 'file away' memories. However, during times of trauma (which, of course is entirely subjective to each individual), our ability to do this may become inhibited. Consequentially, these memories will the 'loop' around the conscious mind with some sensory perceptions that were present at the time, causing great distress. It is widely thought that rapid bi-lateral eye

movement alongside an adaptive Information Processing model (an 8 phase approach which facilitates information processing) can relax the patient, cause a shift of negative to positive emotion and reduce emotional trauma when recalling a memory.

Increasingly, EMDR therapy is being used as a treatment for the following conditions:

- Post-Traumatic Stress Disorder
- Depression
- Anxiety
- Phobias
- Panic attack
- Many forms of trauma

Reported benefits of EMDR include:

- A reduction in re-experiencing traumatic memories
- An increased resilience to coping with trauma and its associated memories without deliberately having to avoid triggers
- Increased ability to socialise and enjoy relationships
- Reduce feelings of anxiety, hopelessness and panic

While grief can affect a person's emotional and mental wellbeing, it is crucial to acknowledge that grief is not a mental health problem but a typical response to their loss and EMDR is not suitable for every person who is grieving. However, some of the more common mental health problems that may affect bereaved parents include prolonged grief, clinical depression; anxiety disorders and Post Traumatic Stress are all symptoms that can be reduced with the use of EMDR. With this in mind, it is important that the clinician providing the EMDR has a good relationship with the client and is able to assess the clients need for EMDR. Assessing the clients need fir EMDR is not the only benefit of having Bereavement Midwives trained in this field but the fundamental role of the Bereavement Midwife is one of support and trust. This fundamental bond allows the client to feel more comfortable when receiving the treatment.

EMDR has been implemented within the existing package of support that our bereaved families already received since 2016, with a plan in place for the whole bereavement team to undergo training. Following on from the positive feedback from our women, the intention is to expand the service to other service users including vulnerable women, those with tocophobia and even to staff members to enhance wellbeing within the workforce.

Baby friendly re-accreditation

The service was successful in its assessment against the new criteria for reaccreditation at stage 3, this was our first reaccreditation. The service achieved this accolade with great success, requiring no actions and achieving great results against all criteria. The neonatal unit received aplomb from the inspectors and they have requested that they move to be assessed separately to achieve accreditation in their own right, which would be outstanding for a NNU of this size.

Following the high performance, the Trust has been advised to work towards sustainability.

Baby Friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services.

These are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. Facilities implement the standards in stages over a number of years. At each stage they are externally assessed by Unicef UK. When all the stages are passed they are accredited as Baby Friendly.

Following accreditation at Stage 3, the initial accreditation lasts for two years; after this, re-assessments will take place on a regular basis to ensure that the standards are being maintained and to explore how the service is building on the good work it has already done.

Flu and Pertussis vaccination programme

The service undertook a very successful pilot of the vaccination programme for flu and pertussis, thereby improving the uptake and health and wellbeing amongst pregnant women, and decreasing the associated risk factors. Following on from this success, Public Health England have commissioned an enhanced service for next year.

New Postnatal Model of Care launched in January

In May 2017 the Senior Midwives for Community reviewed the postnatal care model following a visit to Portsmouth. The model was developed to meet the needs of the local community and staffing models in Portsmouth. The Portsmouth model continued to evolve and is seen as a robust model that utilises resources effectively and delivers individualised patient care in the postnatal period and is a national exemplar within Better Births' (2016).
The senior midwives at Burton adapted the model to suit the needs of our local population and our staff based in the community. The modified Burton Postnatal Model of care has been formulated to deliver safe effective, care designed to meet individual needs and utilise the skills of our workforce. We are working towards an 80% midwife to 20% Maternity Support Worker (MSW) level 3 ratios in the community.

This model has also formed part of the maternity transformation programme for Pan Staffordshire local maternity system and as such innovate change for an area that has often been seen as a Cinderella service.

Quality assurance visit for ante-natal and new-born screening services

On 10th January the service underwent a peer review to assure of the quality and safety of the provision. The visit consisted of reviewing pathways, delivery and the governance of screening. Initial feedback to the wider organisation from the peer review was overall extremely positive with no areas of concern identified.

Overview of Cancer Services

The Burton Hospitals Foundation Trust has taken the following actions to improve the cancer targets and so the quality of its services, by:

- weekly PTL (Patient Tracking List) chaired by Cancer nurse/ manager to provide senior managerial and clinical leadership when reviewing patients on 2 week wait pathways.
- Weekly escalation meeting chaired by Deputy COO (Chief Operating Officer), attended by General Managers and Divisional Directors to ensure patients are treated as soon as possible
- Local KPI's (key performance indicators) for endoscopy and radiology reviewed weekly at the escalation meeting and an agreement what extra capacity (where possible) is needed to improve pathways
- A review of the patient pathways and work is ongoing to remove unnecessary steps, this includes work around national pathways
- Work around the 38 day tertiary referral date which is ongoing
- Planned work around compliance with the 28 day faster diagnosis standard, to be introduced in 2020
- Work with tertiary centres to improve communication, this includes weekly telephone PTL with our main tertiary centre to escalate patients

The National Cancer Peer Review Process has been undertaken annually for many years. This is the second year that the process has changed to align with other reviews of specialist services which are commissioned directly from NHS England. Quality Surveillance Team (QST) formerly *the National Peer Review Programme*. This new team and programme have been developed to meet the requirements of the new health care environment and national specialised commissioning directorate. The mission of the QST is to improve the quality and outcomes of clinical services by delivering a sustainable and embedded quality assurance programme for all cancer services and specialised commissioned services within NHS England.
Each cancer site has completed a self-declaration on the portal and these are available for commissioners to review and seek further assurance where necessary.
Due to the change in process no teams were subject to an internal validation, however the Lead Nurse, Manager supported each team to undertake the self-assessment.

Self-Declaration Process Results

Site	Cycle	Progress to Date	Assessment Result	Issues identified as part of Self Declaration
AOS/ Chemotherapy (these 2 sites are in one section now)	SD	Completed	92%	There is a lack of consultant cover for acute oncology ward reviews, to mitigate this risk an oncology specialty doctor is available to complete ward
Breast	SD	Completed	100%	No issues identified

Site	Cycle	Progress to Date	Assessment Result	Issues identified as part of Self Declaration
Head & Neck Locality	SD	Completed	67%	This is a local support team. There is no specialist ward but team provide an outreach service that attend the wards to train staff as and manage tracheostomies at all times, speech and language therapists and dieticians are available.
Gynae	SD	Completed	100%	No issues identified
Lung	SD	Completed	50%	The Trust has identified there is no cover for the consultant radiologist who does interventional radiology and no cover for the clinical oncologist. Long-term oncology input is still to be confirmed. They are delays in EGFR results. QST to request information if any progress has been made with these issues
Colorectal	SD	Completed	88%	No comments or risks identified. This lower than 100% score is related to the core team members attendance at MDT
Skin	SD	Completed	83%	This below 100% score is related to MDT attendance by the core members.
Brain/CNS	SD	Completed	0%	Please see Trust response to the additional information request from the QST
Urology	SD	Completed	60%	This less than 100% score is related to attendance at MDT for core members and the lack of cross cover for the Consultant Oncologist. Although we do not meet the required Oncology attendance we have a very good working relationship with the Oncologist which is a significant improvement from the previous year.

Proposed level of assessment for 2017

Trust	Site Name	Service Name	Level of surveillance following annual assessment 2016
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Brain and Central Nervous System (Adult)	Level 2
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Local Lung Cancer Team	Level 2
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Local Urology	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Head and Neck (Adult)	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Gynaecological	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Oesophageal and Gastric (Adult)	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Skin (Adult)	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Chemotherapy (Adult)	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Local Breast Cancer Team	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Specialised Colorectal Services	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Head and Neck (Adult)	Level 1

Response to the Questions Raised by the QST following Self Declaration

Site	Issue	Update
Breast	Screening being deferred from March 2017 until September 2017.	This was agreed by NHS England while the service was transferring from UHNM to Derby. Patients are now being called for screening and a plan is in place to review any cancers diagnosed who should have been screened between April 2017 and September 2017.
Colorectal	Lack of MDT quoracy remains a risk; this is due to lack of imaging specialist on 7 occasions and lack of oncologist on 4 occasions.	This issue is ongoing due to a lack of cross cover for the Oncologist from Derby; we are continuing to work on this with them. A lack of Radiologist cover due to vacancies and unplanned leave has at times caused delays but we work with our colleagues to address this as and when it happens. Two long term Locums have been appointed and we are awaiting start dates for them, we are also awaiting a substantive post to start, estimated to be November. This will take our Radiology vacancies from 6 to 3 once all appointed staff have commenced.
	Ongoing changes in the pathway for histopathology services (for KRAS and mismatch repair gene for Lynch syndrome) present risks.	We have now received a Molecular pathway from CWPS with waiting times for tests clear. This has been shared with the teams. CWPS have undergone a work place review and reduced unnecessary delays in their pathways. We recently held a cancer specific meeting with CWPS to review delays and their pathways are much improved.
	Increased endoscopy capacity to meet the demand for GI endoscopy in response to increasing referrals as this can affect cancer waiting time targets. Coupled with a bowel cancer awareness initiative later in 2017, this will add further pressures to clinic and endoscopy capacity.	This increase is an expected rise and as a Trust we have plans in place to increase our Endoscopy capacity over the next 12 months. The awareness campaign has been shelved by PHE.
	CNS resource	The 1.8wte CNS posts are now filled and staff are in post. The band 4 Navigator post is out to advert and interviews are planned for 16th October 2017.

Site	Issue	Update
Lung	Radiology cover – delays in organising lung biopsies for patients.	Radiology has 3 new Consultants due to start. They are reviewing the current service used for outsourcing to try and improve reporting times. Once we are members of EMRAD radiology will be introducing home reporting and there will be a reduction in the administrative processes required when imaging is being reviewed at the large tertiary centres. (Nottingham and Leicester specifically)
	Delays in obtaining molecular results for patients due to samples being transferred between different hospitals.	We have now received the molecular pathway from CWPS and the turnaround times for some tests have improved. We continue to work with CWPS to monitor any delays.
	Pembrolizumab has now been licensed for first line use in stage IIIB/IV lung cancer patients. This will significantly increase the demand for molecular testing.	For new tests we have an agreed process for alerting CWPS about this and the expected increase in demand.
Acute Oncology	Acute oncology admitted patients are not reviewed by a consultant oncologist within 24 hours of admission.	To date we have not had any patients adversely affected by this. If they were the Trust Governance processes would investigate accordingly. An acute oncology consultant is provided by Royal Derby Hospital for 2 sessions per week to review acute oncology admitted patients. These sessions also include outpatient clinic work for this consultant. There are 2.0 WTE band 8a advanced nurse practitioners in post and one 0.8 band 7 CNS in post who provide a nurse led service for acute oncology admitted patients and who review these patients either the same working day or the next, with the support of the visiting Oncologists and also the Trust speciality doctor in Oncology. This service works well and patient's own Oncologists can be easily contacted at Derby if advice is required to support decision making.
	A seven day service is not provided.	A 24 hour help line is provided for chemotherapy patients and the acute oncology nurses are part of this rota. The acute oncology team are informed about any patients admitted over a weekend first thing Monday morning. We aim to provide a 6 day service in the next 12 months, once staff have returned from maternity leave.

	Training for staff in ED and acute medicine needs to be addressed.	Work is ongoing regarding training for staff in ED and Acute Medicine. A meeting is planned with representatives from ED and acute medicine to address the training issues with both nurses and medical staff working in these areas. It is anticipated training will commence and be completed in the next 12 months.
Urology	Joint Urology Clinic non-compliant	Currently there are no plans to offer a joint clinic, whilst we appreciate this is means we are noncompliant with the measure we do have a joint MDT with Derby where treatment options are discussed and the appropriate discusses this directly with the patient

Overall Recommendations

Action Plan Update from 2016:

Action	Plan
Continue to roll out eHNA	All sites using eHNA (electronic tool for Holistic Needs Assessment) strengthening processes with each site
Continue to review the provision of chemotherapy and adapt the service to utilize the day unit appropriately	To use the Chemotherapy MDT meeting to ensure progress
Develop the role of the Cancer Steering Group. Improve escalation processes where necessary.	Terms of reference amended to review functionality in November 2016. Cancer escalation meeting now in place chaired by Deputy Chief Operating Officer
Review MDT Function as per audit cycle	Completed
Meet with MDT Leads to establish any concerns/ items for escalation	Completed
Work with radiology to have a long term solution for interventional radiology	Work with radiology to support their development of services. No solution was identified in 2016. It is anticipated a solution will be achieved in 2017 as part of the collaboration with Derby Teaching Hospitals NHS Foundation Trust.

Action Plan Update from 2017:

Action	Plan
To Review MDT Co-ordinator function and standardise across sites	Complete
Develop further the cancer escalation meetings to improve compliance against targets	Complete

Action Plan 2018

Action	Plan
Roll out End of Treatment Summaries across all tumour sites	Initial meetings with CNS's taken place, to be monitored through CNS Forum and Cancer Steering Group

Workforce

Staff Engagement

The results of the Staff Survey have been summarised and presented in the form of 32 Key Findings. These Key Findings are grouped into nine themes as set out in the table below. The overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged. The last 12 months have been challenging for the Trust and whilst the Trust's staff engagement score fell slightly from 3.80 in 2016 to 3.78, this was average when compared with trusts of a similar type.

Results from annual Staff Survey showing change in performance at the Trust by Key Finding (KF) between 2016 and 2017, and ranking in 2017 compared with all Acute Trusts

Appraisals & support for development	Change since 2016 survey	Ranking compared with all acute trusts in 2017
KF11. % appraised in last 12 months	**Decrease (worse than 16)**	**Highest (best) 20%**
KF12. Quality of appraisals	**No change**	**Average**
KF13. Quality of non-mandatory training, learning or development	**No change**	**Average**
Equality & diversity	**Change since 2016 survey**	**Ranking compared with all acute trusts in 2017**
KF20. % experiencing discrimination at work in last 12 months	**No change**	**Lowest (best) 20%**
KF21. **%** believing the organisation provides equal opportunities for career progression/ promotion	**No change**	**Above (better than) average**

Errors & incidents	Change since 2016 survey	Ranking compared with all acute trusts in 2017
KF28. % witnessing potentially harmful errors, near misses or incidents in last month	**No change**	**Lowest (best) 20%**
KF29. % reporting errors, near misses or incidents witnessed in last month	**No change**	**Below (worse than) average**
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	**No change**	**Below (worse than) average**
KF31. Staff confidence and security in reporting unsafe clinical practice	**No change**	**Average**
Health and wellbeing	**Change since 2016 survey**	**Ranking compared with all acute trusts in 2017**
KF17. % feeling unwell due to work related stress in last 12 months	**No change**	**Below (better than) average**
KF18. % attending work in last 3 months despite feeling unwell because they felt pressure	**No change**	**Above (worse than) average**
KF19. Organisation and management interest in and action on health and wellbeing	**No change**	**Below (worse than) average**
Working patterns	**Change since 2016 survey**	**Ranking compared with all acute trusts in 2017**
KF15. % satisfied with the opportunities for flexible working patterns	**No change**	**Below (worse than) average**
KF16. % working extra hours	**No change**	**Average**
Job satisfaction	**Change since 2016 survey**	**Ranking compared with all acute trusts in 2017**
KF1. Staff recommendation of the organisation as a place to work or receive treatment	**No change**	**Average**
KF4. Staff motivation at work	**No change**	**Above (better than) average**
KF7. % able to contribute towards improvements at work	**No change**	**Average**
KF8. Staff satisfaction with level of responsibility and involvement	**No change**	**Average**
KF9. Effective team working	**No change**	**Average**
KF14. Staff satisfaction with resourcing and support	**No change**	**Above (better than) average**

Managers	Change since 2016 survey	Ranking compared with all acute trusts in 2017
KF5. Recognition and value of staff by managers and the organisation	**No change**	**Average**
KF6. % reporting good communication between senior management and staff	**No change**	**Average**
KF10. Support from immediate managers	**Increase (better than 16)**	**Above (better than) average**
Patient care & experience	**Change since 2016 survey**	**Ranking compared with all acute trusts in 2017**
KF2. Staff satisfaction with the quality of work and care they are able to deliver	**No change**	**Average**
KF3. % agreeing that their role makes a difference to patients / service users	**No change**	**Lowest (worst) 20%**
KF32. Effective use of patient / service user feedback	**No change**	**Average**
Violence, harassment & bullying	**Change since 2016 survey**	**Ranking compared with all acute trusts in 2017**
KF22. % experiencing physical violence from patients, relatives or the public in last 12 months	**No change**	**Lowest (best) 20%**
KF23. % experiencing physical violence from staff in last 12 months	**No change**	**Below (better than) average**
KF24. % reporting most recent experience of violence	**No change**	**Above (better than) average**
KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**No change**	**Lowest (best) 20%**
KF26. % experiencing harassment, bullying or abuse from staff in last 12 months	**No change**	**Below (better than) average**
KF27. % reporting most recent experience of harassment, bullying or abuse	**No change**	**Below (worse than) average**

The survey results are currently being disseminated and Divisional and Trust wide action plans developed, which will be monitored through the performance review process.

The national Staff Friends and Family Test (SF&FT) is a further indicator of staff engagement. The survey is circulated to all staff on a quarterly basis (with the exception of Q3 when the Staff Survey is completed). The SF&FT asks staff how likely they are to recommend the Trust both as a place to work and also receive care, as well as giving the flexibility to ask some additional locally themed questions to help us understand the views of staff working in the organisation.

The table below sets out the results of the SF&FT over the last 12 months in relation to the two national questions. It should be noted that the results for Q4 are not yet available.

	Q2 (16/17)	Q4 (16/17)	Q1 (17/18)	Q2 (17/18)
Q1.Likely to recommend the Trust as a place to receive care	76.33%	79.18%	78.80%	78.80%
Q2. Likely to recommend the Trust as a place to work	63.33%	69.67%	65.04%	66.98%

Although the results of the SF&FT did decline at the start of 2017/18, in comparison to the end of the previous quarter, the position improved in Q2 and the results were significantly better than at the same point in the previous year.

Development of the workforce

The Trust is committed to ensuring that our workforce undertakes the essential safety training required for their roles. Staff can access their essential training either via e-learning or classroom sessions. The e-learning modules are predominantly accessed through the ESR (Electronic Staff Record) system. The ESR system has been undergoing major changes to enhance user experience over the last few years and more recently, employees have been able to set up access to ESR from home. This means that staff can view their compliance and complete training from home should they so wish. Recent figures have shown that 86% of staff are logging into ESR to gain access to their information, putting the Trust in first place in the West Midlands and fifth across England and Wales for ESR portal usage.

Statutory and mandatory training compliance rates have been consistently achieving 90% or above, with the figure remaining at 92% since April 2017, apart from in August 2017 when compliance dipped to 91% due to the in-take of junior doctors on rotation. This was compounded by the fact that there was a problem with the external system that runs reports highlighting which doctors have completed their Doctors in Training Online Generic Induction (DITOGI). This allows training from other organisations to be transferred over. The majority of DITOGI information was received and input through a manual process which saw the compliance return back up to 92% in September 2017.

The Trust is continuing to accept previous training that is mapped to the Core Skills Training Framework (CSTF) electronically from other Trusts through the Inter Authority Transfer (IAT) process in ESR and is currently looking to better utilise this previous training in order to streamline inductions further, to try and reduce the amount of statutory and mandatory training new starters undertake upon commencement with the organisation.

In line with streamlining induction, the Trust is looking to move to a pre-hire e-induction which will see new starters complete an array of statutory and mandatory courses online, prior to starting at the organisation, thus reducing the amount of time spent on induction. The Trust is working towards implementing this for those attending induction in April 2018 onwards.

Leadership
The management and leadership framework is well embedded within the Trust. A programme of management modules including people management and project management are scheduled to run throughout the year. Modules are under continuous review and the delivery plan is adapted to meet workforce needs.
Internally and externally delivered leadership programmes have been available to all levels of staff as part of the framework. The RCN Clinical Leadership Programme concluded with a festive celebration event in December 2017, where participants shared their learning and outcomes from their service improvement projects. This programme has demonstrable outcomes which benefit patient care and experience. Plans are in place to run a sixth cohort in March 2018. In addition, Leading in the NHS, a leadership programme accessed by bands 5-7 staff in non-clinical roles has been extremely successful with its last thirteen participants achieving some excellent outcomes as a result of completing service improvement projects.

Talent for Care
A considerable amount of work has taken place to raise the profile of the work streams within the Talent for Care Strategic Framework. The Trust in collaboration with local Staffordshire partners organised a careers event in November 2017. The event engaged with students, teachers and parents from schools and colleges across Staffordshire. Over 500 people attended and participated in a variety of interactive activities to raise the profile and understanding of the various career opportunities and job roles available within the NHS. It was a great success and plans are underway to organise the event again in 2018.

In addition to the large scale careers event, NHS Champions in the Trust have supported enrichment activities at schools, seven work experience programmes, providing 160 placements and two employability programmes working with Job Centre Plus.

The Trust is committed to the apprenticeship agenda for new and existing employees.

The Apprenticeship Levy was implemented in April 2017, the Trust's levy equates to approximately £650,000. A considerable amount of work has been undertaken to raise the profile of apprentices and the benefits of recruiting into the workforce.
Where possible vacancies have been considered for apprenticeship roles and where appropriate have been converted to offer an entry level role into the organisation. A new Healthcare Support Worker apprenticeship is now implemented and recruitment of a third cohort is underway. The Trust has actively participated in trail blazer groups for the development of the physiotherapy, registered nurse and nursing associate apprenticeship standards. Opportunities to integrate internally delivered courses have led to successful completion of team leading and management apprenticeships.

The Pearson Edexcel accredited centre for the provision of clinical support worker training has continued to receive excellent feedback from external audit processes in relation to the management of the centre and motivation of the learners.

Staff have participated in accredited learning opportunities enhancing skills and knowledge in areas such as caring for children and young people, counselling, dementia, equality and diversity, customer service, understanding autism, working with individuals with learning disabilities, care and management of diabetes, understanding common health conditions, infection control and information, advice and guidance.

Non-medical Student placements

The Practice Education Team's portfolio incorporates pre-registration education for all healthcare students, preceptorship for new registrants and trainee Nursing Associates across the organisation. The team has maintained a quality service despite the current challenging landscape which includes funding models changing for pre-registration education, emerging new roles, new programmes, new apprenticeships and more nurses leaving the nursing profession than joining it.

Research has evidenced that nationally there is a lack of organisational commitment to mentoring roles. However, at Burton Hospitals, the infrastructure and the ethos of the Practice Education team is unique in that we have nurses who work 80% in the clinical area supporting our students, preceptees, trainee nursing associates, mentors, preceptors and coaches and this evaluates as outstanding practice. The team has sustained a high quality service that is unique to Burton Hospitals. We continuously strive to ensure learners have a positive experience and frequently implement new innovations across the organisation to support this. For example, since April 2017 we have implemented a "feeling valued project" which focuses on many new approaches to ensure every student feels welcomed in their new clinical area. This initiative came from a staff members master's dissertation which highlighted this as an issue. Additionally, we have created an online practice mentor update to enable mentors who cannot attend a face to face session an alternative option to support their mentoring role. We have also incorporated Trust sign-off mentor training at the end of the University mentorship training programme rather that it being additional at a later date. Finally, we have created a multi-professional preceptorship programme with bespoke portfolios for all AHP groups.

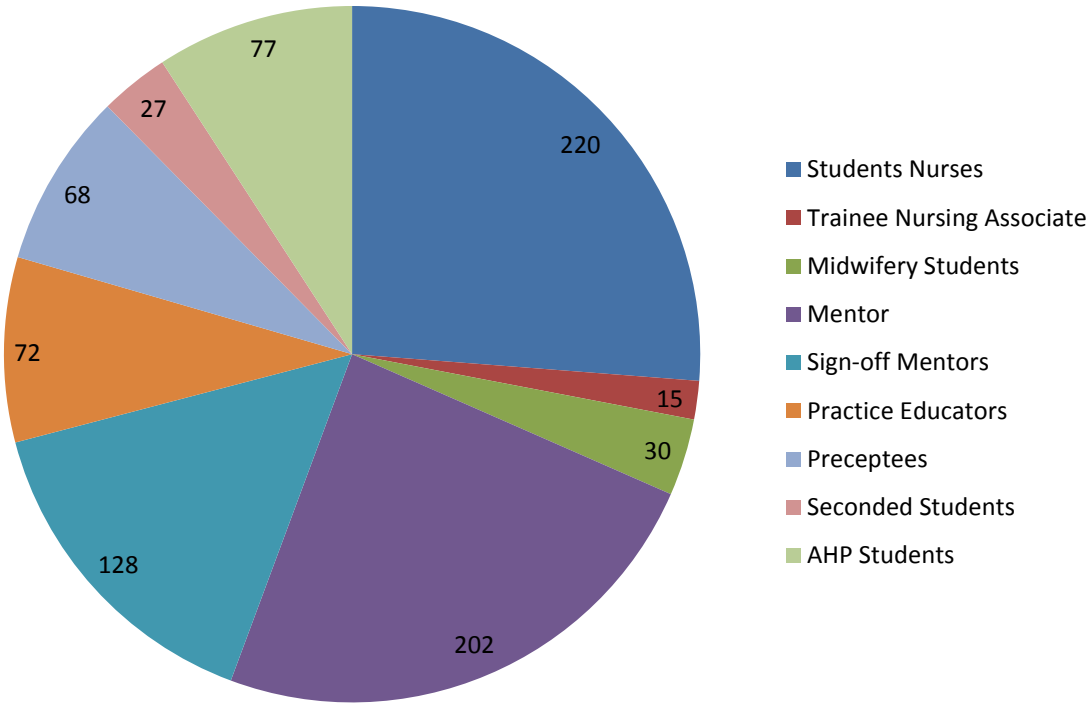
The team have implemented an innovative "Enriched Learning in Clinical Practice" model across the organisation which focuses on enhancing the quality of the student placement learning through a coaching and peer support approach. This has evaluated very positively from mentors, coaches and students. It has enabled increased student nurse placements by 41 which has resulted in us extending our partnership working with other organisations outside of our agreed placement provision with University of Wolverhampton. As a result, we are supporting 15 University of Derby student nurses and 3 University of Nottingham Midwifery students from March 2018. We have started conversations with Staffordshire University and Keele University to determine if we can commence partnerships with them too. It is anticipated that these partnerships will aid the sharing of good practice and enhance our recruitment.

The Trust continues to be successful in recruiting new registrants which is challenging in the current landscape. However, a large proportion of these have graduated from University of Wolverhampton, our onsite provider. Additionally, we

have also maintained recruiting from other universities. Between April 2017-18, 55 newly appointed nurses and AHP's commenced our innovative and robust preceptorship programme. 44 of these were internal students who trained here and 24 were external students from university of Wolverhampton.

Burton Hospitals, in collaboration with nine practice partners and the University of Wolverhampton were chosen by Health Education England to run a trainee nursing associate "trailblazer" project. As a result, we have 5 trainee nursing associates who commenced a 2 year programme in January 2017 and have just started their second year. Recently the Secretary of State of Health announced that 5000 Nursing Associates (NA) will be recruited in 2018 and a further 7500 during 2019. As a result The NA Apprentice model has been developed and it is anticipated that Burton will have 10 new starters commencing in March 2018. The role of the Band 4 Nursing Associate (which has been regulated by the Nursing and Midwifery Council) is to act as a bridge between the Band 2/3 and Band 5 nursing workforce. Upon successful completion of this two year Foundation Degree Nursing Associates will work independently within defined parameters of practice under the supervision of a registered nurse to deliver patient care. This in turn will aid to relieve the current Band 5 deficit as it will reduce the need for as many band 5 registered nurses across the organisation whilst ensuring a safe skill mix and safe patient care.

During April 2017-18 Burton Hospitals have supported the following number of students, mentors, practice educators and preceptees:



The Environment

Refurbishment of the A&E Minors, Reception, Waiting Areas

The A&E Reception and Minors area was last refurbished in 2006 and as one of our most frequently used areas a revamp was long overdue. Not only does the £1m investment make the whole area look new and fresh, we have managed to improve the building fabric, ventilation and lighting to give a better comfort to the patient and visitor alongside this. The real driver for the change is the introduction of 2 streaming rooms and access to GP's within the area to improve patient flow.

Expansion of the Endoscopy Sterilisation Unit at Sir Robert Peel

The Endoscopy service at the community hospitals was full of service issues down to failing equipment and lists were always being re-scheduled or cancelled due to the washers which process the scopes used during the procedures being out of order. The installation of a new £750k bespoke sterile service unit, complete with additional washing capacity. A 2nd endoscopy procedure room due to open on June really cements the Trusts commitment to the community hospitals.

New Mortuary Viewing Area

To be completed over the coming month is a new mortuary viewing area This is an area that has long needed some attention and given the sensitivity of the subject we have given our upmost professionalism to creating a calming and peaceful area for relatives to say goodbye to their loved ones. This includes a new viewing bier, waiting and toilet area, and improved access to and from the facility for relatives.

Catering developments

During the year we have been rolling out a new way we prepare and serve the patient meals on the wards, moving to a bulk service in-line with current quality and delivery standards. To support this the PLACE scores for patient food have gone from strength to strength proving that the service is moving in the right direction, and now more than ever before addressing our patient's needs.

Fire safety improvements

The Trust has always been committed to statuary standard improvements and with the monies available an element is invested in fire safety. This year has been no different, with over £750k being put back into improved emergency lighting, escape routes, fire compartmentation, fire doors and fire alarm systems. This is part of an ongoing programme to provide the safest environment for our patients, visitors, and Staff.

Reprocessing of sterile wraps for re-use in other plastics

This month Queen's Hospital unveiled a polypropylene recycler, which can melt polypropylene sterilisation materials, such as, sterile tray wraps, surgery scrubs, and other similar items made with the same material, into neat plastic blocks. Not only are the materials melted together, but contamination is removed during the melting process, providing optimum reusability as a result.

The machine made its debut on the 22 March, which also marked NHS Sustainability Day, a day that highlights the important role that sustainable development can play in health service delivery.

The Sterimelt is a great innovation and Burton Hospitals has the privileged position of being the second company in the world to own the machine. The first machine belongs to Neville Hall in Abergavenny, who carried out the beta testing with the manufacturers, Thermal Compaction Group (TCG). TCG is a company based in Cardiff, Wales that specialises in sustainable waste solutions. The Trust also has plans to introduce a Plastic Baler and cardboard baler later this year, to create a sustainable recycling hub on its site.

Nutrition

Continuing with the same format as last year's report on Nutrition there are five overarching workstreams:

1. Procurement and Production
2. Changes to our patient feeding system
3. Automation of process
4. Increased commerciality
5. Catering presence at ward level

Progress in the five work streams this year has been;

1 **Procurement and Production.** Work has been starter with the Trusts' Waste and Sustainability Officer identifying areas of procurement that are presently sustainable and others that meet a partial level of sustainability. The two largest groups of products used are food and disposables. Both have to be balanced with their cost, customer requirements availability and effect on the provision of the catering service.

2 **Changes to our Patient Feeding system**. This year there has been a substantial progress in changes to our patient feeding system. We have introduced a hostess trolley service to all but two wards at Queens, which will stay on a pre-plated format. This change provides a more acceptable meal for patients in appearance on the plate which has not only resulted in favourable comments but better consumption rates.

We have begun work on introducing a new plated meal service for the two wards at Queens, Maternity and AAC, also the Treatment Centre and Maternity at Samuel Johnson. All for areas have a more transient patient were a provision for 24 hour hot meals is required.

We continue to work closely with the frailty and dementia teams and have introduced ward dining in a frailty ward, it is hope that this will be expand to other appropriate areas this coming year. Drinking aids to help with hydration throughout the Trust have recently been introduced, targeting frailty and dementia patients. These drinking aids are available to purchase from coffee shops on all three hospital sites so that those that need to continue using them once they are discharge can do so without depleting the wards stocks.

Earlier this year the Trust was chosen to join other Trusts by NHS improvements England to work on a Nutrition Collaborative Group. The overall aim is to improve patient nutrition and hydration by focusing on how we determine what a patient requirements are and how we see that these requirements are delivered to the patient. This work is ongoing and will take most of this coming year to implement most of the changes some of which have been described above.

3 **Automation of process.** Following on from the change of service style of the meals the next step is to improve the delivery of the correct diet and choice to each patient whilst narrowing the time gap between placing the order and the service of the meal.
We have just begun to trial a meal ordering system on a hand held device that will supply information to catering prior to the service in time. Whilst ordering their meal patients will be able to see nutritional and allergen information for what they have ordered.
The programme restricts ordering to those dishes only suitable for the diet a patient has been assigned to, agreed previously by the catering dietitian. This will prevent mistakes, even by new staffs who haven't built up their knowledge on specific diet.

4 **Increased commerciality.** This year we have introduced the Health & Well Being CQUIN that applies to Catering. Vending has been re-tendered and contracted out as a managed service. Planograms for what is available from the vending company are CQUIN compliant.
We have removed high sugar drinks, many of the confectionary lines and high fat crisps and replaced with sugar free, zero and baked products. With other line changes we have significantly reduced sugar, fat and salt in pre-package snack and confectionary items in our retail outlets. The Trust conforms with NHS England guidelines and has signed up to their voluntary reduction scheme which is proposed to be a no sugar sweetened drinks requirement on NHS premises from 1st June 2018.

5 **Catering presence at ward level.** In the last two years catering has had an increasing presence on the wards contributing to the general care of patients. This has been helped by the Trust employing a catering dietitian available to advise on complicated individual patients needs and dishes, menus and diets in general. The new style service allows the catering team have more contact with the wards helping to assist with food related queries ensuring patients receive a nutritious meal.

Catering continues to develop and evolve as a service to meet patient needs in providing a good standard nutritious meal. Our aim is to continue and develop a service that the patient can be confident it meets their needs. Amongst the improvements this next year as mentioned will be around hydration, dementia feeding and communication with the proposed new meal ordering system. We feel we have made major improvements this year but there are many more to come.

Operational Plan 2017/18 & 18/19

The Trust developed its two year Operational Plan. The development of the plan followed a formal planning methodology and describes an organisation which 'supports local communities with excellent healthcare when they need it most' with an ambition to 'be the best, every patient every time'.

The key objectives as laid out in the plan are to ensure that the Trust is financially and clinically sustainable, with plans to ensure that the Financial Control total is met and that plans for collaboration with Derby Teaching Hospitals Foundation Trust (DTHFT) are explored in detail, with a focus on delivering the best clinical pathways for our patients. The Operational Plan also explains how he trust will play an active role in the development of the Staffordshire Sustainability and Transformation Plan (SSTP) and ensure that the Trust is able to meet key operational standards such as the ED 4 hour, Cancer and the 18 week Referral to Treatment (RTT) standards.

7 Day Services

The Trust followed the national guidance, completing an initial self-assessment and working closely with the National and Local Area NHS IQ team, to select the standards to deliver in 2017/18.

The Standards chosen were:

- **Standard 2 – Time to first consultant review**
  - All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the least within 14hrs.

- **Standard 5 – Access to diagnostics**
  - Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:
    - Within 1 hour for critical patients, within 12 hours for urgent patients and within 24 hours for non-urgent patients

- **Standard 6 – Access to consultant directed Intervention**
  - Hospital patients must have timely 24hour access, seven days per week, to consultant directed interventions that meet the relevant speciality guidelines either on site or through formal networks with clear protocols.

- **Standard 8 – On going review**
  - All patients on SAU/AAC/Short Stay/ICU must have been seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others that deteriorate.

The Trust has taken part in two national audits against the clinical standards associated with Seven day services. Results indicate performance above regional and national median. Analysis of the audits has been shared internally, with commissioners and with the national team and highlights the key area of transformation relates to ensuring consistent delivery of Clinical Standard to which aims to ensure consultant review of every emergency admission within the first 14 hours. The national standard is 90% with Burton hospitals reporting 87% and 72% in the past two audits. Two further national audits are scheduled for 2018/19.
Next Steps

- This audit highlights strong performance for Medical specialties and that focussed work required with Surgical Specialties.
- This trend was evident in March 17 audit **but** sample had fewer surgical patients overall and therefore impact on Trust performance diluted.
- Initial findings in Surgical Division suggest non-compliant patients were being managed by protocol.

NHSI Guidance suggests that……

- "Patients with a clear diagnosis, on a well-defined pathway, may have their clinical care delegated from a consultant to another clinician (not necessarily another doctor) in these circumstances;
- the pathway follows a clear written local protocol agreed within the trust clinical governance system and supported by commissioners;
- this protocol describes actions in the event of clinical concern, including robust and rapid escalation to a consultant where appropriate;
- the patient's care is still recorded as being under a named consultant for the purpose of clinical governance;
- Review and sign off of these protocols internally and with CCG required to ensure future compliance;
- Teleconference arranged with NHS England to discuss;
- In light of merger work, reciprocal sharing of recent audits with Derby Teaching Hospitals Foundation Trust (DTHFT) to determine key areas of synergy or learning;
- Meetings arranged with DTHFT to agree future governance and leadership arrangements.

Annex 1: Statement from East Staffordshire CCG on behalf of all South Staffordshire CCGs and Southern Derbyshire CCG.

In line with the Trust quality strategy, their priorities in 2018/19 will build on their previous 2 years. The CCG is pleased that the Trust has continued to make positive improvements in their identified priority areas.

1. **Frailty**
   Work continues with the service now covering 7 days a week. The CCG looks forward to seeing the outcomes of the AMBER care bundle included in the frailty pathway pilot which commenced in November 2017.

2. **Implementation of Adapted Ward Assurance Tool**
   The Trust implemented the new ward assurance tool in 2017 and the CCG has been monitoring the outcomes via CQRMs. The tool is proving helpful in enabling triangulation against other quality indicators.

3. **Improving Discharge**
   The Trust is continuing to work with the Community Health Provider and the County Council to facilitate discharges. Out of hospital placements continue to be challenging, resulting in an increase in the number of patients experiencing delayed discharges.

Quality Overview

- The CCG is looking forward to seeing the improvements in the 3 key areas which the Trust has set for 2018/19.
- The CCG is pleased to see the level of patient and public engagement. This includes events to gain an understanding of the public's ideas, thoughts and concerns, regarding the Burton Derby Collaboration.
- The Trust is commended for its commitment to engaging with staff through listening events and other briefing sessions to keep them updated on the progress of the Burton Derby Collaboration.
- The Trust is commended on their continued Sign up to Safety pledges; one of which is to implement NEWS2 across all wards and clinics.
- The CCG acknowledges that the 4 hour target in A&E continues to be challenging within the Trust and the wider NHS. However, the Trust has implemented reconfigurations of the emergency pathway to try to alleviate pressures in this area.
- The CCG is pleased that the Learning Disabilities Mortality Review (LeDeR) is a standing agenda item for the Trust's Internal Mortality Review Group.
- The CCG continues to welcome the openness of the Trust with regular reporting and discussions about mortality in Clinical Quality Review meetings.
- The work undertaken by the Trust to manage C.*Difficile* and provide additional professional development specifically in relation to improving the service is acknowledged and monitored through CQRM.
- The drive to reduce medication incidents has seen the installation of the 'dispensing robot' which the CCG is pleased to see has impacted positively to reduce the 'number of picking errors'.

- The CCG is aware that the National falls audit showed improvement in areas which were rated red previously, reflecting positive outcomes from the actions taken.
- The CCG recognises the openness of the Trust's reporting of incidents. However, it has been noted that this is the 3rd year the Trust has not included Serious Incidents numbers within their Quality Accounts. There were a number of Serious Incidents which resulted in the Trust identifying a theme and proactively initiating an external review which was then widened to cover a whole speciality.
- The Trust has demonstrated positive internal and external patient experience scores. However, the Quality Account did not reflect changes the Trust has made in response to patient feedback, which Commissioners hear in other forums.
- The CCG recognises the work that the provider undertook to be shortlisted for the Royal College of Midwifery Annual Awards and commend them for this.
- The CCG is pleased to see the positive outcomes from the actions taken to improve services and waiting times for patients with suspected breast cancer. In addition the marked improvement in the 62 day cancer wait target, showing the commitment from the Trust to making improvements in cancer services. However, the Quality Accounts appear not to reflect the concentrated effort the Trust made to turn these cancer waiting times around.
- The CCG notes the lessons learned from audits they carried out and the Trust has demonstrated how these lessons were disseminated through the organisation.
- CCG notes the work undertaken by the Trust to provide developmental opportunities for their workforce, showing investment to enhance skills.
- Although not mentioned in the Quality Accounts, the CCG recognises the Trust compliance with Safeguarding, Mental Capacity Act and Prevent training.
- As suggested in previous years, the Quality Account would benefit from including a summary of lessons learned and improvements made in respect of quality and safety. This could include learning from patient feedback, complaints, compliments, incidents and PALS contacts.
- The Quality Account would benefit from the inclusion of the collaborative work the Trust has undertaken with Virgin Healthcare Services.

The CCG is building on the positive relationship with the Trust and notes the openness in their reporting. It is anticipated this relationship will continue during and after the Burton Derby Collaboration. The CCG recognises the positive impact the Trust's previous Chief Nurse had on the organisation and looks forward to this continued progression going forward. The CCG can state that to the best of our knowledge, the data provided by the Trust is accurate.

Healthwatch Staffordshire Response to Burton Hospitals NHS FT Quality Account 2017/18

Healthwatch Derbyshire (HWD) is an independent voice for the people of Derbyshire. We collect feedback from people about using health and social care services, and what they think could be improved. We share these views with those who have the power to make change happen.

We gather experiences from patients and members of the public through a small team of Engagement Officers, supported by volunteers. We undertake both 'general engagement' to hear about a variety of different experiences, and 'themed engagement' which we use to explore a particular topic in more detail.

The findings of our themed engagement work is analysed and written up into reports, which include recommendations for improvement. Service providers and commissioners are then asked to respond to these recommendations. All our reports, including the responses we receive are published on the Healthwatch Derbyshire website.

The experiences gathered through our 'general engagement' are fed through to organisations on a regular basis throughout the year to give an independent account of what is working well, and what could be improved. Anyone who shares an experience with HWD is able to request a response, and we encourage organisations to consider responses carefully and indicate where learning has taken place as a result of someone's experience. These comments are responded to by the Trust thoroughly and with rigour, setting out learning and next steps that will follow.

We have read the Quality Account for 2017/18 prepared by the Trust with interest. We have considered if and how the content reflects some of the topics which have emerged in the feedback that Healthwatch Derbyshire has collected during the past year.

Healthwatch Derbyshire particularly welcomes the priority around improving discharge. As an organisation, we regularly collect feedback from patients about the importance of excellent communication, information and coordination around discharge from hospital so we welcome this as an area of focus for the Trust. We will be very happy to support and contribute to this priority in the year ahead.

As noted in the Quality Account, in the year ahead Healthwatch Derbyshire will continue to review feedback about the Trust on a regular basis and then will provide feedback to help consider recurring themes or issues.

Annex 2: Statement of Directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    - Board minutes for the period 1 April 2017 to 24 May 2018
    - Papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018;
    - Feedback from Commissioners dated 16/05/2018;
    - Feedback from Governors dated 17/05/2018
    - Feedback from local Healthwatch organisations dated 16/05/2018
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2015;
    - The 2016 national patient survey 31/05/2017;
    - The 2017 national staff survey 06/03/2018.;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 17th May 2017;
    - Care Quality Commission Quality Report dated 22/10/2015;

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

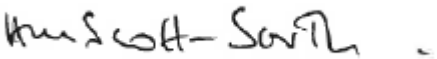
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

By order of the board



John Rivers
Chairman

Helen Scott-South
Chief Executive

Annex 3: Independent auditor's limited assurance report to the Council of Governors and Board of Directors of Burton Hospitals NHS Foundation Trust on the Quality Report

Independent Practitioner's Limited Assurance Report to the Board of Governors of Burton Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Governors of Burton Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of Burton Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge
- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2017 to 25 May 2018

- papers relating to quality reported to the Board over the period 1 April 2017 to 25 May 2018;
- feedback from commissioners dated 16/05/2018;
- feedback from governors dated 17/05/2018;
- feedback from local Healthwatch organisations dated 16/05/2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated April 2015;
- the national patient survey dated 31/05/2017;
- the national staff survey dated 06/03/2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2018; and
- any other information obtained during our limited assurance engagement.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Governors of Burton Hospitals NHS Foundation Trust as a body, to assist the Board of Governors in reporting Burton Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body, and Burton Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management

- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Burton Hospitals NHS Foundation Trust.

Our audit work on the financial statements of Burton Hospitals NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Burton Hospitals NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Burton Hospitals NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Burton Hospitals NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Burton Hospitals NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Burton Hospitals NHS Foundation Trust and Burton Hospitals NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Birmingham

25 May 2018

Annual Accounts 2017 - 2018

Foreword to the Accounts

Financial statements for Burton Hospitals NHS Foundation Trust for the period ending 31 March 2018.

These accounts for the period ended 31 March 2018 have been prepared by Burton Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Independent auditor's report to the Council of Governors of Burton Hospitals NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Burton Hospitals NHS Foundation Trust (the 'Trust') for the year ended 31 March 2018, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/2018; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty relating to going concern

We draw attention to note 1.29 in the financial statements, which indicates that the Trust incurred a deficit of £11.5 million during the year ended 31 March 2018 and, at that date had net current liabilities of £20.6 million. The Trust has received financial support, in the form of working capital loans from the Department of Health, which stand at £48.0 million as at 31 March 2018, £24.0 million of which falls due for repayment in 2018/19. The Trust expects to incur a sizeable financial deficit in 2018/19 and anticipates that it may be some time before it can achieve financial balance on a sustainable basis. Therefore it is anticipated that the Trust will require further substantial support in 2018/19.

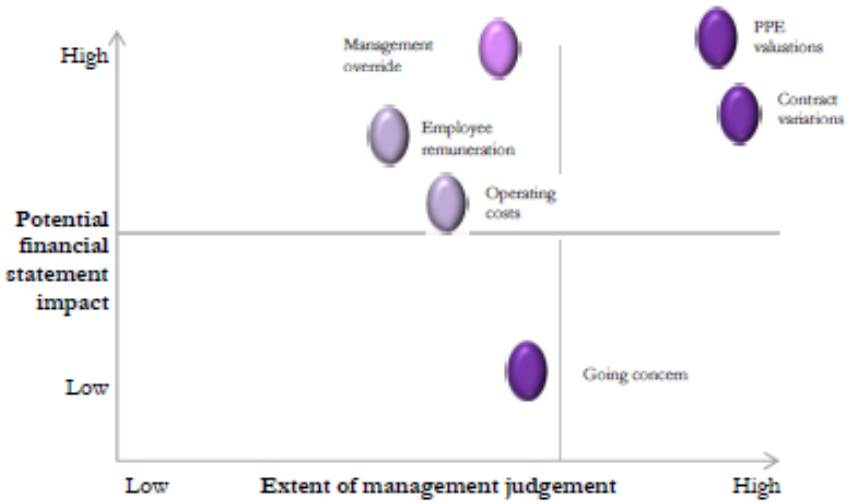
These events or conditions, along with the other matters explained in note 1.29, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Overview of our audit approach

- Overall materiality: £3,715,000, which represents 1.8% of the Trust's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
  - Occurrence and accuracy of income from contract variations
  - Valuation of property, plant and equipment
  - Going concern material uncertainty disclosures

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter	How the matter was addressed in the audit
Occurrence and accuracy of income from contract variations Approximately 85% of the Trust's income is from patient care activities and contracts with NHS commissioners. These contracts include the rates for and level of patient care activity to be undertaken by the Trust. The Trust	Our audit work included, but was not restricted to: • gaining an understanding of the Trust's system for accounting for income from contract variations and evaluating the design of the associated controls; • evaluating the appropriateness of the Trust's accounting policy for recognition of income from patient care activities and assessing its compliance with the Department of Health and Social Care Group Accounting Manual 2017-18;

Key Audit Matter	How the matter was addressed in the audit
recognises patient care activity income during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by the commissioners. As such, there is the risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners. We therefore identified the occurrence and accuracy of income from contract variations as a significant risk, which was one of the most significant assessed risks of material misstatement.	• on a sample basis agreeing amounts recognised as income in the financial statements to signed contracts, and agreeing contract variations to supporting documentation. The Trust's accounting policy on recognition of income is shown in note 1.4 to the financial statements and related disclosures are included in notes 3 and 22. **Key observations** We obtained sufficient audit evidence to conclude that: • The Trust's accounting policy for income from patient activities is in accordance with the Department of Health and Social Care Group Accounting Manual 2017-18 and has been properly applied; and • Income from patient care activities is not materially misstated.
Valuation of property, plant and equipment Revaluations of property, plant and equipment are performed with sufficient regularity by the Trust to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. The Trust is also revising its valuation methodology and it moving to a Modern Equivalent Asset Valuation methodology. This represents a significant estimate by management in the accounts. We therefore identified the valuation of property, plant and equipment as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • assessing the competence, objectivity and capabilities of the valuer used by the Trust; • evaluating management's processeses and assumptions for the calculation of the estimate and the appropriateness of the instructions issued to the valuer, the basis of valuations and the scope of their work; • for a sample of assets revalued in the year, agreeing the valuation in the valuer's report to the Trust's asset register and the financial statements; • challenging the information and assumptions used by the valuer to ensure it was complete and accurate • reviewed the rationale, valuation and accounting for the MEA valuation. The Trust's accounting policy on the valuation of property, plant and equipment is shown in note 1.10 (with a critical judgement and key source of estimation uncertainty in relation to MEA disclosed within notes 1.6 and 1.7 respectively) to the financial statements and related disclosures are included in note 18.1. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the valuation was appropriate and the assumptions and processes used by management in determining the estimate were reasonable; • the valuation of property disclosed in the financial statements is reasonable.
Going concern material uncertainty disclosures	Our audit work included, but was not restricted to: • determining whether the procedures performed by management for identifying material uncertainties that may

Key Audit Matter	How the matter was addressed in the audit
As auditors, we are required to obtain sufficient appropriate audit evidence about the appropriateness of management's use of the going concern assumption in the preparation and presentation of the financial statements and to conclude whether there is a material uncertainty about the entity's ability to continue as a going concern. As at 31 March 2017 loans stood at £40 million and the Trust reported a deficit of £6.9 million. Going forwards further support was required as the Trust were forecasting a deficit position of £9.7 million and it was expected that the loan drawdown would reach up to £105.5 million by 31 March 2023. The Trust was reporting in its month 8 finance report, a loss as at November 2017 of £7.6 million against total budgeted loss for the year of £9.7 million. To receive the 70% of the £5.4 million STF relating to Financial Performance the Trust needed to deliver a deficit no greater than £14.9 million by 31 March 2018. We therefore identified going concern material uncertainty disclosures as a significant risk, which was one of the most significant assessed risks of material misstatement.	cast significant doubt on the Trust's ability to continue as a going concern were appropriate; • assessing the appropriateness of the assumptions and judgements underpinning the cash-flow forecasts used by management to assess the existence of material uncertainties relating to going concern • verifying that the disclosures within the financial statements explaining the material uncertainty that casts significant doubt on the Trust's ability to continue as a going concern are appropriate and accurately explain the events and conditions that gave rise to the uncertainty and the assumptions and judgements made by management in its assessment; and • verifying that the disclosures within the financial statements comply with the reporting requirements detailed in Department of Health Group Accounting Manual 2016/17. The Trust's accounting policy in respect of the going concern basis of preparation is shown in note 1.29 to the financial statements. **Key observations** We obtained sufficient audit assurance to conclude that the disclosures made by the Trust in note 1.29 were appropriate.

Our application of materiality

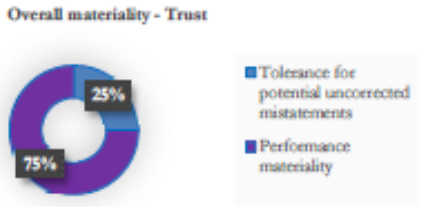
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£3,715,000 which is 1.8% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding. Materiality for the current year is at the same percentage level of gross operating costs as we determined for the year ended 31

	March 2017 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Specific materiality	Remuneration of senior officers and remuneration report CETV values were set at values of £100,000 and £250,000 respectively, given the sensitivities of these disclosures and as we believe they are of specific interest to the reader of the accounts.
Communication of misstatements to the Audit Committee	£ 186,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business. It included an evaluation of the Trust's internal controls including relevant IT systems and controls over key financial systems.

Our work involved obtaining evidence about the amounts and disclosures in the financial statements to give us reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. The scope of our audit included:

- undertaking an interim audit visit where we:
    - obtained an understanding of and evaluated the Trust's overall control environment relevant to the preparation of the financial statements, including its IT systems,
    - completed walk through tests of the Trust's controls operating in key financial systems where we consider that there is a risk of material misstatement to the financial statements;
    - performed interim testing, on a sample basis of operating expenditure and non-healthcare income.
- performing year end testing on the Trust's financial statements, which focussed on gaining assurance around the Trust's material income streams and operating costs, testing the Trust's employee remuneration costs and the notes to the accounts to ensure that they were compliant with the Department of Health and Social Care's Group Accounting Manual for 2017/18.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report set out on pages 5 to 104, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information

and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge of the Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable set out on page 68 in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- Audit committee reporting set out on pages 40 to 42 in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit committee does not appropriately address matters communicated by us to the Audit committee is materially inconsistent with our knowledge obtained in the audit.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities set out on page 87, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2017/18, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - 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 to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Burton Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Mark Stocks

Mark Stocks
Partner
for and on behalf of Grant Thornton UK LLP

The Colmore Building
20 Colmore Row
Birmingham B4 6AT

25 May 2018

Accounting Policies

1.1 Basis of Preparation of Accounts

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust 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 2017/18 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, 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 particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of Plant, Property and Equipment, Intangible assets, inventories and certain financial assets and financial liabilities at their value to the business by reference to their current costs.

1.3 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.4 Income Recognition

Income is accounted for by applying the accruals convention. The main source of income for the Trust is from commissioners (Clinical Commissioning Groups and NHS England) in respect of healthcare services provided under local agreements. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material considerations of sale have been met, and is measured as the sums due under the sale contract.

Interest revenue is accrued on a timely basis, by reference to the principal outstanding and interest rate applicable.

Revenue relating to patient spells that are part completed at the year end are apportioned across financial years.

1.5 Expenditure

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

1.6 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Property, Plant and Equipment:
The Trust carried out a revaluation exercise as at 1st April 2017 using the "Single Site Modern Equivalent Asset Alternative Site" basis. This assumes the assets would be replaced with a modern equivalent, i.e. not a building of identical design but with the same service potential as existing assets. This was done in conjunction with the Trust's professional Valuers GVA. The impact of this was to reduce the value of Land and Buildings as at 1st April 2017 by £18.56 million. A further valuation was carried out at 31 March 2018 using the same basis to ensure a true and fair view was reflected. This increased the value of net assets by £2.3 million.

Going Concern
In accordance with International Accounting Standard 1 the Directors of the Trust have assessed whether the Trust is a 'going concern'. In concluding that the Trust is a 'going concern' the Board of Directors have considered the Trust's overall financial position and expectation of future financial support. In the context of IAS 1(which assumes the anticipated continuation of non-trading entities in the public sector) and confirmation of continuing cash support from the Trust Development Authority the Board of Directors has concluded that the Trust is a going concern. See additional disclosure at Note 1.29.

Potential Merger with Derby Teaching Hospitals Foundation Trust
The Trust is considering a merger with Derby Hospitals Foundation Trust that could happen during the financial year ending 31 March 2018. However as at 31 March 2018 no final decision has been made. Burton Hospitals NHS Foundation Trust have prepared independent plans for 2018/19 that show the Trust will be a going concern should the merger not go ahead.

Burton Hospitals NHS FT Charitable Fund
The Trust has established that as the Corporate Trustee it has the power to exercise control to as to obtain economic benefits. Total income received was £438,000 and total resources expended was £1.3 million which is not considered

material to the Trust. Therefore Directors have determined not to consolidate the Charitable Funds into the Foundation Trust's accounts on the grounds of materiality.

STRIDE Partnership
The Trust is a 50% Shareholder in a partnership called STRIDE. The Accounts are not consolidated with the accounts of the Trust on the grounds of materiality. The total expenditure for STRIDE in the years ended 31 March 2018 was £ 126K.

1.7 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property, Plant and Equipment:

i. The Trust carried out a revaluation exercise as at 1st April 2017 using the "MEA alternative site" basis. This was done in conjunction with the Trust's professional Valuers GVA. A further valuation was carried out at 31 March 2018 using the same basis.
ii. Anticipated building and plant “lives" were based on the Trust's current strategic plans for its estate.
iii. Equipment was valued based on depreciated replacement cost using estimated lives appropriate to the nature of the equipment.

In addition the Trust has recognised a number of assets used by external service management contracts as being assets embedded under a Finance Lease. The value of these assets has been estimated and appropriate disclosures are contained in Notes 18.2 and 27.

Provisions
Provisions disclosed in Note 28 are based on reasonable accounting estimates of future costs.

Finance Leases
Where the trust has recognised embedded Finance Leases in respect of assets supplied under a managed service contract these are valued based on estimates or actual costs as supplied by the service provider.

1.8 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.

Pension Costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when 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 the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Other Pension Schemes
In line with the Government's auto enrolment pension roll-out, the Trust also offers the NEST Pension Scheme to employees who may not be eligible to join the NHS Pension Scheme. The NEST Pension Scheme is a defined contribution scheme.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant GAM 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 exercise), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for year ending 31 March 2012. The Scheme regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pensions Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this employer cost cap assessment, any required revision to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

NEST Pension Scheme

As of 1 April 2013 it became a statutory requirement to enrol all eligible staff into a workplace pension scheme. Where employees are not eligible to enrol in the NHS Pension Scheme they are enrolled in the NEST Pension Scheme as an alternative. The employee can choose to "opt out" of the scheme after they have been auto-enrolled, this opt out lasts for three years, after which the Trust is required to re-enrol the employee. The Trust is required to make employer contributions of 1% of the employees qualifying salary to the NEST Pension Scheme. For the period 1 April 2017 to 31 March 2018 the Trust has contributed £4,494.

1.9 Intangible non-current assets

Recognition
Intangible non-current assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Valuation and Depreciation
Intangible non current assets held for operational use are valued at historical cost and are amortised over the estimated life of the asset on a straight line basis. The

only intangible assets currently recognised in the Trust's accounts are computer software systems.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives.

1.10 Property, Plant and Equipment

Recognition
Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Subsequent additional expenditure on PPE is recognised if the value of that expenditure also exceeds the recognition threshold.

Valuation
Land and buildings used for the trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value as at 31 March 2018. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of Financial Position date. Fair values are determined as follows:

Land and buildings – these are valued based on the anticipated lives within the Trust's current Estates Strategy. Additionally the alternative site valuation method was used where appropriate.

Until 31 March 2008, the depreciated replacement cost of specialised buildings had been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Increases arising on revaluation are taken to the revaluation reserve except when it reverses a revaluation decrease for the same asset previously recognised in the Statement of Comprehensive Income, in which case it is credited to the Statement of Comprehensive Income to the extent of the decrease previously charged there. A revaluation decrease is charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the Statement of Comprehensive Income.

Equipment was valued using depreciated historic cost based on the anticipated remaining useful life of the assets.

Depreciation, amortisation and impairments
Land and assets under construction are not depreciated.

Otherwise, depreciation and amortisation are charged on a straight line basis to write off the costs or valuation of tangible and intangible non-current assets, less any residual value, over their estimated useful lives. The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

Tangible current assets are depreciated based on the expected remaining useful life. When arriving at the appropriate lifespan for individual buildings the plans contained within the Trust's Estates Strategy is considered. The Trust's accounting policy on assigning asset lives is:

Buildings including dwellings - in accordance with advice of professional valuer or 35 years where this is not yet known.

Plant & machinery - between 5 and 15 years
Transport equipment 7 years
Information technology 5 years*
Furniture & fittings 10 years
Intangible assets (including Meditech V6 IT system) - up to 15 years

At each Statement of Financial Position date, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the Statement of Comprehensive Income. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is

credited to the Statement of Comprehensive Income to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

* the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
* the sale must be highly probable i.e.:
  management are committed to a plan to sell the asset;
  an active programme has begun to find a buyer and complete the sale
  the asset is being actively marketed at a reasonable price;
  the sale is expected to be completed within 12 months of the date of classification as 'held for sale'; and
  the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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. 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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.11 Donated assets
Under Department of Health instructions the receipt of donated assets is now shown as a credit to the Statement of Comprehensive Income rather than to a Donated Asset Reserve.

Donated property plant and equipment assets are recognised at their fair value on receipt and are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.12 Revenue grants and other contributions to expenditure
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 Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee
Amounts held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged directly to the Statement of Comprehensive Income.

As at the Statement of Financial Position date the Trust has equipment supplied under the terms of endoscopy, pathology and catheter laboratory classified as a finance leased assets. These have a net valuation as at 31 March 2018 of £1.6million.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

The Trust as lessor
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 so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the 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 on a straight-line basis over the lease term.

1.14 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable estimate. This includes Fuel Oil. The Trust recognises some inventory items as "Work in Progress" and this relates to part manufactured pharmacy products which are valued based on the cost of the constituent ingredients.

1.15 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.

1.16 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the balance sheet date, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its estimated carrying amount is the present value of those cash flows, discounted using the discount rates supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts would be recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it. The Trust does not currently recognise any onerous contracts.

1.17 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the NHS Trust pays an annual contribution which in return settles all clinical negligence claims. The contribution is charged to the Statement of Comprehensive Income. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at Note 28 but is not recognised in the NHS Foundation Trusts Accounts.

1.18 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.19 Financial assets

Financial assets are recognised on the Statement of Financial Position when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets

are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value plus initial direct costs.

Financial assets are classified into the following categories: financial assets 'at fair value through profit and loss'; 'held to maturity investments'; 'available for sale financial assets', and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

The Trust's financial assets as at 31 March 2018 are disclosed in Note 30.1. As at 31 March 2018 the Trust does not have any financial assets held at fair value or held to maturity.

Financial assets at fair value through profit and loss and are assets held for trading

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Statement of Comprehensive Income. The net gain or loss incorporates any interest earned on the financial asset.

The Trust's financial liabilities as at 31 March 2018 are disclosed in Note 30.2. As at 31 March 2018 the Trust does not have any financial liabilities held at fair value

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the Statement of Comprehensive Income on de-recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method. The only loan currently recognised by the Trust has arisen as a result of a capitalisation of a finance lease.

Fair value is determined by reference to quoted market prices where possible.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Income to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

The Trust's financial liabilities as at 31 March 2018 are disclosed in Note 31.2.

1.20 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received.

Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.
Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or "other financial liabilities".

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Statement of Comprehensive Income. The net gain or loss incorporates any interest earned on the financial asset.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 Value Added Tax

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.

1.22 Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Statement of Comprehensive Income. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the Statement of Financial Position date.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 32 to the accounts.

1.24 Public Dividend Capital (PDC) and PDC dividend

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

A charge, reflecting the cost of capital utilised by the NHS foundation 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 NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or

payable. In accordance with the requirements laid down by the Department of Health (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 thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.25 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

1.26 Corporation Tax

NHS Foundation Trusts are potentially liable to corporation tax in certain circumstances. The Trust has not identified any transactions that are subject to corporation tax in the period covered by these accounts.

1.27 Accounting for Annual Leave

The Trust has taken the decision in the year ending 31 March 2018 not to include an accrual for Annual Leave not taken. This is because the value is no longer material

1.28 Consolidation of Charitable Funds

The Burton Hospitals NHS Trust Charitable Fund is controlled by the Burton Hospitals NHS Foundation Trust acting as Corporate Trustee. The estimated net value of the Charity as at 31 March 2018 was £1.09 million. The Trust has taken the decision not to consolidate this within the accounts of the Trust on the grounds of materiality.

1.29 Going Concern

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Board of Directors has carefully considered the principle of “Going Concern” and the Directors have concluded that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern.

The Trust has recorded operating deficits of £1.8 million in 2013/14, £10.6 million in 2014/15, £17.2 million in 2015/16, £8.2 million in 2016/17 and £11.5 million in 2017/18. Consequently the Trust has received financial support, in the form of Working Capital loans from the Department of Health which stand at £48.015 million as at 31 March 2018 of which £24.010 million falls due for repayment in 2018/19. The Trust expects to incur a sizeable financial deficit in 2018/19 and anticipates it may be some time before it can achieve financial balance on a sustainable basis. Therefore it is anticipated that the Trust will require further substantial financial support in 2018/19.

Although these factors represent material uncertainties that may cast significant doubt about the Trust’s ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the Department of Health Group Accounting Manual the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

The Trust has agreed contracts with its local commissioners for 2018/19 and services are being commissioned in the same manner as in previous years and there are no discontinued operations. Similarly no decision has been made to transfer services or significantly amend the structure of the organisation at this time*. The Board of Directors also has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health to continue to deliver the full range of mandatory services for the foreseeable future.

The Directors consider that this provides sufficient evidence that the Trust will continue as a going concern for the foreseeable future. The Trust has received significant support in the recent past, has made no decision to request dissolution from the Secretary of State and has no reason to believe that support will not be provided.

Throughout the year ended 31 March 2018 the Trust was progressing a possible merger with Derby Hospitals Foundation Trust. As at the date of these financial statements no final decision has been made.

1.30 Contingent Liabilities

Contingent liabilities are not recognised, but are disclosed in Note 29, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

1. 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

2. 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.

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

IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the GAM: early adoption is not therefore permitted. The Trust has reviewed this Standard and does not think it would materially change the Financial Asset values as reported in these accounts if it had been implemented already.

IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the GAM: early adoption is not therefore permitted. The Trust has reviewed this Standard and is not anticipated that IFRS 15 will material change the Trust's income reporting.

IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the GAM: early adoption is not therefore permitted. The Trust will need to consider if vehicles held on short term operating leases will be classed as Finance Leases. As at 31st March 2018 the Trust held operating leases on 98 vehicles as part of the Staff Salary Sacrifice Car Scheme with an estimated depreciated value of £1.4 million. However as the risks appertaining to the vehicles lie with the drivers it is possible that the leases will continue to be classed as Operating Leases.

IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018. It is believed that any such transactions would not be material in the accounts of the Trusts.

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2018

	Note	Year to 31 March 2018 £000	Year to 31 March 2017 £000
Revenue from patient care activities	3	172,919	168,958
Other operating revenue	5	29,393	28,203
Operating expenses	7	(211,451)	(202,439)
Operating surplus (deficit)		**(9,139)**	**(5,278)**
Investment revenue	14	19	19
Finance costs-Interest charges on finance leases	16	(665)	(578)
Surplus/(deficit) for the financial year		**(9,785)**	**(5,837)**
Dividends payable on Public Dividend Capital		(1,720)	(2,453)
Gains on Disposal of assets		(22)	93
Retained surplus/(deficit) for the year		**(11,527)**	**(8,197)**
Other Comprehensive Income			
Impairments	18	(11,230)	(642)
Revaluations	18	0	1,961
Total Comprehensive Income/(Expenditure) for the Period		**(22,757)**	**(6,878)**

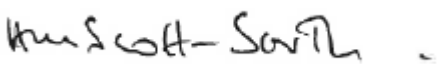
Notes:

The total comprehensive expense as detailed above is the sum of both the retained deficit and movements on reserves.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	17	4,840	5,161
Property, plant and equipment	18	102,047	117,034
Total non-current assets		**106,887**	**122,195**
Current assets			
Inventories	21	4,289	4,417
Trade and other receivables	22	16,093	18,191
Cash and cash equivalents	23	3,145	4,516
		23,527	**27,124**
Non-current assets held for sale		**0**	**0**
Total current assets		**23,527**	**27,124**
Total assets			
Current liabilities			
Trade and other payables	24	(18,394)	(24,000)
Borrowings	25	(24,360)	(349)
Provisions	28	(1,179)	(541)
Other liabilities	26	(152)	(1,217)
Net current assets		**(20,557)**	**1,018**
Total assets less current liabilities		**86,330**	**123,213**
Non-current liabilities			
Borrowings	25	(25,170)	(39,781)
Provisions	28	(477)	(776)
Total assets employed		**60,683**	**82,656**
Financed by:			
Taxpayers' equity			
Public dividend capital	SOCiTE	55,376	54,591
Retained earnings	SOCiTE	(28,705)	(17,202)
Revaluation reserve	SOCiTE	34,011	45,267
Total taxpayers' equity		**60,683**	**82,656**

Signed



Helen Scott-South
Chief Executive
23 May 2018

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital (PDC)	Retained Earnings	Revaluation Reserve	Total
	£000	£000	£000	£000
Balance 1 April 2017	54,591	(17,202)	45,267	82,656
Changes in taxpayers' equity for period				
Deficit for the financial year	0	(11,527)	0	(11,527)
Transfers in respect of revaluation reserve	0	26	(26)	0
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Impairments	0	0	(11,230)	(11,230)
PDC Received	785	0	0	785
Asset disposals	0	0	0	0
Other gained or losses	0	(1)	0	(1)
Other Reserve movements	0	0	0	0
Balance at 31 March 2018	**55,376**	**(28,705)**	**34,011**	**60,683**

	Public Dividend Capital (PDC)	Retained Earnings	Revaluation Reserve	Total
	£000	£000	£000	£000
Balance 1 April 2016	54,591	(9,006)	43,949	89,537
Changes in taxpayers' equity for period				
PDC received				
Deficit for the financial year	0	(8,197)	0	(8,197)
Transfers in respect of revaluation reserve	0	0	0	0
Net gain/(loss) on revaluation of property, plant and equipment	0	0	1,961	1,961
Impairments	0	0	(642)	(642)
Asset disposals	0	0	0	0
Other Reserve movements	0	0	0	0
Balance at 31 March 2017	**54,591**	**(17,202)**	**45,267**	**82,656**

STATEMENT OF CASHFLOWS FOR THE PERIOD ENDING 31 MARCH 2018

	Year to 31 March 18 £000	Year to 31 March 17 £000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	(9,139)	(5,278)
Depreciation and amortisation	5,841	6,102
Impairments	5,039	254
Non Cash donations credited to income	(271)	(70)
(Increase)/Decrease in Trade and Other Receivables	2,167	(11,234)
(Increase)/Decrease in Inventories	128	(304)
Increase/(Decrease) in Trade and Other Payables	(4,981)	5,589
Increase/(Decrease) in Other Liabilities	(1,065)	208
Increase/(Decrease) in Provisions	339	(933)
Net cash generated (used) from operating activities	(1,943)	(5,666)
Cash flows from investing activities		
Interest received	19	19
Purchase of Property, Plant and Equipment	(7,205)	(4,808)
Sales of Property, Plant and Equipment	48	634
Net cash generated from/(used in) investing activities	(7,138)	(4,155)
Cash flows from financing activities		
PDC received	785	0
Movement in Loans from Department of Health	9,751	12,864
Movement in other loans	0	(3)
Capital element of finance lease rental payments	(528)	(528)
interest paid	(610)	(413)
Interest element of finance lease	(18)	(18)
PDC Dividend paid	(1,838)	(2,488)
Cash flows from other financing activities	168	(31)
Net cash generated from/(used in) financing activities	7,710	9,383
Increase/(decrease) in cash and cash equivalents	(1,371)	(438)
Cash and Cash equivalents at 1 April	4,516	4,954
Cash and Cash equivalents at 31 March	3,145	4,516

Notes to the Accounts

2 Segmental Analysis

The Trust operates as only one key segment: the provision of healthcare. The principal financial report received by the Trust Board reports the position for the Trust as a single entity.

3.1 Mandatory and non-mandatory split of income

Of the total income from activities £172.1 million is mandatory and £0.8 million is non-mandatory income.

4 Private patient cap

The private patient cap as previously enforced under Section 44 of the 2006 NHS Act has been withdrawn and therefore the Trust will no longer report on this.

5 Other operating revenue

	Year to 31 March 18 £000	Year to 31 March 17 £000
Education and Training	6,638	6,740
Research and Development	76	67
Charitable and other contributions to expenditure	271	71
Non-patient care services to other bodies	7,456	6,609
Sustainability and Transformation Fund	7,855	7,549
Other income	7,097	7,167
	29,393	28,203
Other income includes		
Car parking	1,353	1,413
Estates recharges	177	157
Pharmacy sales	2,449	2,908
Staff accommodation rentals	117	149
Staff Benefit Schemes	553	648
Clinical tests	109	114
Clinical excellence awards	0	76
Catering	473	572
Other	1,866	1,130
	7,097	7,167

6 Revenue

Revenue from Patient Care Activities	172,919	168,958
Other operating revenue	29,393	28,203
	202,312	197,161

7 Operating expenses

	Year to 31 March 18 £000	Year to 31 March 17 £000
Healthcare Services from NHS and DHSC bodies	11,315	10,733
Purchase of Healthcare Non NHS bodies	205	1,105
Staff and Executive directors costs	135,375	130,996
Non-executive directors costs	126	116
Drugs	17,988	18,231
Supplies and services – clinical	10,889	11,894
Supplies and services – general	2,499	2,450
Establishment	1,059	1,077
Transport	296	405
Premises- Business Rates	947	910
Premises Other	7,664	7,343
Provision for impairment of receivables	101	131
Increase in other provisions	329	(353)
Changes in the Discount Rate	80	(64)
Operating Leases	557	658
Depreciation and amortisation	5,841	6,102
Impairments and reversals of property, plant and equipment	5,039	254
Audit fees-Statutory	55	39
Clinical negligence insurance	5,379	3,842
Legal Fees	6	7
Patient's Travel	152	25
Consultancy Costs	1,648	2,085
Training and Conferences	434	478
Car Parking & Security	107	69
Redundancy	18	0
Hospitality	10	9
Insurance	0	0
Losses and Ex Gratia Payments	18	50
Loss on Disposal of assets	18	0
Other*	3,297	3,847
	211,451	202,439

***Other Includes**

Internal Audit Fees	140	159
Subscriptions	456	359
FP10 Dispensing Fees	274	297
Other Contracted Services	1217	957
Tests/Screening	203	179
Clinical Waste	220	245
Refuse Collection Non Clinical	142	110
Oxford Fertility Services	124	130
Insurance	19	172
Other	502	1,239
	3,297	3,847

8 Operating leases

8.1 As lessee

The Trust holds short term leases for a number of smaller assets including equipment and vehicles on 2 or 3 year leases.
It also leases equipment and vehicles supplied to staff under Salary Sacrifice arrangements.

	Year to 31 March 18 £000	Year to 31 March 17 £000
Payments recognised as an expense	557	658

Total future minimum lease payments	As at 31 March 18 £000	As at 31 March17 £000
Within 1 year	457	534
Between one and five years	353	390
	810	924

9 Employee costs and numbers

9.1 Employee costs

	Year to 31 March 18 £000	Year to 31 March 17 £000
Salaries and wages	104,641	101,119
Social security costs	9,576	9,139
Apprenticeship Levy	508	0
Agency staff	8,839	8,785
NHS Pension Costs	12,061	11,953
	135,625	130,996

9.2 Average number of persons employed

	Year to 31 March 18 Total Number	Year to 31 March 17 Total Number
Medical and dental	288	300
Administration and estates	663	649
Healthcare assistants and other support staff	655	658
Nursing, midwifery and health visiting staff	912	899
Scientific, therapeutic and technical staff	273	266
Bank and agency	255	239
	3,047	3,011

10 Pension Costs Future Contributions

The Trusts estimated employers contribution to the NHS Pensions Scheme for the year ended 31 March 2019 is £12.3 million.

11 Retirements due to ill-health

During the financial year 2017/18 there was 1 (3 in 2016/17) retirement from the Trust on the grounds of ill health. The estimated additional pension liabilities of this will be £90,000 (£70,159 2016/17). The cost will be borne by the NHS Pensions Agency.

12 Prior Year Adjustments

There are no prior year adjustments.

13 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust did not pay any interest under the terms of this Act.

14 Investment revenue

	Year to 31 March 18 £000	Year to 31 March 17 £000
Interest Revenue (Bank Accounts)	19	19
Total	19	19

15 Other gains and losses

	Year to 31 March 18 £000	Year to 31 March 17 £000
Loss on disposal of property, plant and equipment	22	0

16 Finance Costs

	Year to 31 March 18 £000	Year to 31 March 17 £000
Interest on Loans from Department of Health	656	542
Interest on obligations under finance leases	9	36
Total	665	578

17.1 Intangible Fixed Assets

	31 March 18 £000	31 March 17 £000
Gross cost at 1 April	6,574	5,400
	6,574	5,400
Additions - donated	0	8
Reclassifications	250	1,197
Disposals	0	(32)
Gross cost at 31 March	6,823	6,574
Amortisation at start of period	1,412	926
	1,412	926
Provided during the year	571	518
Disposals	0	(32)
Amortisation at 31 March	1,983	1,412
Net book value		
- Purchased at 31 March	4,827	5,142
- Donated at 31 March	13	19
Total at 31 March	4,840	5,161

Reclassifications include items moved from Assets Under Construction.

17.2 Revaluation reserve balance for intangible assets

As at 31 March 2018 the balance on the Revaluation Reserve held no value in respect of intangible assets.

18.1 Property, plant and equipment - for the year to 31 March 18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 17	13,864	94,979	1,952	2,550	20,195	313	10,082	1,877	145,812
Additions purchased	0	2,721	0	885	1,627	0	1,312	7	6,552
Additions leased	0	0	0	0	0	0	0	0	0
Additions donated	0	43	0	0	226	0	2	0	271
Impairments charged to operating expenses	(1,956)	(3,083)	0	0	0	0	0	0	(5,039)
Impairments charged to Revaluation Reserve	(4,970)	(6,170)	(90)	0	0	0	0	0	(11,230)
Reversal of impairments charged to operating expenses	0	0	0	0	0	0	0	0	0
Reversal of impairments charged to revaluation reserve	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	(250)	0	0	0	0	(250)
Revaluation	0	0	0	0	0	0	0	0	0
Transfer to Assets Held for Sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	(19)	(674)	0	0	0	(693)
Cost or Valuation at 31 March 18	6,938	88,490	1,862	3,167	21,374	313	11,396	1,884	135,424
Depreciation at 1 April 17	0	5,613	205	0	13,561	230	7,673	1,496	28,778
Charged during the year	0	2,493	64	0	1,685	20	906	102	5,270
Impairments charged to operating expenses	0	0	0	0	0	0	0	0	0
Impairments charged to Revaluation Reserve	0	0	0	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0	0	0	0
Reversal of impairments charged to revaluation reserve	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	(8)	0	0	8	(0)
Revaluations	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(671)	0	0	0	(671)
Depreciation at 31 March 18	0	8,106	269	0	14,566	250	8,579	1,606	33,377

Net Book Value									
- Purchased at 1 April 17	13,864	85,817	1,747	2,550	5,237	84	2,409	285	111,992
- Finance Leased at 1 April 17	0	1,149	0	0	756	0	0	30	1,935
- Donated at 1 April 17	0	2,400	0	0	641	0	0	66	3,107
- Total at 1 April 17	13,864	89,366	1,747	2,550	6,634	84	2,409	381	117,034
- Purchased at 31 March 18	6,938	77,144	1,593	3,167	5,621	64	2,810	216	97,551
- Finance Leased at 31 March 18	0	1,077	0	0	505	0	0	15	1,597
- Donated at 31 March 18	0	2,163	0	0	682	0	7	47	2,899
- Total at 31 March 18	6,938	80,384	1,593	3,167	6,808	64	2,817	278	102,047
Asset Financing									
Owned	6,938	79,307	1,593	3,167	6,303	64	2,817	263	100,450
Finance Leased	0	1,077	0	0	505	0	0	15	1,597
	6,938	80,384	1,593	3,167	6,808	64	2,817	278	102,047

Valuation Land, Buildings and Dwellings

An independent "desktop" valuation of the Land, Buildings and Dwellings was carried out by GVA Grimley at 1 April 2017 and 31 March 2018. In accordance with International Financial Reporting Standards a Modern Equivalent Asset methodology was applied and, where appropriate the single alternative site used. The estimated useful lives of the relevant assets was calculated in accordance with the Trust's current strategic plans for its estate. The last full valuation was carried out as at 31 March 2015

18.1 Cntd **Property, plant and equipment - for the year to 31 March 17**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April16	13,275	93,283	1,944	1,193	18,678	313	12,047	1,933	142,666
Additions purchased	0	1,228	0	2,381	1,333	0	758	0	5,700
Additions leased	0	0	0	0	397	0	0	0	397
Additions donated	0	0	0	0	59	0	3	0	62
Impairments charged to operating expenses	0	(254)	0	0	0	0	0	0	(254)
Impairments charged to Revaluation Reserve	0	(642)	0	0	0	0	0	0	(642)
Reversal of impairments charged to operating expenses	0	16	(16)	0	0	0	0	0	0
Reversal of impairments charged to revaluation reserve	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	(1,024)	(164)	0	0	(9)	(1,197)
Revaluation	589	1,348	24	0	0	0	0	0	1,961
Transfer to Assets Held for Sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(108)	0	(2,726)	(47)	(2,881)
Cost or Valuation at 31 March 17	13,864	94,979	1,952	2,550	20,195	313	10,082	1,877	145,812
Depreciation at 1 April 16	0	2,753	133	0	12,049	210	9,514	1,375	26,035
Transfers by Modified Absorption	0	0	0	0	0	0	0	0	0
Charged during the year	0	2,860	72	0	1,579	20	885	168	5,584
Impairments charged to operating expenses	0	(0)	0	0	0	0	0	0	(0)
Impairments charged to Revaluation Reserve	0	0	0	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0	0	0	0
Reversal of impairments charged to revaluation reserve	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(67)	0	(2,726)	(47)	(2,840)
Depreciation at 31 March 17	0	5,613	205	0	13,561	230	7,673	1,496	28,778

Net Book Value									
- Purchased at 1 April16	13,275	86,805	1,811	1,193	5,208	104	2,523	435	111,352
- Finance Leased at 1 April 16	0	1,221	0	0	618	0	0	38	1,877
- Donated at 1 April 16	0	2,504	0	0	802	0	10	85	3,402
- Total at 1 April 16	13,275	90,530	1,811	1,193	6,629	104	2,533	558	116,632
- Purchased at 31 March 17	13,864	85,817	1,747	2,550	5,237	84	2,409	285	111,992
- Finance Leased at 31 March 17	0	1,149	0	0	756	0	0	30	1,935
- Donated at 31 March 17	0	2,400	0	0	641	0	0	66	3,107
- Total at 31 March 17	13,864	89,366	1,747	2,550	6,634	84	2,409	381	117,034
Asset Financing									
Owned	13,864	88,217	1,747	2,550	5,878	84	2,409	351	115,099
Finance Leased	0	1,149	0	0	756	0	0	30	1,935
	13,864	89,366	1,747	2,550	6,634	84	2,409	381	117,034

18.2 Net book value of assets held under finance leases 2017/18

	£000
Valuation Gross cost 1 April 17	5,315
Additions during the year	0
Valuation Gross cost 31 March 18	5,315
Depreciation at 1 April 17	3,380
Charged during the year	338
Depreciation at 31 March 18	3,718
Net Book Value as at 31 March 18	1,597

Assets include equipment provided under Endoscopy and Pathology managed service contract and buildings, equipment and fittings provided under a Catheter Laboratory service contract.

18.3 Assets held for sale as at 31 March 18

There are no assets held for sale at the Balance Sheet Date
The Margaret Stanhope Centre was sold in March 2017.

19 The net book value of land, buildings and dwellings at 31 March 2018 comprises

	31 March 18 £000	31 March 17 £000
Freehold	87,838	103,828
Long Leasehold	0	0
Short Leasehold	1,077	1,149
	88,915	104,977
Protected assets	0	0
Non-Protected assets	88,915	104,977
	88,915	104,977

20 Capital Commitments

As at 31 March 18 the Trust had signed up to capital contracts and the future commitments under these at the balance sheet total £98k (prior year £456k).

21 Inventories

21.1 Inventories

	31 March 18 £000	31 March 17 £000
Drugs	1,237	1,380
Work in Progress	79	77
Consumables	2,924	2,909
Energy	49	51
	4,289	4,417

Work in Progress relates to pharmacy products that are in the process of being manufactured for resale.

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21.2 Inventories recognised in expenses

	Year to 31 March 18 £000	Year to 31 March 17 £000
Inventories recognised as an expense in the period	24,311	24,003

22 Trade and other receivables

22.1 Trade and other receivables

	31 March 18 £000	31 March 17 £000
Trade Receivables	7,809	11,459
Capital Receivables	0	155
Provision for the impairment of receivables	(954)	(853)
Prepayments	1,590	1,231
Accrued income	2,406	2,006
PDC	153	35
Other receivables	5,089	4,158
Total	16,093	18,191

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by government to buy NHS patient care services no credit scoring of them is considered necessary.

Receivables due from NHS bodies including NHS England, CCGS, Health Education England, English NHS Trusts and Foundations Trusts was £7.81 million at 31 March 2018. (£11.43 m 31.3.17)

22.2 Outstanding receivables not impaired

	31 March 18 £000	31 March 17 £000
By up to three months	9,551	12,715
By three to six months	2,169	2,021
By more than six months	1,331	1,071
Total	13,051	15,807

22.3 Provision for impairment of receivables

	31 March 18 £000	31 March 17 £000
Balance at start of period	853	843
Increase in Provision	101	131
Amounts Utilised	0	(121)
Balance as at 31 March	954	853

23 Cash and cash equivalents

	31 March 18 £000	31 March 17 £000
Balance at start of period	4,516	4,954
Net change in year	(1,371)	(438)
Balance at 31 March	3,145	4,516
Made up of		
Cash with Government Banking Service	3,064	4,416
Commercial banks and cash in hand	81	100
Cash and cash equivalents as in Statement of Financial Position	3,145	4,516

As at 31 March 18 the Trust held £1,571 (£2,228 31.3.17) in respect of third party cash.

24 Trade and other payables

	31 March 18 £000	31 March 17 £000
Trade Payables	7,479	7,531
Trade payables - capital	2,024	2,617
Social Security Costs	1,421	1,362
Taxes payable	1,531	1,531
Other payables	2,889	7,162
Accruals	3,050	3,796
	18,394	23,999

Payables due to NHS bodies including NHS England, CCGS, Health Education England English NHS Trusts and Foundations Trusts was £4.79 million at 31 March 2018. (£7.51 m 31.3.17)
Accruals includes £191K accrued interest on Department of Health Loans (2016/17 £162K)

25 Borrowings

	Current		Non Current	
	31 March 18 £000	31 March 17 £000	31 March 18 £000	31 March 17 £000
Finance Leases	350	349	1,165	1,517
Working Capital Loans from Department of Health	24,010	0	24,005	38,264
Other Loans	0	0	0	0
	24,360	349	25,170	39,781

Notes

1. Working Capital Loan:

The Trust is in receipt of "distressed" Trust funding from the Department of Health.
The net loan is £48.015 million as at 31 March 18.
Repayments are due
£24.04 million in November 2018
£7.9 million in January 2020
£4.97 million in March 2020
£0.37 million in April 2020
£1.37 million in June 2020
£0.36 million in July 2020
£3.3 million in September 2020
£0.28 million in October 2020
£2.00 million in November 2020
£1.03 million in December 2020
£1.48 million in January 2021
£0.95 million in March 2021

26 Other Liabilities

	Current	
	31 March 18	31 March 17
	£000	£000
Deferred Income	152	1,217
	152	1,217

27 Finance lease obligations

The Trust currently has equipment supplied as part of managed service contracts for endoscopy, pathology and catheter laboratory contracts.

	31 March 18 £000	31 March 17 £000
Gross Building Lease Liabilities	1,019	1,122
of which Liabilities are due:		
-not later than one year	92	92
-later than one and not later than five years	370	367
-later than 5 years	557	663
Finance charges allocated to future periods	(9)	(20)
Net buildings lease liabilities	1,010	1,102
-not later than one year	91	90
-later than one and not later than five years	367	361
-later than 5 years	552	651
	1,010	1,102

	31 March 18 £000	31 March 17 £000
Gross Plant and Machinery Lease Liabilities	515	791
of which Liabilities are due:		
-not later than one year	264	276
-later than one and not later than five years	251	515
-later than 5 years	0	0
Finance charges allocated to future periods	(10)	(27)
Net Plant and Machinery lease liabilities	505	764
-not later than one year	259	259
-later than one and not later than five years	246	505
-later than 5 years	0	0
	505	764

28 Provisions

	Current		Non Current	
	31 March 18 £000	31 March 17 £000	31 March 18 £000	31 March 17 £000
Legal claims	44	59	0	0
Other	1,135	482	477	776
	1,179	541	477	776

	Redundancy	Legal Claims	Other	Total
	£000	£000	£000	£000
As at 1 April 17	0	59	1,258	1,317
Arising during the period	0	0	593	593
Change in the Discount Rate	0	24	56	80
Utilised during the period	0	(17)	(53)	(70)
Reversed unused	0	(22)	(242)	(264)
As at 1 April 18	0	44	1,612	1,656
Expected timing of cash flows:				
Within one year	0	44	1,135	1,179
Between one and five years	0	0	212	212
After five years	0	0	265	265
	0	44	1,612	1,656

"Other" provisions include £0.66 million in respect of Injury Benefit Provisions.
Legal claims are handled by NHS Resolution and therefore the net provision is calculated based on the net cost to the trust arising from the policy excess.

£121.9 million is included in the provisions of the NHS Resolution at 31 March 2018 in respect of clinical negligence claims against the Trust. (£82 million 31 March 2016)

29 Contingencies

29.1 Contingent liabilities

	31 March 18 £000	31 March 17 £000
Legal claims	48	29

The legal claim contingent liabilities recognises the potential cost to the Trust should the actual cost to the Trust exceed the estimate charged to the Statement of Comprehensive income based on guidance issued by NHS Resolution as the likely outcome.

29.2 Contingent assets

The Trust has no contingent assets.

30 Financial instruments

30.1 Financial assets

	Loans and receivables	Assets held at fair value through the I & E	Total
	£000	£000	£000
Receivables NHS and DH bodies	7,826	0	7,826
Receivables with other bodies	4,601	0	4,601
Cash at bank and in hand	3,145	0	3,145
Total at 31 March 18	15,572	0	15,572

30.2 Financial liabilities

	Other	Liabilities held at fair value through the I & E	Total
	£000	£000	£000
Finance Leases	1,515	0	1,515
Loans	48,015	0	48,015
Provisions	1,656	0	1,656
Payables NHS and DH bodies	5,012	0	5,012
Payables other bodies	13,382	0	13,382
Total at 31 March 18	69,580	0	69,580

30.3 Maturity of financial liabilities

	31 March 18 £000
In one year or less	43,933
In more than one year but not more than two years	13,267
In more than two years but not more than five years	11,563
In more than five years	817
	69,580

30.4 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust's main borrowings are Interim Working Capital Loans with interest fixed at 1.5%. Other loans are notional borrowings attributable to Finance Leased assets. Therefore the Trust is not subject to interest rate risk.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its Prudential Borrowing Limit. The Trust is not, therefore, exposed to significant liquidity risks.

Market Risk

The Trust Board routinely monitors the market risks facing the Trust. Financial plans are produced and amended in accordance with changing market conditions.

Risk Management Strategy

The Trust has a detailed risk management strategy to ensure that all risks, financial or otherwise are carefully considered and reported through the "Quality", "People", "Finance and Performance" and "Audit" Committees.

31 Related Party Transactions

Burton Hospitals NHS Foundation Trust is a public benefit corporation authorised by NHS Improvement.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Burton Hospitals NHS Foundation Trust.

Foundation Trusts are not controlled by the Secretary of State therefore the Trust needs to consider whether government bodies and other NHS organisations are related parties under the terms of IAS 24.

The Department of Health is regarded as a related party. During the year Burton Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent organisation. These include:

	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000
Department of Health	55	5	0	0
Burton Hospitals Charitable Funds	271	0	0	5
Other DH Group Bodies	164,223	18,208	7,814	4,789
Other Government	74	22,692	507	2,983

Included within "Income" are receipts for services provided to the following organisations:

East Staffordshire Clinical Commissioning Group	£38.88 million
South East Staffs and Seisden Peninsular Clinical Commissioning Group	£44.18 million
Southern Derbyshire Clinical Commissioning Group	£22.48 million
West Leicestershire Clinical Commissioning Group	£12.88 million
NHS England (for Specialised Services)	£9.59 million
Health Education England (Training & Education)	£5.92 million
Cannock Chase Clinical Commissioning Group	£6.36 million

The Trust takes part in the National Audit Office's annual National Fraud Initiative. This identifies where staff members may hold employment contracts with other organisations. Each case identified is investigated. No material related parties requiring disclosure were identified.

The Trust has also received revenue and capital payments from Burton Hospitals Charitable Fund. The Trust Board also acts as the Corporate Trustee of the Charity.
The Trustees Report and Audited Annual Accounts of the Charitable Fund are contained within a separate document.

The £271K disclosed as Trust Income relates to the value of Plant Property and Equipment donated to the Trust that are classified as Donated Assets by the Trust.
No key management services were provided to the Trust as part of a Personal Services contract. All Senior Managers were employed directly by the Trust or were employed by other NHS Bodies and their costs recharged to the Trust.

The Trust's Director of Finance was employed by Staffordshire and Stoke on Trent Partnership NHS Trust and the Chief Executive and Chief Operating Officer ere both employed by Derby Teaching Hospitals NHS Foundation Trust and all 3 were seconded to Burton Hospitals NHS Foundation Trust and their costs recharged. Total expenditure spent with these Trusts including the salary recharge costs and other goods and services were

Derby Teaching Hospitals NHS Foundation Trust	£2.2 million
Staffordshire and Stoke on Trent Partnership Trust	£0.251 million.

The Trust is a 50% Shareholder in a partnership called STRIDE. The Accounts are not consolidated with the accounts of the Trust on the grounds of materiality. The total expenditure for STRIDE in the years ended 31st March 2018 was £ 126K.

32 Third party assets

As at 31 March 2018 the Trust was holding £901 behalf of patients (£124 as at 31 March 2017).

Additionally various 3rd party deposits of £670 were held (£2,143 as at 31 March 2017).

33 Intra Government Balances

Balances with :	Receivables £000	Receivables due after more than one year £000	Payables due within one year £000	Payables due after more than one year £000
Department of Health	0	0	0	0
Public Health England	0	0	0	0
NHS England & Clinical Commissioning Groups	4,726	0	3	0
Health Education England	23	0	7	0
English NHS Trusts	1,318	0	1,800	0
Foundation Trusts	1,748	0	2,979	0
Special Health Authorities	0	0	0	0
Receivable from NHS NDBPs	0	0	0	0
Local Government Bodies	25	0	0	0
Other NHS Bodies	0	0	0	0
Other "Whole Government Account" Bodies	482	0	2,983	0
Total Government	8,321	0	7,772	0

34 Losses and Special Payments

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Losses				
Cash Losses	0	0	7	8
Bad Debts	169	27	822	21
Damage to Property	0	0	0	0
Total Losses	169	27	829	29
Special Payments				
Compensation Payments	3	4	0	0
Ex Gratia Payments	38	55	56	67
Total Special Payments	41	59	56	67
Total Losses and Special Payments	210	86	885	96

35 Termination Costs

The Trust incurred termination costs to the value of £48,000 during 2017/18 (nil 2016/17)

36 Off Payroll Costs

As at 31st March the Trust had no persons earning more than £220 per day that are classed as "off payroll" transactions.

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