NHS
University Hospitals Plymouth
NHS Trust

Leading with excellence, caring with compassion

Annual Report and Accounts 2017/18

Credits

This Annual Report has been produced in-house by the Communications Team with contributions from a wide range of staff throughout our Trust.

Contents

This Annual Report articulates our vision for the future and strategy, reports on our performance last year in an honest and fair way and also includes our Quality Accounts. The structure of the report is as follows:

Foreword

The pressures facing the NHS continue to be the subject of a considerable amount of political, media and public interest. Whilst the Care Quality Commission's Annual State of Care report for 2016/17 showed that the quality of health and social care was being maintained, it is important to remember that the challenges facing our health and social care system can have a very real impact on people's lives both in terms of those who are in need of our care and those who provide it.

We have much to be proud of in the care we provide and what has been achieved in 2017/18. Despite the challenges posed by increasing demands on our services, we have managed to make substantial progress in a number of critical areas including:

- Securing a clear and unified commitment to integrating health and social care services in Plymouth for the benefit of the people we serve.
- Securing significant additional funds for capital investment including a £26 million investment that will create four new interventional radiology theatres at the heart of Derriford Hospital.
- A successful bid to be part of NHSI's Lean Programme which will create a common approach and language of improvement to support closer working and better outcomes for patients.
- Delivering a significant improvement in our financial position, providing us with a stronger foundation from which we can provide sustainable services to our patients.
- Receiving ministerial approval to change our name to University Hospitals Plymouth NHS Trust from 1 April 2018. Supported by staff and partners and the public, this recognises and cements our status as an organisation involved with education, training and research.

We also continued to make progress in providing a rewarding and supportive environment in which to work with the results of the National Staff Survey 2017 showing further improvements since last year. We do, however, recognise that we still have plenty to do, particularly in light of the extraordinarily challenging environment in which people are working. We are liaising with trades unions to agree the key issues which we need to focus on, and as we have committed to previously, we will commence our 'Big Conversation' Programme to work with staff to identify the improvement actions we need to take.

Given that the National Health Service was 70 years old on 5th July 2018, it is the perfect opportunity to celebrate the achievements of one of the nation's most loved institutions which has delivered huge medical advances and improvements to public health. It has also pioneered new treatments like the world's first liver, heart and lung transplant.

However, none of this would be possible without the skill, dedication and compassion of our staff and volunteers who continue to do very special things 24 hours a day, 7 days a week, 365 days a year. As part of our #NHS70 celebrations, University Hospitals Plymouth NHS Trust and Livewell Southwest came together for a special award ceremony in June 2018. The #NHS70 Pride of Plymouth Awards are a way to recognise a selection of the many, many excellent people we have delivering NHS services in Plymouth.

In the meantime, we would like to express our deepest gratitude to all of our staff and volunteers for their continued dedication and incredible compassion at such a challenging time.

You will be able to read about these things and much more in this Annual Report and Quality Account, which we hope you will agree demonstrates that Plymouth continues to have a hospital to be proud of.

Ann James
Chief Executive

Richard Crompton
Chairman

Pauline Young reviewed Plymouth Hospitals NHS Trust – 5★
7 September at 13:46 ·

My partner was recently diagnosed and treated at Derriford Hospital for cancer. From the beginning of this terrible period in our lives, each and every single member of staff has been SUPERB. Despite self evidently high workloads, we have been treated as individual human beings throughout, with an excellent level of information being provided, sensitivity to our reactions and appointments generated quickly and running relatively well to time. As for the surgeon, Mr TK - what a man - we owe him and his team a massive debt of gratitude for not only their skill, but also, we believe, their determination to get the best outcome for their patient. When it came to recovery on Wolf, Bernie had nothing but praise for the efficiency and care he received from all the nurses he encountered but particular individuals that stood out were Leah, Faye, Pat, AnnMarie, and Ellie, as well as Taz on Recovery. Many heartfelt thanks to everyone for everything xxx

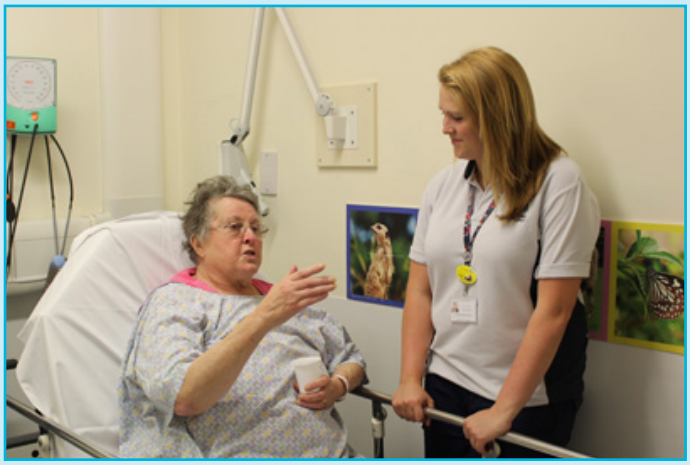
Our Year in Pictures

April 2017

It takes a village, or so they say. Well, certainly we have great support from our community in Plymouth. Students from Sir John Hunt Community College spent two days redecorating the day room on Hartor Ward, giving it a complete makeover. The team of Year 13 students transformed the patients' day room on this Healthcare of the Elderly ward which will help many patients, including those with dementia. We think you'll agree, the finished look is remarkable.

May 2017

The latest independent survey finds the majority of inpatients feel they are well looked after by staff, during their time in hospital. They also report having confidence and trust in the doctors and nurses treating them, as well as being treated with dignity and respect during their stay. The Trust improved its scores in eighteen areas, compared to last year's survey.



June 2017

The Physiotherapy team are successful in reducing the length of stay for patients, by introducing a late shift within the Emergency Department. Physiotherapists had trialled this in December, to address the increasing number of referrals occurring towards the end of the day. They found it had a beneficial effect on patient discharges and sought funding for a permanent post, which saw the employment of a permanent late-shift physiotherapist (Hayley pictured) as a result. An audit a year later shows that 16 patients (on average per month) are being discharged on the day of assessment during the late shift.

July 2017

“Volunteers don’t get paid not because they are worthless, but because they are priceless,” Elizabeth Pollard, Voluntary Services Manager, told some of the many hundreds of people who attended the annual Volunteers’ Lunch at Derriford Hospital. The lunch was attended by Lord Mayor of Plymouth Councillor Wendy Foster and Deputy Chief Executive, Nick Thomas. Christine Knight, who volunteers in the League of Friends bookshop, said: “I have done this for 20 years because I love meeting people and it’s a way of giving something back.”

August 2017

Results from the Patient-Led Assessment of the Care Environment (PLACE) give Derriford Hospital its highest ever scores, since the introduction of the PLACE standards in 2013. In addition, it is also now rated higher than the national average in many areas. In particular, the Trust has seen big improvements in its assessment for both food and dementia care. This year's hospital inspection was carried out by a team of 20 patient assessors, including members of Healthwatch Plymouth, our Patient Council, hospital volunteers and shadow governors.

September 2017

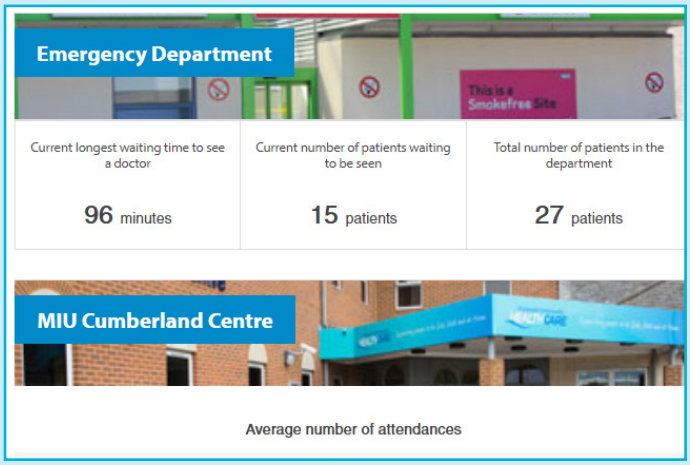
A nurse working at Derriford Hospital wins a national award for her outstanding work with bowel cancer patients. Maria Lawson received a Gary Logue Colorectal Nurse Award from the charity Beating Bowel Cancer. Maria, colorectal oncology nurse, was nominated by patients and received the award for her dedication, support, encouragement and her willingness to go the extra mile for her patients.

October 2017

National Improvement and Efficiency Lead, Lord Carter comes to see our eOutcomes work, which we are progressing with software solutions company, Intouch. Intouch believe we are one of the most advanced, if not the most advanced, hospital in the country in using such an electronic system. In the week before the visit, out of a total of circa 9,000 clinic attendances, we processed 6,300 outcomes electronically, capturing the outcomes for patients in real time. This means that at the point the patient left clinic, all the relevant the data was on the system, ready to be actioned.

November 2017

Our new Acute Asessment Unit opens for patients. Staffed by teams from Derriford and Livewell Southwest, the unit will deal with minor illness and ambulatory care as well as provide a dedicated pathway and space for patients with frailty. Professionals working in the unit include GPs, therapists, nurses, doctors, pharmacists, administration and management. “A big thank you to everyone involved, from Plymouth Hospitals, Livewell Southwest and GPs, for making this happen for our urgent care patients,” said Ann James as she cut the ribbon.

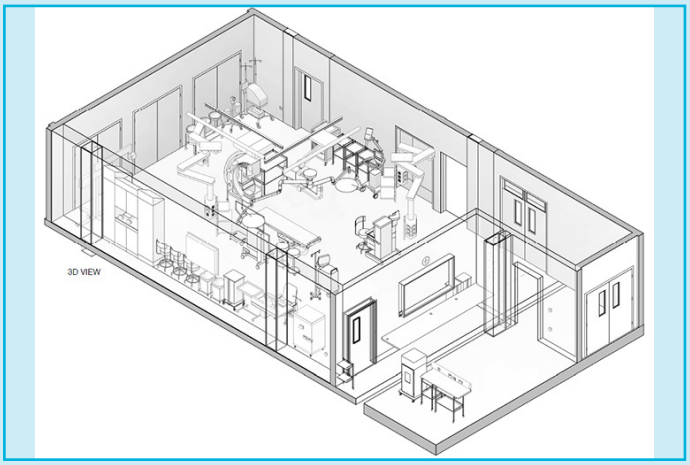


December 2017

If you live in Plymouth or the surrounding areas, you can now find out how long you might have to wait to be seen in our Emergency Department (ED) or one of our Minor Injuries Units (MIUs), by visiting our website. We are now streaming live waiting times for our ED and predicted waiting times for our MIUs – Cumberland Centre (Plymouth), South Hams Hospital (Kingsbridge) and Tavistock Hospital, on our website: https://www.plymouthhospitals.nhs.uk/urgent-waiting-times

January 2018

We appoint Jonathan Cope, GP to our new clinical role of Associate Medical Director (Primary Care). The role is a part of the hospital senior management team and will play a vital part in the development of partnerships with GPs. Jonathan has gained a wealth of experience from a wide range of clinical and managerial roles over the past 25 years. More recently he has been the Managing Partner at the Beacon Medical Group, which brought four practices together. Jonathan has also previously held roles at the LMC in Devon and at Health Education England as well as being awarded PULSE GP of the Year in 2016.



February 2018

Dr Henrietta Hughes, the National Freedom to Speak Up Guardian, visits Derriford Hospital to see how staff are being supported to speak up, as part of her visits to local Guardians across the NHS. With each Trust in the country having at least one Guardian in place, Dr Hughes heads up the National Guardian's Office. Dr Hughes learns more about the work taking place and says: "It was lovely to hear about the work that's happening to foster an environment at the Trust to enable staff to speak up. It was very helpful to hear reflections about how important support is for all staff at this very busy time in particular, and how valuable staff find the more informal route through the Guardians."

March 2018

Plymouth is awarded just over £26m in an announcement made by the Secretary of State for Health. The money will be used to build four Interventional Radiology theatres with full imaging capability and an eight-bedded short stay area for patients. The new unit will be built in an existing lightwell space with two of the four theatres on the emergency floor, level 6, of Derriford Hospital. One of the theatres will be a hybrid theatre which means it will also support the development of our vascular surgery service.

About our Trust

Who we care for
Plymouth Hospitals NHS Trust is the largest hospital in the south west peninsula, providing comprehensive secondary and tertiary healthcare. Our geography gives us a secondary care catchment population of 450,000 with a wider peninsula population of almost 2,000,000 people who can access our specialist services. The population is characterised by its diversity – the rural and the urban, the wealthy and pockets of deprivation, and wide variance in health and life expectancy. We work within a network of other hospitals to offer a range of specialist services such as kidney transplant, cardiothoracic surgery and neonatal intensive care and high risk obstetrics.

A Regional Specialist Teaching Hospital
We provide comprehensive training and education for a wide range of healthcare professionals. The Trust works in partnership with both Peninsula School of Medicine and Dentistry and the University of Exeter Medical School. We also support the Universities of Plymouth and Exeter in the delivery of courses for the Faculty of Health and Social Work. With university campuses in Plymouth, Exeter, Truro and Taunton, along with teaching facilities in Bristol, the Faculty of Health and Social Work is one of the largest providers of nursing, midwifery, social work and health professional education and training in the South West.

Leading transformation
At Plymouth Hospitals NHS Trust, we are working hard with partners across Devon's Sustainable Transformation Plan and more locally in Plymouth to improve the services available for patients. Our Medical Director, Dr Phil Hughes, is the clinical lead for the Acute Service Review being run as part of Devon STP, whilst in Plymouth we have recently signed a partnership agreement with one of the larger GP groups, Beacon Medical Group.

A big employer and city player
We recognise our role in the city as a big employer with circa 7,000 staff and volunteers and as an influential organisation, for example in our ability to attract investment into research. Our Chief Executive, Ann James, sits on the Plymouth Growth Board whilst our role as host for the South West Defence Medical Group connects us to the military tradition of the city. We have a tri-service staff of 200+ military doctors, nurses, and allied health professionals fully integrated within the hospital workplace, working and training alongside their NHS counterparts, treating the local community.

Our Trust's services benefit greatly from the skills of military clinicians, particularly in Trauma & Orthopaedics, Radiology and the Emergency Department. Many of them bring unique experiences and knowledge from their deployments and this, in turn, benefits Plymouth Hospitals NHS Trust and our patients.

Our Hospitals and Centres
We provide services for patients at the following main sites as well as through clinics at other local hospitals and care centres:

- **Derriford Hospital including The Royal Eye Infirmary (REI)**

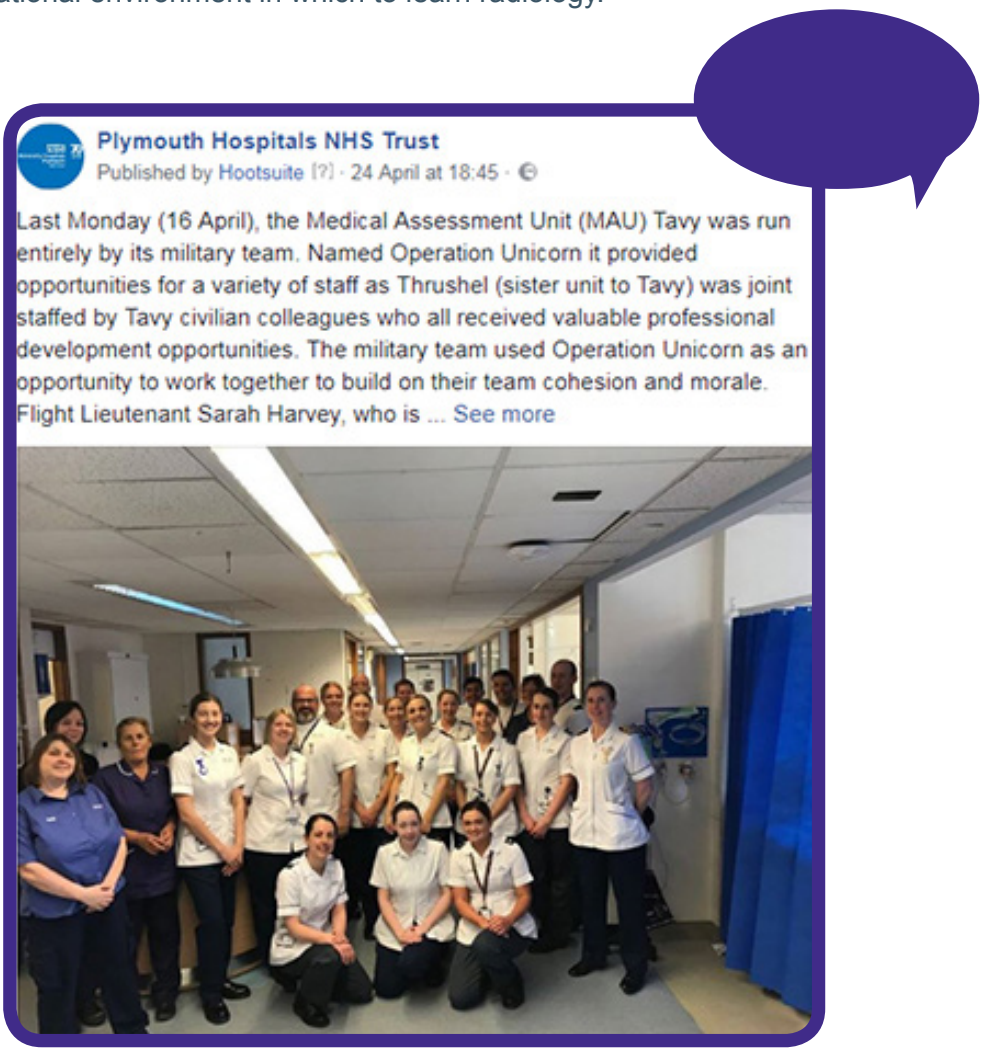
We offer the widest range of hospital based services in the Peninsula. What sets our Trust apart from the majority of acute hospital trusts is both the scope and scale of the services we offer on one site.

- **Minor Injuries Units**
  We offer urgent care for minor injuries and illness at the Minor Injury Unit, Cumberland Centre as well as at minor injury units in Tavistock and Kingsbridge.

- **Child Development Centre**
  Developmental services for young children are provided at the Child Development Centre, Scott Business Park.

- **The Plymouth Dialysis Unit**
  Patients needing treatment for renal failure are cared for in state-of-the-art, purpose-built facilities in Eaton Business Park.

- **Radiology Academy**
  The Plymouth Radiology Academy is the only purpose-built Radiology Academy in the world and provides an inspirational environment in which to learn radiology.



Our Strategic Context

We pride ourselves on leading with excellence and caring with compassion.

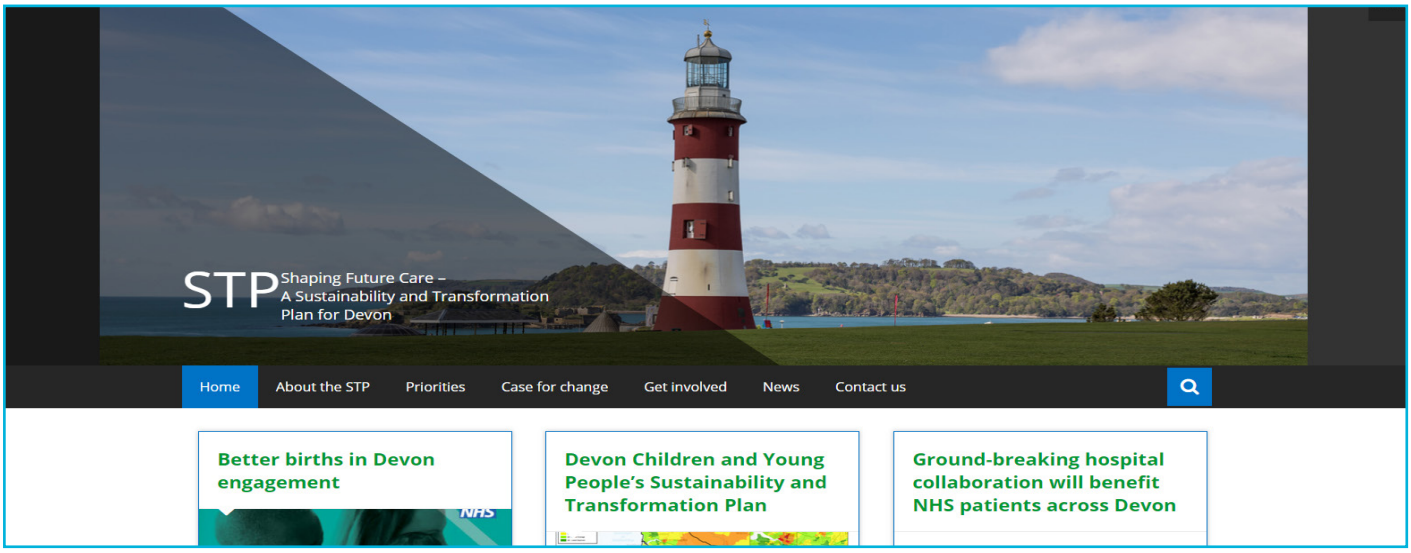
Our Values
The values defining the way we do things are:

- Putting Patients First
- Taking Ownership
- Respecting Others
- Being Positive
- Listening, Learning and Improving

Listening
We have been on a journey in the last few years, working together with our staff to create a sustainable organisation in which clinical teams and those closest to patients lead services, with support from a visible and accessible senior leadership team. This is done within a culture which is open and transparent and in which everyone is encouraged, as our fifth value says, to listen, learn and improve. Our staff survey results and system-wide CQC inspection report are both testament to the progress we are making.

We use social media and our online channels to both listen and respond to patients, carers and staff and to tell our own story of the great achievements of our staff and the challenges we are facing. Examples include the way we communicated our winter pressures. You can find this video online. The video was viewed more than 4,500 times, shared 40 times and attracted many comments. A small selection of the comments can be seen below.

There were 100,319 attendances at our Emergency Dept



Our part in Devon's Sustainable Transformation Plan (STP)

The NHS and local councils are developing and implementing shared proposals to improve health and care in every part of England. These are called Sustainability and Transformation Plans (STP).

The STP has been a positive catalyst for Devon. It has helped leaders build a collaborative and system-wide approach across the NHS and local government. As a result, Devon is in a stronger position in which to further integrate health and care services for the benefit of its population. The collective work by leaders, including those of Plymouth Hospitals NHS Trust, has helped tackle the historical challenges and, as a result, financial and service performance has improved.

The latest assessment by NHS England and NHS Improvement rates the Devon STP as one of 14 systems making real progress. The focus of working as part of an integrated health and care system in Devon, and as an STP, has been the driver for developing innovative new approaches, as well as some major successes:

- ***'Best care for Devon':*** improved performance against national NHS standards has seen Devon move into the top 25% nationally on urgent care and mental health.

- ***Reducing delayed transfers from hospital:*** joint work between the NHS and local authorities has seen delays fall from 6.6% to 5.6%. Devon is on track to reduce delays to target levels, freeing up 79 hospital beds and supporting winter plans. South Devon performance is already in the top 20% in England.

- ***High-quality social care:*** across Devon, 86% of adult social care providers are now rated by the Care Quality Commission (CQC) as either 'Outstanding' or 'Good'. This exceeds the overall national average for England of 80%.

- ***Groundbreaking collaboration:*** all four organisations providing acute hospital services have agreed a 'mutual support' approach to benefit patients. NHS England has highlighted it as an "exemplar of joint working". Our Acute Services Review has developed 'Best care for Devon' standards for urgent and

emergency care, stroke and maternity services, with clinical recommendations to provide services at all four of Devon's major hospitals if these standards are met. This approach will be supported by new clinical networks.

- ***'The best bed is your own bed':*** We are enhancing community services to support thousands more people to live independently at home. This has led to a reduction in acute and community hospitals beds by 213 over the past two years whilst at the same time improving outcomes for people and service performance

- ***No health without mental health:*** Devon has many leading and innovative mental health services. These include liaison psychiatry in each A&E to ensure people get the right help when they need it, psychological therapies for people with long-term conditions, specialist support for women with postnatal depression and a new specialist unit opening next year so women can stay near their families as they do not need to travel outside the county.

- ***All GP Practices in Devon rated 'Outstanding' or 'Good'*** in the latest CQC assessment.

- ***Innovative collaboration between the NHS and social care:*** an award winning campaign, led by Devon County Council with support from the NHS, is having a positive impact on recruiting people to work in the health and care sector in Devon.

- ***Managing service demand:*** Devon has taken action to prioritise clinically appropriate referrals into hospitals. This has reduced elective activity last year by 5.37%, compared to a 1.25% increase nationally.

- ***Both Clinical Commissioning Groups (CCGs) have improved their ratings, as part of the annual assessment by NHS England.***

- ***Living within our means:*** historical overspending has been reduced from £229million to £61million in the past two years. This includes saving £25million on agency spend. The Devon system is aiming for financial balance in 2019/20.

In addition, the STP has focused on driving clinical improvement as well as productivity, efficiency and sustainability. For example, STP leaders have signed up to the national Getting It Right First Time programme, which is helping to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes. We're also using the Model Hospital approach, ensuring that everything we do is based on best practice.

This commitment to drive clinical quality was the focus of collective work to look at acute services, vulnerable services (such as ophthalmology) and other developments, such as the Peninsula approach to pathology, and the work as one of four national pilots for a radiology network. The STP has also actively engaged with Healthwatch, MPs, local authorities' Overview and Scrutiny Committees, and patients and the public. For example, Healthwatch representatives sit on the STP Clinical Cabinet, and patients and user groups were fully involved in the Acute Services Review and the group involved in developing improvements to mental health.

PROUD!

It was just after 12noon on a Friday in December when Brogan Barnett, 23, and Danielle O'Hea, 25, nurses from Derriford Hospital in Plymouth, were on a day off searching for a Christmas jumper for Brogan to wear to their Christmas meal later that evening. They were close to giving up on their search and were about to go home, when they decided to look in one last shop.

As they walked into the clothing store, Brogan noticed someone on the ground, and despite the relative calmness within the shop, she instinctively realised something wasn't right.

"I saw feet sticking out and to begin with thought that it might be some kind of training as there wasn't really any commotion," explains Brogan. "However, something made me walk us over that way and that's when we realised there was someone on the floor and they were not in a good way."

"A member of staff from the shop was performing CPR and there was a defibrillator by the patient's feet, but it wasn't being used," Danielle describes. "We explained to the staff that we were nurses and offered to help, which they accepted and moved aside to allow us to take over.

"Brogan took over giving CPR as I got the defib [defibrillator] ready, whilst the staff from the shop remained on the phone to the Ambulance Service."

The patient was identified as Sara Ogbonna, 24 from London, who was in Plymouth visiting her boyfriend, a student at Plymouth University. Whilst he was in lectures, Sara decided to take a wander around the shopping centre, on the lookout for a Secret Santa gift. Whilst she has some memory of how she was feeling prior to the day, she has no memory of what happened to her in the shopping centre.
"I don't think I was feeling well that morning," Sara tries to recall. "I remember someone from work had commented previously that I had looked pale and I remember that I was feeling tired but then I was feeling tired a lot. I can't remember any of what happened to me."

Sara looks to Danielle and Brogan to fill in the blanks for her. The two nurses, who have been nursing together for the past two years and are also close friends, talk Sara through their recollections of the day.

"We were giving CPR for around 15 minutes as we waited for the ambulance," explains Brogan. Remarkably, this was Brogan's first time giving CPR on a patient, on previous occasions she had delivered it on a manikin as part of the nurses' vital training.

"In hospital there is always someone who knows more than you," explains Danielle. "You're so supported. You have things to hand, like meds and oxygen and it's not long before a doctor comes along. But there, we just had each other, our hands and the defib."

As Brogan continued the chest compressions, Danielle gave Sara two shocks with the defibrillator and return of spontaneous circulation was obtained by the two nurses. They handed Sara's care over to the paramedics, who then took her to Derriford, to receive immediate treatment in the Emergency Department's resuscitation area.
Still in the shopping centre, Danielle and Brogan took up the offer of a coffee with the staff from the shop,

who were all visibly shaken up. The two nurses debriefed the staff.

“We talked through with the staff about how they felt, we explained that it was ok to feel upset, shocked, to cry and also the importance of talking about the event and possible reasons for the incident. We explained what the paramedics had done and what might happen up at Derriford,” explains Brogan.
“When we finally walked out of the shopping centre, it felt so surreal and we just kept asking, ‘what has just happened?’”

Meanwhile, at Derriford, Sara had been ventilated and taken to the Cath Labs, where she underwent investigations and specialists looked at her heart. From there she spent a few days in the hospital’s Intensive Care Unit, before being transferred to the cardiac high dependency ward, Torcross.

“I remember being on the ward and wanting to eat but I felt wobbly,” Sara recalls. “People were trying to feed me but I wanted to do it myself. My auntie tried to tell me what had happened but I just couldn’t remember anything. It was as though I wasn’t there.

“It took me a while to realise what had happened to me and to let it sink in. I remember I wasn’t allowed out of bed and I didn’t get it. But one day I tried to get out of bed and couldn’t walk or even hold myself up.
“Everyone around me was worried but so happy to see me doing things and talking. I didn’t understand their emotions because I had missed so much – the crucial bits. So I didn’t know how to act towards everyone, even family.”

“I found it difficult afterwards and I did struggle until I knew you were awake and doing ok,” Brogan tells Sara. “I was working a night shift and I called Torcross at 3.00am, whilst I had a break, to see how you were doing. The nice nurse I spoke to said you were sitting up and talking and the relief I felt; I think I burst into tears.”

“You sent me a text just after too,” Danielle kindly adds.

That day and the subsequent events that followed have clearly had a very big impact on all three women, evident as they sat down together for the first time since it happened to reflect on everything.

“I remember meeting Brogan and Dani for the first time in Torcross Ward, I was quite shy,” Sara remembers. “I didn’t know what to say but ‘thank you’. I had no idea of what else to say.

“My family stepped in, thank God and became chatty and laughing with them. I felt pretty left out, I wanted in on this. Brogan and Dani were lovely strangers but to them they knew me well, which is sweet.

“I just thank them from the bottom of my heart for walking back to me when I was in need. I can’t thank them enough for being so brave and having initiative. They may do this at work but it’s always different outside of duty.

“They really did shine that afternoon. I thank God for them both.”
“I see that day very often,” Brogan reflects. “It puts it into perspective, especially with us all being of similar age. The way our day had panned out, with one thing after another, it felt as though we were meant to be there.”

Danielle’s reflections also highlight not only how invaluable the training our staff receive is but also how important it is for people to know how to use these life-saving pieces of equipment and to recognise what to do in these circumstances.

“When we were performing CPR, all I could hear was Jackie Williams [the Trust’s Matron for Resuscitation], it was as though she was on my shoulder, talking me through what to do,” Danielle describes. “There were moments when Sara took what looked and sounded like, to those around us, a breath but actually it wasn’t, it was a false breath, and all I could hear was Jackie saying ‘that’s not a breath’, which meant we didn’t stop the CPR, which would have lost us precious time.”

Sara was on Torcross Ward for a few days before being transferred to a hospital closer to her home in London, where she was fitted with an internal defibrillator, also known as an implantable cardioverter defibrillator.

“I’ve now got two wires that go into my heart. If a change in rhythm is detected by the defibrillator then it will shock me,” explains Sara.

The nurses were really keen to stress that early intervention was crucial and to also offer reassurance to anyone who might find them in a similar situation.

“The shop staff had done really well in starting the CPR,” adds Danielle. “It is so important that even if it’s not the best CPR, it is started as soon as you realise the patient is unresponsive and not breathing.
“Early defibrillation is crucial too. I think there is a concern from people that they are going to do something wrong, but the defibrillators in the community have really clear instructions on them, which monitor the patient and tell you when you might need to shock them. There’s no way of accidentally shocking someone. If in doubt, it’s best to put the pads on someone as it will then help with monitoring them.”

The two nurses’ actions have been commended by their trainer, Jackie. “I think it is commendable what they did. They are clearly very supportive of one another and work extremely well together. They were absolutely amazing.

“When we train staff in life support, we explain to them that this is a life skill and although we are teaching them predominately to use it in their roles in the hospital, it will be something that will be taken out into

the community, as Brogan and Danielle have demonstrated. The availability of Automated External Defibrillators in public areas is growing year on year and we need to encourage staff and the public to be aware of their existence and to use them."

Jackie continues: "I would hope that other colleagues, should they find themselves in this situation out in the community, would feel empowered by what they have learned during their training. The importance of the chain of survival is critical to maximise survival, early recognition and call for help, early good quality CPR and early electricity in the form of a defibrillator."

Sara has now returned to work in London but is still regularly visiting her boyfriend in Plymouth, as well as Danielle and Brogan.

"I'm glad they were there at the time," expresses Sara. "I am glad I took up the courage to make contact with them now; I think we will keep in contact."

"I am so grateful we are able to sit here with you now when we didn't know how you would be," adds Brogan. "We will definitely keep in touch."

Our Performance

CQC report into the Plymouth health and care system

The Care Quality Commission published its report into the Plymouth health and social care system in February 2018, following the system review which took place in December. The review looked at how hospitals, community health services, GP practices, care homes and homecare agencies work together to provide care for those aged 65 and over.

Overall the report was a positive one. It recognised good relationships between leaders of health and social care services, a shared commitment to improving services and a recognition from the inspectors that:

“Plymouth is on a journey to integration. There was a compelling vision for integration within Plymouth, developed in collaboration with system partners and local people and linked to the Devon STP…. There was a shared ambition among system leaders to progress with vertical integration of service delivery to include primary care, community, acute and social care.”

The inspectors recognised the particular pressures staff at our hospital face. Their report supported a shared vision of integrated services with Livewell Southwest as a way to ensure we can offer local people the best possible health and social care.

The report also identified many challenges, including people having varied experiences of services – some excellent and some not good at all. In their feedback the inspectors identified an over-reliance on bed-based care and said a shift is needed to keeping people well in their own homes.

The challenge is to translate a compelling vision into frontline practice. We are committed to working to deliver the best possible care for local people all of the time, through integrated provision. We have to support our staff in being able to do this, but this report confirms that as a system, we have a vision and shared ambition to go forward.


Danielle Lean ▸ Plymouth Hospitals NHS Trust
20 September at 21:06 ·
I would like to say a massive thank you to the ENT department and the children's theatres my son was booked in to have grommets, adenoids and tonsillectomie yesterday, after speaking with the surgeon we just went ahead with the adenoids and hopefully we won't be back, at the pre op on Friday the nurse made my son so comfortable and at ease and made me and my husband feel so much better, the care then continued yesterday on the day of the op we were made to feel at ease with everyone, and jack was made to feel at ease and he didn't seem worried at all, he was more concerned about not playing on the iPad even when he 1st come round. The after care was fantastic and today jack has decided his voice sounds better now. Thank you again all of you you made 2 nervous parents feel at ease and happy
Tina Orme, James Bonner and 4 others
Rachel Bunting ▸ Plymouth Hospitals NHS Trust
23 September at 21:38 ·
I want to sing my praises to ED tonight. I had the privilege of working with them for a short period this evening. Every member of staff was friendly, calm, warm and helpful despite working in an extremely stressful situation. I salute you. You are all amazing.

Our Performance Against Key Standards

Whilst we have much to be proud of in the quality of care that we give to our patients, like many hospitals up and down the country, we face a significant challenge in providing responsive services and continue to work to improve our performance against a number of key national standards.

The daily average number of attendances to our Emergency Department increased to 275 per day in 2018/19, nine more per day than in 16/17 (Figure 1). The total year-on-year increase was 3,193 ED attendances. In addition to this, we saw an extra 778 patients through our new Acute Assessment Unit and took responsibility for 29,581 minor injuries attendances from August 2017 when we took ownership of the Minor Injuries Units in Plymouth and the surrounding areas.

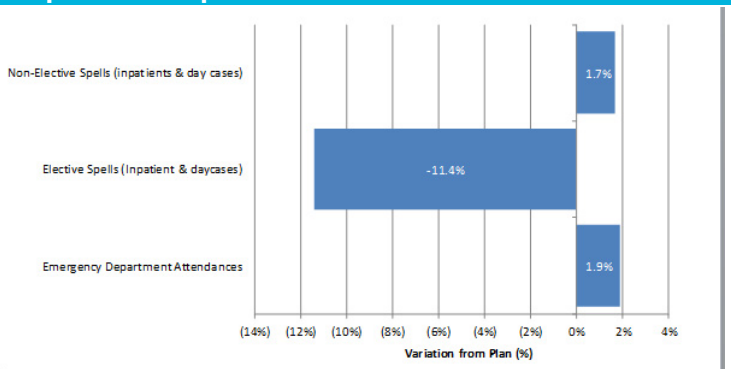
The number of emergency patients admitted into the hospital increased by 1,974 to 58,726 in 2017/18. This ever increasing demand for emergency care has contributed to the elective underperformance highlighted in Figure 2. This has taken the form of high levels of cancelled operations, an increasing age/acuity profile leading to longer lengths of stay, decreased bed availability and difficulty discharging where packages of onward care are required.

Figure 1: Operational context

Delayed Transfers of Care - A recent piece of work to validate delayed transfer of care data following a regional comparison has revealed a historical underestimation of the number of bed days attributed to patients whose discharges are delayed. The new, more accurate reporting methodology has resulted in the sharp increase evident in Figure 1.

High Triage Attendances - The continuity of monitoring the high-acuity patients attending ED (Triage category 1 & 2 patients) has been interrupted following the switch to the Australasian Triage Scoring System before Christmas, an introduction made by the Trust alongside the new ECDS (Emergency Care Data Set). The Australasian Score works in a similar fashion but is considered to provide a score more appropriate for the type of patients attending a modern Emergency Dept. This change has shifted the baseline % making up-to-date reporting of trends difficult and will take a few months before we can show sensible and comparable trends.

Figure 2: Actual activity compared with plan in 2017/18



Achieving the NHS waiting times targets has been extremely challenging in 2018/19 due principally to the increased emergency demand the Trust has faced this year. The Trust has had to make some very difficult decisions to ensure safe care for our emergency patients which included cancelling 930 operations on the day of admission because of a lack of suitable ward or critical care beds.

Referral to Treatment Times (RTT) have increased as a result of the emergency demand on beds and services, an issue highlighted by the national NHS directive to cancel all routine elective activity in January to cope with emergency demand. We also took the decision to reallocate an Orthopaedic elective ward to deal with the increase in winter emergency medical admissions, many of whom were sick elderly patients requiring onward care packages before they could be discharged.

Waits for diagnostic tests have been affected by the same issues with the ongoing need to cancel outpatient appointments to accommodate the increasing demand for diagnostic tests for sick inpatients. This is particularly important when the test might help the patient's discharge and free up valuable beds for emergency medical patients waiting in our assessment units.

Cancer patients are always the highest elective priority, however with our diagnostic resources stretched and such a high volume of emergency patients requiring beds/surgery/diagnostics, we have struggled to achieve the Cancer Standards. Despite this we have recently implemented a new 'gold standard' prostate pathway for our patients and continually strive to ensure the best outcomes, even when our resources make more timely treatment a challenge.

More information about elements of our performance can be found in the Quality Report on page 91.

Figure 2: Summary performance against national targets in 2017/18

Target	Standard Required	What did Plymouth Hospitals achieve?
Incidence of MRSA bacteraemia	0	3
Incidence of avoidable Clostridium difficile	<35	2
Referral to treatment times		
Incomplete pathways	92%	Achieved in 0 out of 12 months
52 week waits	0	108
Direct Access Audiology	95%	Achieved in 9/12 months
Emergency Department		
Maximum time in ED of four hours from arrival to admission, transfer or discharge	95%	83.75%
Cancer urgent referral to first outpatient appointment waiting times:		
All cancer two week wait	93%	92.2%
Two week wait for symptomatic breast patients (cancer not initially suspected)	93%	27.7%
Cancer diagnosis to treatment waiting times:		
31 day (diagnosis to treatment) wait for first treatment: all cancers	96%	95.7%
31 day wait for second or subsequent treatment: surgery	94%	92.5%
31 day wait for second or subsequent treatment: anti-cancer drug treatments	98%	99.4%
31 day wait for second or subsequent treatment: radiotherapy treatments	94%	87.3%
Cancer urgent referral to treatment waiting times:		
62 day (urgent GP referral to treatment) wait for first treatment: all cancers	85%	79.3%
62 day wait for first treatment from consultant screening service referral: all cancers	90%	86.9%
62 day consultant upgrade wait for first treatment: all cancers	85%	77.3%
Diagnostic waits:		
Diagnostic test waiting times	<1%	12.3%
Cancelled operations		
Cancelled operations by the hospital for non-clinical reason on the day of or after admission, who were not treated within 28 days	0	14.3%
Cancelled operations by the hospital for non-clinical reasons on the day or after admission	No target	3.24%
Other key standards		
Access to genito-urinary medicine clinics (48 hours)		99.9%
% stroke patients spending 90% of their stay on ASU	80%	73.7%
Mixed sex breaches	0	11
% patients receiving appropriate VTE risk assessment	95%	94.8%
* based on first 11 months of 17/18 as we reported VTE one month in arrears to ensure we have all of the appropriate data sources available to get an accurate measure		

NHS Clinical Activity	2014/15	2015/16	2016/17	2017/18
Elective spells	62,321	62,774	62,877	59,446
Emergency and non-elective spells	53,152	54,623	56,752	58,726
Outpatient attendances	485,423	487,435	492,968	485,812
ED attendances	92,780	94,560	97,126	100,319
Babies delivered	4,555	4,570	4,180	4,166

#ThinkMIU

We ran a #ThinkMIU behaviour change campaign in November and December 2017, ahead of anticipated winter pressures. The aim of #ThinkMIU was to increase attendances at the Minor Injury Units (MIUs) and thus relieve pressure on the area treating those with minor conditions within the Emergency Department at Derriford. It was successful, increasing attendances at the three MIUs over and above expected growth rates.

We would like to thank the public for supporting our #ThinkMIU campaign, which in turn helped support Derriford Hospital over the very busy winter period. By more people choosing to use MIUs, this helped staff in our Emergency Department treat patients who needed to be there more quickly and safely. The video detailing what care is available at our MIUs is available here.

NHS
Plymouth Hospitals
NHS Trust

Our 2017/18 year in numbers

125,790
patients cared for on our wards

THANK YOU

5,248
Thank You cards and compliments

485,812 outpatient appointments

4,685
patients recruited into research studies

100,319
attendances at our Emergency Department

★ ★ ★ ★ ★

4,166 babies delivered

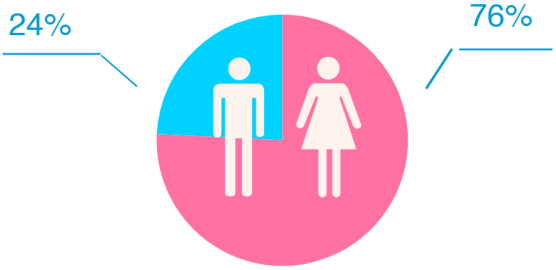
4.5 stars on NHS Choices

A helping hand

550+
volunteers

We are grateful to our volunteers for all they do to help patients

Employed
7,154 members of staff



Improving Our Patients' Experience
We recognise the importance of placing more emphasis on "putting patients at the centre of everything we do" and have built on existing good practice to design our services around our patients' needs. As part of our commitment to improve services and the experience of our patients we have actively sought to engage with patients and members of the public. Patient workshops are used to engage with members of the public to ensure wishes of our patients and carers are reflected in everything we do.

Our aim is to be a safe and highly effective hospital which is highly rated by our patients and one which staff are happy to work in. In achieving this, we seek to constantly improve our services, shaped by what our patients tell us, and be quick to respond to problems and fix underlying causes.

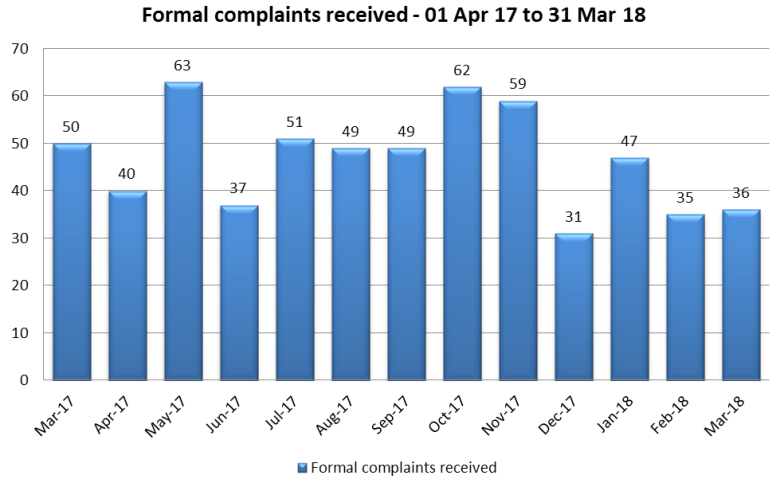
Patient Council
Our Patient Council, which was established in October 2014, is now well established with 10 members and a full schedule of both formal and informal meetings. The Patient Council was established to embed the patient perspective into day to day activity. Its key purpose is to represent the voice of hospital patients, carers and visitors and act alongside the hospital as a critical friend. Throughout 2017-18, the Council held six normal and five informal meetings. Council members are involved in a number of activities including PLACE assessments, car parking consultation, delivery of patient experience training and bringing the patient element to discussions and patient support groups. See the Patient Council report on page 35.

Patient Experience Strategy
In January 2016 we reviewed our existing Patient Experience Strategy to ensure we continue to strive for excellent patient experience in all elements of our service through delivery of our patient experience ambitions. Delivery of these ambitions are tracked through the Patient Experience Implementation Plan which is updated annually and includes a number of key actions to improve the patient experience including our new Welcome Centre, introduction of the PALS clinics in wards and department, Carers Policy Review including support for carers, work to improve mealtimes and dementia friendly status awards for areas in the hospital. Delivery of the strategy is monitored monthly through our Patient Experience Committee which is responsible for reviewing all patient experience related information with the purpose of achieving the Trust's vision of "Putting patients at the centre of everything we do".

Patient Feedback
We seek this through
- Friends and Family Test
- Patient Surveys - for the period 1 April 2017 to 31 March 2018 we received feedback from 728 patients, 96.29% rated their overall care as excellent, very good or good.
- Care Opinion and NHS Choices, websites where patients have the opportunity to register comments, anonymously if they choose to do so. During the past year 159 pieces of feedback were posted on the Patient Opinion website relating to Plymouth Hospitals NHS Trust.
- The Trust has maintained strong links with both Healthwatch Plymouth and Healthwatch Cornwall, both of which are represented on the Patient Experience Committee. Communication links are also in place with Healthwatch Devon.

Complaints

During 2017/18 we received 592 formal complaints, which are detailed in the table below by month. This represents a 7.56% reduction compared to the same period in 2016/17. 4,432 PALS enquiries were received during 2017/18 which would indicate concerns are being managed at an earlier stage and via appropriate routes. For the same period 560 complaints were closed.



Throughout the coming year we will continue to use this valuable information to influence changes made to improve the services we provide for our patients. We improved accessibility to our Patient Advice & Liaison Service (PALS) by increasing the number of staff available in the Welcome Centre on the main hospital entrance.

On completion of the investigation of each complaint, a judgement is made by the Trust as to whether or not the complaint has been upheld. As it is closed, each complaint is classified as 'upheld' or 'not upheld'. Definitions of the classifications are outlined below along with the numbers cases for each outcome.

Outcome	Definition	Number	Percentage
Upheld	Complaints in which the concerns were found to be correct on investigation	374	66.79%
Partially upheld	Complaints in which some of the concerns were found to be correct on investigation	110	19.64%
Not upheld	Complaints in which the concerns were not found to be correct on investigation	76	13.57%
Ongoing	Complaint investigation ongoing therefore, outcome has not yet been confirmed	32	N/A

Complainants have the right to refer any complaint they feel has not been resolved adequately at local level to the Parliamentary and Health Service Ombudsman (PHSO). For the period 1 April 2017 to 31 March 2018 the Trust received seven requests for information and investigation from the PHSO.

Of those, three cases were not upheld and no further action was required from the Trust, one case was partially upheld, two are ongoing and awaiting the PHSO's final report, and one has been referred back to the PHSO for their review following further local resolution.

Compliments
During the past year the Trust has worked with all areas of the Trust to actively identify compliments received whether that be a formal thank you letter, card or box of chocolates. We are pleased to report that for 2017/18 the Trust received 5,411 expressions of thanks for the care received. The many letters of praise highlight the fact that it is often the little things that matter most to patients when they are admitted or have to attend hospital.

Patient Advice and Liaison Service (PALS)
Our Patient Advice and Liaison (PALS) Team have handled 4,432 enquiries in the last year.

Improving patient care
Throughout 2017/18 we continually reviewed patient feedback, complaints, compliments and other sources of external intelligence and were able to identify a number of areas where improvement could be made to the quality of the services provided. Some of our key achievements are detailed below, further details are included in the Quality Account.

Hospital Guides
We are all aware that Derriford Hospital can seem very daunting to navigate; our Hospital Guides and wayfinding are key to helping people get to their destination easily. Development and introduction of a uniform for the guides in 2016 created an identity by making them very visible to all patients, visitors and staff to the hospital site. You will find our Hospital Guides located at the main reception desk.

Signlive
Video link British Sign Language interpreting services were introduced for our deaf patients. We also improved our engagement through attendance at the Plymouth Deaf Community Forum on 13 November to speak to the deaf community about the new video link British Sign Language initiative SignLive and agreed to go back every three months to talk to them about the service and provide an opportunity to feedback about hospital services in general.

Dementia Care
We introduced a new icon to the SALUS system to identify those patients with confusion/delirium – the Pink Forget-me-not. This means that the Blue Forget-me-not will only be used on SALUS for people with a confirmed diagnosis of dementia. Staff can easily identify patients with dementia and ensure person-centred care to meet the specific individual needs of the person, who may be confused or disorientated in hospital.

Medical Assessment Unit (MAU)
Following a complaint, the MAU consultant lead and palliative care associate specialist introduced an education programme for all doctors regarding management of pain relief in terminally ill patients.

Tamar Ward
On Tamar Ward (our Short Stay Ward), the ward manager and occupational therapists have started a lunch club every Tuesday and Thursday. We encourage all patients to sit out of their beds to eat all their meals in the waiting area, put out table cloths and centre pieces. This is to encourage mobility and enhance recovery by getting up, dressed, moving, socialising.

Oncology Services
Chemotherapy Day Case Unit opened on level 5 in the former Lyd Ward. This was as a direct result of feedback from patients, relatives and external assessment bodies for the need for improved privacy, dignity, comfort and above all, space for patients. In May, the former Day Case Unit space opened as additional clinic rooms and waiting area for oncology and haematology outpatients.

Critical Care
Following a year-long pilot Critical Care Patient Diaries were introduced – staff and family members write in the diary to help patients understand what has happened to them in Intensive Care.

Paediatric Wards
We purchased 30 new parent beds and installed them in July 2017 so parents can stay comfortably with their children overnight.

Our Patient Council reports

This year has seen the Patient Council grow and develop into a more effective team, each member bringing diverse skills, knowledge and character to the table. There have been many excellent presentations from senior hospital staff, both clinical and management. We have also, on several occasions at informal meetings, met with the Chief Executive, Ann James and Chairman of the Trust Board, Richard Crompton and had chance to question them and discuss issues.

This education, along with our contact with key senior clinical and management staff, has enabled members to get a deeper understanding of how an organisation as complex and big as Derriford Hospital functions. We are united in wanting to see the hospital provide the best service it can to its patients, despite the increasing demands that an elderly population with more complex health needs, underfunding and problems recruiting junior doctors and nurses, brings. These issues are compounded by a shortage of GPs in Plymouth so that many patients have no access to Primary Care and so turn up at the Emergency Department. If we help even a bit, by bringing the patient perspective to the table and engaging in informed and responsive debate with staff, then what we are doing is worthwhile.

Demographically, we are an older group of people top heavy in cancer experience. This year we seek to actively widen our outlook by recruiting some younger members and others with knowledge of other areas of the hospital. We bring a variety of life skills and experience to the table and skills we may have learnt from our occupation or profession. One member, Sue, is championing access to services for disabled patients. Two members have a lot of IT experience and actively work with the hospitals small Communications team to improve the web site. We each have our own individual experience of life changing illness and treatment at Derriford and for many of us this is what drives us to be a critical friend to Derriford and strive to make a difference.

We have all been aligned to an area of clinical service and been allocated a matron. This has developed faster in some cases than others. The idea is that if we build a relationship with a ward and staff and make ourselves available to be involved in projects, then as we become trusted, we can have a real input into improving life on the wards for patients, carers and staff by highlighting what the patients want and what

will improve the patient experience. One of our members, Brian, has been involved with the End of Life Steering Group and has seen huge improvements in the care of the dying and provision of two side rooms on ten wards especially for end of life Care with early access to the Palliative Care Team and privacy for relatives.

The tremendous pressure the hospital has been experiencing in the last few months has meant that we have made less progress with our clinical alignments than we would have liked but that can't be helped. Throughout 2017/18, the Council met monthly to manage the ever increasing agenda.

Council members continue to be involved in a number of activities including:

- PLACE assessments
- Smoking group
- Breast cancer support group 'Bosom Pals'
- Car parking – Trust Board consultation
- Priority scoring system for surgical care group
- Complex discharge arrangements
- Mystery patient programme
- End of life care
- Infection control patient information
- Patient information review
- Representation at Patient Experience Committee
- Disability awareness activities
- Kings Fund collaborative working – Surgical patient pathway
- Dementia training
- Trust website development
- University training sessions
- Patient bedside locker consultation

A personal example of progress from Sue Kelley, a founder member of the Patient Council:
I have been a member of the Patient Council since it started and it has been an enjoyable experience. I feel I have learnt a lot about the way in which the hospital operates. I did wonder at the start if the Patient Council was going to be tokenistic but this has not been the case. Our views have been sought on various topics and we have been able to bring issues raised by other patients to the meetings and where things require change or more investigation this has happened. I have also been involved in raising awareness of sensory disabilities with various departments and I am the Patient Council representative on the hospital's Equality, Diversity and Inclusivity Working Group. In May this Group will be setting up events for the NHS Equality, Diversity and Human Rights Week in order to raise awareness of the issues for staff and patients and what support is available and identify areas for requiring further work and support.

Jane Hitchings
Chair

Scott Milway
Vice-Chair

PROUD!

Quality Improvement – Building on Great Foundations

It has been another year where our staff have worked hard across a range of areas to make sure improvement is at the centre of our care.

Some examples of the approaches we have taken this year are:

- Continuing work on 'harm-free' care such as reducing the incidence of falls and pressure sores
- Detailed work on improving sample processing in pathology
- Creating team improvement huddles to improve the number of people getting to the right specialty bed and improving the flow through our newly formed Acute Assessment Unit
- Improving theatre safety by using the Human Factors approach and debrief

In all of our approaches we have emphasised staff and patient involvement, using data to monitor and gauge, and working through teams. We have also continued to build an appetite for quality improvement by delivering sessions at induction sessions for new staff.

In March 2018, we were successful in a bid to be one of the seven organisations selected for the first cohort of the National Lean Programme. The new programme will provide a system of management to further promote a culture of respect and empowerment to drive continuous improvement. We are adopting this approach jointly with our partners Livewell Southwest.

We expect the programme to start in summer of 2018 and it will also provide a catalyst to integrating services, genuinely building a culture of improvement and higher value – putting 'people first'.

Plymouth Healthwatch reports

Over the last twelve months Healthwatch has continued to work with staff from Plymouth Hospitals around patient experience. This has been in the form of regular patient and public engagement on the Derriford site, a focused patient experience survey of the Surgical Assessment Unit and the annual Patient Led Assessment of the Care Environment (PLACE) evaluation.

Feedback from our regular engagement sessions is collated and presented to the hospital's Patient Experience Committee identifying positive and negative themes of patient experience. This is used to identify future work strands to improve patient experience.

In June and July 2017, we conducted several visits to the Surgical Assessment Unit after a request from the Patient Experience Manager to look at patient experience of the triage system following referral into the unit. Healthwatch also engaged with the staff team to understand from their perspective what they saw as patient experience challenges on the unit. From our discussions with patients, relatives and staff we identified recommendations to improve patient experience that have led to information boards about the triage process being placed in the waiting area and a review of the patient confidentiality process.

Patient-Led Assessments of the Care Environment is the national system for assessing the quality of the patient environment and aims to help organisations understand how well they are meeting the needs of their patients and identify where improvements can be made. These assessments are made by patient representatives from both the hospital and Healthwatch and look at the cleanliness and condition of wards and outpatient departments and how well they meet the needs for those patients with disabilities and dementia. The assessment occurred over three days and overall we believe that improvement to the environment continues to be made. We found the hospital to be clean, the majority of areas well maintained and staff really engaged in the process.

Healthwatch Plymouth is looking forward to working with the Trust over the forthcoming year to ensure that patient experience continues to be part of the process in developing services at Derriford Hospital.

Nick Pennell, Chair, Plymouth Healthwatch

Our challenge moving forward

- Quality and culture: Improve quality and strengthen our culture in the context of sustained operational and financial pressures.
- Urgent care: Develop and deliver a robust capacity and improvement plan to deliver the national 4 hour standard on a sustainable basis.
- Elective care: Secure sufficient elective capacity to deliver national requirements in terms of Referral To Treatment (RTT) times, volumes and 52 week waits.
- Finance and efficiency: Deliver an extremely challenging financial improvement plan effectively utilising all available tools such as Model Hospital and GIRFT.
- Workforce: Develop innovative but realistic workforce plans to address capacity gaps and known workforce issues (e.g. Junior Doctors and agency costs).
- Integration: Improve integration of clinical pathways to provide greater operational resilience.
- STP: Continue to nurture relationships with the STP to optimise quality, operational and financial benefits for the Trust and the population we serve

7,439 followers on Facebook

Our plan is underpinned by our desire to maximise the system impact of culture change and continuous improvement using NHS Improvement's LEAN programme

- We are committed to embedding a quality improvement philosophy in all that we do by becoming part of a new programme of work with NHS Improvement to deliver a "lean management system."
- The three-year 'lean programme' will build on the success of NHSI's partnership with the Virginia Mason Institute, which saw leaders and clinicians across selected trusts receive tools and hands-on support, including coaching, mentoring and education in lean techniques.
- It also builds on other independent programmes in the NHS, such as those rolled out by Western Sussex Hospitals, Royal Bolton Hospital and providers in the north east.

More information about our plans to improve quality can be found in the Quality Report on page 91.

PROUD!

We are incredibly lucky to have some of the most committed and dedicated volunteers as part of our #1bigteam, giving their time to work with patients, visitors and staff here at the Trust.

One such volunteer is Vera Mitchell, who was formally recognised and honoured at Buckingham Palace for her services to NHS patients in Plymouth. Watched by her son, daughter-in-law and dear friend, Vera was made an MBE (Member of the British Empire) by the Duke of Cambridge, Prince William, on Tuesday 12 December.

"He made me feel like the only person in the room," Vera fondly reminisced. "I was aware of nothing in this world but him. Not as Prince William but as a compassionate and perceptive human being. It was such a privilege and joy to meet him and receive this honour, whilst also knowing that I was being watched by my family. It was so special. None of this would have happened without this place; it is a privileged gift from Derriford Hospital. I just hope the people who are Derriford know how much I love them."

A long-serving volunteer in various departments, Vera has been selflessly giving her time, sharing her experiences and supporting patients and staff at Derriford Hospital for more than 17 years.

In 1998, Vera was diagnosed with cancer for the third time and after treatment and recovery, she wanted to give something back to the hospital and that she most certainly has.

Well-known and respected by so many, Vera has given her time to ensure our patients, and their experiences, are at the centre of all we do. Volunteering in our Emergency and Critical Care Departments, Vera spends at least two days each week supporting patients, often at times of great emotional distress for patients and staff. She is also a volunteer with our Chaplaincy team.

Vera gives her time to working with clinical colleagues to put the needs of our patients first in service redesign, as well as ensuring policies and information on infection control are strongly patient focused. Additionally, thanks to Vera setting up and chairing the Trust's Patient Experience Committee, she has ensured that our complaints process is more responsive and she has helped the Trust in ensuring we find the right 'voice' in the tone and content of our written communications with our patients; advising staff on template letters and information leaflets. These are just some of Vera's many incredible achievements.

4,118 frontline staff members vaccinated against flu

Incidents Involving Data

We see hundreds of thousands of patients each year and have more than 7,000 staff working for us. Whilst we have strict information management policies, occasionally an incident occurs when information has not been handled in the correct way. We continue to improve our monitoring and reporting, therefore we are more aware of incidents and each is fully investigated and, where relevant, changes are made to any controls in place.

All incidents with an Information Governance element are recorded on the Trust Incident Reporting System (Datix). The Information Governance Team use the NHS Digital checklist (republished May 2015) to score Information Governance Incidents in conjunction with the Caldicott Guardian and the Senior Information Risk Owner. Those scored as two or above are uploaded to the NHS Digital online reporting tool. These will, in turn, be reported to the Department of Health and the Information Commissioner's Office (ICO). Level two incidents are also reported to NEW Devon CCG via the Strategic Executive Information System (StEIS) by the Trust Risk and Incident team.

In the 2017/18 financial year there has been one level two Serious Incident Requiring Investigation. This has been reported on the NHS Digital Information Governance Incident Reporting Tool. The Trust has cooperated fully with the ICO who have welcomed the remedial actions taken. The Trust has continued to actively raise Information Governance awareness and encourage the reporting of incidents.

Plymouth Hospitals NHS Trust IG breach type	Level 2 Incidents	Total
Lost/Found Paperwork		0
Lost/Stolen/found unencrypted Device		0
Lost/Stolen/found encrypted Device		0
Inappropriate Disclosure (error)	A patient received information relating to another patient	1
Non Secure Electronic/Paper Disposal		0
Unauthorised Access/Disclosure (Knowingly)		0
Technical Security Failing		0
Inappropriate Storage of Paperwork		0
Failure to maintain Information Standards (Electronic and Paperwork)		0
Non Secure Transfer (Electronic and Paperwork)		0
Not Processed Fairly or for the Specified Purpose		0

13,320 followers of our two main Twitter accounts

Preventing Fraud
We have a clear strategy for tackling fraud, corruption and bribery which is documented in the counter fraud policy. This strategy details responsibilities and how to report suspicions of fraud or bribery.

The Trust is contracted with Audit South West to provide a Local Counter Fraud Specialist (LCFS) who works with the Trust to help ensure risks are mitigated and that the Trust systems are resilient to fraud and corruption. The Audit Committee receives and approves the Counter Fraud Annual work plan and Annual Report, monitors the adequacy of Counter Fraud arrangements and reports on progress to the Board of Directors.

The risk-based programme of anti-fraud work was delivered in 2017/18 addressing all strategic areas of the national counter fraud strategy. The LCFS has developed key relationships across the Trust and this coupled with work undertaken by the LCFS has resulted in the development of an anti-fraud culture.

During 2017/18 the LCFS dealt with five investigations which to date has resulted in one dismissal and action to recover monies, one final written warning, no further action on two and one ongoing investigation.

PROUD!

Patients and visitors to Derriford Hospital have been receiving a welcome of a different kind from a recruit to the Hartor ward team.

Henry, an 11 year-old Golden Retriever, visits patients on the healthcare of the elderly ward to help with their treatment and recovery.

“We were told that Henry is part of the staff on the ward here right away,” said Gerald Pearce, a patient on Hartor. “He helps me with my day and it’s lovely to have him on the ward. He gives us a change, a break up to the day and it makes it something a little bit different than the ordinary ward.”

And the presence of their new-found canine friend hasn’t been lost on the staff either: “Henry’s visits are enjoyable for all the staff too and it is a great boost to morale – it’s real therapy. He provides a calming effect on what can be a very busy ward. We all love having him here” added Teresa Beer, Ward Manager for Hartor.

“It’s quite amazing as we have found that some of our patients who suffer with dementia remember Henry week after week. Sometimes he will go around and sit by a patient’s bed, allowing them to stroke him whilst he sits there happily, and others like to feed him dog biscuits.”

As a registered therapy dog, Henry visits once or twice a week with his owner, Christine Gentle. Henry is one of many therapy dogs used to help patients - and staff - throughout the hospital.

Emergency Preparedness, Resilience and Response (EPRR)

Last year, terrorist incidents hit closer to home with attacks across the summer months, significantly testing emergency response arrangements in Manchester, London and surrounding areas. Whilst very challenging for all involved, such horrendous events provide an opportunity to share learning through lived experience with other organisations. The Major Trauma Clinical Network cascaded lessons identified by the hospitals involved and this has been reviewed by our Trust. This vital information is key in the development of our own major incident plans, to strengthen arrangements in place for our community locally.

Over the year, whilst we did not respond to a major incident involving casualties, plans were activated in response to business continuity incidents. On Friday 12th May 2017, the cyber-attack on Microsoft Windows operating systems had an impact on many organisations including the NHS. A significant proportion of our services were back running normally within eight hours, with the balance resolved by the following Monday. The impact upon patient safety and service provision was minimised due to the fast actions of staff on duty that day, ensuring the patient safety and security of IT systems both during the incident response and recovery phase.

Across the year, business continuity plans have been revised and developed to ensure a more co-ordinated approach to any period of disruption to critical services. These have been activated during power supply interruptions and weather extremes (both heat and cold). After each event, consideration is given as to where plans worked well and areas for improvement.

Following self-assessment against the EPRR Core Standards, NHS England and NEW Devon CCG reviewed the evidence provided and reported the Trust as 'substantially compliant'. As a Major Trauma Centre, the Trust is also considered to be a strategic asset and as such was visited by the NHS England Regional EPRR team, to meet with staff and re-affirm our arrangements in place. We received very positive feedback from this visit and the team were particularly impressed with the engagement of staff in resilience arrangements.

To build on the learning from incidents, we are now working with other hospitals and the ambulance service to develop plans around capacity and capability to receive casualties both in major and mass casualty incidents.

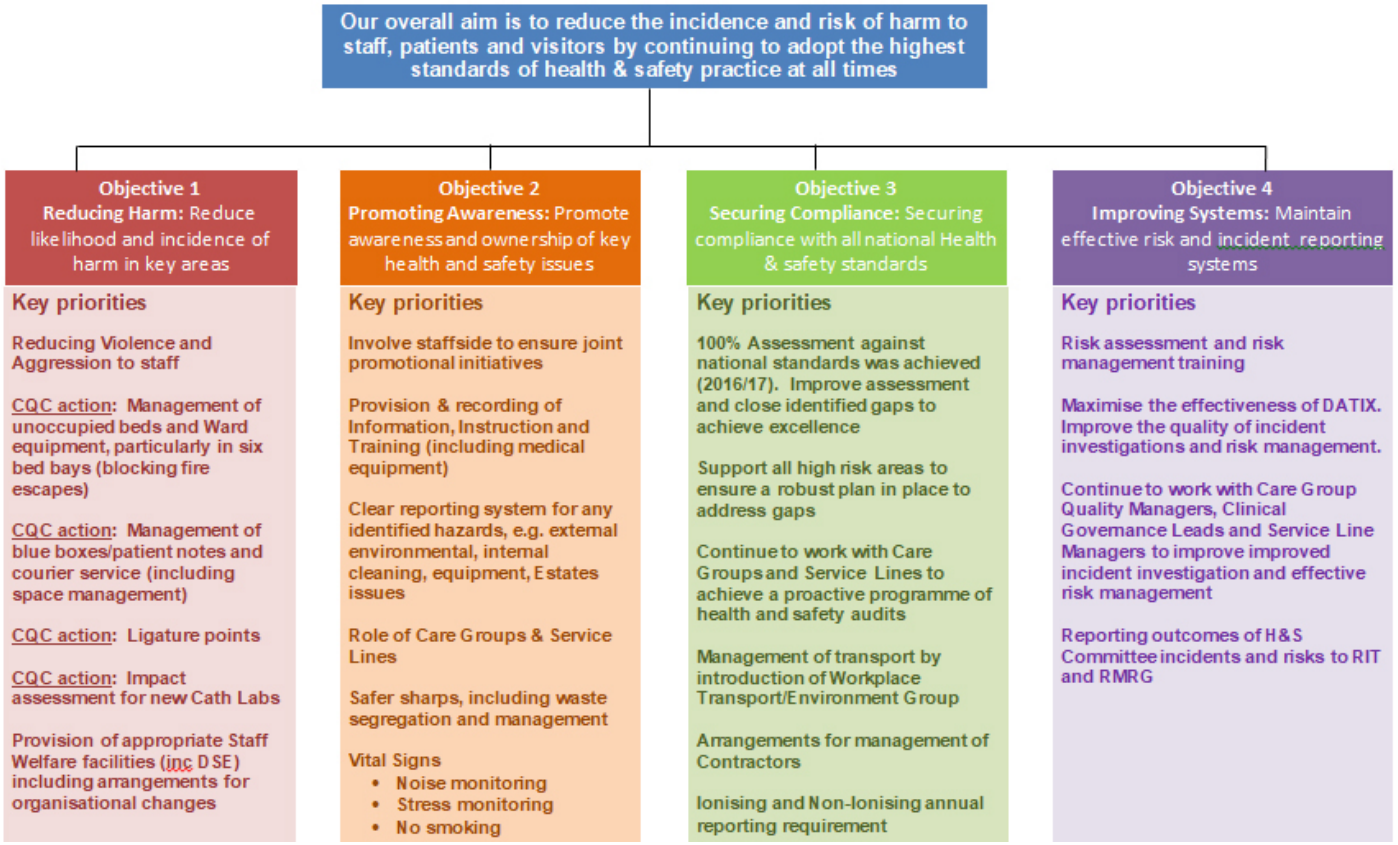
There were 33,200 attendances this year at our Royal Eye Infirmary Emergency Dept, our Acute Assessment Unit and our Minor Injuries Units (since August)

Health and Safety

The specialist health and safety leads have continued with the Trust's overall aim to reduce the incidents and risk of harm to staff patients and visitors, by continuing to adopt the highest standards of health and safety practice at all times. The key objectives have been to:

- Reduce harm by reducing the likelihood of incidents of harm in key areas
- Promote awareness and ownership of key health and safety issues
- Secure compliance with all national health and safety standards and
- Maintain effective risk and incident reporting systems

The Trust Health and Safety Committee has continued to monitor the Trust's overall key objectives and has made significant strides during the years in securing outcomes of the Health and Safety initiatives mentioned above.



NHS
Plymouth Hospitals
NHS Trust

Our size and scale

30

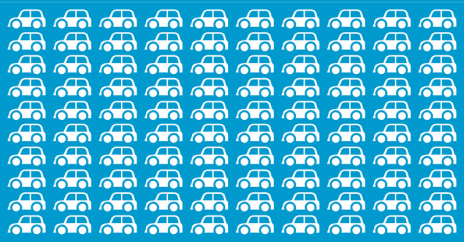
the number of football pitches we are equivalent to in size

220

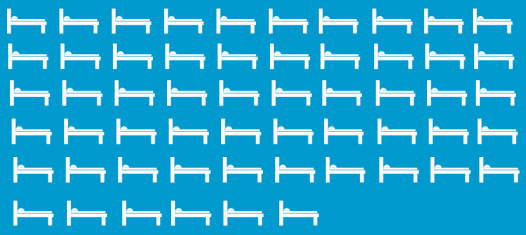
miles of pipework (from Plymouth to Birmingham)

5

miles of corridor



1,660 car parking spaces

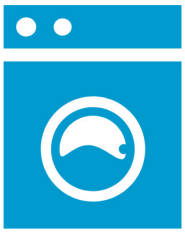


930 established beds including neonatal cots

Each year our 'housekeeping' includes:

1,160 tonnes of clinical waste

849,233 meals



3.4 million laundry items

672 tonnes of general waste

234 tonnes of recycling

How Environmentally Friendly are we?
We work to provide sustainable healthcare to patients in a way which does not harm the local environment. This year saw the Trust's Environment Group continue to grow and champion environmental matters throughout the site. Made up of representatives from staff, patients, local employers and the public, the group has continued to promote and enhance the internal and external environment and challenge the Trust where it thinks projects don't take account of environmental issues and principles.

Discussions are underway for a creation of a gardening club on the Derriford site. This will be a great opportunity for interested parties to develop garden skills, whether amateur or experienced, and contribute to a further green area that can be enjoyed by patients, visitors and staff. We have also continued to encourage the site deer to stay at the back of the hospital, rather than cross the site's busy road and run the risk of having accidents with vehicles.

Since the creation of the Derriford Orchard on the site of the old hospital helipad, this project has seen the planting of 20 native species of fruit trees along with the sowing of a wildflower meadow. This work is intended to be supplemented with the planting of edible hedges such as blackberries to create a welcoming environment where staff, patients and visitors can sit peacefully and help themselves to nature's gift of fruit. The scheme has been funded by Plymouth City Council as part of their mitigation plans for the trees removed in the bus interchange project, which has also seen the replanting of trees including a new replacement Monkey Puzzle tree across the hospital grounds.

This year we will again work with the Horticultural Department at Duchy College to look at students designing gardens and planting in some of the hospital's internal lightwells. The purpose of the project is to brighten up often dull areas of the estate, creating interesting habitats that are easy to maintain whilst also giving a big visual improvement for staff, patients and visitors.

In our strive to become a more sustainable 'environmentally friendly' organisation, we are looking at where we can opt for more 'greener' options. This includes single use items such as coffee cups, plastic cups, straws and plastic cutlery, and how we dispose of and segregate our waste. We are developing an action plan to tackle these issues. In addition, we are in the process of refreshing our Green Travel Plan to encourage more patients, visitors and staff to opt for more greener travel options, where possible.

Our gas fired Combined Heat and Power Plant continued to supply Derriford Hospital with over 60% of its electricity and the Incinerator Heat Recovery Unit saw 2,000 tonnes of waste turned into heat which was supplied back to the hospital.

Type	Amount used
Electricity	16,689,905 KWH
Gas	56,724,808 KW
Water	175,837 m3* * This includes water from the Trust's bore hole

PROUD!

In summer 2017, staff from our Plym Children's Theatres introduced a project to improve the experience of children having surgery.

Known as the 'Thirst Project', the aim is to allow children to drink clear fluids up to an hour before their operation, resulting in reduced stress response, post-op nausea and vomiting, as well as improving cooperativeness. Previously, some children had been fasting for up to 16 hours.

Dr Simon Martin, Consultant Paediatric Anaesthetist at Plymouth Hospitals NHS Trust, said: "The Plym Children's Theatres Team is really pleased with the quality improvement work that we have introduced. The recovery staff helped introduce a series of measures and have continued to collect data on over 1200 patients to ensure we continue to improve. We are aiming to have 95% of our patients having fluids within four hours and are currently at 80%. Before we started the project, only 60% of our patients had had fluids within this time.

"A long fasting time can increase anxiety, nausea and vomiting and perception of pain in children. Evidence on gastric emptying and experience from other centres show it is safe to give clear fluids up to an hour before general anaesthesia and we have found that it has been particularly helpful in improving the cooperativeness of children with additional learning needs."

All additional information needed is sent prior to the child's operation. If you would like to find out more please call Plym Theatre reception on 01752 432431.

Click here to read the Information for Parents/Guardians and Children guide.

Research, Development and Innovation

Our Trust has seen a significant increase in recruitment to its mixed portfolio of research during 2017/18, with a recruitment of 4,685 patients to research projects. In the patient survey 98% of patients stated they would recommend taking part in research to others.

The Trust has a research portfolio of 602 active studies with 391 of these actively recruiting. In year, 147 new projects were opened, a mix of academic, commercial and non-commercial projects.

The Trust continues to support Plymouth University and the Peninsula School of Medicine and Dentistry with grant funded projects and has partnered in four National Institute for Health Research (NIHR) projects this year.

Collaborations
Quintiles has now become IQVIA and the south west partnership remains a key channel for the introduction of commercial research into the Trust. Another source of exposure for the Trust to the pharmaceutical industry is the adoption of the TriNetX platform. This is a global healthcare research network, enabling a collaborative approach between healthcare organisations, biopharmaceutical companies, and Contract Research Organisations (CROs), to improve effective trial design and efficiency, delivery and to accelerate patient identification for recruitment.

We became a TriNetX member to allow patients the earliest opportunity to access new and innovative treatments and improve their outcomes by participating in all types of clinical research. Further working collaborations are being developed with LiveWell Southwest and the primary care environment to ensure the people of Plymouth have the opportunity to benefit from participation in research.

New Challenges
In November the haematology research unit treated the first patient in the world as part of a Phase 1, first into human study, with a brand-new class of anti-cancer therapy. The agent is known to affect apoptosis (otherwise known as programmed cell death) and in pre-clinical testing was extremely active in animal models. Based on our haematology department`s track record of delivery with early phase clinical trials, they were amongst a handful of centres across the world to be involved in this study. These new targeted treatments are very much the future of cancer care and it is important for our local population that we can access them in this way. This is also further evidence that we have the capacity, ability and reputation to allow cutting-edge medicines to be trialled here.

4,685 people were recruited to take part in research

Out and about

Once again Research and Development staff braved the elements to attend both Yealmpton and Totnes shows to talk to people about research and the work being done at Derriford to support new treatments, process and pathways and a number of showgoers took the opportunity to sign up to be contacted about relevant projects in the future.

Innovation

In 2018/19 Research and Development will become Research, Development and Innovation, building on the significant innovation growth and success achieved over the last two years. The enthusiasm and support innovation has had from staff at all levels across the Trust will continue to be harnessed for the benefit of the healthcare environment. Successes of the year include:

- Family Bereavement Bag
- Intravitreal injection guide
- DISTRACT ME Colouring pack to reduce stress and anxiety

Recognition for Research and Innovation

We were congratulated by both the pharmaceutical industry and academia for recruiting not only the first patient nationally to several studies but indeed the first patient globally to a number of complex interventional studies. Our awards and nominations during the year include:

- Royal College of Anaesthesia - NIHR Trainee Research Network 2017
- Shortlisted for Innovation in Education category of HSJ awards 2018
- Shortlisted in the HSJ awards 2017: Most effective adoption and diffusion of existing best practice: Providing a whole system flow in Motor Neurone Disease Care in rural South West England, Peninsula Motor Neurone Disease Care Network hosted by Plymouth Hospital Trust

PROUD!

Families of loved ones who have sadly passed away are now welcomed into a refreshed and calming environment, thanks to our Charitable Funds Committee.

The newly refurbished bereavement room, which features new furniture and accessories, and a calming colour change, was opened in May 2017 by Chairman, Richard Crompton.

Claire Jukes, Patient Experience Support Manager at Derriford Hospital, said: “The difference this room has made has been significant to our bereaved families. It’s more welcoming and calming and has a relaxed atmosphere.

“Following the death of my own father, I remember visiting the room and that being my lasting impression of the hospital. The feedback received to date has been very positive and one family has commented on how calming the room is and also what a beautiful picture there is on the wall. The Patient Services Department really are grateful to the Charitable Funds Committee for providing us with the funds to make the important changes to this room.”

Our newly refurbished bereavement room, located on Level 7 near the Chapel, is used around 150 times a month, and is where all family meetings take place following the loss of a loved one.

A Huge Thanks to our Supporters

We want to say a huge thank you for making what we do possible. It has been a very exciting year for our charity with some key developments taking place to raise the profile of what we can do, alongside making a huge difference to our patients and their families across all areas of the Trust. Plymouth Hospitals Charity exists to provide the best possible care to patients by using donations and legacies given to the charity to raise standards over and above that which NHS funding alone can provide. We are dedicated to creating more patient friendly environments; purchasing equipment for diagnosis and treatments as well as being able to enhance staff development and education to provide better care.

This is all possible because of our amazing supporters. Many people over the year have made donations, some sizeable, some from pocket money, but all gratefully received and all helping towards making improvements.

We have a general fund that distributes money to where the need is greatest as well as lots of specialist funds that link directly to different ward areas, so donors can be assured their money will be spent according to their wishes.

You can find out more about our Charity in our Charity Annual Review on our website.

A huge thank you for all your support ... here are a few examples of how we've used your generous donations in 2017/18

PLYMOUTH HOSPITALS CHARITY

£109,965 to refurbish the Chemotherapy day case unit on Lyd Ward

£43,452 to decorate our Mustard Tree Centre for patients affected by cancer

£25,575 to purchase a Paediatric Simulation Manikin

£12,490 to support Resuscitation Training

£13,000 to support the Learning Disability Advocacy Service

£3,500 to purchase bereavement bags for relatives who have experienced a loss

PLYMOUTH HOSPITALS CHARITY

Wow, what a difference our donors have made ...

*£8,650 to refurbish the Colposcopy Department in the Lancaster Suite

* £6,445 towards Manual Handling Equipment on our ICU wards

* £1,638 to purchase physiotherapy equipment to aid patients

*£500 to purchase Children's Theatre Gowns

Our Accountability Report

Corporate Governance Report

Our Board of Directors

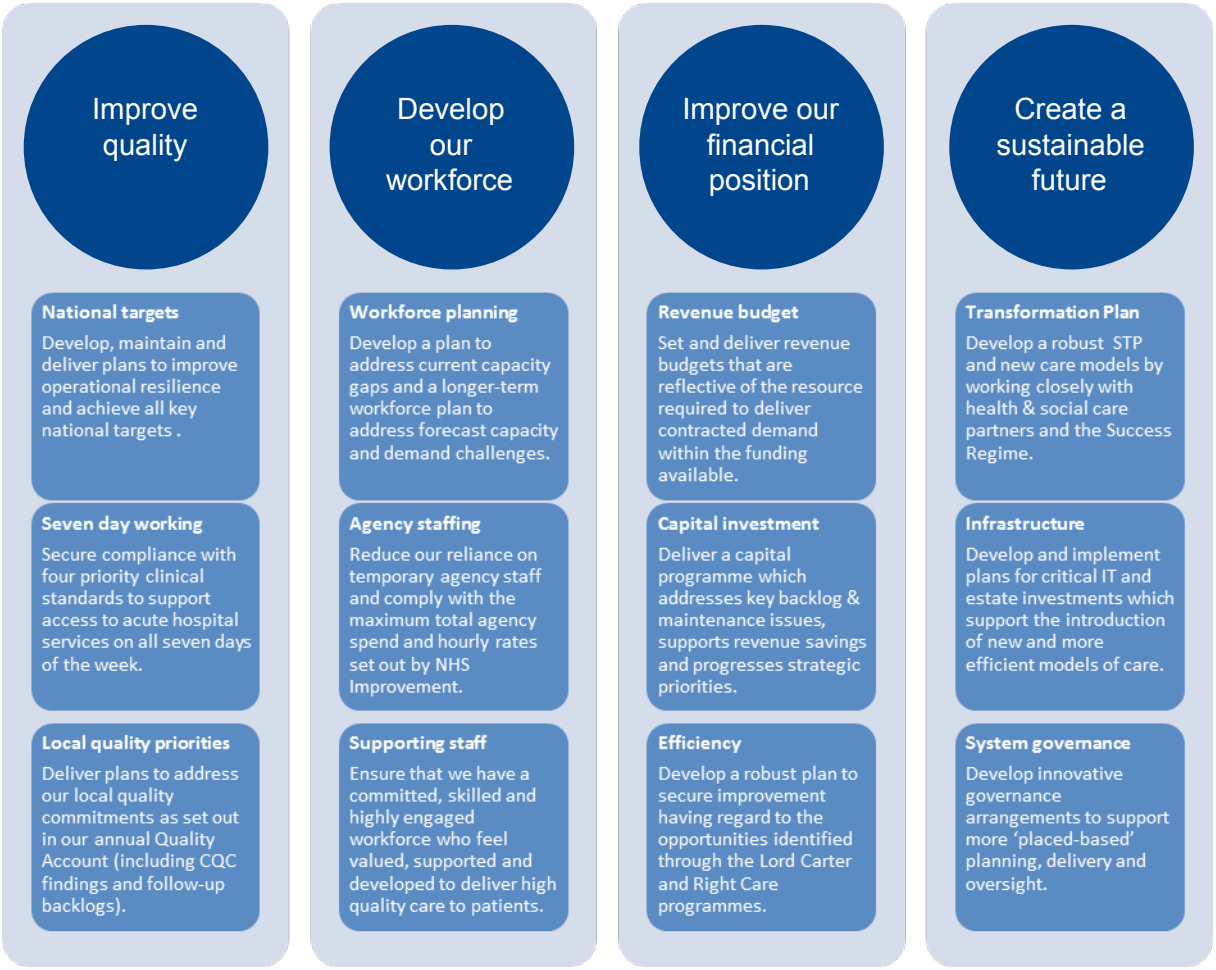
The Board of Directors, led by the Chairman, sets the Trust's strategy, its vision, values and culture. The Board is accountable for the delivery of high quality, safe services to patients and is collectively accountable for the organisation, its decisions and performance; it comprises voting and non-voting members.

The Trust's Standing Orders set out the matters reserved to the Board and our Standing Financial Instructions and Scheme of Reservation and Delegation define our financial decision making framework.

The Chief Executive is supported by a team of Executive Directors, who together are responsible for the overall day to day management of our operational services, our finances and delivering the Board's strategy.

In 2017/18, the Trust Board approved an Operating Plan which identified four overarching aims, as summarised in the following diagram.

Our 2017/18 Operating Plan was built on these four key workstreams:



The risks to these overarching objectives are set out in the Board Assurance Framework. In reviewing the risks to these objectives, the Board is supported by its sub-committees, which review in more depth the risks and assurances associated with different aspects of the Board's responsibilities. The Board's sub-committees are explained in more detail below.

Members of the Board of Directors in 2017/18

Board members' details, together with declarations of their relevant interests and Committee membership, are detailed on the following pages. Directors must comply with the Trust's Standards of Business Conduct and are required to declare any interests that are relevant and material on appointment or which may arise during the course of their term of office. A register of Board members' interests is maintained by the Board Secretary and is included with every set of public Trust Board papers.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduced a 'fit and proper person' test for Directors of NHS organisations. The Trust Board approved a local 'fit and proper person' test in 2015 to enable the Trust to demonstrate that it has the appropriate systems and processes in place to ensure that all new appointees to, and holders of, Director posts, are, and continue to be, fit and proper persons. This process has been updated to incorporate subsequent Care Quality Commission guidance. In November 2017 the Board noted that an annual review and self-assessment in accordance with the Trust's agreed process had demonstrated compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including the revisions introduced in 2017, and that Board appointees had met the 'fit and proper person' test.

Non-Executive Directors

We have six Non-Executive Directors and two Associate Non-Executive Directors on our Board. Non-Executive Directors are appointed by NHS Improvement; Associate Non-Executive Directors are appointed by the Trust. The following served on the Board during 2017/18:

V – voting Director
NV – non-voting Director

Richard Crompton, Chairman (V)
Richard was appointed in August 2012 for four years and re-appointed for a further four years in August 2016, and then re-appointed for a further two years until July 2020. A former Chief Constable of Lincolnshire Police, Richard also served with the Metropolitan Police and former Devon & Cornwall Constabulary. Partnership working has been a constant theme throughout Richard's career and he continues to be closely involved with organisations aimed at improving services, particularly those for the most vulnerable.

Declarations of interests:

- Independent Chairman, Somerset Safeguarding Adults Board.
- Independent Chairman of the Safeguarding Panel for Dimensions UK, a national provider of a range of services for the learning disabled and autistic.
- Independent Chairman, Wiltshire Safeguarding Adults Board.

Giles Charnaud (V)

Giles stepped down as the Chief Executive of Rowcroft House Foundation Limited (Rowcroft Hospice) in 2016. He was appointed to our Board in 25 September 2016 for four years. Having also worked previously for the National Blood Service and South Devon Healthcare NHS Trust, Giles brings considerable experience within the charity sector at leadership and board level and at a senior management operational level within the NHS.

Giles has declared no interests.

Professor Jacky Hayden, CBE (V)
Jacky brings to the Board a strong track record of medical leadership, both as a general practitioner and as a medical educator. With a clinical background in general practice for more than 30 years, she was the first general practitioner to be appointed as Postgraduate Dean in England and the first female doctor to be appointed as a Regional Adviser in General Practice. Jacky was awarded her CBE in 2013, the same year she was named as one of the Health Service Journal's Top 50 Inspirational Women. She is President of the Academy of Medical Educators. Jacky was appointed in October 2016 for four years.

Declarations of interests:
- Member of the Council of the Academy of Medical Educators.
- Member of the Council of the Faculty of Medical Leadership and Management.
- Member of the Medical Practitioner Tribunal Service Committee.
- Professor of Postgraduate Medical Education University of Manchester.
- Visiting Professor Lancaster University.

Professor Elizabeth Kay, MBE (NV)
Foundation Dean of the Peninsula Dental School, Liz was appointed Associate Non-Executive Director in 5 September 2016 for a four year term. She is a committed clinician and teacher and a Public Health Academic Consultant working with Public Health England, focusing on the delivery of appropriate care to those who find clinical care particularly challenging. Liz sits on the Editorial Boards of three journals, including the British Dental Journal and peer-reviews papers for a large number of other academic publications. In addition, she authors textbooks in collaboration with colleagues from around the world. Liz was awarded her MBE in 2017 for services to dental education.

Declarations of interests:
- Director and Trustee of Oral Health Foundation Charity (President Elect 2017).
- Chair of management board of research funding committee of the British Dental Association.
- Advisory Board Oasis Healthcare.
- NICE Quality Standards Committee for Oral Health Promotion Care Homes and Hospitals.
- British Dental Association Health and Sciences Committee member.
- Board member, South West Academic Health Science Network.
- Trustee, British Medical and Dental Student Trust.

Mike Leece, OBE (V)
Mike was appointed to the Board in June 2015 and was re-appointed for a further two years in 2017. Mike operates his own consultancy business and has held a number of Non-Executive Director appointments in

the public and private sectors. Prior to this, he was the Chief Executive of the National Marine Aquarium in Plymouth, following nine years as a Chief Executive Officer for an international defence contractor.

Declaration of interests:
- Chairman and Director, Water Powered Technologies Limited.

Elizabeth Raikes (V)
A chartered accountant by profession, Elizabeth was a Chief Executive in the public sector for twelve years, most recently with Torbay Council, before her appointment to this Trust in September 2012. She brings considerable experience of close and successful partnership working with commissioners, community health and social care colleagues and the acute sector in Torbay. Elizabeth was re-appointed for a further two year term in September 2016.

Declarations of interests:
- Spouse is a governor of Plymouth Marjon University.

Estelle Thistleton (V)
Estelle was appointed in September 2016 for four years. A former Chair of Cardiff and District NHS Trust, Estelle is now a specialist in leadership development, working alongside leaders from most UK public sectors, providing consultation in personal and organisational development. Estelle began her NHS career as a nurse and has held various nursing appointments in England and Wales, including Assistant Director of Nursing in Gwent. She has also held a number of voluntary Chair and Trustee appointments in educational, children's and arts charities.

Declarations of interests:

- Director Maine Partnership Ltd, a consultancy in leadership development that does business with the NHS.

Henry Warren (NV)
Appointed as an Associate Non-Executive Director in April 2013, Henry brings significant commercial and financial knowledge and experience to the Board, gained over a number of years in public and private practice. A former partner in Deloitte, more recently Henry became involved with a portfolio of businesses, both as an investor and Non-Executive Director. These businesses are primarily concerned with developing problem-solving technology, such as the provision of renewable energy. Henry was re-appointed for a further two year term in April 2017.

Declarations of interests:
- Senior Independent Governor and Chair of Audit Committee, Plymouth University.
- Chairman and Director of Fluvial Innovations Ltd.


Jamie Snape
@jamiesnapeuk
@Derriford_Hosp A huge thank you to Derriford Hospital, particularly the amazing staff on Woodcock Ward for looking after my baby girl the last few days. It's inspiring to watch you work, you're a credit to the NHS and absolute heroes in my eyes. Thank you! #NHSheroes
Zoe Young @punc13zoe
Thank you again @Derriford_Hosp @sue_timminsNHS for your wonderful care and treatment of my aunt with her #fracture Amazing people from every department to get her 'fixed'. My family and I are very grateful
#ProudofPlymouthNHS

Executive Directors

The Chief Executive is appointed by the Chairman of the Trust and the Chief Executive appoints the members of her Executive team. All eight of our Executive Directors are on permanent contracts.

Ann James, Chief Executive (V)
Ann took up her appointment as Chief Executive in September 2012. As former cluster Chief Executive of NHS Devon, Plymouth and Torbay, her commitment to clinical engagement supported the successful development of two clinical commissioning groups, recognised at the time as best practice for their collaborative approach. Ann led one of the country's largest primary care trusts as Chief Executive of NHS Devon, between January 2010 and June 2011, following more than three years as Chief Executive at Cornwall and Isles of Scilly Primary Care Trust.

Declarations of interests:
- Leadership Fellow, St George's House, Windsor Castle.
- Interim Chair, South West Leadership Academy.
- Health and Medical Champion, Chamber of Commerce.
- Member, One Plymouth.
- Chair, Health Education SW Membership Council.
- Acute Sector Representative, Health Education SW Board.
- Chair, National Institute for Health Research Comprehensive Local Research Network Partnership Group.
- Member, Plymouth Growth Board, Champion for People, Communities and Institutions.
- Board Member representing Acute Sector, NHS Leadership SW.
- Governor, Devonport High School for Girls.
- Personal association with managing director of Langage Farm, a company with which Plymouth Hospitals NHS Trust has a commercial relationship. I have no influence over contracts with Langage Farm.

Kevin Baber, Chief Operating Officer (V)
Kevin was appointed in April 2013. Prior to joining the Trust, Kevin was Chief Executive of Peninsula Community Health in Plymouth. Originally qualifying as a nurse in 1986, Kevin has three decades of healthcare experience and was previously Managing Director of Community Health Services for NHS Cornwall and Isles of Scilly. Kevin also has extensive experience in private healthcare, having been General Manager of a large independent hospital in the Nuffield Health Group. Between January 2017 and March 2018 Kevin took on a revised portfolio as Director of Strategic Development in order to support the wider system work with which the Trust is increasingly involved.

Declarations of interests:
- Employer Member of the SW Sub-Committee of the Advisory Committee on Clinical Excellence Awards.
- Partner is Associate Director, Medicines Optimisation, at Devon Partnership Trust.

Lee Budge, Director of Corporate Business (NV)
With a background in public finance and audit, Lee joined the Trust from the Audit Commission in April

2011 at the conclusion of a period of secondment. Lee leads on Board risk and assurance, regulatory compliance, health and safety, information governance and corporate business.

Declarations of interests:
- Trustee of Plymouth Access to Housing.
- Member of a band which fundraises on behalf of St Luke's Hospice, Plymouth.

Greg Dix, Chief Nurse (V)
Greg was appointed in February 2013. With nursing experience in the UK and abroad, Greg has also worked as a clinical nurse lecturer in Wales and in 2010 became the Director of Nursing and Governance at Taunton and Somerset NHS Foundation Trust. From October 2016 Greg took on the additional portfolio of Chief Operating Officer, returning to his substantive post as Chief Nurse in March 2018.

Declarations of interests:
- Specialist advisor with the Care Quality Commission.
- Associate Professor in Nurse Leadership, Faculty of Health and Human Sciences, Plymouth University.
- Chair of Governors, Scott Medical and Healthcare College, Plymouth.
- Board Trustee of a multi academy trust 'Inspiring School's Partnership'

Phil Hughes, Medical Director (V)
Phil joined the Trust as a consultant in 1993, having trained in London and Manchester. He is a senior examiner for the Royal College of Radiologists and an Executive Member of the British Society of Skeletal Radiologists. Phil has previously been the Trust's Clinical Director for Imaging, Associate Director of Planning and Assistant Medical Director. After a period as Interim Medical Director, Phil was appointed Medical Director in November 2013.

Declarations of interests:
- Director, Hughes Diagnostics.
- Designated Member with Plymouth Radiology Consultants LLP.

Steven Keith (NV)
Steven joined the Board in February 2016 as Director of People. Steven is the Trust's Executive lead for staff engagement, our organisational development and employment strategies, and workforce planning. He is also responsible for providing professional human resources and organisational development advice and support to the Trust Board. Steven works closely with other Directors, senior managers and clinicians to ensure that we have the right staff in the right place, with the right skills to support the delivery of high quality care to our patients.

Declarations of interests:
- Member of Plymouth Employment and Skills Board as a representative of the Health sector.

Neil Kemsley (V)
Neil joined Plymouth Hospitals NHS Trust as Director of Finance in November 2015. After graduating through the NHS South West Finance Training Scheme in 1994, Neil progressed through the finance

ranks at United Bristol Healthcare Trust and University College London Hospitals before becoming Deputy Director of Finance at King's College Hospitals and then Portsmouth Hospitals, where he later became Director of Finance and Investment. In 2009, after relocating back to the South West, Neil became Director of Finance, Contracting and Performance in NHS Devon and then for the PCT cluster for Devon, Plymouth and Torbay. From 2013 to 2015 he worked for NHS England as Finance Director, originally covering Bristol, North Somerset, Somerset and South Gloucestershire and then, from July 2014, from South Gloucestershire to the Isles of Scilly.

Declaration of interests:
- Spouse is a Project Accountant at Sirona Care and Health, a community interest company providing services in the Bath, Wiltshire and Bristol areas.

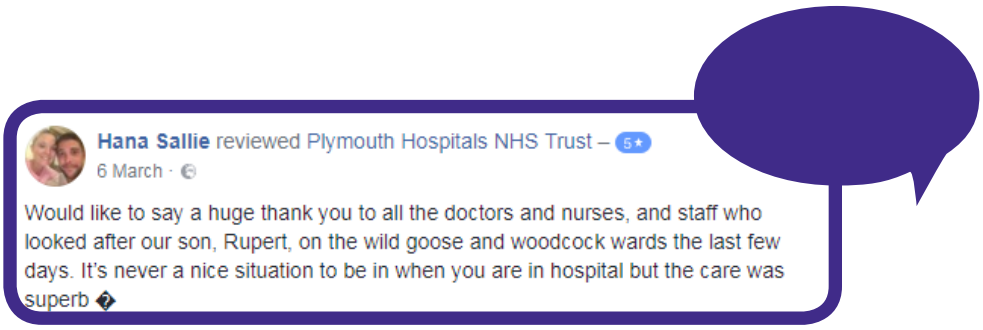
Phill Mantay, Director of Transformation (NV)
Previously this Trust's Acting Director of Finance between September and November 2015, Phill joined the Board from January 2016 as Director of Transformation. In February 2018 Phill commenced a secondment to another NHS Trust.

Phill declared no interests during this time with this Trust.

Nick Thomas, Director of Site Services and Planning (NV)
Nick joined the NHS in 1984, became a member of the Chartered Institute of Public Finance and Accountancy in 1988, and was subsequently an examiner for that organisation for a number of years. Nick joined the Trust in 1994 as Deputy Director of Finance and holds Director portfolios for Information Management & Technology (IM&T) and Planning & Site Services. He joined the Board in October 2013. Nick was appointed Deputy Chief Executive in October 2015.

Declarations of interests:
- Trustee of Plymouth Access to Housing.
- Non-Executive Director, Plymouth Science Park Ltd.

Professor Rob Sneyd, Dean of the Plymouth University Peninsula School of Medicine and Dentistry, attends our Board meetings by invitation.



Directors' attendance at public Board meetings 2017/2018

The Board met in public on six occasions during the year. Agendas, papers and declarations of interest are published on the Trust's website. The Board also holds confidential meetings from which the public are excluded for reasons of commercial or personal sensitivity.

Non-Executive Directors	Meetings attended
Richard Crompton, Chairman	6 of 6
Giles Charnaud	5 of 6
Jacky Hayden	6 of 6
Liz Kay	4 of 6
Mike Leece	4 of 6
Elizabeth Raikes	4 of 6
Estelle Thisleton	5 of 6
Henry Warren	6 of 6

Executive Directors	Meetings attended
Ann James, Chief Executive	6 of 6
Kavin Baber	6 of 6
Lee Budge	5 of 6
Greg Dix	6 of 6
Phil Hughes	5 of 6
Steven Keith	5 of 6
Neil Kemsley	5 of 6
Phill Mantay	3 of 5
Nick Thomas	4 of 6

Board evaluation and effectiveness

The Board held development sessions during 2017/18 with the aims to:

- Ensure that it had a good understanding of the environment in which it operates.
- Maximise the Board's influence through formal and informal engagement to build understanding and relationships with other key stakeholders.
- Enhance the Board's knowledge through a series of 'master-classes' on subjects relevant to its role and responsibilities.
- Maintain the Board's visibility by adopting a personable and interactive approach to leadership through effective engagement with staff and patients.
- Develop the Board's skills by using external facilitation to objectively review and observe performance and optimise effectiveness as a team.

Among the diverse topics covered in Board Development Plan during 2017/18 were:

- Mental health
- Medical productivity, and the national Model Hospital and Getting It Right First Time Initiatives
- Plymouth Hospitals Charity
- Strategy
- IM&T
- Medical staffing
- Impact and effectiveness in delivering the Trust's 2017/18 Annual Plan

Standing Committees of the Board
Our Board has seven sub-committees, six of which are chaired by Non-Executive Directors. They are:
- Audit
- Remuneration
- Finance & Investment
- Safety & Quality
- Human Resources & Organisational Development
- Research
- Charitable Funds

Audit Committee
The Audit Committee ensures that an effective system of internal controls is in place and maintained. Independently of the Trust Board, it reviews and scrutinizes the Trust's objectives and of the associated risks and controls set out in the Board Assurance Framework. A Committee comprised only of Non-Executive Directors, it met on six occasions during the year and is chaired by Elizabeth Raikes. Its core membership is Elizabeth, Jacky Hayden, Mike Leece and Henry Warren. Jacky, Mike and Henry also chair other Committees of the Board. All other Non-Executive Directors, with the exception of the Chairman, receive papers and may attend if they wish. The Directors of Finance and Corporate Business regularly attend and all other members of the Executive team routinely receive papers and attend when the agenda demands.

Non-Executive Directors' attendance at Audit Committee meetings during 2017/18 was:

Non-Executive Directors	Meetings attended
Elizabeth Raikes, Chair	6 of 6
Giles Charnaud	6 of 6
Jacky Hayden	6 of 6
Liz Kay	0 of 6
Mike Leece	5 of 6
Estelle Thisleton	1 of 6
Henry Warren	5 of 6

Remuneration Committee
This Committee oversees the performance and remuneration of the Executive team. It is comprised only of Non-Executive Directors and all our Non-Executive Directors are members of it. It's chaired by Elizabeth Raikes. It met twice during 2017/18: in July 2017 to approve the objectives of all members of the Executive team for 2017/18, review their appraisals for 2016/17 and to approve recommendations for temporary Executive portfolio and remuneration arrangements. It met in February 2018 to review those arrangements again and to consider guidance from NHS Improvement on Very Senior Managers' appointments and pay.

Members' attendance at Remuneration Committee meetings during 2017/18 was:

Non-Executive Directors	Meetings attended
Elizabeth Raikes, Chair	2 of 2
Giles Charnaud	2 of 2
Richard Crompton	2 of 2
Jacky Hayden	2 of 2
Liz Kay	1 of 2
Mike Leece	1 of 2
Estelle Thistleton	1 of 2
Henry Warren	2 of 2

Finance and Investment Committee
This Committee oversees the delivery of the Trust's financial plans, ensures action is taken to address key financial risks and scrutinizes major businesses cases prior to review by the Trust Board. Henry Warren is the Committee's Chairman. Other Non-Executive members are Giles Charnaud, Mike Leece and Elizabeth Raikes. Elizabeth stepped down from the Committee in February 2018. This Committee met on thirteen occasions in 2017/18. Board members' attendance was:

Core NED/Executive Member	Meetings attended
Henry Warren, Chairman	13 of 13
Giles Charnaud	11 of 13
Mike Leece	10 of 13
Elizabeth Raikes	10 of 12
Chief or Deputy Chief Executive	11 of 13
Director of Finance	11 of 13
Chief Operating Officer	5 of 13
Director of Corporate Business	4 of 13

Safety & Quality Committee

This Committee is responsible for overseeing delivery of the Trust's quality plans and providing assurance to the Board on the key quality risks. It met six times in 2017/18 and is chaired by Jacky Hayden. Board members' attendance was:

Core NED/Executive Member	Meetings attended
Jacky Hayden, Chair	6 of 6
Giles Charnaud	5 of 6
Chief Operating Officer	2 of 6
Chief Nurse	4 of 6
Medical Director	3 of 6
Director of Corporate Businesss	4 of 6

On occasions when the Directors of Nursing and Medicine were not present, Deputy Directors were in attendance.

Human Resources and Organisational Development Committee

This Committee oversees delivery of the Trust's people objectives, addresses our key people risks, delivery of our People Strategy and is responsible for HR policy scrutiny and approval. It met on six occasions during the year and is chaired by Mike Leece. Early in 2017 it reviewed its membership and this now includes four Board members. Their attendance during 2017/8 was:

Core NED/Executive Member	Meetings attended
Mike Leece, Chair	6 of 6
Estelle Thisleton	5 of 6
Director of People	2 of 6
Chief Nurse or nominee	4 of 6
Medical Director's nominee	3 of 6

Research Committee

This Committee's primary aim is to develop and oversee the implementation of the Trust's strategy for research, teaching and innovation, including the identification and management of associated risks. This Committee is chaired by Liz Kay and includes membership drawn from the Trust's Executive team and from the University of Plymouth. It met three times during the year. Board members' attendance was:

Core NED/Executive Member	Meetings attended
Liz Kay, Chair	3 of 3
Chief Executive	3 of 3
Chief Nurse	2 of 3
Medical Director	2 of 3

Charitable Funds Management Committee

The Plymouth Hospitals General Charity was registered with the Charity Commissioners for England and Wales on 27 July 1995 under a Model Declaration of Trust for an NHS umbrella charity where the Trust acts as sole corporate trustee. In line with good practice, and in order to reduce any conflict of interest, real or perceived, the corporate trustee appoints a Charitable Funds Management Committee to oversee the management, investment and disbursement of funds within the regulations provided by the Charity Commission and to ensure statutory compliance.

The Committee meets six times a year. Giles Charnaud chaired the Committee between February and November 2017, when Executive Directors Lee Budge and Kevin Baber were appointed joint Chairs. The charity is seeking independent external assurance that certain of its governance arrangements conform to best practice.

PROUD!

Massive congratulations to members of our Communications Team and Nursing Team who won both Gold and Silver at the CIPR South of England and Channel Island PRide Awards. The awards ceremony, held at The Mercure Bristol Grand Hotel, Bristol in November, was attended by Amanda Nash and Brydie Bruce from the Communications Team, along with Matrons Sue Timmins and Judy Frame (pictured).

The teams were shortlisted for their successful campaign, #letsbeopen, which recognised the invaluable role and contribution families and carers provide to their loved ones when they are in hospital and resulted in the introduction of open visiting (07:30-22.00) to the 30+ adult wards* at Derriford Hospital.

It also saw the development and implementation of a Visitors' Charter, which outlines the standards that we ask all of our visitors to respect, for example, ensuring that no more than two people visit at any one time, supporting and encouraging the patient during mealtimes, observing quiet times or being asked to leave for a short period of time, such as during doctors' rounds, etc.

The campaign won Gold in the category for 'Healthcare Campaign', which recognises the most effective public relations work done by a charitable or not-for-profit organisation, and Silver for a 'Not-For-Profit Campaign', which is awarded to a successful campaign in support of a healthcare issue, product, service or initiative.

"Our Communications Team worked hand-in-hand with our nursing team to ensure all views were heard and considered and ultimately ensure that the #letsbeopen campaign worked, as well as it could for everyone," said Ann James, Chief Executive of Plymouth Hospitals NHS Trust. "It is excellent that, not only has the change in visiting times made such a difference to so many patients and their loved ones, but the work and commitment behind it is being professionally recognised by winning these awards. A huge well done to all."

Governance Statement

Scope of responsibility

I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable Officer Memorandum.

Governance framework of the organisation

Board composition

The Trust has had a fully constituted Board for 2017/18. There were no substantive changes to the appointed Non-Executive or Executive Directors during the year.

Board committee structure

The committees of the Trust Board comprise:

- Audit.
- Remuneration.
- Safety & Quality.
- Finance & Investment.
- Human Resources & Organisational Development.
- Research.

The Terms of Reference for each committee are reviewed and approved by the Trust Board on a regular basis. Each committee is chaired by a Non-Executive Director. Committee attendance for each Non-Executive and Executive Director is summarised in the Trust's Annual Report.

Board performance

The Board held regular development sessions throughout 2017/18. These were informed by a Board Development Plan which sought to:

- Maximise the Board's influence through formal and informal engagement to build understanding and relationships with other key stakeholders.
- Enhance the Board's knowledge through a series of 'master-classes' on subjects relevant to our role and responsibilities.
- Maintain the Board's visibility by adopting a personable and interactive approach to leadership through effective engagement with staff and patients.
- Develop the Board's skills by using external facilitation to objectively review and observe our performance and optimise our effectiveness.

In reality, these sessions focused on ensuring that the Board had a good understanding of the environment in which we are working and did not incorporate a more formal assessment of its performance. The Board will need to reflect on these issues, identify its key areas of development and update its development plan accordingly in 2018/19.

Compliance with the Corporate Governance Code
Corporate governance is the way in which an organisation is directed, controlled and led. It defines relationships and the delegation of roles and responsibilities of those who work within the organisation, determines the rules and procedures through which the organisation's strategic objectives are set, and provides the means of attaining those strategic objectives and monitoring performance. Most importantly, it defines where accountability lies throughout the organisation. The Board's activities are based on the principles of good corporate governance and nationally publicised best practice.

Risk assessment

Strategic aims and objectives
The Trust's current strategy is set out in 'At the Heart of Health in the Peninsula' which was published in May 2013. In 2017/18, the Trust produced an Operating Plan which identified four overarching aims, as summarised in the following diagram.

Key risks to the achievement of our objectives
Key risks to the achievement of our objectives have been regularly reviewed and updated throughout the year. The key areas of focus have included:
Improve quality
- National constitutional standards
- Operational pressures
- Elective referrals
- Medical and nurse staffing

Develop our workforce
- Workforce planning
- Recruitment & retention
- Medical and nursing education

Improve our financial position
- Budget delivery
- Productivity

Create a sustainable future
- System transformation.
- Financial sustainability
- Long-term capital investment

Progress in mitigating these risks has been reviewed by the Trust Board and its committees throughout the year. This process is described further under the section titled 'The risk and control framework'.

Information Governance
The Trust's information risk management process is led by the Senior Information Risk Owner (SIRO). Information governance related incidents are recorded on the Trust's DATIX system. A national Department of Health scoring system is used to categorise the severity of the incident – Level 0 and Level 1 incidents are reviewed using local procedures whilst Level 2 (the most severe) incidents are reported through the national IG Toolkit and shared with the Information Commissioner's Office.

NHS England's Serious Incident Framework was updated in March 2015 and requires NHS organisations to report level 2 IG incidents on the NHS serious incident management system, STEIS, as well as the IG Toolkit. STEIS incidents are onward reported to NEW Devon CCG. The Trust IG team ensure that Root Cause Analysis methodology is used to investigate these incidents.

The information governance team reviews all reported incidents, works to promote good practice and ensures that we identify and act on lessons learned from these incidents. Level 2 incidents are investigated using Root Cause Analysis methodology.

In the 2017/18 financial year there has been one Level 2 Serious Incident Requiring Investigation. This related to a patient receiving information relating to another patient and has been reported on the NHS Digital Information Governance Incident Reporting Tool. The Trust has cooperated fully with the ICO who have welcomed the remedial actions taken.

The risk and control framework

Purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the 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 Plymouth Hospitals NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts

Capacity to handle risk
The Trust Board is supported by its sub-committees which review in more depth the risks and assurances associated with different aspects of the Trust's responsibilities. These are:

- Safety & Quality Committee
- HR & OD Committee
- Finance & Investment Committee.

Clinical leadership remains a central part of our governance architecture as it helps us remain focused on our primary goal of delivering high quality care. With this in mind, we have organised the Trust into a series of business units known as 'Service Lines'.

We have also established four 'Care Groups' each of which is headed by a Clinical Director who is a member of the Trust Management Executive. Each Service Line is aligned to a Care Group.

Our risk framework
The Trust has a 'Risk Management Framework' which has been approved by the Trust Board. The Framework sets out the key responsibilities for the management of risk and seeks to ensure that the risks to the achievement of the Trust's objectives is understood, reported and appropriately mitigated.
The Board Assurance Framework (BAF) is the key strategic tool for the management of risk and assurance. The Framework enables the Board to demonstrate how it has identified and met its assurance needs in relation to the delivery of the Trust's objectives. The BAF includes:

- A description of identified risks and potential consequences together with the source of the risk.
- The Board risk owner and the relevant 'Assurance Group'.
- Arrangements or controls in place to oversee and mitigate risk.
- Current evidence to substantiate whether or not the risk is being effectively managed and/or mitigated.
- Identified gaps in processes and/or outcomes required to mitigate the risk and an 'assurance rating'.
- Further action commissioned by the Assurance Group.

Furthermore:

- Actions required to mitigate risks or improve the level of assurance are identified and incorporated within the forward work programme of the relevant committee.
- The Board and its committees review the framework on a monthly basis to ensure that key risks are identified and seek assurance that appropriate mitigating actions are being taken.
- The Audit Committee reviews aspects of the assurance framework on a regular basis to satisfy itself that appropriate systems of control are being maintained.
- Serious or significant risks are added to the Board Assurance Framework and actions to mitigate these risks are monitored at the relevant level of the Trust.

Essential standards of quality and safety
The Care Quality Commission (CQC) is the organisation which regulates and inspects health and social care services in England. All NHS hospitals are required to be registered with the CQC in order to provide services and are required to maintain specified essential standards of quality and safety in order to retain their registration.

As part of its role the CQC is required to monitor the quality of services provided across the NHS and to take action where standards fall short of the essential standards.

Their assessment of quality is based on a range of diverse sources of external information about each Trust which is regularly updated and reviewed. This is in addition to their own observations during periodic, planned and unannounced inspections.

No enforcement action was taken against the Trust during 2016/17 and the Trust was not the subject of a responsive inspection. The Trust was, however the subject of a planned CQC inspection in July-August 2016 as a follow up to the comprehensive inspection that was carried out in April 2015.

During the previous inspection we were rated as 'Requires Improvement' overall. The follow up inspection therefore focussed on those areas rated previously as 'Requires Improvement' and 'Inadequate'. The CQC also inspected the Well Led domain at Trust level. The CQC's Quality Report was published in November 2016.

Whilst we have again been rated as 'Requires Improvement' overall for our services, the report clearly demonstrates significant improvements across the core services. The CQC have aggregated the ratings from the previous inspection and given new overall ratings for each core service. Inspectors have reported a marked improvement and there are no more 'Inadequate' ratings. Our rating for each of the five domains assessed by the CQC is shown below:
Of the 18 domains rated as 'Requires Improvement' or 'Inadequate' for Derriford Hospital in 2015 we have improved in 13. Of particular note is the dramatic improvement in Outpatients and Diagnostic Imaging. For Mount Gould Hospital we improved in the Safe Care domain from 'Requires Improvement' to 'Good'.

Safe	Requires improvement ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Requires improvement ●
Well-led	Good ●

The report recognises many areas of outstanding practice including "an outstanding response from the critical care teams and the hospital trust to areas of concern raised in the previous report".

The Quality Report details a number of Requirement Notices. A Requirement Notice is issued where the CQC assess:

- The provider is acting in breach of the regulations.
- The impact on people using the service is not immediately significant.
- The provider should be able to improve its standards within a reasonable timeframe.
- The provider has no history of poor performance that gives rise to wider concerns.

The action plan designed to address the Requirement Notices is in the process of being implemented. Monthly updates on the implementation of our actions and ongoing programmes of work to address the issues raised by the CQC have been provided to the CQC, NEW Devon Clinical Commissioning Group and NHS Improvement.

The Trust continues to be fully registered with the CQC across all of its locations without conditions and continues to monitor compliance across all of the fundamental standards. We are on a journey of continuous improvement and we continue to monitor, review and constantly improve the quality of care across the services that we provide.

Well-led framework
The CQC will be conducting a 'well-led' inspection in May 2018. This will look at our overarching arrangements for managing the services we provide and will include consideration of our vision, strategy & culture, our leadership capacity & capability, how we engage and involve staff & patients and our overall approach to learning and improvement. The results of this inspection will be made public in due course.

Use of resources
The Trust has established comprehensive arrangements for reviewing and improving economy, efficiency and effectiveness in the use of our resources. We are is actively engaged in the Carter, Getting It Right First Time (GIRFT) and Model Hospital work programmes and continue to use benchmarking to identify variations in performance and/or practice.

NHS Provider licence conditions
NHS trusts are legally subject to the equivalent of certain provider licence conditions and must self-certify under these licence provisions. The Trust Board has certified that:

- It has processes and systems that identify risks to compliance with licence conditions, relevant legislation and the NHS Constitution.
- It has reviewed review whether their governance systems meet those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

Staff survey
Last year we made a big improvement with our staff survey results and I am pleased to be able to share this year's survey result which describes our progress and continuous improvement. We are generally moving our scores upwards with fewer results in the bottom 20% of all acute trusts for key findings. I am particularly pleased that:

- 57.2% of all staff responded (an improvement on last year's 48%) to the independently-run survey which puts us in the top 20% for response rate and means we can be more confident in how representative this information is.
- There is an increase in confidence in raising concerns and reporting unsafe clinical practice.
- The majority of staff appreciate and understand the importance of their role and the impact to our patients.
- There is an increase in the quality of non-mandatory training, learning or development.

- More staff feel able to contribute towards improvement in their area of work.
- More staff feel recognised and valued by the organisation and managers.
- Most staff feel supported by their immediate line manager.

Overall we are making steady progress but we still have plenty to do. As with the last two years, we have, in discussion with the joint trades unions, started to pull out the key issues which we need to focus on, and as we have committed to previously, we will then commence our Big Conversation Programme to work with staff to identify the improvement actions we need to take.

Quality governance

The Francis, Keogh and Berwick reports reinforced the critical importance of maintaining effective quality governance arrangements. The Trust's current quality arrangements include:

- A weekly quality governance meeting led by key Directors to review key governance events.
- A Quality Assurance Committee to review compliance across a range of governance themes.
- A Quality Improvement Committee to oversee delivery of the Trust's quality improvement priorities.
- Oversight of the Trust's quality governance arrangements by the Safety & Quality Committee.
- Monthly reports to the Trust Board showing the Trust's performance across a wide-range of safety and quality metrics.
- A Reducing Errors and Achieving Change Together (REACT) bulletin to share learning gathered from SIRI investigations.
- Quality Managers within the Surgery and Medicine Care Groups.
- A Clinical Effectiveness Group to oversee the introduction of new devices and procedures.

We will continue to develop our quality governance arrangements throughout 2018/19.

Quality Account

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. This is reviewed by the Trust Board and the Safety & Quality Committee to ensure that it represents a balanced view and that there are appropriate controls in place to ensure the accuracy of data contained within it. Independent assurance on the 2017/18 Quality Account will be provided by our external auditors.

Data quality

The Trust has continued to adopt a pro-active approach to data quality in 2017/18 by developing a risk-based approach to assessing the key performance data presented to the Trust Board and subjecting this to independent internal audit scrutiny to test and report on its accuracy, reliability and validity. This includes a rolling programme of audit reviews of the systems and data which underpin reporting against national performance standards such as waiting times.

NHS Pension Scheme

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.

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

Environmental obligations
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.

Review of effectiveness

Approach to reviewing effectiveness
As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:
- External audit reports.
- Internal audit reports.
- Assessments by external agencies.
- Care Quality Commission inspections.
- Internal management 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 activities of the Trust Board, its sub-committees and the Trust Management Executive.

Significant issues
We have much to be proud of in the quality of care that we give to our patients but continue to face severe challenges in a number of key areas. For example, Emergency Department attendances have risen by 15% over the past 5 years which has been compounded by a significant increase in the acuity of patients.

The most significant issues facing the Trust in 2017/18 may be summarised as follows:
- Operational pressures: The Trust continues to face significant pressure from a sustained increase in the number of emergency attendances, high levels of acuity and a high volume of delayed transfers of care (DTOCs) to the wider community. This continues to result in medical outliers, the cancellation of elective operations and crowding in the Emergency Department.

- National performance standards: We continue to face a significant challenge in consistently meeting a number of key national performance standards. The hospital has been under operational distress for a considerable time which has had a major impact on the efficient delivery of front line services and the ability to maintain management focus on the delivery of high impact changes.
- Workforce challenges: We recognise the importance of ensuring that we have the right staff, in the right place and, at the right time but, in common with the wider NHS, the Trust continues to face significant workforce challenges. We face challenges in recruiting staff in some key professions and service areas. We are, however, developing a stronger plan for addressing these issues on a sustainable basis by, for example, proactive ongoing recruitment and the establishment of new clinical roles such as Doctors' Assistants.

We are approaching the second year of our two year plan which focuses on establishing equilibrium between demand and capacity, through significant improvements in both front door assessment and alternate pathways to admission and also faster discharge to more appropriate settings of care.

In last year's Annual Governance Statement I commented that fundamental system transformation was needed if we are to meet the increasing demands on health and social care within the finite resources available. I am pleased to report that the unequivocal direction of travel for commissioners is a fully integrated health and care organisation for the Plymouth system.

This integrated / PLACE based provider of care, a single organisation, will deliver the Devon STP's vision of developing and implementing a new model of care which puts early intervention, prevention and community based care for our citizens at the centre of everything we do, only requiring acute and specialist care when absolutely necessary.

We will continue to work with our partners within the wider health & social care community to do what is right for our patients and the population we serve by developing a sustainable future.

Conclusion
My review confirms that whilst many key components of an effective system of internal control are in place as at 31 March 2018, there is still scope for strengthening the Trust's arrangements to provide a sound basis for securing delivery of our objectives. This will continue to be a key area of focus for the Trust's leadership team throughout 2018/19.
Signed (on behalf of the Trust Board)

Ann James, Chief Executive


Marc Walsh It was really busy with people contastantly com
the door but standards didn't drop. Everyone on duty was very
professional in dealing with everyone's various needs, nurses would
pass me and constantly ask if I was ok or needed anything. Natalie in
particular had a great sense of humour and banter with me despite
being busy and it made my time in the hospital pass quickly. All the
stretched staff were amazing and a credit to the hospital so I just
wanted to say so, to kind of give something back for the amazing job
they do! Everyone's quick to moan about hospitals but the nurses don't
get the credit they deserve. I would really appreciate it if you could pass
on my words to them. They are fantastic
Emma Penter reviewed Plymouth Hospitals NHS Trust –
30 March at 18:14 ·
Just wanted to say a huge shout out of thanks to all the staff at Derriford
(particularly the fracture clinic & x-ray departments but also A&E and the
wards) we've been up there a lot recently with my son who fractured his arm
badly, involving an operation and an overnight stay, 2 plaster casts and 2
additional x rays after. And EVERY member of staff we have encountered
has been kind, caring and gone out of there way to make my 6 yr old son
feel special. He found the whole experience really positive (when it could
have been quite scary and traumatic times) all because of the people he
encountered who reassured and nurtured him.
I was also up and down to Derriford lots due to pregnancy complications
last year and again was only ever treated with kindness, respect,
professionalism and empathy.
Our NHS staff are truly wonderful, wonderful people. So thank you Derriford
staff. You are true superheroes, every one of you x

Remuneration Report

Not subject to audit

The remuneration of the Trust's Executive Directors is overseen by a committee of the Trust Board, known as the Remuneration Committee. The Committee is comprised of Non-Executive Directors. They are guided by the Department of Health's advice on pay for very senior NHS managers who are not part of the Agenda for Change terms and conditions of employment. All Executive Directors are appraised by the Chief Executive, who is herself appraised by the Chairman, and appraisal documentation is provided to the Remuneration Committee. Executive Directors are employed on substantive Trust contracts. The remuneration of Non-Executive Directors is established by the Trust Development Authority and all are subject to appraisal.

Subject to audit

Salaries and allowances

2017/8	Salary for duties as a director or senior manager (bands of £5,000)	Salary for duties other than as a director or senior manager (bands of £5,000)	Expense payments (taxable) total to nearest £100	Salary sacrifice arrangements total to nearest £100	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£000	£	£	£000	£000
Richard Crompton, Chairman	35-40		5,000			40-45
Michael Leece, Non-Executive Director	5-10					5-10
Elizabeth Raikes, Non-Executive Director	5-10		500			5-10
Henry Warren, Associate Non-Executive Director	5-10					5-10
Giles Charnaud, Non-Executive Director	5-10					5-10
Estelle Thistleton, Non-Executive Director	5-10					5-10
Jacky Hayden, Non-Executive Director	5-10					5-10
Liz Kay, Associate Non-Executive Director (see note 3)	5-10					5-10
Ann James, Chief Executive	185-190		300	500	20-22.5	205-210
Kevin Baber, Chief Operating Officer	140-145		200	500		140-145
Greg Dix, Director of Nursing	140-145		300	500	117.5-120	260-265
Neil Kemsley, Director of Finance	135-140			5,000	20-22.5	160-165
Steven Keith, Director of People	120-125				22.5-25	145-150
Nick Thomas, Deputy Chief Executive and Director of Planning & Site Services	115-120			500	5-7.5	120-125
Phil Hughes, Medical Director	110-115	75-80		500		190-195
Phill Mantay, Director of Transformation (see note 4)	85-90			5,200	10-12.5	100-105
Lee Budge, Director of Corporate Business	80-85			600	22.5-25	105-110

2016/7	Salary for duties as a director or senior manager (bands of £5,000)	Salary for duties other than as a director or senior manager (bands of £5,000)	Expense payments (taxable) total to nearest £100	Salary sacrifice arrangements total to nearest £100	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
Richard Crompton, Chairman	30-35		5,300			35-40
Terence Lewis, Non-Executive Director (see note 1)	0-5					0-5
Michael Leece, Non-Executive Director	5-10					5-10
Elizabeth Raikes, Non-Executive Director	5-10		1,600			5-10
Henry Warren, Associate Non-Executive Director	5-10					5-10
Michael Williams, Non-Executive Director (see note 1)	0-5					0-5
Giles Charnaud, Non-Executive Director (see note 2)	0-5					0-5
Estelle Thistleton, Non-Executive Director (see note 2)	0-5					0-5
Jacky Hayden, Non-Executive Director (see note 2)	0-5					0-5
Liz Kay, Associate Non-Executive Director (see notes 2 and 3)	0-5					0-5
Ann James, Chief Executive	185-190		100	500	47.5-50	235-240
Phill Mantay, Director of Transformation	105-110			4,300	35-37.5	145-150
Neil Kemsley, Director of Finance	135-140			4,900	75-77.5	215-220
Phil Hughes, Medical Director	115-120	65-70	600	500		185-190
Kevin Baber, Director of Operations	140-145		100	700		140-145
Steven Keith, Director of People	125-130				55-57.5	180-185
Nick Thomas, Deputy Chief Executive and Director of Planning & Site Services	115-120		100	500	60-62.5	180-185
Lee Budge, Director of Corporate Business	90-95			6,100	22.5-25	120-125
Greg Dix, Director of Nursing	125-130		100	500	25-27.5	150-155

Notes

1. Term of office completed 24 September 2016
2. Appointed 1 October 2016
3. The services of this non-executive director are provided by the University of Plymouth who invoice the Trust accordingly.
4. Note covers period to 28 January 2018 only; on secondment to another organisation from 29 January 2018
5. Salary for duties as director includes only that proportion of remuneration relating to non clinical duties as a director or senior manager of the Trust. All remuneration for clinical work undertaken during the period is disclosed as other remuneration .
6. Pension related benefits are shown net of pension contributions made by the director or senior manager during the period.
7. Expenses payments relate to the taxable part of the reimbursement of expenses such as travel and subsistence.

Name and title	Real increase in pension at retirement age (bands of £2500) £	Real increase in pension lump sum at retirement age (bands of £2500) £	Total accrued pension at retirement age at 31 March 2018 (bands of £5000) £	Lump sum at retirement age related to accrued pension at 31 March 2018 (bands of £5000) £	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
Ann James, Chief Executive (see note 2)	1-2,500	1-2,500	55,000-60,000	150,000-155,000	1,066	1,009	47
Phil Hughes, Medical Director (see note 1)							
Kevin Baber, Chief Operating Officer (see note 1)							
Greg Dix, Director of Nursing	5,000-7,500	10,000-12,500	30,000-35,000	80,000-85,000	531	410	117
Nick Thomas, Director of Planning & Site Services	1-2,500	2,500-5,000	45,000-50,000	145,000-150,000	1,031	949	72
Lee Budge, Director of Governance (see note 3)	1-2,500	0	10,000-15,000	0	128	102	25
Neil Kemsley, Director of Finance	1-2,500	0	45,000-50,000	120,000-125,000	861	786	67
Steven Keith, Director of People	1-2,500	0	30,000-35,000	80,000-85,000	563	506	52
Phill Mantay, Director of Transformation	1-2,500	0	20,000-25,000	50,000-55,000	285	255	28

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

The Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period,

Notes
1. Opted out of the NHS pension scheme
2. Opted out of the NHS pension scheme from 1 August 2017
3. No lump sum shown for members of the 2008 scheme

Fair Pay

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in the organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the post of Chief Executive, the highest paid director when payments for clinical work are excluded, was £186,850 (2016-17 £186,850.) This was 7.0 times (2016-2017 7.1) the median banded remuneration of the workforce, which was £26,614 (2016-17 £26,350.) The range of banded remuneration was from £6,844 to £186,850 (2016-17 £6,648 to £186,850.)

In 2017-18 twenty employees (2016-17 sixteen) received total remuneration in excess of the Chief Executive's, with total remuneration ranging from £188,541 - £249,855 (2016-2017 range £187,756 - £353,568.)

Total remuneration includes salary, non-consolidated performance related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Off Payroll Engagements

Off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months

	Number
Number of existing engagements as of 31 March 2018	2
Of which the number that have existed	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	1
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	0

All new off-payroll engagements between 1 April 2017 and 31 March 2018, for more than £245 and that last longer than six months

	Number
Number of new engagements, or those that reached six months duration between 1 April 2017 and 31 March 2018	2
Of which	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	2
Of which	
Number engaged directly (via PSC contracted to the Trust)	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

None of the off-payroll engagements related to a board members or senior officers with significant financial responsibility.

20 individuals have been deemed “board members and/ or senior officers with significant financial responsibility” during the year.

Sickness absence data

Trusts are required to disclose the total number of full time equivalent staff years, total days lost (adjusted to the Cabinet Office measure), and a calculated average absences per staff year. The following figures relate to the calendar year 2017.

	2017 Number	2016 Number
Total Days Lost	57,788	54,363
Total Staff Years	6,124	5,888
Average working Days Lost	9	9

Exit packages

There were no exit packages during the year

Analysis of staff costs

	Total	Permanently employed	Other
	£000	£000	£000
Salaries and wages	233,820	232,276	1,544
Social security costs	23,403	23,403	0
Apprenticeship levy	1,136	1,136	0
Pension cost - employer contributions to NHS pension scheme	27,564	27,564	0
Temporary staff - external bank	8,991		8,991
Temporary staff - agency/contract staff	8,030		8,030
TOTAL GROSS STAFF COSTS	302,944	284,379	18,565
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	(261)	(261)	0
Recoveries from other bodies in respect of staff cost netted off expenditure	(830)	(830)	0
TOTAL STAFF COSTS	301,853	283,288	18,565
Included within:			
Costs capitalised as part of assets	2,152	2,050	102
Operating expenditure analysed as:			
Employee expenses - staff & executive directors	296,090	277,627	18,463
Research & development	3,146	3,146	0
Education and training	444	444	0
Early retirements	21	21	0
Total employee benefits excl. capitalised costs	299,701	281,238	18,463

Average Staff Numbers

	Total	Permanently employed	Other
Medical and dental	942	924	18
Ambulance staff	2	2	
Administration and estates	1,410	1,368	42
Healthcare assistants and other support staff	1,083	965	118
Nursing, midwifery and health visiting staff	1,889	1,733	156
Nursing, midwifery and health visiting learners	2	2	
Scientific, therapeutic and technical staff	1,155	1,144	11
Other	8	8	
Total average numbers	6,491	6,146	345
Of which:			
Number of employees (WTE) engaged on capital projects	54	52	2

Expenditure on consultancy in 2017/18 was £603,000 (2016/17 £189,000.)

PROUD!

Dozens of trainees started an exciting new pilot programme in hospitals and care homes across Devon in summer 2017, training in a new role to become Nursing Associates. Devon was selected as one of 11 pilot sites nationally and the only one in the south to develop the role. The Nursing Associate position is a new role alongside existing others, which is designed to bridge the gap between health and care support workers, who have a care certificate, and graduate registered nurses and offers opportunities for health care assistants to progress into nursing roles.

Nursing Associate Trainee Leanne Richards said: “The role provides a fantastic opportunity to progress in my career by completing my studies at the same time as earning my regular salary. My ultimate goal is to qualify as a registered nurse and this could be the ideal route to achieving the career I have long aspired to. The training itself is proving to be both stimulating and challenging. It requires absolute commitment to full time work, college days and self- study but the feeling of achievement when you manage to juggle all three is well worth it. I have already acquired so many new practical skills whilst on my first placement, gained a much wider knowledge of different elements of healthcare practice and appreciated a new level of responsibility.

“I would be lying if I said it was easy, but so far I’m feeling increasingly positive that the introduction of the Nursing Associate role is a step in the right direction in providing quality patient care.”

Our People

#1BigTeam

Last year we set out Our People Vision, and this year we have worked hard building on the foundations and developing a safe, supported and enjoyable space for our staff to work and our patients to be treated.

The outstanding care our patients receive is down to the dedication of our staff, their knowledge, their kindness and commitment - to our patients and our Trust.

Our People Vision
We aspire to being an outstanding hospital and a preferred employer for talented people. To do this we need to create and sustain a culture in which our staff feel genuinely engaged and fulfilled at work, and motivated to not only deliver great care, but to identify and pursue continued improvements, now and for the future.

How does it feel to work with us?
As an employer of choice we actively seek to understand how our staff feel working in the Trust. We encourage open conversations, at all levels, about what people enjoy most about coming to work, what could we do more of across the organisation and what ideas do staff have to make the working environment that bit better; knowing this help us to make the right changes, changes that staff will have suggested, driven and together implemented.

We use a number of engagement activities with associated measures to gauge how our workforce feel; for more information on 'Staff Feedback' please see page 104.

We know that our staff have good solutions to problems; getting their ideas heard is very important but it is not always clear to staff how they can do this. We are continually working on raising the profile of opportunities for staff to have their voice heard through ways such as Your Voice, Big Conversations and Fab Change Week. These all support the opportunity for practical and compassionate changes as a result of feedback.

We heard from some staff that they wanted to feel more connected to patients, to understand how their role makes a difference to patient pathways. A staff volunteer programme, thought-up by our staff council, Your Voice, has been launched. This programme aims to bring non-clinical and clinical colleagues working closely together, with patients being at the heart of the scheme, a positive and engaging partnership. It is an open and inclusive opportunity available to all Trust employees.

We believe that this scheme will benefit our patients and their families from the moment they walk through the main entrance greeted by our Hospital Guides, to the simple and genuine companionship offered through the time taken to talk, read or do a jig-saw puzzle, with our Healthcare of the Elderly staff volunteers.

Celebrating the diversity of our people
We are committed to recognising and valuing the diversity of our staff and ensuring they feel that our

processes and support for them is fair and equitable. As part of this, we undertook a self-assessment against the goals of the national Equality Delivery System. As part of the assessment we held a patient focus group to look at how fair and accessible our services are and feedback from this was generally very positive. The assessment identified areas of focus that will be supported by the work of the Leadership, Improvement, Culture and Engagement Steering Group, which has oversight of our equality, diversity and inclusion work, within the framework of our Equality and Diversity Policy.

Our policy sets out our commitment to support all protected characteristics fairly and consistently. We have processes to support those with disabilities, for example the provision of reasonable adjustments in the workplace, in order that staff can fulfil their potential in the workforce. The policy encompasses not only how we support our staff but also how we recruit, promote and train them as well and we actively measure these activities in relation to all of the protected characteristics including disability. This gives us both assurance that we are delivering what we need to across the wide spectrum of our workforce but also enabling us to identify areas that require intervention or further understanding. We continue to work with Project Search, to provide internships to young people with Learning Disabilities. This work is in partnership with City College Plymouth, Pluss and Serco, who also provide work placements

Staff numbers by Staff Group,
figure as of 31st March 2018

Scientific and Technical Staff (inc ODPs)	241.65
Healthcare Assistants and Clinical Helpers	1211.00
Administrative and Clerical Staff	1351.44
Allied Health Professionals and Therapists	351.70
Estates and Ancillary Staff	144.16
Healthcare Scientists	247.19
Medical and Dental Staff	901.49
Nursing and Midwifery	1738.93
Total (wte)	**6187.58**
Total Headcount	**7021**
Annual Turnover	10.3%
Annual Sickness Absence	4.28%

Staff numbers by gender

Gender	Board	Senior Manager	Other	Grand Total
Female	5	110	5185	5300
Male	11	68	1642	1721
Total	16	178	6827	7021

Table showing number of new staff recruited over the financial year (by staff group)

Staff Group	Total
Add Prof Scientific and Technic	38.75
Additional Clinical Services	213.73
Administrative and Clerical	176.92
Allied Health Professionals	67.39
Estates and Ancillary	8.49
Healthcare Scientists	24.70
Medical and Dental	309.03
Nursing and Midwifery Registered	250.64
Grand Total	1089.64

PROUD!

Patients Norman Bosworth and Leslie Stuart enjoyed a game of bingo on Monkswell Ward in the build-up to Christmas, thanks to the efforts of Healthcare Assistant Stevie Spence.

Stevie organised the bingo cards, insisted on buying the Christmas hamper prizes from her own money and then came in on her day off to run the activity – all to make sure patients on the ward she works on are kept happy and active.

Les and Norman thought it was great fun, although Norman complained that Les kept winning!

Stevie said: “It’s no trouble at all. I like to do it. I love to see the patients enjoying themselves.”

Matron Juliette Richardson thinks Stevie is a star.

We’d be inclined to differ slightly and we hope you’ll agree... this is what a real Christmas angel looks like.

The Trade Union (Facility Time Publication Requirements) Regulations 2017

Under the Trade Union (Facility Time Publication Requirements) Regulations 2017, the Trust is required to publish within its Annual Report, the questions and information below in relation to trade union facility time.

Table 1 - Relevant union officials
What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
59	53.71

Table 2 - Percentage of time spent on facility time
How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	13
1-50%	45
51%-99%	0
100%	1

Table 3 - Percentage of pay bill spent on facility time
Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

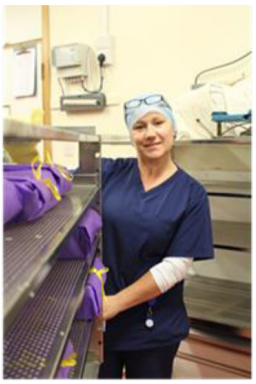
First column	Figures
Provide the total cost of facility time	£121,307
Provide the total pay bill	£278,378,383
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.04%

Table 4 - Paid trade union activities
As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	3.75%

Quality Account 2017/18

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Chief Executive's Statement

It gives me great pleasure to present Plymouth Hospitals NHS Trust's annual Quality Account, representing our report on the quality of services we provided in 2017/18 and our key priorities for improvement in 2018/19.

The pressures facing the NHS continue to be the subject of a considerable amount of political, media and public interest. Whilst the Care Quality Commission's Annual State of Care report for 2016/17 showed that the quality of health and social care was being maintained, it is important to remember that the challenges facing our health and social care system can have a very real impact on people's lives both in terms of those who are in need of our care and those who provide it.

We have much to be proud of in the care that we provide and what has been achieved in 2017/18. Despite the challenges posed by increasing demands on our services, we have managed to make substantial progress in a number of critical areas including:

- Securing a clear and unified commitment to integrating health and social care services in Plymouth for the benefit of the people we serve
- Securing significant additional funds for capital investment including a £26 million investment that will create four new interventional radiology theatres at the heart of Derriford Hospital
- A successful bid to be part of NHSI's Lean Programme which will create a common approach language of improvement to support closer working and better outcomes for patients
- Delivering a significant improvement in our financial position providing us with a stronger foundation from which we can provide sustainable services to our patients
- Receiving ministerial approval to change our name to University Hospitals Plymouth NHS Trust from 1 April 2018. Supported by staff and partners and the public, this recognises and cements our status as an organisation involved with teaching, education and research

We also continued to make progress in providing a rewarding and supportive environment in which to work with the results of the National Staff Survey showing further improvements since last year.

We do, however, recognise that we still have plenty to do, particularly in light of the extraordinarily challenging environment in which people are working. We are liaising with trade unions to agree the key issues which we need to focus on, and as we have committed to previously, we will commence our 'Big Conversation' Programme to work with staff to identify the improvement actions we need to take.

Given that the National Health Service will be 70 years old on 5th July 2018, it is the perfect opportunity to celebrate the achievements of one of the nation's most loved institutions which has delivered huge medical advances and improvements to public health. It has also pioneered new treatments like the world's first liver, heart and lung transplant.

However, none of this would be possible without the skill, dedication and compassion of our staff and volunteers who continue to do very special things 24 hours a day, 7 days a week and 365 days a year. As part of our #NHS70 celebrations, Plymouth Hospitals NHS Trust and Livewell South West will be coming together for a special award ceremony in June 2018. The #NHS70 Pride of Plymouth Awards are about recognising a selection of the many, many excellent people we have delivering NHS services in Plymouth.

In the meantime, we would like to express our deepest gratitude to all of our staff and volunteers for their continued dedication and incredible compassion at such a challenging time.

I am therefore pleased to present our annual Quality Account for 2017/18, which I believe to be a fair and accurate report of our quality and standards of care.

Ann James
Chief Executive

Review of 2017/18

Our commitment to quality
Our vision is to provide excellent care, with compassion, wrapped around people's individual needs to the population of Plymouth and surrounding areas. We are committed to placing quality at the heart of everything we do ensuring that we build quality into all parts of our service and rigorously focus on its delivery.

In terms of our more specific priorities for 2018/19, we have completed a consultation process with patients, staff and other key stakeholders to identify key areas of focus for the coming year.

A number of key documents were considered when selecting the draft priorities including the Board Assurance Framework, Sign Up for Safety, Quality Improvement Strategy, CQC and NHSI areas of focus.

We do many amazing things yet sometimes we do not always achieve the high standards we aspire to. We deliver highly complex, specialist treatment every day but we do not always get the simple things right. We are passionate about continuously improving the quality and safety of care provided to our patients.

Towards the end of the year we have sought to finalise our strategic direction to improving the quality of care delivery. Our key aims focus on people, quality, sustainability, partnerships and impact, these are set out in the diagram below.

Our aim is to be a safe and highly effective hospital which is highly rated by our patients and one in which staff are happy to work. In achieving this, we seek to constantly improve our services, shaped by what our patients tell us, and be quick to respond to problems and fix underlying causes.

We are committed to delivering safe, caring, effective, responsive and well-led services as this means that our patients will be treated with care, compassion, dignity and respect in addition to receiving high quality clinical care that is personal to each individual's needs.

Building Capability
Plymouth Hospitals and Livewell Southwest have taken further steps to improve patient care, support closer working and provide better outcomes for patients.

Following an application and assessment by NHS Improvement, the two organisations have been selected to be part of the first 'Lean' programme delivered by NHS Improvement.

The three-year programme will support the delivery of a lean management system which will see both organisations working towards a shared goal of continuous improvement. The programme will support the improvement of services through better system working, more sustainable services and streamlining coordination of care.

This programme will build on our strong existing quality improvement work which aims to implement ideas from staff who work in wards, theatres, patients' homes, community clinics, admin and non-clinical areas, and also from patients and service users to ensure the delivery of health care which is safe, effective, patient-centred, efficient and equitable.

Care Quality Commission

The Care Quality Commission (CQC) is the organisation which regulates and inspects health and social care services in England. All NHS hospitals are required to be registered with the CQC in order to provide services and are required to maintain specified fundamental standards of quality and safety in order to retain their registration. As part of its role the CQC is required to monitor the quality of services provided across the NHS to make sure that they provide people with safe, effective, compassionate, high-quality care and to take action where standards fall short of the fundamental standards. Their assessment of quality is based on a range of diverse sources of information about each Trust in addition to their own observations during periodic, planned and unannounced inspections.

The Trust has registered its locations against the relevant regulated activities with the Care Quality Commission with no additional conditions applied to its registration.

No enforcement action was taken against the Trust during 2017/18 and the Trust was not the subject of a responsive inspection.

Planned Inspection

The Trust was the subject of a planned CQC inspection in July-August 2016 as a follow up to the comprehensive inspection that was carried out in April 2015. During this inspection we were rated as 'Requires Improvement' overall. The Quality Report published following the inspection detailed a number of Requirement Notices. A Requirement Notice is issued where:

- The provider is acting in breach of the regulations; the impact on people using the service is not immediately significant; and the CQC assess that the provider should be able to improve its standards within a reasonable timeframe
- The provider has no history of poor performance that gives rise to wider concerns

93% of the actions designed to address the Requirement Notices are now complete. Monthly updates on the implementation of our actions and ongoing programmes of work to address the issues raised by the CQC have been provided to the CQC, NEW Devon Clinical Commissioning Group and NHS Improvement.

The significant ongoing open actions relate to delivery of the four-hour Emergency Department performance standard and reduction of waiting times and delays for an outpatient appointment.

Core sevice	The CQC found that:	What are we doing to put this right?
Responsive Care		
Urgent and Emergency Services	Improvement was required in delivery of the four-hour performance standard.	• Operationally the breach data is now reviewed daily by a senior executive and departmental members for learning / action purposes with an increased focus on a whole organisation approach to enhance flow in a steady sustainable manner. • The Acute Assessment Unit continues to try to recruit advanced nurse practitioners to facilitate increased access to our ambulatory pathways and in addition increase our acute physician consultant numbers to extend the opening hours and deliver a 7 day service as part of our plans for 2018/19. • A project board is now in place and terms of reference agreed to develop an outline business case for the redesign of the Emergency Department, proceeding to a full business case for approval in 2018/19.
Outpatients and Diagnostic Imaging	Improvements were required in the reduction of waiting times and delays for an outpatient appointment.	• Ophthalmology accounts for c.46% of the overall time critical backlog. The service has therefore developed a detailed action plan and trajectory to focus on reducing the backlog numbers. • The managed discharge process continues to be implemented in some service lines to remove long wait patients from the waiting lists where clinically appropriate to do so in conjunction with GP practices to ensure continuity in care management. • A range of improvement activities related to closer working with primary care / community providers and innovation with the use of alternative methods to a face to face appointment are being developed. This will give scope to create additional capacity for time critical patients as some non-time critical patients will be managed in a different way to how they are currently. • A series of meetings are underway with the service lines where there are high numbers of time critical patients, to discuss the challenges and explore opportunities for booking these patients. • Developing plans with the high volume service lines for developing alternative approaches to follow up care, e.g. Patient Initiated Care. • Following a meeting at the end of February NHS Improvement has offered the Trust support in exploring alternative methods of good practice to reduce the follow up backlog. • Reviewing any incidents related to the follow up backlog.

Plymouth System Review
The CQC undertook a review of the Plymouth health and social care system in December 2017. The review looked at how hospitals, community health services, GP practices, care homes and homecare agencies work together to provide care for those aged 65 and over.

Overall the report was positive and recognised good relationships between leaders of health and social care services, a shared commitment to improving services and recognition from the inspectors that "Plymouth is on a journey to integration. There was a compelling vision for integration within Plymouth, developed in collaboration with system partners and local people and linked to the Devon STP. There was a shared ambition among system leaders to progress with vertical integration of service delivery to include primary care, community, acute and social care."

The inspectors recognised the particular pressures that staff at Derriford Hospital face. Their report supports our vision of vertical integration with Livewell Southwest as a way to ensure that we can offer local people the best possible health and social care services.

The report also identified many challenges, including people having varied experiences of services – some excellent and some poor. In their feedback the inspectors identified an over-reliance on bed-based care and highlighted that a shift is needed to keeping people well in their own homes. These are issues that we have identified and are working jointly to solve.

Our challenge is to translate our compelling vision into frontline practice. We are committed to working to deliver the best possible care for local people all of the time, through integrated provision. We have to support our staff in being able to do this, but this report confirms that as a system, we have a vision and shared ambition to go forward.

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Inspection
In November 2017 the Trust was subject to a specialist inspection of our compliance with the Ionising Radiation (Medical Exposure) Regulations. The final report identified a number of areas where compliance with IR(ME)R required improvement. An action plan has been developed in response to these findings and has been submitted to the CQC's IR(ME)R Inspection Manager who is satisfied with the action plan and will continue to liaise with the Trust to monitor progress in delivery of the actions.

We continue to monitor compliance across all of the fundamental standards. We are on a journey of continuous improvement and we continue to monitor, review and constantly improve the quality of care across the services that we provide.

Our overall performance in 2017/18
The average number of daily attendances to our Emergency Department continues to increase. In March 2018, there was a daily average of 269 attendances. Furthermore, patients who arrive at our Emergency Department are more acutely unwell, with over 23.3% of patients triaged in the highest two categories in March 2018, this equates to 64 patients per day.

To help improve the flow through our emergency services we opened the new Acute Assessment Unit in November 2017.

The level of operational pressure has resulted in a significant increase in elective cancellations throughout 2017/18. An increase in medical outliers and a delayed discharge position which remains poor has added to the level of challenge.

Throughout this time we saw more patients attend and be admitted as emergencies. This meant we did not have beds available for those patients coming in for planned operations, with a particular lack of critical care beds resulting in the cancellation of planned surgery.

Between April 2017 and the end of March 2018 the following cancellations occurred:

- 1925 on the day cancellations for hospital reasons (equating to 3.24% over the year)
- 275 not rebooked within 28-days as per national standard
- 6422 cancellations between 0-7 days before planned treatment (the 1925 are a subset of these)

We tried to give patients and their families as much notice as possible when cancelling their surgery and did everything we could to discharge people as quickly and safely as possible.

The core quality metrics we have used and reported throughout 2017/18 are shown in Annex A.

Review of Services
During 2017/18, Plymouth Hospitals NHS Trust continued to provide (or sub contract) 64 NHS services. The Trust has reviewed all data available on quality of care in all these NHS services.

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

Goals agreed with Commissioners
An element of Plymouth Hospitals NHS Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. The Trust received the majority of CQUIN funding in 2017/18 on the basis of high levels of achievement of milestones. Under the 2 year contract, most schemes will continue into 2018/19 except for two, as dictated by CQUIN guidance. Further information on CQUINs can be found on the NHS England website, which included below.
www.england.nhs.uk/nhs-standard-contract/cquin/

Assurance Statements
Underpinning quality in the organisation we have a series of assurance statements, a summary of each is set out below, with further details included within Annex C Assurance Statements.

- Clinical Coding: This is the process by which patient diagnoses, treatments and comorbidities recorded in the patient's written clinical notes and on accompanying systems are translated into codes using a set standardised code-set. The accuracy of this clinical coding is a fundamental indicator of the accuracy of patient records and drives the income received for that patient's stay in addition to feeding the data through to numerous national indicators including mortality
- Data Quality: Clinicians and managers need ready access to accurate and comprehensive data to support the delivery of high quality care. Improving the quality and reliability of information is therefore a fundamental component of quality improvement
- Duty of Candour: The Trust ensures Duty of Candour requirements are implemented following any 'moderate harm' or above graded incident once it has occurred. Where a patient safety incident has caused harm, an apology is offered to the relevant person, which is a sincere expression of sorrow or regret for any possible harm and distress caused
- Revalidation: Medical & Nursing - Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice in their chosen field and able to provide a good level of care. Nursing and midwifery revalidation also requires all Nursing & Midwifery Council registrants to revalidate every 3 years in order to maintain their registration

Clinical Audit
Clinical audit provides a means of measuring how well care is being provided compared to expectations of good practice. It underpins several quality improvement areas for the Trust, particularly:
- Demonstrating clinical governance
- Promoting and enabling best practice
- Improving patient experience and outcomes
- Facilitating corporate learning
- Encouraging staff development
- Provides a platform for ongoing quality improvement

The Trust has a yearly programme of clinical audits which are categorised into the following priorities:

Priority 1 - External must do (national audit)
Priority 2 - Corporate must do (for example clinical record keeping audits)
Priority 3 - Service Line must do (for example compliance with NICE guidance)
Priority 4 - Specialist Interest

During 2017/18 the Trust participated in 98% of open, relevant national audits as defined by Healthcare Quality Improvement Partnership (HQIP). These audits are detailed in Annex D.

During 2017/18 hospitals were eligible to enter data for five National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies. Plymouth Hospitals NHS Trust submitted data for four studies which are detailed in Annex D.

In 2017/18 we also completed 33 planned 'Priority 2' audits including clinical record keeping audit and Ionising Radiation (Medical Exposure) Regulation (IRMER), 38 'Priority 3' audits, 67 'Priority 4' audits and 34 Service Evaluations. A number of improvements have been made as a result of these audits. Examples of audits and the associated improvements are summarised in Annex E.

Follow-up Backlogs

Patients often require a 'follow up' appointment with a healthcare professional following an initial consultation, operation or procedure. These appointments can include, for example, a discussion about test results, an assessment of how a patient is progressing in recovering from or living with a disease, how a patient is responding to a drug therapy treatment or how they are progressing following surgery. Additionally patients will receive follow up care from therapies such as physiotherapy, speech and language therapy, occupational therapy and dietetics.

Despite the fact the hospital completed around 400,000 follow up consultations in 2017-18 there were still a large number of patients who did not receive their follow up appointment by the date the healthcare professional indicated would be appropriate. This is important to both the patient and the hospital due to any associated clinical risk with having an appointment later than originally deemed appropriate and it also represents a commitment made to the patient that has not been met by the hospital.

At the end of March 2018 the number of patients who had not received their appointment by the date indicated was 34,867. This is compared to 30,535 in March 2017. The Trust has an electronic system of flagging patients as being 'time critical' for the follow up appointment, with time critical indicating the patient may be at risk of harm if they wait longer to be seen than the date given. This allows for prioritisation of appointments to the highest risk patients.

The number of time critical patients who have waited past their see by date stands at 8,063 at the end of March 2018. The services that account for the largest number of patients are ophthalmology, neurology, gastroenterology, hepatology and rheumatology (together over 71% of the total). A combination of competing clinical priorities, including pressure to achieve waiting times for new patients and reduced clinic capacity (due to the need to increase ward rounds as a result of higher numbers of medical patients admitted to the hospital), means current practices need to be reviewed as a priority to eliminate the at risk backlog.

The number of ophthalmology patients in the higher risk categories has increased in the past 12 months, and accounts for 43% of the overall at risk numbers, due to the difficulties in securing and retaining consultant specialist roles. The service is the largest outpatient based service in the hospital and accounts for around 8.5% of total routine referrals. To manage the increased demand and to release capacity the service line has developed a comprehensive action plan to reduce the number of patients who have waited past their see by date.

Moving forward, services are working together with clinicians from both the community and the hospital to develop alternative ways of providing follow up care. Changes to the patient's pathway will provide follow up care in the most appropriate place for the patient, which may not be a hospital based appointment. We will also improve our clinical administration processes to support timely decision making around patient management and to prevent unnecessary delays in appointments.

Learning from Deaths

Background

The Care Quality Commission (CQC) published its report Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England in December 2016, which make recommendations about how the approach to learning from deaths could be standardised across the NHS. The Secretary of State accepted all these recommendations and asked the National Quality Board (NQB) to develop a framework for the NHS on identifying, reporting, investigating and learning from deaths in care. The NHS has a long tradition of learning from care provided to patients. The framework builds on that tradition but recognises that the NHS can do better particularly in relation to the care of vulnerable people.

The key findings of the CQC report were as follows:

- Families and carers are not treated consistently well when someone they care about dies
- There is variation and inconsistency in the way that trusts become aware of deaths in their care
- Trusts are inconsistent in the approach they use to determine when to investigate deaths.
- The quality of investigations into deaths is variable and generally poor
- There are no consistent frameworks that require boards to keep deaths in their care under review and share learning from these

The CQC's recommendations have been translated into seven national work streams. The Department of Health (DH) has set up Learning from Deaths Programme Board to support their implementation. Each work stream is led by the relevant healthcare body. The first step in this programme was the publication of the new Learning from Deaths framework in March 2017. In particular this identifies a need to focus on learning from the care provided to patients with learning disabilities and severe mental health needs who die in NHS care. Most of these deaths will occur in acute settings.

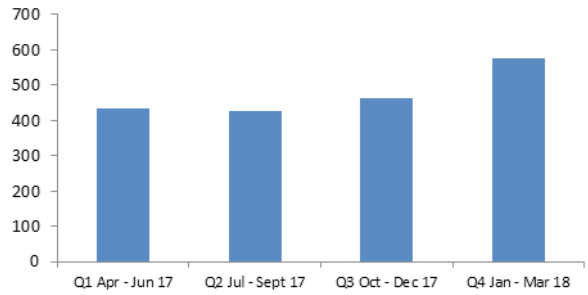
In March 2017, the National Quality Board introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

- By September 2017, publish an updated policy on how the Trust responds to and learns from the death of patients in its care and should publish on their website an updated policy on how they respond to and learn from the deaths of patients in their care.
- From Q3 2017 onwards, publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings including information on reviews of the care provided to those with severe mental health needs or learning disabilities
- From June 2018, publish an annual overview of this information in Quality Accounts, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year

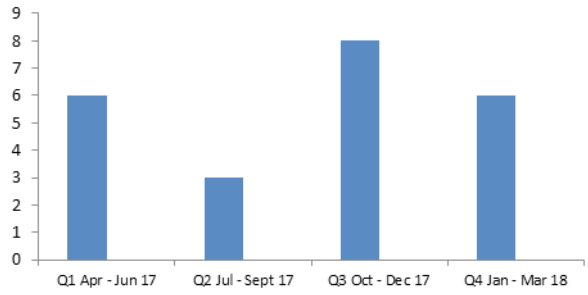
Our performance

The following section shows the indicators we are using to track hospital mortality. We remain committed to preventing avoidable deaths by monitoring mortality and learning lessons from unexpected deaths.

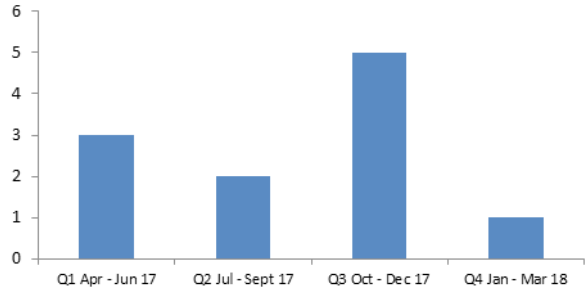
- Total number of in-patient deaths (including Emergency Department deaths for acute Trusts). There have been a total of 1898 inpatient deaths for the year April 1st 2017 – 31st March 2018 including patients who have died in the Emergency Department



- Of these deaths 23 have been subjected to case record review using the Royal College of Physicians Structured Judgement Review (SJR)
- Of the 23 that were subjected to a Structured Judgement Review (SJR) 11 have been completed



- From these reviews an estimate can be made of how many deaths were judged more likely than not to have been due to problems in care



Statement from the Royal College of Physicians

Our National Mortality Case Record Review (NMCRR) Programme has produced a Structured Judgement Review (SJR) tool to support the analysis of adult deaths in hospitals. However, we are very clear that the SJR does not allow the calculation of whether a death has a greater than 50% probability of being avoidable, and should not be used to compare trusts.

Quality Improvement Projects
Sepsis - Sepsis is a life threatening condition requiring early assessment, recognition and treatment using an agreed sepsis treatment plan
Handover - Following further work and listening to feedback, a joint nursing and medical handover form has been developed to support a more collaborative approach to handover also resulting in less duplication of clinical details
Falls - We know we can improve the way we assess the risk of a fall for a patient in our hospitals, and how we can reduce this risk. The work around reducing falls is focussed much more on planning specific care for the individual patient. As well as a general falls assessment a patient's individual needs will also be taken into consideration

Patient Feedback

Friends and Family Test Patients

Our Inpatient & Daycase results have remained steady throughout 2017/18, although Emergency Services has dropped slightly. All results are published monthly on the Trust website. Further detail is shown in Annex B Core Indicators.

% of patients recommending by month	Inpatient & Daycase	Emergency Services
April 2017	95.69%	91.56%
May 2017	95.42%	89.07%
June 2017	95.63%	93.75%
July 2017	95.85%	95.00%
August 2017	95.92%	94.79%
September 2017	96.24%	92.70%
October 2017	96.63%	92.96%
November 2017	96.48%	88.79%
December 2017	96.40%	82.62%
January 2018	96.14%	90.35%
February 2018	95.75%	94.74%
March 2018	95.79%	90.37%

Patient Reported Outcome Measures (PROMs)
A summary of our PROMs results in 2017/18 is shown in Annex B. PROMs are used to assess the quality of care delivered to patients from their perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using surveys from before and after the operation. The four procedures are hip replacements, knee replacements, groin hernia and varicose veins.

PROMs describe a patient's health status or health-related quality of life at a single point in time, and are collected through short questionnaires. The health status information is collected from patients before and after a procedure and provides an indication of the outcomes or quality of care delivered to our patients.

Participation rates have improved overall for varicose veins and groin hernia, but reduced slightly for hips and knee replacement. The latest figures at March 2018 are shown below:

Participation Rate Hernia	Participation Rate Hip	Participation Rate Knee	Participation Rate Vein
10%	48%	38%	86%

Seven Day Working
The aim of the 7 day standard is to end current variations in outcomes for patients admitted to hospital at the weekend. We have set up a 7 Day Working Project Group which oversee compliance with the four priority national standards.

- A working group has been established with a formal Terms of Reference and membership across Care Groups and the CCG
- NHS England have been providing support via their Southern Seven Day Leads and have been to PHNT for two site visits including meeting our Medical Director and have been given an overview of our non-elective pathways
- The Trust has been given a deadline to meet the four priority national standards by March 2020:
  Standard 2 – Time to first consultant review
  Standard 5 – Diagnostics
  Standard 6 – Intervention / key services
  Standard 8 – Ongoing services

The Trust regularly audits compliance of the 7 day standard. The next audit is due in late May with the reporting deadline in June 2018.

The Trust has met the additional requirement around having clearly defined pathways in place for the four “urgent network standards” including, emergency, vascular, major trauma and hyper-acute stroke patients.

Staff Feedback

Friends and Family Test Staff
The Friends and Family Test for staff was introduced in 2013 and alongside the national staff survey is a data source used to monitor staff satisfaction.

Staff are asked to respond to two recommender questions which seek to understand how staff feel about working for and the care the organisation gives. The opportunity to feedback is given to all staff at three opportunities a year.

Our performance is summarised in the table below:

Staff FF Question	2015/16	2016/17	2017/18
How likely are you to recommend Plymouth Hospitals NHS Trust to friends and family if they needed care or treatment?'	87.%	82%	75%*

**Quarter 2 data for 17/18*

Having a compassionate, skilful and dedicated workforce is central for delivering outstanding care to our patients. Every interaction between patients and staff, builds our reputation and helps deliver great care.

We are working hard at understanding the experience of our staff – both when things are going well and when things need to be improved. We embed the importance of quality improvement for all staff from the time they start in the Trust. Staff are encouraged to be involved in improvements within their team.

The HR & OD team have worked closely with colleagues across various teams throughout the Trust, including Service Improvement, Communications and the Learning from Excellence Team to build a culture that helps staff make changes through their ideas and feedback. The culture supports staff both to speak up if they have concerns and to celebrate the work and care that is going well.

National Staff Survey
The National Staff Survey gives us an annual report on how our staff feel about working in the organisation. In 2017 over 3600 of our staff gave us their feedback – the highest number of views we have ever received. This equates to 57% of our staff responding, putting our response rate into the highest 20% of acute trusts.

Nationally, the survey data evidences what has been a year of extreme pressure for NHS staff and it shows 21 out of 32 key findings worsening. Our data tells that despite experiencing the same pressures as in the national picture, our results have continued to improve across many areas. We have further reduced the number of areas where we were in the bottom 20% from 8 in 2016 to 2 in 2017. Our rate of improvement remains greater than the average of acute trusts.

Big Conversations
We continued our Big Conversation approach with staff begun in 2016 – again focusing on a small number of key areas for improvement. We again adopted an appreciative inquiry approach asking staff to tell us

about how things work when they are at their best. Over 700 staff participated in conversations focusing on the following areas:

- **Patient Care:** understanding how best to support staff with delivering the quality of care they aspire to deliver whilst recognising how their role makes a difference to our patients
- **Contributions to Improvement**: encouraging staff to get involved in making changes to improve things for their service or patients
- **Training and Development:** Understanding what good quality training is like for staff

It is exceptionally encouraging that all the areas of focus both from 2015 and 2016 have shown improvement in the 2017 results. All five of the areas of greatest improvement in staff experience have come from the areas we have concentrated on through the Big Conversations

Your Voice
Your Voice is the opportunity for all staff to take part in conversations with the senior leaders in our organisation.

This year we have taken **Your Voice** on tour, hosting over 20 conversations with the executive team (including a number with Ann James) with teams all across the Trust. Staff shared both what is going well and what they would like to see changed. Work is taking place with local leaders to help turn the ideas into action.

Valuing our staff and Learning from Excellence
Staff (and patients) in our Trust can say thank you via our 'Say Thank you and Help us Learn from Excellence' programme of work. The Learning from Excellence Team is made up of both clinicians and organisational development members and seeks to help ensure there is a mechanism to show staff they are valued and to capture the learning when things go well.

Staff who are nominated receive a card which details what they have done. During our 2016 Big Conversation, staff told us they wanted personal feedback from colleagues and patients that was personal to them and meaningful. Over 1000 cards have been sent (one third from patients). Learning from what has gone well is being spread positively across the Trust.

Freedom to Speak Up Guardian
We have three Freedom to Speak Up Guardians in the Trust. In their first year they have made an enormous impact on the culture of the organisation by positively encouraging staff to speak up when things are wrong. Feeling confident and secure in reporting unsafe clinical practice is the area of greatest improvement in terms of staff experience in the national survey scoring 3.60 in 2016 and 3.71 in 2017. We attribute this almost entirely to the excellent work the guardians have done.

Charlotte Burgoyne, Dr Jamie Read and Louise Shalders will continue working across all staff groups to raise awareness and report directly to the chief executive and the Trust Board.

Recruitment
Having the right staff with the right skills is a commitment that the Trust has given and is absolutely

paramount in the delivery of quality patient care. There remain national shortages in key staff groups and the persistence of certain hard to recruit to areas has led to alternative workforce models and the development of several new roles. Following the publication of the NHS Workforce Strategy and the size of the financial challenge over the short to medium term, the Trust will need to continue to adapt to both the new healthcare workforce landscape and continue to deliver significant efficiencies in order to maintain financial robustness.

Significant inroads have been made in the reduction of the Trust's reliance on temporary staffing. However temporary staffing across the Trust remains an issue and, whilst bank, agency and locum spend is necessary to maintain safe services, departments have developed new ways of working.

The past 12 months have seen a record-breaking number of nursing preceptees welcomed into the Trust. However, competition for preceptees in the short term will be fierce due to the number of students registering for higher education places and the market led model now being followed in terms of commissioning.

Progress against 2017/18 priorities

During 2017/18 we continued to focus on quality improvement. Our strategy has been to focus on key priorities for the organisation and to oversee these through the Quality Improvement Committee. We have continued to develop the capability of our staff within the organisation, enabling them to improve the quality of care they offer. We have continued to foster the links between hospitals and other organisations to work together to improve the quality of care to patients across the community.

Last year we identified three priority areas for improvement as follows, achievement against each of these priories is set out below:

- Priority 1: Staffing
- Priority 2: Reduce the number of patients who are cancelled
- Priority 3: Improve the quality & reliability of care

Priority 1: Staffing – Improve the patient experience by ensuring our wards and departments have the correct levels of staff with the appropriate skills

Background
Having the right nursing staff in the right place at the right time is a fundamental element to the delivery of safe, high quality care. Organisations must ensure the level of nursing staff, including registered nurses midwives and support staff, are correct for the acuity and dependency needs of our patients.

What we did well
We were one of 32 hospitals selected to work with Lord Carter and the Department of Health to consider collectively the challenges faced in nursing and midwifery staffing. The outcome of this work has been shared nationally and includes guidance on ensuring staff rosters are produced as efficiently as possible using an electronic system, the use of agency and temporary staffing and reviewing some nursing roles. The safer staffing return continues to be submitted monthly, with March 2018 showing a 86.20% fill rate. This information will continue to be submitted and inform our nursing dashboards and shared with matrons and senior nurses. A monthly staffing paper is produced and reported to our Nursing and Midwifery Operational Committee with the key performance indicators included from our ward dashboards and model hospital.

Patient acuity and dependency scores continue to be recorded in real time using the Safe Care System. This ensures we accurately match staffing levels to the patients in our care. This is calculated in the form of Care Hours per Patient Day and helps to inform the decision making when moving staff from one ward to another.

Nursing and midwifery staffing is monitored and reported monthly via NHS Choices and the Trust website. We publish our staffing levels for each shift on a poster at the entrance to our wards and have a poster in each bay stating the name of the nurse responsible for their care and the nurse in charge of each shift.

We introduced the new trainee nursing associate role as part of the multi-disciplinary workforce in January

2017. This role aims to bridge the gap between health support workers who have a qualification and graduate registered nurses. As part of the Devon wide Sustainable Transformational Programmes 69 trainee nursing associates were recruited, 17 of whom will be based at Derriford Hospital.

We recruited 4 whole time equivalent health care assistants to the nursing pool, who work flexibly across the hospital to cover absence and vacancies.

The E-rostering system enabled us to effectively redeploy nursing hours across the hospital.

All staffing information is now available in a format that allows us to compare the relationship between the care and experience our patients receive.

We introduced electronic auditing of our practice so we know exactly how well we are doing.

Daily feedback sessions through safety briefs was introduced in 2017 in our admission areas, this has now been extended to include theatres. The session provides an opportunity for our staff to be aware of times when we have not treated patients in a timely fashion and also to celebrate and learn from those occasions when we get it right.

The hospital website nursing and midwifery pages have now been launched and whilst we are still adding to the pages the website is much more user friendly, attractive and enables the user to access the current vacancies. The web pages include professional development and specialist areas for nurses to consider as a career.

We fully implemented the Care Hours per Patient Day guidance, which allows us to review the number of nursing hours needed to care for our patients safely.

What we need to work on

#GoldenTime was introduced in our inpatient ward areas in 2017. This provides an hour each day where matrons work alongside their clinical teams. Whilst maintaining this has been challenging due to operational pressures, the matrons remain committed to this project and have designed an evaluation form which is circulated to collect feedback and collate potential improvements for the future.

During recent months supervisory time for ward managers has on occasion been less frequent than we would wish. The Trust is committed to providing protected time to allow ward managers to undertake a supervisory role to provide oversight to all aspects of care on the ward.

Nursing Open Days are held every 2 months and at the most recent event 38 nurses were interviewed and 36 offered a position on the day. The recruitment team attended the national apprenticeship show in February and Skills South West have held a variety of presentations and group sessions at the local job centre. The Trust is now working with the Devon wide Proud to Care recruitment initiative and will be partnering with other care organisations across Devon to develop a stronger collective offering for people considering a career in health care.

Further guidance has been published from NHS England to support healthcare organisations ensure the correct staffing levels are achieved in maternity and neonatal care, learning disability services and the emergency department.

An annual nurse staffing establishment review was undertaken in May 2017 which found that whilst there are occasions where the wards are not staffed to the full establishment the ward numbers are set at the correct level.

Audits continue to show that the public perception is that the wards do not have enough nurses on duty. However further work needs to be done to understand the root cause of patients' perception of staffing levels.

We will be recruiting another 20 trainee nursing associates (TNAs) in September 2018 (Cohort 3).

Cohort 1 - has 17 trainee nursing associates, including 2 staff working jointly with University Hospital Plymouth and the Minor Injury Units. All 17 have successfully completed their first year of the programme which is a fantastic achievement. Their second year commenced January 2018 They continue to rotate 6 monthly through their clinical environments; it is hoped their final 2 months of the programme will be spent in the clinical area where they will be employed as a band 4 nursing associate from Jan 2019.

There will be further opportunity for some of the TNAs from Cohort 1 to apply to continue their Nurse training via the Apprenticeship route.

Cohort 2 – has 8 trainee nursing associates; these are mid-way through their first year and have just started their second rotation and progressing well.

Next steps
We recognise the importance of ensuring that we have the right staff, in the right place and at the right time, but in common with the wider NHS, the Trust continues to face significant workforce challenges. We continue to adopt innovative approaches to the recruitment of clinical staff but face challenges in recruiting staff in some key service areas. We are developing a stronger plan for addressing these issues on a sustainable basis

- Review shift patterns and flexible working policies for our staff to assure them that we continue to support and offer improved work life balance through flexible working which does not compromise a safe roster
- Plymouth Hospitals is working closely with the STP to look at how the nursing associate role can be effectively integrated into the existing nursing workforce
- Through the planned local workforce summit organised for April 2018 review the current workforce and its requirements and plan a programme of work towards securing the workforce of the future. This local strategy will take into account the NHSE publication "Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027" and review all nursing, medical and health professional roles
- Develop a Workforce Strategy which aligns the many streams of work currently underway across the organisation

Priority 2: Reduce the number of patients who are cancelled and ensure patients are able to access services within acceptable timeframes

Background

Patients have the right to expect timely care which is in line with best practice. The Trust has recently experienced difficulties with capacity which resulted in cancellations for patients and longer waits for treatment than we would like.

What we did well

We opened the Acute Assessment Unit (AAU) in November 2017. The new AAU deals with minor illness, ambulatory care as well as provide a dedicated pathway and space for patients with frailty.

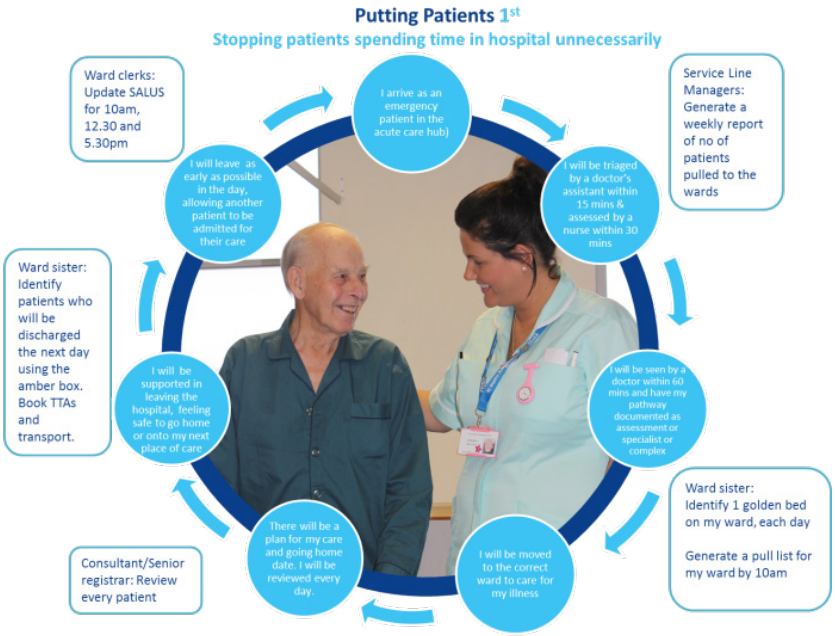
In November 2017, the process for referring complex discharge patients, reviewing patients for their care requirements post-discharge, and commencing discharge arrangements was changed.

The new process saw a centralised system adopted to review and assess patients for their discharge needs using a single Integrated Hospital Discharge Team nurse and social worker as a 'responder' each day, with the aim to ensure that all patients were reviewed for their discharge needs, and discharge planning commenced as soon as possible after the patient was referred and before medically fit for discharge.

Next steps

We need to continue to drive the delivery of the Putting Patients First Programme and work with health and social care partners to ensure there is a reduction in the overall numbers of beds used within the hospital in urgent care.

Through 'right sizing' the hospital we will remove inefficiencies and waste and more importantly reduce the daily frustration of clinicians and clinical management by enabling them to treat their patients without the pressures of operational pressures. There will be an unrelenting focus on reducing the average length of stay and ensuring we are able to stay within our safe staffing levels and bed base.



Priority 3: Improve the quality and reliability of the care we provide to our patients

Background
Untreated sepsis can progress to severe sepsis, multi-organ failure, septic shock and ultimately death. Septic shock has a 50% mortality rate. The mortality rate for sepsis in children is estimated to be 10 – 15%. It is the most common cause of direct maternal death and around 35,000 people die from sepsis in England each year.

There is a chance that if patients in hospital deteriorate they may not receive the necessary response in a timely fashion. This may cause patients to be more unwell, affect their treatment, increase length of stay and alter their views about their experience in hospital.

What we did well

Sepsis
The year has seen a focus on educating our staff and sharing the learning from our acute admission areas with those wards where the highest incidences of sepsis are likely.

Over the last 12 months it has become increasingly apparent that our focus in acute admission areas needs to continue on ensuring effective care delivery when the system is hard pressed.

The Trust is continuing to work on our electronic observations (e-obs) project which will be a key enabler to identify sepsis in patients.

Deteriorating Patients
We defined the high level metrics which provide assurance to the organisation that we are minimising risk to patients. The graphs below show cardiac arrest and medical emergencies per 1000 bed days.

We have a policy that sets out the minimum standards for patient observations and monitoring, which we regularly audit.

Scan4Safety
In January 2016, the Department of Health announced that Plymouth Hospitals NHS Trust had been selected to act as one of six sites across the UK to pilot a project called Scan4Safety.

Scan4Safety is a project that aims to increase patient safety, improve patient experience and to reduce operational costs by introducing GS1 standards.

How are GS1 standards making a difference in Plymouth?
Using barcodes will lead to safer patient care and improved processes by scanning patients and products in a more efficient way, saving time and reducing errors. These include product recall, catalogue management

and paying suppliers electronically.

What have we achieved in 2017/18?

There are three core elements we needed to implement in Plymouth Hospitals NHS Trust to lay down the foundations of Scan4Safety to identify every place, every product and every person.

- Location Coding (Place) - This is defined by a Global Location Number (GLN) being assigned to all locations across the Trust both physically and in the electronic property management system
- Catalogue Management (Product) – This is defined by a Global Trade Item Numbers (GTIN) being assigned to all products and services held within the product catalogue system
- Patient Identity (Person) – This is defined by all patients being identified by a Department of Health compliant Global Service Relationship Number (GSRN) wristband, which is associated with their patient records

The Trust has completed its initial implementation of Scan4Safety. All hospital areas are now identified using barcodes.

We have started the roll out of scanning patients and products starting within our orthopaedic and neurosurgery theatres.

Through collaboration with our workforce and suppliers, and other trusts on the Scan4Safety programme, we have a system that can help ensure that every product used in hospital is assigned to the right location, to the right patient, and is backed up by the right purchase orders and invoices. This will benefit Plymouth and the wider NHS as it delivers efficiencies that will help enhance the quality of care we can provide.

Sample mislabelling

A significant piece of work has been completed in the last year to reduce the number of errors as a consequence of samples being mislabelled. This work consisted of standardising the phlebotomy trolleys; 90 of these new standardised trolleys have been rolled out across the hospital.

Next steps

- Integrating Pharmacy services with our community colleagues
- Scan4Safety: the Trust is now working on plans to use the standards created for Product, Patient & Place (location) within new use cases and also implementing new standards. We hope to have more exciting news on the progress made with Scan4Safety next year
- Build on 2017 achievements in the management of sepsis
- Further reduction of pressure ulcers and falls by 10%

Celebrating Our Successes

Whilst we faced a number of key challenges in 2017/18 there is much to be proud of. During the year we improved the quality of our services in many areas; some of our key achievements are described below.

The Ten Commitments

The national 'leading change, adding value' framework for nursing, midwifery and care staff was launched in May 2016, by Professor Jane Cummings, Chief Nursing Officer for England. The strategy offered 10 commitments, which our matrons and heads of nursing adapted into 10 key improvement projects which built on our previous success with the 6 C's. The aim was to add value to a patient's care to achieve improved outcomes, a good patient experience and better use of resources. The commitments we made and the impact against each is described below:

Commitment 1
We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff.

Action: Matrons became flu vaccinators to support staff uptake

What we did: Matrons established mobile flu clinics by taking their trolleys to staff on wards and departments to encourage them to have their flu vaccinations. As a result we achieved the highest percentage of staff vaccinated in 2017/18.

MAMA Wellbeing Maternity wallets were recently introduced. The wallets display colourful, easy to understand key health information on both sides, to support women right through their pregnancy, which is why they will be given to them at their booking in appointment.

Health and wellbeing events were also set up for all staff groups.

Commitment 2
We will increase the visibility of nursing and midwifery leadership and input in prevention.

Action: Implementation of #GoldenTime and measuring the impact on our staff. #Goldentime is an initiative where our matrons allocate a protected hour every day to spend time on the wards talking to staff, patients and their relatives.

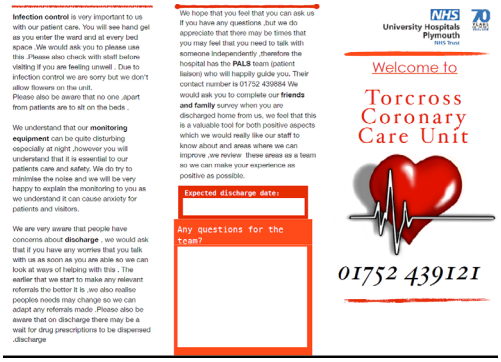
What we did: In July 2017 #GoldenTime was re-launched and now takes place between 12-1pm. Matrons undertake #GoldenTime on their own wards. The recent operational pressures have meant

maintaining this initiative has been particularly challenging. Matrons now focus on achieving consistent sessions, particularly in light of the work undertaken in NHS Fab Change Week in November 17 where the #KeepOnMoving programme was introduced.

Commitment 3
We will work with individuals, families and communities to equip them to make informed choices and manage their own health.

Action: Ensure patients are supported to make informed choices by increasing their knowledge regarding their medication on discharge.

What we did: In March 2018 our Cardiology Matron, Tim Parham undertook a piece of work on the cardiology wards to improve information given to patients at the point of discharge. Details for patients included information about discharge medications and who to contact should they have any queries after leaving the hospital. The effectiveness of this work will now be reviewed, assessing the benefits of further roll out across our wards.



Commitment 4
We will be centred on individuals experiencing high value care.

Action: Ensure high value care by achieving our hospital-acquired pressure ulcer and falls reduction plans

What we did: From April 2017 these areas were monitored through the hospital's Harm Free Group meeting which meets monthly, with an update to the Patient Experience Committee twice a year. Our Matron for Harm Free Care, Steve Shearman provides regular updates on progress through his harm free report. Catheter infections have also reduced through the last year.

Commitment 5
We will work in partnership with individuals, their families, carers and others important to them.

Action: Working in partnership to ensure 50% of our adult wards/departments meet the dementia friendly standards.

What we did: Following self-assessment against the dementia standards an improvement plan was developed addressing each of the key areas. In conjunction with local authority agencies, the Trust has introduced 'Dementia Friendly Status' awards. Fracture Clinic, Chestnut Unit, Clinical Decision Unit, and the four healthcare of elderly wards have all been successful and have been awarded 'Dementia Friendly status'. We continue to strive to ensure these standards are common place.

We reviewed our 'Getting to Know You' leaflet which helps staff to know a little more about our patients, and enables us to provide treatment with the privacy and dignity that they deserve.

Hundreds of staff from all areas of the hospital have undertaken Dementia Friends training; this will continue to be rolled out further.

The #letsbeopen campaign was introduced by former Matron Emma Wilkinson and following her departure, has been led by Matrons Judy Frame and Sue Timmins, supported by the Communications Team.

To support the change, a Visitors' Charter for adult inpatients was developed, outlining what we will do as staff and what we ask our visitors to do. The charter includes standards that we ask all of our visitors to respect, such as ensuring that no more than two people visit a patient at any one time, supporting and encouraging the patient during mealtimes, observing quiet times or being asked to leave for a short period of time, such as during doctors' rounds, etc

Commitment 6
We will actively respond to what matters most to our staff and colleagues.

Action: We will respond to the needs of our staff by ensuring they have a voice through our Staff Tea with Matron initiative.

What we did: Following the success of our Tea with Matron for patients, we introduced Tea with Staff, where staff are offered the opportunity to meet with matron. This also provides an opportunity to link patient and staff experience.

Matrons meeting with staff informally allows for real time feedback from those at the front line of patient care which is vital in ensuring the care we give is delivered effectively. This time allows members of our teams to talk openly about their day to day challenges.

The new Preceptor Council was introduced to provide our preceptees a safe place to voice their concerns and issues to senior members of staff, with an action plan put in place and a review date within 8 weeks. It provides joint leadership, support and development to our trainee nurses within University Hospital Plymouth.

We also took Your Voice on tour, hosting over 20 conversations with between staff and the executive team.

Commitment 7
We will lead and drive research to evidence the impact of what we do.

Action: We will ensure our patients receive evidence based care.

What we did: We have a well established reputation for high quality research and development and a strong record of participation in clinical trials. Our Research and Development team successfully recruited over 4,000 patients to National Institute for Health Research (NIHR) studies, between April 2017 and March 2018.

Plymouth Hospitals was invited to participate in a new national research study which explored the impact of patient experience data on the quality of care provided in acute NHS hospital trusts. The study initially started in 2016 and is due to complete in 2018 and involved a particular focus on cancer and dementia patient experience.

In order to explore further opportunities to improve through research, we submitted a successful application to become a member of the Advisory Board, which is a global research, technology and consulting organisation for nursing executives. Membership will enable us to share best practice and learn from our international colleagues.

Commitment 8
We will have the right education, training and development to enhance our skills, knowledge and understanding.

Action: We will roll out block training across our wards.

What we did: Block training is now in place for our Maternity areas and most inpatient wards. The training provides a standardised approach for all our staff. It ensures protected time for a number of staff at one time to focus on the specific needs of an area, resulting in more effective use of training time.
We have also introduced Nurse Degree Apprenticeships, which is an exciting new opportunity to support five of our staff to undertake this new programme starting with Plymouth University in September 2018.

The new 'shortened' Nurse Degree Programme is the first of its kind for Plymouth University. This new nursing apprenticeship route assists staff to follow a career pathway to gain skills, knowledge and experience to become a registered nurse. We are currently receiving applications to shortlist.

Commitment 9
We will have the right staff in the right places and at the right time.

Action: We will embed the Safe Care system across our wards including the roll out of 'Red Flag' functionality.

What we did: Our Red Flag Policy was ratified and published following consultation with our matrons and senior sisters. Red flags are occurrences which may be an indicator that the quality of care for a patient

has declined such as unplanned omission of medications, delays in pain relief, monitoring of vital signs and staffing levels. Raising red flags help to inform relevant staff in real time that action needs to be taken to ensure safe and effective care for our patients.

Making best use of resources we have and matching knowledge and skills to the current acuity and dependency of our patients.

Commitment 10
We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes.

Action: We will ensure our wards are fully utilising SALUS (electronic patient tracking system).

What we did: All wards and maternity areas are now using SALUS, an electronic whiteboard patient information and monitoring system, using a number of symbols.

Complex discharge team are now using Salus as a single repository for information sharing to facilitate safe discharge for patients with complex needs.

The blue forget me not symbol was introduced on Salus to aid staff in the identification of patients with diagnosed dementia, and likewise a pink forget me not for those patients with confusion.

Following the launch of Scan4Safety in 2016, the use of printed wristbands has been rolled out across the hospital. Printed wristbands are extremely important for patient safety and are a vital part of the Scan4Safety project and mean that staff are able to quickly and positively identify the patient.

In 2017 point of care scanning was extended to include orthopaedic and neurosurgery theatres, this provides the ability to scan an implantable device or 'product', before surgery and track it to the 'patient' and 'place'.

Scanning the wristband will reduce the risk of preventable mistakes, including patients receiving incorrect results/wrong procedures. In the case of a product recall, it means that we can easily see which patients are affected and ensure that appropriate action is taken quickly.

Acute Assessment Unit

In November we opened the Acute Assessment Unit Opens to patients. Ann James, Chief Executive said "A big thank you to everyone involved, from Plymouth Hospitals, Livewell Southwest and GPs, for making this happen for our urgent care patients,"

The new AAU deals with minor illness, ambulatory care as well as providing a dedicated pathway and space for patients with

frailty. It provides an opportunity for the whole system to work together and allows a multi-disciplinary team approach which, ultimately, benefits our patients and their experience of urgent care. Professionals working in the unit include GPs, therapists, nurses, doctors, pharmacists, administration and management.

The unit aims to help relieve pressure on the nearby Emergency Department and offer treatment and care which provides an alternative to hospital admission for appropriate patients.

Bereavement Bags

The death of a loved one is an event that all of us are likely to experience at some point during our lifetime. Dealing effectively and positively with grief caused by such a loss is central to a bereaved relative's recovery process.

The bereavement bag was conceived by Senior Sister Ali Griffiths following her own personal experience of bereavement following the death of her mum. Her aim was to provide an alternative to the Trust standard plastic carrier bags, being used for bereaved families to collect their loved one's belongings.

The idea of the bereavement bag was to allow individuals to collect their loved one's belongings whilst maintaining a sense of dignity and respect during what may be a very distressing time for them. The bag is designed to maintain a sense of solemnity and be a recognisable symbol around the hospital so staff and public can show sympathy and understanding towards those experiencing bereavement.

Cancer services

There were a number of key improvements made for cancer services, which are detailed below:

- 18 side rooms were refurbished to improve comfort and dignity for patients in their last days of life and their carers
- Successful bid to the Point of Care Foundation to undertake a pilot project on Hartor Ward, improving conversations when patients are reaching the end of life, including the concept of a pastoral friend (with chaplain team) and improved documentation
- Implementation of the national best practice pathway for prostate cancer
- The new lung pathway was developed in line with national optimal lung pathway, this will be implemented in 2018
- Thoracic surgical cancer centre pathways were developed and an additional consultant was appointed
- Review and changes to cancer multi-disciplinary meetings to improve efficiency
- Designed and successful application of an 18month cancer nursing development post to develop specialist nurses
- Implemented stratified pathways of care and new system to provide remote monitoring for patients on colorectal cancer follow up and plan to roll out to further sites

- New posts; nurse consultant and advanced nurse practitioner in oncology/cancer care

The impact of these and other changes were evidenced through improved scores in the recent national cancer patient experience survey 2016/17.

The National Cancer Taskforce objectives provides our plan for the next 3 years and we will continue to plan and work towards ensuring the best quality, timely and efficient care and treatment in line with local need and national guidance.

We are very grateful to our local and national charities such as the Plymouth and Cornwall Cancer Fund, Macmillan Cancer Support, Teenage Cancer Trust, Mesothelioma UK, Trust Charitable Fund who continue to support patients and staff to improve cancer care delivery.

Carers

Our staff recognise that carers have an important role in the effective and safe delivery of treatment and care of patients in hospital; this role will often cross the boundaries between the patient's home and the hospital setting. We have been working hard to identify, involve and support carers in the hospital setting in order to get the care of the patient right.

At Plymouth Hospitals NHS Trust we promote the patient carer relationship; ensuring the carer is able to continue in the caring role to improve. For some patients the involvement of their carer is critical to the delivery of care in hospital, e.g. children, patients with dementia, those with a learning disability and patients who are approaching the end of their life.

In liaison with Plymouth Caring for Carers and Kernow Carers we opened the Carers Hub near the main entrance of the hospital. The Carers Hub is dedicated to improving the quality of life of local carers, by providing information and practical support to any carer aged 18 and over who is providing unpaid care to someone in Plymouth.

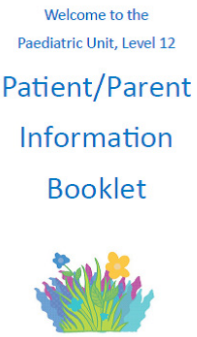
We reviewed our Carers Policy and set out the mechanisms in place to identify and engage with carers. In addition a number of mechanisms to support carers while contributing to care delivery in hospital were introduced.

Children's Services

The Gold Dust Appeal has begun to impact the look and feel of the Children's Wards on Level 12. Characters have been introduced to improve way finding and add colour and interest to the area.

We have also used this opportunity to join the “Use the stairs” campaign utilising characters and colourful message suitable for children.
Further work is planned to ensure we capture the interactive element of the Gold Dust Appeal. We plan to utilise “Sensory Guru” software and computer systems to provide interactive play areas around level 12.

As a result of feedback from the Children and Young Persons Inpatient and Day Case Surgery Survey, we are improving our parent facilities. With the help of Children’s Happy Hospital, we have purchased new beds, re-decorated and provided refreshment facilities for our parent accommodation.
We have also re-vamped and relaunched our parent/patient information leaflet that provides parents and children with information about facilities.



During March 2018, the paediatric wards took part in Nutrition and Hydration Week 2018. The wards each chose a theme and displayed a variety of topics to highlight the importance of Nutrition and Hydration to Children.

We have also introduced a consultant shift to Children’s Assessment Unit to improve the late afternoon, early evening cover. The purpose of this shift is to reduce waiting times, reduce unnecessary admissions and improve access to senior doctors who can make early decisions about treatment.

Within community paediatrics we have been developing new ways of collaborative working with colleagues in the local authority, voluntary organisations and other health services. This has included opportunities for staff to spend time with other services, supporting joint working and sharing of information.

We have also been exploring new ways of delivering support. We have successfully piloted workshops for parents around behaviour and sensory difficulties, with plans for ongoing delivery. Our Clinical Psychology Service has been delivering the Circle of Security parenting programme, which considers how secure parent-child relationships can be supported and strengthened.

We have also welcomed the nursing teams from Plymouth’s special schools in to our service, allowing for improved collaborative working with our education colleagues.

The Neonatal Intensive Care Unit has introduced Parent Volunteer Support Workers who will be instrumental in promoting Family Integrated Care (Ficare), on the unit.

Plymouth NICU has also been successful in achieving stage 1 Baby Friendly Accreditation. This means that our neonatal unit has the necessary policies, guidelines and processes are in place to NICU to implement the Baby Friendly standards effectively.

Critical Care

A set of 3 delirium awareness videos using patient experiences for education and training have been developed and a patient story of delirium has been written which we hope to get published. Delirium has been the main focus of a locally held conference “BACCN Disentangling Delirium Day”.

We have raised awareness through our active “twitter presence” tweeting under Critical Care Rehabilitation Team hashtag @plymouthicurehab and #recoveryforall campaign. All these are often retweeted and responded to by our patient group.

Dementia friendly award

Plymouth Hospitals NHS Trust are partners in the Plymouth Dementia Action Alliance (PDAA) and have been working with other agencies, organisations and businesses towards improving the lives of people living with dementia in Plymouth. The Trust has a multi-agency Dementia Steering Group which leads the developments in care and services provided to people with dementia in hospital.

The steering group has led on a number of developments, including the development of Dementia Champions, an accreditation scheme for dementia friendly wards and departments including a range of ways in which to make care in hospital more person-centred to the individual needs of people with dementia.

We work closely with local care homes, social services teams, The Alzheimer’s Society and Older Persons Mental Health Services, to ensure that people living with dementia are appropriately supported once leaving hospital.

Staff training on dementia is included in the mandatory training programme and includes induction training, dementia friends awareness sessions, and specialist dementia continuing professional development education.

The Trust is involved with the National Audit of Dementia Care in Hospital programme. We are proud of the developments made to the standards of care for patients with dementia and the support of their families. We will continue as active members of the PDAA and with the recommendations from national audit and our work towards the dementia improvement plan , to identify further ways in which hospital services and care for people with dementia can be improved.

Disability awareness week

Our very first Disability Awareness Week was organised on 5th-9th March 2018; the main aim was to raise awareness of various types of disability and define the Trust’s vision of equal access for all.

The event gave our staff and visitors the chance to share their views on the difficulties people with a wide

range of disabilities may face and thereby allow us to improve our understanding of how to help and become more inclusive. We believe it is important to encourage a culture within the organisation which continually considers a person's individual needs whether that is physical, sensory or communication related.

During the week, a range of teams and local services occupied stands in the main entrance and outside Restaurant 7, providing information and guidance to both staff and members of the public.

We were very privileged to work with the Macular Society, Caring for Carers, Sensory Solutions, Plymouth Head & Neck Cancer Group, Alzheimer's Society and members of the Patient Council. Teams at the hospital were also involved, with staff from Patient Services, Audiology Department, Royal Eye Infirmary and Learning Disabilities Team promoting their services.

Plymouth Citybus demonstrated their disability awareness bus and the volunteer mobility buggy drivers explained how recent donations have funded a new buggy. In addition Hovis, our Pets as Therapy dog, came to visit with his owner Moira; as always he was a huge favourite.

Hospital guides

We are aware that the Derriford Hospital building can seem very daunting to navigate. Our hospital guides and wayfinding initiatives are key to helping people get to their destination easily.

Development and introduction of a uniform for the guides in 2016 created an identity by making them very visible to all patients, visitors and staff to the hospital site. You will find our Hospital Guides located at the main reception desk.

In addition to our Hospital Guides we have also created the role of a volunteer Mobility Driver. This role has been created to take over the mobility service which was offered initially to patients during the bus interchange works. Such was its popularity the service was extended and this has now been developed into a volunteering role transporting patients in between the main hospital entrance and disabled car park F.

An application was made to the Charitable Funds Committee to replace the current mobility buggy with a newer and more accessible service. The application was successful; the newer buggy will have a ramp for wheelchairs to be able to drive straight onto without having to disembark and will also be fitted with seatbelts. Following patient feedback the

newer buggy will allow the service to be extended and run up to Rowan's House as well as the REI and maternity entrances.

Learning Disabilities Team

People with learning disabilities (LD) have an equal right to healthcare. We believe it is important to provide services and staff which enable people with learning disabilities to use our services.

In November 2017 the Derriford User Group together with staff and patients for their new Annual Joint Learning Disability Champion meeting held at Derriford Hospital. Attended by the Derriford User Group (DUG) members, who have a learning disability and have used, or still use, hospital services, and the Learning Disability Link Practitioners from the Trust, the event was organised to not only thank both staff and patients, but to also ensure those with learning disabilities are able to have a greater say on improving the patient experience in an acute care setting.

Making mealtimes matter

For the fourth year running to coincide with the National Nutrition and Hydration Week in March 2018 the hospital ran a number of different initiatives as part of our Making Mealtimes Matter Campaign, which aims to raise awareness of the importance of nutrition to aid our patients' recovery. We showcased a number of initiatives which have been developed to improve patient mealtimes and invited members of our Trust Board to join ward staff in assisting the mealtime service for our patients.

As part of the campaign patients, visitors, staff and members of the public were given the opportunity to sample dishes from the inpatient menu and to talk to staff about the importance of patient mealtimes. The campaign was generously supported by a number of our local suppliers and retailers in order to illustrate our partnership working.

Throughout the day, clinical staff were on hand to discuss the importance of keeping hydrated, how patients' nutritional intake can be improved through protected mealtimes and improving the mealtime experience. Dietetic staff were available to advise on the Malnutrition Universal Screening Tool (MUST) assessment and explain its importance. Speech and Language Therapy (SALT) staff were also available to talk about their service and how it supports patient recovery. The event was a huge success and the feedback was extremely positive.

In 2017 we launched the mealtime volunteers' initiative to enhance the experience for patients during mealtimes. This is aimed at non-clinical staff who wish to have more direct involvement in patient care. This is gathering pace and we have an increasing number of staff and student volunteers taking up this opportunity. Having supportive encouragement at mealtimes has been shown to improve the nutritional intake for patients. We are working with carers to encourage more visiting and active involvement at mealtimes.

The new patient menu which was launched in autumn 2016 has proven to be very popular and patient feedback has been consistently positive. The review included extending choice for breakfast and lunch and moving to a lighter option for supper. The afternoon tea service was also extended to prove a wider choice of energy dense and healthy snacks. Since the menu overhaul, further improvements have been made including increasing the choice of ice-cream flavours, a firm favourite with our patients, introducing more savoury items to the snack list, the introduction of an allergen free menu and the introduction of "petite purees", an energy dense, smaller portion for our elderly patients.

This year, the appointment of a dedicated Food Services Dietician has enabled us to carry out a comprehensive nutritional analysis of the patient menu in order to check compliance with the BDA: Nutrition and Hydration Digest. The analysis has highlighted that there are a few further refinements required to ensure our menu fully meets the Digest requirements and these will be explored over the coming months.

Maternity Services

Following on from the successful implementation of the new triage service a dedicated team of four midwives now cover the maternity line. Based in the South West Ambulance headquarters in Exeter the team receive calls 08.00 to 19.00 hours, 7 days per week, offering advice to women and heath care professionals. The triage assessment area within the acute hospital setting is more efficient with reduced waiting time for women and their families.

Our SALUS electronic whiteboard system has been introduced to all ward areas, with work continuing on the adaptation of maternity specific attributes. This has contributed to improved bed management between all areas.

A complete refurbishment of all birthing rooms, washroom facilities and clinical areas on central delivery suite is now complete; the addition of mood lighting and window decoration for each room offers a more aesthetically relaxing clinical area.

We are delighted that women across Derriford's geographical footprint now have access to specialist perinatal mental health care from pregnancy until one year after the birth of their baby. One in five women suffers from a mental health condition during the perinatal period and suicide is the most prevalent non direct cause of maternal death in the UK. Women living in Cornwall have had access to specialist perinatal mental health care for some time. Now women living in Plymouth and West Devon also have access to this vital specialist care. Our newly appointed perinatal mental health link midwife works across the three teams to ensure good communication of women's care needs among their care professionals.

With safety at the heart of the development of midwives, we carry out a robust and comprehensive training programme working together with multidisciplinary professionals both within the wider trust arena and external stakeholders. After a bid to charitable funds we have been able to replace and obtain quality training resources. Service users have actively been involved in facilitating study days to share their experiences with MW's to help improve the quality of care provided. We have MW Champions who are specialists within an area that a interests them such as care of the mother in HDU, mental health, suturing, screening, diabetes and facilitate in the cascading of information to their colleagues.

We are in the process of implementing the development of a new model for midwifery supervision within the maternity service to ensure that midwives are supported, valued and able to provide safe care for women and their families.

Patient Experience National Network Awards (PENNA) 2017

At the end of November 2017 the Trust submitted five applications to the Patient Experience National Network Awards (PENNA). We were very pleased to discover that all five applications had been shortlisted in at least one category, with the #Letsbeopen Campaign shortlisted in two.

We had even more to celebrate when we won two of the categories and runner up in the third.

Winners
Healthy Bones Mobile Unit
PENNA Category: Bringing Patient Experience Closer to Home

Empowering care in partnership: #letsbeopen
PENNA Category: Strengthening the Foundation

Runner up
Empowering care in partnership: #letsbeopen
PENNA Category: Turning it Around When it Goes Wrong

Shortlisted
'Signlive' - Providing patients, visitors and staff with more choice for hearing services
PENNA Category: Communicating Effectively with Patients and Families category

Bereavement Bags
PENNA Category - Support for Care Givers, Friends and Family

Patient Diaries in Intensive Care
PENNA Category - Personalisation of Care

Pets As Therapy

In September 2017 we were introduced to Hovis who is a Pets as Therapy (PAT) dog and his owner Moira. The Pets as Therapy charity was set up in 1983 to enhance health and wellbeing in the community through the visits of volunteers and their behaviourally assessed animals.

We are lucky to have two Pets As Therapy dogs who work with our staff, Hovis and Pixie. Their visits help to bring everyday life closer to our patients and with it all the happy associations of home comforts.

Safeguarding

Our safeguarding service continued to improve and evolve in 2017/18. Safeguarding Children, Adult Services within the Trust continue to be managed as one. The Learning Disability Service has now transferred to the Quality Governance team. The new post within the Trust of physical Interventions lead now sits within the safeguarding team. This service is starting to increase availability of conflict resolution and physical interventions support and Training throughout the Trust. This is an exciting development and offers significant support to staff under pressure from physically and verbal patient challenge.

Safeguarding training is revised annually as a minimum and is available for staff at all levels, on-line or face to face for levels 1 and 2, with more complex level 3 multi-agency training available to staff who require this. Safeguarding Adult and Children level 1 and 2 training complies with the skills for health and intercollegiate document recommendations.

The process for referral into the safeguarding teams continues to be revised and improved to ensure it is evolving with service need. The safeguarding children's team is available to offer support and advice and provide quality assurance Monday-Friday 08:30 – 16.30 minimum. The team continue to work within the hospital and with multi-agency partners to ensure children are safe and Trust is represented at operational and strategic level.

For adults at risk the safeguarding alert process introduced to highlight and monitor concerns is increasing referrals into the department, with a 100% increase within the year. The safeguarding adult team are available Monday- Friday 09:00 – 17:00. Processes are currently under review to ensure best use of resources to meet need and that our processes are aligned to other local areas.

The safeguarding team as a whole continue to support our staff and collate information monitoring themes and trends. They communicate with multi-agency colleagues as needed. The team ensure the Trust is compliant with the Children's Act (1989/2004) and the Care Act 2014. We work closely with multi agencies including Local Safeguarding Adult and Children's Boards to ensure compliance with standards.

Welcome Centre and Patient Services

In an effort to sustain the visibility and accessibility of our Patient Advice & Liaison Service (PALS) the Welcome Centre was opened on the main concourse in June 2016.

Since that time further improvements have been made to the facility and we are currently awaiting new furniture to provide the environment we want to achieve. We now have two members of the PALS team present in the Welcome Centre throughout the working week.

Carers have an important role in the effective and safe delivery of treatment and care of patients in hospital; this role will often cross the boundaries between the patient's home and the hospital setting. It is important that we are able to identify, involve and support carers in the clinical setting in order to get the care of the patient right. For this reason we also work closely with the Plymouth and Cornwall Carers teams who have a presence for two days per week in Patient Services. These teams provide advice and support to our patients, families and carers.

Recently the Patient Services office has been refurbished and a new meeting room facility created to meet visitors in a private and confidential setting. The refurbishment has provided a better and more welcoming environment within which Patient Services and the Carers teams can meet our patients, families and carers.

Moving Forward 2018/2019

Our new strategy is based on the five year forward plan and works towards health and social care integration. As before our matrons and heads of nursing adapted the 10 commitments into 10 key improvement projects; these will be refreshed for the coming year focusing on an overarching theme of deconditioning and promoting independence for our patients.

Carers Booklet

Development of the new Carers Booklet will be pivotal in providing additional support for our carers and ensuring they are treated as equal partners in care delivery for patients.

#endPJparalysis

From 17 April 2018, we will be taking part in a national campaign, which is led by Professor Brian Dolan, to get one million patients dressed in their own clothes and up and moving over 70 days.

Increased activity whilst staying in hospital can help recovery, reduce muscle wastage, maintain independence and lead to patients getting home sooner.

We are asking relatives, family and friends to help us #endPJparalysis by encouraging loved ones in hospital to get up and get moving as soon as they are able to. They can do this by ensuring patients have the following items with them:

- well-fitting footwear
- day clothing
- night clothing
- glasses and/or hearing aids
- walking aid
- toiletries

Nursing Documentation
Good record-keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. A common issue highlighted in complaints and incident reports is poor record-keeping and care documentation. As part of a quality improvement programme a project is underway to review all nursing documentation to ensure that the highest standards of written documentation are maintained and improved.

Defence Medical Welfare Service (DMWS)
Any hospital treatment whether planned or unplanned can be stressful and bring with it feelings of isolation, stress and worry, all of which may hamper recovery. DMWS Welfare Officers provide practical and emotional support to ensure that no family goes through the worry of injury or illness alone. They work with patients when their medical needs are being met but when other issues, problems or social influences may be distracting them from their recovery.

Maternity Voices
We will establish a Maternity Voices group at Plymouth Hospitals, to provide a forum for staff and patients to work together to ensure that health professionals listen to and take account of the views and experiences of people who use their maternity services.

Support at mealtimes project
We are running a Mealtime Volunteering Campaign, which gives staff who do not normally work in patient facing roles, the opportunity to help out with the mealtime service on the hospitals' wards.

The Trust's Communications Team has been mealtime volunteering since 2015 on Monkswell Ward and it has proved to be a huge success. From the perspective of the ward it not only helps build relationships with other staff groups who normally would not experience a good deal of contact with ward staff and patients, it improves the patients' mealtime experience. The feedback from patients is also very positive, as they enjoy speaking to different members of staff and appreciate the extra help needed at mealtimes.

Our Plans for 2018/19

In order to deliver our improvement priorities we must be an organisation which embraces continuous improvement and is fully committed to greater staff engagement and participation. In order to capture the creativity and knowledge of our staff, we need to provide support in identifying problems, developing and testing solutions and sharing knowledge. Our core purpose is to deliver excellent care, with compassion, wrapped around people's individual needs to the population of Plymouth and surrounding areas. We seek to do this through our Trust Values:

- Putting Patients First
- Taking Ownership
- Respecting Others
- Being Positive
- Listening, Learning and Improving

We have the ambition of creating an authentic improvement culture at Plymouth Hospitals NHS Trust. That means getting ideas and actions from wards, theatres, admin areas, patients and service users.

As defined within our strategic direction, our key areas of focus will be:

To ensure care is provided closer to people's homes where possible, so that people have care wrapped around them and have to tell their story only once.

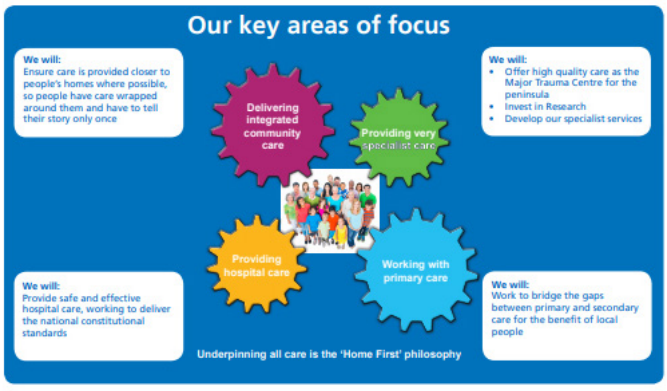
To provide safe and effective hospital care, working to deliver the national constitutional standards.

To offer high quality care as the major trauma centre for the peninsula, invest in research and develop our specialist services.

To bridge the gaps between primary and secondary care for the benefit of local people.

Our Quality Improvement Strategy

In 2018 we will be enhancing our approach to Quality Improvement. Following a successful bid to NHS Improvement, we will become one of five exemplar sites in the UK to test the use of 'lean' improvement methodologies' as our underpinning strategy supporting the integration of Livewell Southwest and Plymouth Hospitals.



The three-year programme will support both organisations to work together to deliver continuous improvement of services through better system working, help us develop more sustainable services and streamline how we deliver care by integrating our

treatment pathways.

This approach will help us make it easier for patients to access joined up care, cut down waiting times and improve safety.

This programme will build on our strong existing Quality Improvement work which aims to implement ideas from all of our staff, clinical and non-clinical, and also from our patients and service users to ensure the delivery of health care which is safe, effective and patient-centred.

We will be focusing on building on the successes we have already made and learning from those occasions where care could have been delivered more successfully. We aim to:

- Ensure all of our staff understand our clear and concise plan that describes the improvements in the services we will provide over the next three years and their role in it
- Provide the support and conditions that will enable that to happen at every level in the community and in the hospital
- Provide our staff with the skills they will require to bring about such change

Our aim is to deliver care of the highest standard in line with that delivered by the best health care systems in the world.

Our Quality Account priorities

As in previous years the Trust has sought the involvement and feedback of key stakeholders, to ensure that our plans reflect the needs of our patients and communities. We have done this by consulting with staff, key stakeholders, patients and members of the pubic using various methods including surveys.

The consultation process took place between February and March 2018 and identified three specific areas on which to focus our attention in 2018/19. These priorities link directly to those set out in our strategic aims, Quality Improvement Strategy and Operational Plan 2017/19.

Priority 1 – Staffing – Improve the patient experience by ensuring our wards and departments have the correct levels of staff with the appropriate skills.

Having the right nursing staff in the right place at the right time is a fundamental element to delivery of safe high quality care for our patients. Patient feedback from a number of sources shows us patients do not always feel the wards are adequately staffed. It is essential we build highly effective teams and provide assurance to patients and the public that staffing on the wards are at the right levels.

Priority 2 - Ensure all patients receive high quality care by working with other providers to ensure that their care is provided by the right staff in the right place and at the right time

Patients with complex care needs have the right to timely safe discharge care which is in line with best

practice. The Trust has recently experienced difficulties with capacity which resulted in cancellations for patients and longer waits for treatment than we would like.
We recognise that good end of life care enables people to live in as much comfort as possible until they die and to make choices about their care and where to spend their last days.

Maternity Services should maximise the opportunity for women to be fully involved in making well informed decision about their care.

Priority 3 - Reduce the overall number of patients who suffer harm whilst under the care of the hospital

There is a chance that if patients in hospital deteriorate they may not receive the necessary response in a timely fashion. This may cause patients to be more unwell, affect their treatment, increase length of stay and alter their views about their experience in hospital.

Patient falls and pressure ulcers are known to cause extended length stay and significant discomfort for patients. We will continue to improve falls prevention by focusing on planning specific care for the individual patient and working with our Tissue Viability Team on targeted areas to reduce the number of pressure ulcers.

Untreated sepsis can progress to severe sepsis, multi-organ failure, septic shock and ultimately death. Septic shock has a 50% mortality rate. The mortality rate for sepsis in children is estimated to be 10 – 15% and is the most common cause of direct maternal death. We will continue to implement systematic screening and treatment for these patients.

A more detailed analysis of our current position in each of these areas and our plans for improvement are set out in Annex F.

Sign Up to Safety

Sign up to Safety is a national initiative to help NHS organisations achieve their patient safety aspirations and care for their patients in the safest way possible. We want to give patients confidence that we are doing all we can to ensure the care they receive will be safe and effective at all times. Our work is shaped around the following key areas:

- How do we create lasting change and a future where patients and those who care for them are free from avoidable harm?
- How can we create a safety culture that leads to lasting change? If we create a culture where staff and patients are treated with empathy and kindness when things go wrong, we can learn more about what we can do differently to make care safer
- If the solutions and proven interventions exist already, we can support staff with examples of evidence based interventions and tools to inspire and motivate them to use best practice to treat every patient
- Do we capture data and learn from incidents and investigations effectively? If we do this we will have a

good chance of preventing things from going wrong in the future

Additional detail is described in Annex G.

eNotes

The paper record is a major barrier to effective transformation both within the hospital and throughout the patient journey. It is almost inconceivable to imagine that an organisation of the scale and complexity of Plymouth Hospitals NHS Trust would continue to rely upon paper based patient records.

During 2017 we launched a programme of work to implement an electronic solution for patient records (eNotes) that would transform the patient's current paper hospital note into a digital format. Patient case notes were scanned to a digital format, enabling instant access for multiple viewers in different locations at any one time.

Although the system only currently allows viewing of the existing record, we will be implementing electronic forms within the same platform to replace the hundreds of paper forms in use throughout the Trust.

Since the first clinic went live in Acute and Community Paediatrics, there have been:

- Over 1000 eNoted Outpatient Appointments
- Over 200 Clinics with eNotes Patients
- Over 900 Hospital case notes have been scanned

One of the many benefits of the system will be the speed of accessibility to records, removing the need to request paper notes. Multiple users will be able to see the same record at any one time from numerous devices both on the Derriford and peripheral sites using our secure network connections.

It provides a single point of access to patient information which is currently stored in various formats and locations, both paper and electronic. All information will be stored electronically and confidential health records will be available to authorised staff from any computer workstation or from any hand-held device. We will continue to implement e-Notes across all areas.

Annex A - Quality Metrics

National Metrics

Description	2014/15	2015/16	2016/17	2017/18	Target	What this means
Incidence of C-Diff (patients aged 2 years and over)	35	42^	37	43	<35	Lower is better
Incidence of MRSA	0	2	2	3	0	*Lower is better*
RTT Incomplete Pathway : Of all patients waiting on an RTT pathway, at least 92% should have been waiting for < 18 weeks	Achieved in 0 out of 12 months	Achieved in 0 out of 12 months	Achieved in 0 out of 12 months	Achieved in 0 out of 12 months	92%	*Higher is better*
Maximum time in ED of four hours from arrival to admission, transfer or discharge	90.7%	85.2%	84.3%	83.8%	95%	*Higher % is better*
All cancer two week wait	93.7%	89.8%	93.2%	92.2%	93%	*Higher % is better*
Two week wait for symptomatic breast patients (cancer not initially suspected)	65.4%	44.5%	77.5%	27.7%	93%	*Higher % is better*
31 day (diagnosis to treatment) wait for first treatment: all cancers	98.2%	96.9%	95.8%	95.7%	96%	*Higher % is better*
31 day wait for second or subsequent treatment: surgery	94.8%	92.9%	90.9%	92.5%	94%	*Higher % is better*
31 day wait for second or subsequent treatment: anti-cancer drug treatments	99.8%	99.6%	99.3%	99.4%	98%	*Higher % is better*
31 day wait for second or subsequent treatment: radiotherapy treatments	96.7%	93.5%	96.7%	87.3%	94%	*Higher % is better*
62 day (urgent GP referral to treatment) wait for first treatment: all cancers	86.0%	81.1%	79.2%	79.3%	85%	*Higher % is better*
62 day consultant upgrade wait for first treatment: all cancers	78.5%	80.8%	78.6%	77.3%	85% Local Target	*Higher % is better*
62 day wait for first treatment from consultant screening service referral: all cancers	91.9%	90.6%	86.9%	86.9%	90%	*Higher % is better*
Access to genito-urinary medicine clinics (48 hours)	100%	100%	100%	99.9%	100%	*Higher % is better*
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	1.73%	3.51%	3.03%	3.24%	-	*Lower % is better*
Cancelled operations by the hospital for non-clinical reasons on the day or after admission, who were not treated within 28 days	8.80%	16.1%	15.3%	14.3%	5%	*Lower % is better*
Delayed transfers of care				6.73%	-	Lower % is Better

Other local metrics

Description	2014/15	2015/16	2016/17	2017/18	Target	What this means
Rate of C-diff per 100,000 bed days (patients aged 2 years and over)	12.3	14.3	12.3	13.4	-	*Lower is better*
Hand hygiene compliance rates	95%	97%	97%	97%	95%	*Higher % is better*
Patient falls resulting in harm or death (moderate harm and above)	49	36	39	44	-	*Lower is better*
Incident reporting rate – per 100 admissions	10.5	11.6	11.1	11.07	-	*Higher is better*
Percentage of reported patient safety incidents resulting in severe harm or death.	0.67%	0.43%	0.24%	0.31% *	-	*Lower is better*
Total Number of patient Safety Incidents reported to NRLS (includes No Harm through to Serious Harm & Death)	12,179	13,591	13,169	14,936		Higher is better
Number of Never events	2*	2	4	3	0	*Lower is better*
Number of complaints	773	646	609	563	Reduce by 10%	*Lower is better*
Number of PALS enquiries	4348	4672	4127	4432	-	*Lower is better*
Number of cardiac arrest calls	178	186	152	137	-	Lower is better
Grade 2, 3 & 4 pressure Ulcers	355	181	135	174	-	*Lower is better*
% patients receiving appropriate VTE risk assessment	95%	95.3% Mar15 – Feb 16	95.3% Mar 16 – Feb 17	94.8% Mar 17 - Feb 18	95%	*Higher is better* **
% patients receiving appropriate thromboprophylaxis	97%	97.2% Mar15 – Feb 16	96.4% Mar 16 – Feb 17	97.7% Mar 17 - Feb 18	95%	*Higher is better*
Mortality (HMSR) (Relative Risk)	98 Jan 14- Jan 15	104 Jan 15- Jan 16	104 Jan 16 – Jan17	107 Jan 17 – Jan 18	-	*Lower is better* ***
% stroke patients spending 90% of their stay on ASU	72%	72%	74%	73.3%	80%	Higher is better
Fractured NOF – delays to surgery < 36hrs	78%	71%	71%	68%	85%	Higher is better

Other local metrics

* 1 never event incident occurred in 2010 and was reported in the 2014/15 period.

** During previous years the Trust's auditors for the Quality Account have found discrepancies when comparing the paper hospital record and our electronic discharge system for VTE. Although the error rate is low the trust believes that the indicator does represent our performance and is working to correct the issue with the introduction of e-prescribing.

*** HSMR benchmark data is reviewed and nationally rebased each year, hence the rise in the reported figure does not reflect poor performance.

Annex B - Core Indicators

Comparative Core Quality Account Indicators

Core Indicator 12 – Summary Hospital Level Mortality Indicator

(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period

(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period

SHMI (Summary Hospital-Level Mortality Indicator)	Oct 14 – Sep 15	Oct 15 – Sep 16	Oct 16 – Sep 17
Plymouth - SHMI Value Banding	1.001 2	0.9866 2	1.0306 2
National highest – SHMI Value Banding	1.177 1	1.1638 1	1.2473 1
National lowest - SHMI Value Banding	0.652 3	0.6897 3	0.7270 3
NHS trust average - SHMI Value	1.004	1.0034	1.0050

% of patient deaths with palliative care coded at either diagnosis or speciality level	Oct 14 – Sep 15	Oct 15 – Sep 16	Oct 16 – Sep 17
Plymouth	18.6	20.7	20.2
National highest	53.5	56.3	59.8
National lowest	0.2	0.4	11.5
NHS trust average	26.6	29.7	31.5

*The palliative care indicator is a contextual indicator.

Core indicator 18 - Patient Reported Outcome Measures (PROMS)
(i) groin hernia surgery
(ii) varicose vein surgery
(iii) hip replacement surgery
(iv) knee replacement surgery

Pre-operative participation and linkage Participation from April 2016 – March 2017					
	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	1322	986	68.4%	797	83.45%
Groin Hernia	247	20	8.1%	11	55%
Hip Replacement	397	391	98.5%	320	81.8%
Knee Replacement	384	410	106.8%	315	76.8%
Varicose Vein	294	165	56.1%	151	91.5%

Post-operative issue and return Participation from April 2015 – March 2016					
	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate
All Procedures	986	982	99.6%	573	71.8%
Groin Hernia	20	20	100%	12	60%
Hip Replacement	391	390	99.7%	279	71.5%
Knee Replacement	410	408	99.5%	294	72.1%
Varicose Vein	165	164	99.4%	114	71.3%

PROMS Total Health Gain *Participation from April 2017 – September2017*								
Procedure	Measure	Modelled Records	Average Pre-Op Q Score	Average Post-Op Q Score	Health Gain	Improved	Unchanged	Worsened
Groin Hernia	EQ-5D Index	10	0.78	0.87	0.067	5	2	3
	EQ VAS	9	75.33	80.77	5.44	6	1	2
Hip Replacement Primary	EQ-5D Index	249	0.31	0.77	0.46	222	11	16
	Oxford Hip Score	270	16.02	38.28	22.25	266	1	3
	EQ VAS	237	59.07	71.32	12.25	147	22	68
Knee Replacement Primary	EQ-5D Index	220	0.38	0.71	0.32	182	16	22
	Oxford Knee Score	244	17.75	35.00	17.24	233	4	7
	EQ VAS	212	66.89	72.25	5.36	123	22	67
Varicose Vein	Aberdeen Varicose Vein Questionnaire	102	24.10	17.75	-6.34	81	0	21
	EQ-5D Index	99	0.74	0.81	0.07	42	34	23
	EQ VAS	93	74.98	74.33	-0.65	38	18	37

Plymouth Hospitals NHS Trust has taken the following action to improve its PROMS activity:

- Identification and appointment of clinical lead for each area
- Continue to monitor response rates for varicose veins and groin hernias and work with staff to improve the number of returns
- Reporting to the Clinical Effectiveness Group

Next steps will include review of outcome data against other similar organisations and local monitoring of our patients reported health gains. Following a national review the PROMS process a decision will be made about the requirement to continue collecting hernia and varicose veins feedback.

Core Indicator 19 – Readmission with 28 days
Percentage of patients re-admittted to hospital within 28 days of being discharged
(i) 0 to 15
(ii) 16 or over

Compared to other Large Acute Trusts	2009/10	2010/11	2011/12
% Patients readmitted to hospital within 28 days of being discharged for 0 – 15 year olds	10.46	10.43	12.18
National highest	15.35	14.11	14.94
National lowest	6.04	6.41	6.40
NHS trust average	9.76	9.96	10.02

Compared to other Large Acute Trusts	2009/10	2010/11	2011/12
% Patients readmitted to hospital within 28 days of being discharged for 16 year olds and over	10.29	9.65	9.50
National highest	13.18	14.06	13.80
National lowest	8.95	9.20	9.34
NHS trust average	11.12	11.38	11.44

Please note that these indicators were last updated in December 2013 and future releases have been temporarily suspended pending a methodology review

Core Indicator 20 - Trust's responsiveness to the personal needs of its patients
Patient experience as measured by scoring the results of five questions from the National Inpatient Survey focusing on responsiveness to personal needs. The scores shown below represent a composite of the five questions:

Were you involved as much as you wanted to be in decisions about your care and treatment?
Did you find someone on the hospital staff to talk to about your worries and fears?
Were you given enough privacy when discussing your condition or treatment?
Did a member of staff tell you about medication side effects to watch for when you went home?
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

	2013/14	2014/15	2015/16	2016/17
Plymouth Hospitals NHS Trust	69.1	68.9	65.1	67.5
National highest	84.2	86.1	86.2	85.2
National lowest	54.4	59.1	58.9	60.0
NHS trust average	68.7	68.9	69.6	68.1

Plymouth Hospitals NHS Trust continues to monitor performance against these questions in its local survey programme, using the meridian system. This is shared with matrons and ward sister / charge nurse. A dedicated piece of work is underway to improve information at the point of discharge, where patients have been asked to meet with staff to redesign information provision.

Core Indicator 21 – Friends and Family Test Staff
The percentage of staff employed by, or under contract to, for quarter two of 2017/18 who would recommend the Trust as a provider of care to their family or friends.

Description	Total Responses	NHS Digital Workforce Headcount	Work		Care	
			Percentage Recommended	Percentage Not Recommended	Percentage Recommended	Percentage Not Recommended
Plymouth Hospitals NHS Trust	173	6744	47%	34%	75%	9%
NHS Trust Average - England	137,225	1,149,300	63%	19%	80%	6%
National highest	3470	16,518	96%	0%	100%	0%
National lowest	0	664	25%	64%	43%	29%

Plymouth Hospitals monitors the recommended scores for all Friends and Family test areas, using the meridian system.

Core indicator 21.1 – Friends and Family Test Patients
Percentage of patients discharged following an inpatient stay or emergency treatment for February 2018 who would recommend the trust as a provider of care to their family or friends.

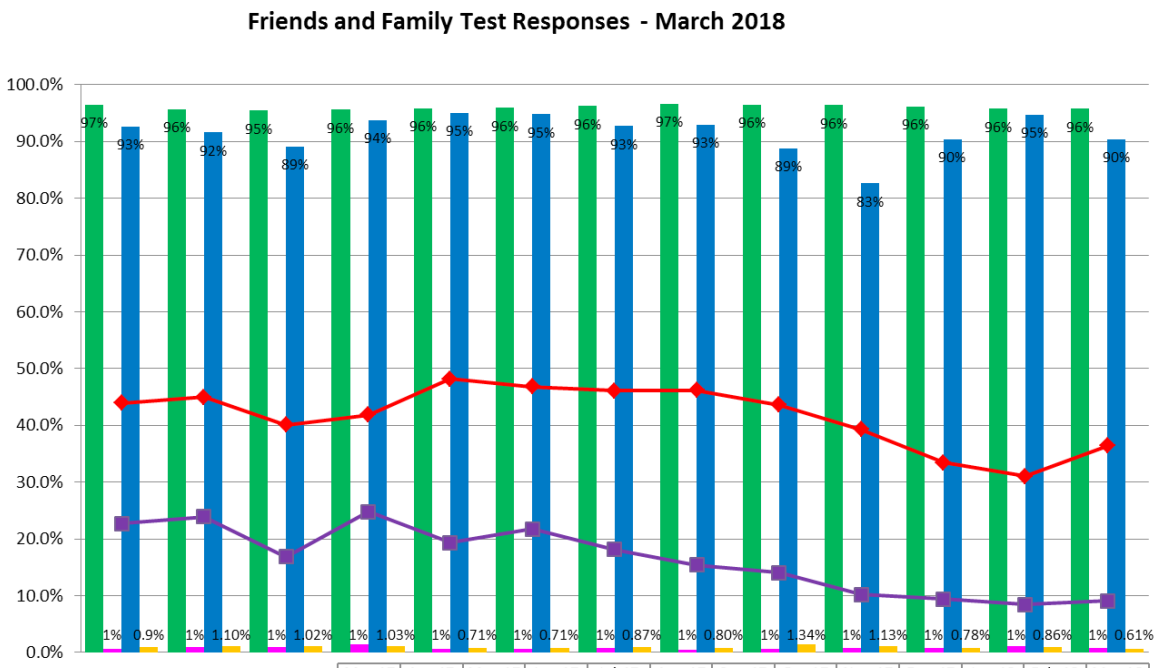
	Inpatient & Daycase			Emergency		
	Response Rate	Percentage Recommended	Percentage Not Recommended	Response Rate	Percentage Recommended	Percentage Not Recommended
Plymouth Hospitals NHS Trust	31.0% (5,464)	96%	1%	8.4% (12,393)	95%	1%
NHS Trust Average -England (excluding Independent Sector Providers)	23.9%	96%	2%	8.8%	88%	6%
National highest	100%	100%	0%	69.7%	100%	0%
National lowest	3.6%	82%	9%	0.0%	67%	20%

The Friends and Family Test is now in place across all areas of the Trust and provides valuable feedback from our patients, encompassing all adult, children and carers including inpatient, emergency care, maternity, outpatient and day case across both hospital and community based locations.

Patients are asked ‘How likely are you to recommend our ward to friends and family if they needed similar care or treatment’ based on the following potential responses:

1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don’t know

The chart below illustrates the response from March 2017 to March 2018.



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Inpatient & Day Case Recommended	96.5%	95.7%	95.4%	95.6%	95.9%	95.9%	96.2%	96.6%	96.5%	96.4%	96.1%	95.8%	95.8%
Inpatient & Day Case Not Recommended	0.6%	0.89%	1.00%	1.34%	0.57%	0.66%	0.82%	0.51%	0.56%	0.83%	0.82%	1.12%	0.82%
ED Recommended	92.7%	91.6%	89.1%	93.8%	95.0%	94.8%	92.7%	93.0%	88.8%	82.6%	90.4%	94.7%	90.4%
ED Not Recommended	0.9%	1.10%	1.02%	1.03%	0.71%	0.71%	0.87%	0.80%	1.34%	1.13%	0.78%	0.86%	0.61%
Inpatient & Day Case Response Rate	43.9%	45.0%	40.1%	41.8%	48.2%	46.8%	46.1%	46.2%	43.6%	39.3%	33.4%	31.0%	36.4%
ED Response Rate	22.7%	23.9%	16.8%	24.8%	19.3%	21.7%	18.1%	15.4%	14.1%	10.2%	9.4%	8.4%	9.1%

Through the qualitative feedback element of Friends and Family Test we ensure patients' views are heard and shared. Whilst the recommender score provides a gauge of overall patient satisfaction, the qualitative feedback gathered through the Friend and Family Test provides an opportunity to understand our successes and areas for improvement in more detail.

Using a number of collection methods helps maintain our response rates and the paper based approach also allows real time feedback to staff through our red post box system. Each ward and department has a feedback poster displayed within view of patients, staff and visitors showing the number of patients seen during the period, number of survey responses along with the recommender score and examples of comments.

Core Indicator 23 - Venous Thromboembolism
Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Description	Plymouth Hospitals	National highest	National lowest	NHS trust average
Core indicator 23 Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during 2017-18				
Quarter 1 April 2017 to June 2017	95.0%	100%	51.8%	95.1%
Quarter 2 July 2017 to September 2017	94.4%	100%	71.9%	95.2%
Quarter 3 October 2017 to December 2017	94.5%	100%	76.1%	95.3%

* During previous years the Trust's auditors for the Quality Account have found discrepancies when comparing the paper hospital record and our electronic discharge system for VTE. Although the error rate is low the Trust believes that the indicator does represent our performance and is working to correct the issue with the introduction of e-prescribing.

Core Indicator 24 – C.difficile
The rate per 100,000 bed days of trust apportioned cases of C. difficile infection that have occurred within the trust amongst patients aged 2 or over during the reporting period.

Description	2013/14	2014/15	2015/16	2016/17
Plymouth Hospitals NHS Trust	13.9	12.3	14.3	12.4
National highest	37.1	62.6	67.2	82.7
National lowest	0*	0*	0*	0*
NHS Trust average	14.7	15.0	14.9	13.2

Core Indicator 25 – Patient Safety Incidents* (Comparison data against all Acute Trusts)

Number and rate of patient safety incidents reported within the Trust during the reporting period	Plymouth Hospitals	National highest	National lowest	NHS trust average
Patient safety incidents: Rate per 1,000 bed days Apr 2016 to Sep 2016	41.9	150.6	16.3	42.9
Patient safety incident: number	6246	13485	286	4534
Patient safety incidents: Rate per 1,000 bed days Oct 2016 to March 2017	41.4	149.7	13.7	42.2
Patient safety incident: number	6245	14506	295	4714
Patient safety incidents: Rate per 1,000 bed days Apr 2017 to Sep 2017	42.5	174.6	14.8	44.2
Patient safety incident: number	6339	15228	294	4804

Number and percentage of such patient safety incidents that resulted in severe harm or death.	Plymouth Hospitals	National highest	National lowest	NHS trust average
Patient safety incidents: Rate per 1,000 bed days Apr 2016 to Sep 2016	0.17	0.60	0	0.15
Patient safety incident: number	25	98	0	17
Patient safety incidents: Rate per 1,000 bed days Oct 2016 to March 2017	0.13	0.53	0	0.15
Patient safety incident: number	19	92	0	17
Patient safety incidents: Rate per 1,000 bed days Apr 2017 to Sep 2017	0.14	0.64	0	0.15
Patient safety incident: number	21	121	0	17

* PHNT has an open reporting system which allows any member of staff to report an incident and we do not want to discourage incident reporting. PHNT do not validate every No Harm and Minor Harm incident prior to reporting to NRLS, we allow our staff to make that decision based on their clinical opinion however all Moderate Harm, Serious Harm and Death Caused by Incidents are validated. We do recognise the need to continue to educate staff around what is a reportable incident and what is not, as well as investigate the opportunity to simplify our incident reporting system.

Core Indicator – KF 21 - National Staff Survey 2017
Percentage believing that the Trust provides equal opportunities for career progressions or promotion

Description	Total Percentage		
	2015	2016	2017
Acute Trusts Average	87.0%	87.0%	85.0%
National highest	96.0%	95.0%	94.0%
National lowest	76.0%	67.0%	69.0%
Plymouth Hospitals NHS Trust	86.0%	88.0%	85.0%

Core Indicator KF 26 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

Description	Total Percentage		
	2015	2016	2017
Acute Trusts Average	26.0%	25.0%	25.0%
National highest	42.0%	36.0%	38.0%
National lowest	16.0%	16.0%	19.0%
Plymouth Hospitals NHS Trust	26.0%	23.0%	22.0%

Annex C - Assurance Statements

Clinical Administration Programme
The Trust established the Clinical Administration Programme as a means to support the organisation in the delivery of a successful, high quality and cost effective administration service to our patients and clinicians. We are working to create an administration service that supports and matches the high quality clinical care that we offer that gets it right for patients first time. In the past patients have experienced some issues associated with our administration including:

- Difficulties contacting clinical services
- Booking a new outpatient appointment
- Cancellation of clinic appointments
- Data quality issues affecting the management of patient pathways

The Trust has invested heavily in new technologies and a number of these have been implemented with the benefits of each now being realised.

Digital Dictation
The implementation of this solution has provided greater visibility of workload, activity and performance which has enabled a continued reduction in the delays around transcription and authorisation of clinical correspondence. The Trust is now looking to develop its speech recognition and mobile device capability to further quicken the production of our clinical correspondence.

Self-Check-in and Patient Calling
The implementation of self-check-in has resulted in less queuing for patients attending our clinics along with the provision of a more confidential environment for our patients.

Enhanced Telephony and Reminder Services
The enhanced telephony system has been successfully implemented across a number of areas including the Outpatient Management Centre, Imaging and PALS. In addition to this the programme has implemented an improved outpatient appointment reminder service. The key benefits of this project have been to improve patient experience in contacting the hospital, reduced levels of non-attendance (DNA) and patient reschedules and reduced wastage costs. This service has expanded over the last 12 months to include to automation of contacting patients in order to arrange their outpatient appointment; this avoids the sending of a letter. We have also commenced an automated reminder service for minor outpatient procedures and some day-case admissions.

Electronic-outcomes
This project replaces the current outmoded and paper based method of recording clinical outcomes and future care plans. This solution has now been rolled out across the majority of specialties and a number of the key benefits are now being demonstrated, these include:

- Minimises missing information so improving patient safety
- Reduced waiting times
- Reduced time needed on reception
- Improved Data Quality reducing validation time

- Improved Referral to Treatment (RTT) times

As at time of production over 7,500 outcomes from outpatient appointments are being processed weekly. With a relatively small number of clinicians left to engage and train this project is nearing completion

Electronic Internal Referrals
The Trust has committed to developing a solution which removes the need to send paper around the organisation. Not only will this speed up the referral process it will also improve patient safety through the development of an auditable process.

Electronic Communication to Primary Care
The Trust has purchased a system which, at the point of approval by the relevant clinician, automatically sends outpatient clinic letters to the patient's GP practice. Following a successful pilot we are currently undertaking a roll-out programme to ensure that all GP practices across Devon and Cornwall are able to access letters about their patients in this way. To date over 16,000 letters have been sent via this route to those practices which have gone live.

Communication to Patients
The Trust has been looking for some time to make more efficient the way in which it manages its written communications to its patients. To this end the Trust is about to go out to procurement for a solution which offers e-mail, access to a web-portal and a hard copy letter depending on the patient's choice. The web-portal element will also offer the Trust and its patients an opportunity to manage follow-up appointments differently.

Workforce Structures
We need to improve our clinical administration, for our patients and also for our staff who work in administration. One of the things we want to do is create an attractive career pathway in clinical administration. This element has been developed well with the new Outpatient Management Centre arrangements. We have also implemented the role of Clinical Administration Manager which provides an ideal next step for Team Leaders and Medical Secretaries. We also need to ensure that we have the right number of staff at the right grade delivering a high quality service to our patients and the clinical teams. For this reason the programme will be assessing, in conjunction with the service lines, what the staffing requirement is for individual teams and ensuring that we have the right staff doing the right jobs.

Training, Improved Supervision and Delivery of Service Standards
The Trust has invested in a clinical administration training function with the intention of providing a more sustainable approach to ensuring our staff have the right tools and knowledge to enable them to do their jobs. This is being supported by the Clinical Administration Manager role mentioned above. The key deliverables for this are to:

- Ensure that all staff have received adequate training and support to enable them to effectively carry out the role that is expected of them
- Ensure all staff receive adequate and effective supervision to ensure the achievement of service standards

- Development of a set of agreed service standards along with action planning to ensure that individual departments achieve what is required of them

In order to achieve this, the Trust has invested in its Clinical Administration Training function and agreed a training strategy which significantly broadens capacity and capability to deliver effective training and education to our staff.

During the financial year 2017/18 nearly 800 members of staff attended training sessions across the modules being offered. These modules include Access Policy, RTT Basics and RTT Masterclass. Additional modules will be offered this year which will include training on Primary Target Lists (PTLs), the Data Quality Handbook and Administrative Process Notes (APNs). This will be in addition to refresher modules for the training already delivered.

Supporting our NHS Professionals (NHSP) colleagues
The Trust has committed to ensuring that all members of staff whether permanent or temporary feel equipped to carry out their role. To this end close links have been developed with the NHS Professionals to ensure that staff joining us on placement for the first time have been offered the essential training to enable them to transition into their role effectively. We also provide them with a NHSP administrators training manual which covers the key points in the training session and contains the training needs assessment and request form as well as useful contacts.

Clinical Coding
Clinical Coding is the process by which patient diagnosis and treatment is translated into standard, recognised codes which reflect the activity that happens to patients. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

Plymouth Hospitals NHS Trust was subject to a successful Information Governance Clinical Coding audit, undertaken in October 2016, by Rosalind Ward for the period 2016/17. The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) is detailed in the table below. The Trust was previously subject to an Information Governance Clinical Coding audit by D&A Consultancy in September 2013 and 2014 and Rosalind Ward in October 2015. The Trust is still achieving Level 2.

Criteria measured	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Primary diagnosis incorrect (%)	5%	5%	10%	10%	8%	10%
Secondary diagnosis incorrect (%)	2.29%	4.9%	4.9%	13.53%	12.41%	13.25%
Primary procedures incorrect (%)	2.78%	2.5%	1.4%	5.79%	4.71%	6.25%
Secondary procedures incorrect (%)	0.86%	5.1%	3.9%	11.83%	8.33%	11.38%

Data Quality

Clinicians and managers need ready access to accurate and comprehensive data to support the delivery of high quality care. Improving the quality and reliability of information is therefore a fundamental component of quality improvement.

The Trust monitors the accuracy of data in a number of ways including the monthly Data Quality Steering Group (DQSG), chaired by the Business Intelligence Manager. This group utilises the Trust's internal data quality summary reports and external dashboards to monitor key indicators. Within the Performance & Management Information Department is an RTT validator who carries out the data quality actions from the DQSG and a number of analysts support data quality reporting.

Each service line area in the Trust has one or more data quality champions, led by the clinical administration managers. These operational data quality leads ensure their area is performing in accordance with the required standards. As well as internal data quality summary reports, there is a variety of data quality reports used by the operational teams to validate and correct issues.

All data quality reports, guidance and summaries are coordinated by the data quality handbook, an electronic handbook providing a central point for all information. The data quality champions and their operational teams have detailed guidance to support them with undertaking data quality work and access to Administrative Procedure Notes (APNs) which explain the operational processes.

In 2017 internal audit completed a data quality audit pertaining to the A&E 4 hour performance standard. This audit and previous audits on referral to treatment waiting times, stroke and cancer waiting times provide assurance against these essential performance indicators.

During 2016 and 2017 the Trust worked closely with the Elective Improvement Team from NHS Improvement (NHSI) to support progress towards achieving the 18 week RTT target. During this time the team from NHSI validated the information and data quality processes and reported back the following:

"There is a comprehensive data quality methodology in place within the Trust which is supported by a range of data quality indicators and reports all available at specialty level. Where new DQ issues are identified locally, the Trust has the flexibility to respond by developing additional reporting. The data quality improvement process is clear with accountability positioned within the operational teams."

And

"The Trust is making a conscious decision to move away from a validation approach (i.e. correcting data retrospectively ahead of national returns) and more towards real-time audit; this is an approach that the IST fully supports and should be recognised as best practice."

National Data Quality Validity and Benchmarking

The Trust provides submissions to the Secondary Uses Service (SUS). This is a single source of comprehensive data which enables a range of reporting and analysis in England and is run by NHS Digital. The table below shows the percentage of valid records in the published data at month 10 2017/2018 for two

key indicators:

Patient Pathway	Valid NHS Number	Valid GP Practice
Admitted patient care	99.3%	100%
Outpatients	99.6%	100%
Accident & emergency care	98.3%	100%

The Trust remains top in the peninsula for data quality assurance on the SUS Data Quality Dashboards with a total combined score of 99.6%

Duty of Candour
The Trust ensures duty of candour requirements are implemented following any 'moderate harm' or above graded incident once it has occurred. There are key steps in the process as shown in the diagram below.

Where it is felt a 'candour conversation' is required, it is important to identify the most appropriate person to conduct such a conversation, which in most circumstances would be the clinician with whom the patient has an active clinical relationship.

We ensure an accurate account of the incident is provided, containing all the facts known about the incident at the date of the notification, particularly including what happened, why and how and what can be learned to prevent a further occurance.

We ensure the person(s) communicating with the patients and/ or relevant person:

- Has a good understanding of the facts relevant to the case
- Has excellent interpersonal skills, including being able to communicate with patients and/or relevant persons in a way they can understand, avoiding excessive use of medical jargon
- Is willing and able to offer an apology, reassurance and feedback to patients and/or their carers
- Is able to maintain a medium to long term relationship with the patient and/or their carers, where possible, and to provide continued support and information
- Is culturally aware and informed about the specific needs of the patient and/or their carers
- Where a patient safety incident has caused harm, an apology is offered to the relevant person, which is a sincere expression of sorrow or regret for any possible harm and distress caused

Duty of Candour diagram

Infection Control

The Trust has made significant progress towards modernising the service it offers and meeting the challenging new agenda being set at both local and national levels. The Infection Prevention and Control Team has dramatically changed the way it has worked in order to deliver a more clinically-orientated and relevant service. This approach has been effective in both improving clinical practice and reducing rates of hospital-associated infection.

Over the last few years, there have been significant improvements in hand hygiene compliance and clinical practice audit scores, such as the Saving Lives High Impact Interventions. Infections due to meticillin-resistant and susceptible Staphylococcus aureus (MRSA and MSSA), Escherichia coli and Clostridium difficile have fallen, as have rates of surgical site infection. Considerable Trust-wide effort is required to maintain and continue these improvements, particularly if the Trust is to continue to achieve the MRSA bacteraemia and C. difficile reduction targets.

The Quality Premium sets out the ambition for clinical commissioning groups (CCGs) to deliver a 10%

or greater reduction in all Escherichia coli bacteraemias over 2017-18, using January to December 2016 as the baseline year. During this period Plymouth Hospitals NHS Trust recorded 60 post 48 hour cases (compared to ~100 for the previous three years). The subsequent objective will be to reduce all Gram negative bacteraemias by 50% by 2010-21. Achieving these reductions will be a key challenge over the next few years.

Progress towards achieving key targets for 2017/18 was as follows:

- Reduce MRSA bacteraemias in line with agreed local and national targets. Between April 2017 and March 2018, there were 3 MRSA bacteraemias (Target: no cases for the year).
- Reduce Clostridium difficile in line with agreed local and national targets. Between April 2017 and March 2018, 43 cases of hospital-apportioned Clostridium difficile were recorded, of which 2 were considered avoidable and 37 non-avoidable, with a decision awaited on the other 4 cases (Target: fewer than 35 avoidable infections).
- Achieve a 5% reduction in all cases of MRSA. Between April 2017 and March 2018, there were 22 new cases of MRSA compared to 18 the previous year.
- Achieve a 5% reduction in all MSSA bacteraemias. Between April 2017 and March 2018, there were 25 MSSA bacteraemias compared to 46 the previous year.
- Maintain the mean ward closure time due to epidemic gastroenteritis below 7 days. Between April 2017 and March 2018, there were no ward closures due to norovirus.
- Reduce other infections according to national and local priorities. Reductions achieved, notably a reduction from 67 E. coli bacteraemias to 56.
- Comply with current and new national mandatory surveillance requirements. Compliant.
- Support and assist in the implementation of screening high-risk patients for meticillin-resistant and susceptible S. aureus (MRSA and MSSA). Compliant.
- Continue to follow local and national guidance to control and reduce Resistant Gram-negatives including Carbapenemase-Producing Enterobacteriaceae (CPE). Compliant.
- Support and assist in the screening of patients for CPE. Complete.
- Continue to perform surgical site surveillance, including post-discharge surveillance, on all major procedures. Complete.
- All wards to perform at least a monthly Hand Hygiene audit with compliance of at least 95%. Between April 2017 and March 2018, the overall Trust hand hygiene compliance was 97%.
- All wards to perform at least monthly Saving Lives High Impact Intervention audits for in use medical devices and score 100%. Data available on balanced scorecard.
- All wards to achieve compliance with Infection Prevention and Control audits. Data available on balanced scorecard.
- Maintain availability of alcohol hand gel in clinical areas as close to 100% as possible. Between April 2017 and March 2018, the availability of alcohol hand gel in clinical areas was 95%.
- Continue to develop and update the IPC website. Completed.
- To comply with national legislation and guidance including the Health and Social Care Act (Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance), Care Quality Commission Essential Standards, Winning Ways and national guidance on the management of MRSA and C. difficile. Compliance reviewed and evidence folders updated.

Information Governance Toolkit
The Information Governance Toolkit is a Department of Health online system which all NHS organisations and their partners complete on an annual basis. Completion of the toolkit allows the Trust to demonstrate that it complies with national standards for handling information. It covers personal information, i.e. that relating to patients/service users and employees, and corporate information, e.g. financial and accounting records. The Trust achieved a score of 76% for Version 14.1 (2017/18) of the Information Governance Toolkit which was submitted by 31 March 18 and was given a green rating for this attainment level.

Research and Development
Plymouth research income remains similar to previous years, in part due to £1m NIHR grant income, with recruitment exceeding target and expectation. We have had significant challenges this year, not least due to the overstretched resources from winter pressures. Commercial income fell in 2017/18 in direct correlation to a reduction of commercial pipeline in 2016/17. This has been addressed and we expect a rise in commercial income again in 2018/19; however this represents a small proportion of overall recruitment in comparison to our NIHR delivery.

There are currently 315 (open to recruitment) research projects ongoing in the Trust. We have recruited 4689 patients into research projects this financial year to date with a 98% retention rate. 112 new research projects opened in the year, 37 commercial and 75 non-commercial.

Plymouth continues to have a varied and mixed portfolio of research projects. This includes Phase 1- 4 clinical trials (drug studies), ranging from complex interventional first in human studies to observational studies testing patient related outcomes. Apart from enhanced patient outcomes and reduced admissions and outpatient appointments, commercial interventional studies deliver the additional benefit of significant drug savings both to the Trust and Devon Clinical Commissioning Group.

Our highly skilled research delivery and administration workforce has allowed Plymouth to grow the number of complex studies, particularly within haematology, hepatology and oncology. These service lines are supported by clinical academic posts building on our collaboration with the University of Plymouth.

The Trust continues to add to the pipeline for commercial research as an active member of the IQVIA (previously Quintiles) Peninsula Prime Site Consortium. The Peninsula Prime Site has received IQVIA's Certificate of Achievement in both 16 and 17. This award is only given to top-performing sites in IQVIA's Prime and Partner program that have demonstrated excellence in clinical research performance and quality.

The importance of our key relationships and collaborations with the wider healthcare community, Livewell, primary care, public health, Peninsula Clinical Research Network, Peninsula Academic Health Science Network are recognised and being further developed as we move forward into 2018/19. We aim to take advantage of all research opportunities available for the benefit of our patients, the Trust and the wider healthcare community.

In the coming year we will rebrand, becoming Research, Development and Innovation, RD&I, building on the significant innovation growth and success achieved over the last 2 years. Several reputation-enhancing

medical innovations have potential to provide a recurring income stream. Examples are an intra- vitreous injection guide for ophthalmology; episiotomy guide scissors, proprietary multiple sclerosis and severe asthma severity scales; a trans-oesophageal pacing technique for non-invasive cardiac ablation; and a "bereavement" bag (a discreet bag in which to place the belongings of recently deceased patients). The enthusiasm and support Innovation has had from staff at all levels across the Trust will continue to be harnessed for the benefit of the healthcare environment, ensuring that benefits are shared with the wider NHS audience.

Plans remain on course for a new research facility, the T3 building (Tomorrow's Treatments Today) with two very successful meetings held in January to help inform on the design of the building. Further engagement will be sought with NIHR, Wellcome Trust, AHSN and the pharmaceutical industry.

Conclusion
Plymouth Hospitals NHS Trust remains committed to its research agenda to make available to its patients the most innovative treatments at the earliest opportunity and further support the healthcare community through education and training.

Medical Revalidation
Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice in their chosen field and able to provide a good level of care. This means that holding a licence to practice is becoming an indicator that the doctor continues to meet the professional standards set by the General Medical Council (GMC) and the specialist standards set by the medical Royal Colleges and Faculties.

Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC. Licensed doctors have to revalidate usually every five years, by having annual appraisal based on the General Medical Council's core guidance for doctors, Good medical practice.

Revalidation and medical appraisal are led in the organisation by Dr Philip Hughes, Medical Director and Responsible Officer. He is supported by a medical appraisal lead, a senior manager and an appraisal administrator.

The Appraisal and Revalidation Team participate in quarterly regional network events, ensuring they are aware of current developments and best practice in the field. The Trust submits quarterly returns as required by NHS England, as well as a detailed annual audit.

The Annual Medical Appraisal and Revalidation Report was presented to and approved by the Trust Board in September 2017.

Nursing Revalidation
Nursing and midwifery revalidation requires all Nursing & Midwifery Council (NMC) registrants to revalidate every 3 years in order to maintain their registration.

The Chief Nurse is the appointed Responsible Officer, who is leading on the management of revalidation

for Nursing & Midwifery Council registrants. The Trust has a Revalidation Policy which outlines individuals' roles and responsibilities, the support available to registrants and confirmers and the Trusts monitoring and compliance arrangements.

The administration function is designed to provide advance notice to registrants and their managers of revalidation dates and detail what associated support and guidance is available. Revalidation completion rates are monitored and escalation arraignments are in place for those who are approaching their registration date and have not completed revalidation, or where registration has lapsed.

During the last year, the Trust confirmed revalidation for all registered nursing and midwifery staff who were due for revalidation.

Annex D - National Clinical Audits

Audit Name	Status	% of cases submitted
National Emergency Laparotomy Audit (NELA)	Continuous data collection	100%
National Joint Registry (NJR) Hip replacement Knee replacement	Continuous data collection	N/A
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme • Secondary • Organisational	 Did not participate Completed	 0% N/A
Bowel Cancer (NBOCAP)	Continuous data collection	100%
National Lung Cancer Audit (NLCA)	Continuous data collection	100%
Head and Neck Cancer Audit (DAHNO/HANA)	Continuous data collection	100%
Oesophago-gastric Cancer (NAOGC)	Continuous data collection	100%
National Prostate Cancer Audit	Continuous data collection	100%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Continuous data collection	100%
Adult Cardiac Surgery	Continuous data collection	100%
Cardiac Rhythm Management (CRM)	Continuous data collection	100%
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Continuous data collection	100%
National Heart Failure Audit	Continuous data collection	100%
National Vascular Registry	Continuous data collection	N/A
Diabetes (Paediatric) (NPDA)	Completed	100%
National Diabetes Audit (NDA) – Adults - National Inpatient Audit (NaDIA, NDIP)	Continuous data collection	100%
Inflammatory Bowel Disease (IBD) Programme	Continuous data collection	100%
Falls and Fragility Fractures Audit programme (FFFAP) • Inpatient Falls • National Hip Fracture Database	Continuous data collection	100%
Sentinel Stroke National Audit programme (SSNAP)	Continuous data collection	100%
National Ophthalmology Audit	Continuous data collection	100%
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Completed	86%
National End of Life audit	Completed	100%
Medical and Surgical Clinical Outcome Review Programme • Cancer in Children, Teens and Young Adults • Acute Heart Failure • Perioperative Diabetes	In progress Completed Completed In progress	N/A 100% 100% N/A
National Audit of Dementia	In progress	100%
National Maternity and Perinatal Audit	Continuous data collection	100%
Child Health Clinical Outcome Review Programme (NCEPOD) Chronic Neurodisability Young People's Mental Health	In progress	N/A 87.5% 100%
Learning Disability Mortality Review Programme	Continuous data collection	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Continuous data collection	100%
Neonatal Intensive and Special Care (NNAP)	Continuous data collection	100%

Non NCAPOP audits		
Case Mix Programme (CMP)	Continuous data collection	100%
BAUS Urology Audits Radical Prostatectomy Audit Nephrectomy audit Percutaneous Nephrolithotomy (PCNL) Cystectomy	 Completed Completed Completed Completed	 100% 100% 100% 100%
RCEM – Procedural sedation in adults (care in emergency departments)	Completed	100%
National Bariatric Surgery Registry	Completed	100%
RCEM – Pain in children	Completed	100%
RCEM – Fractured Neck of Femur	Completed	100%
Neurosurgical National Audit Programme	Continuous data collection	100%
Major Trauma Audit	Continuous data collection	100%
National Comparative Audit of Blood Transfusion programme Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients TACO Audit	 Completed Completed	 100% 100%
National Cardiac Arrest Audit (NCAA)	Continuous data collection	100%
Elective Surgery (National PROMs Programme) Unilateral Hip Replacement Unilateral Knee Replacement Varicose Veins Surgery Groin Hernia Surgery	Continuous data collection	100%
UK Parkinson's	Completed	100%
Serious Hazards of Transfusion (SHOT)	Completed	100%

Category	Comments
National Confidential Enquiries	
During 2017/18 hospitals were eligible to enter data into five NCEPOD studies. The Trust submitted data for four studies, equating to 97% participation. Full details of national confidential enquiries can be found at www.ncepod.org.uk. Details are listed below:	

Title of Study	Status	Number (%) of cases included	Action
Acute Heart Failure The aim of this study is to identify and explore avoidable and remediable factors in the process of care for patients admitted to hospital with acute heart failure.	Completed	100%	6 questionnaires completed and submitted. The organisational questionnaire was submitted. No further action required and awaiting the final report publication date.
Cancer in Children, Teens and Young People The aim of the study is to review patients under the age of 25 years old that have had unplanned admission to critical care within 30 days of receiving systemic anti-cancer therapy (SACT). This study also reviews the decision making and consent process around the prescription of SACT.	Completed	0	An organisational questionnaire was returned to NCEPOD. No individual cases were selected for review by NCEPOD.
Chronic Neurodisability The aim of the study is to review patients under the age of 25 years old that have had unplanned admission to critical care within 30 days of receiving systemic anti-cancer therapy (SACT). This study also reviews the decision making and consent process around the prescription of SACT.	Completed	87.5%	All clinical questionnaires (8) were returned to NCEPOD. One set of patient records were not available for submission and this is reflected in the cases included percentage.
Perioperative Diabetes The aim of this study is to identify and explore remediable factors in the process of care in the perioperative management of surgical patients with diabetes across the whole patient pathway from referral for surgery (elective) or admission to hospital (emergency) to discharge from hospital.	In progress	40%	2 questionnaires completed and submitted. Additional performance data was requested and submitted in December 2017. The deadline for completion has been extended to 30th March 2018.
Young People's Mental Health The aim of this study is to identify the remediable factors in the quality of care provided to young people treated for mental health disorders; with specific reference to depression and anxiety, eating disorders and self-harm.	Completed	100%	5 questionnaires completed and submitted. Organisational questionnaire submitted. No further action required and awaiting the final report publication date.

Annex E - Example Outcomes from Clinical Audits

Audit Description	Comments
PRIORITY 1: Mandatory National Audits	
National Joint Register	A letter was received from the National Joint Register highlighting that the Trust is an outlier and one of the worst performing in respect of knee replacement revisions. NJR indicated that it is possible that within the national data some revisions are deliberately under-reported because of a perception that it will reduce the risk of an individual or unit becoming an outlier. The Trauma and Orthopaedic Service Line has confirmed that there have been data collection and entry concerns due to a shortage and change of administrative staff. New processes have been implemented and a local performance report is being developed to highlight missing submissions from the NJR. The NJR data is now input in a timely manner and 100% of all appropriate operations are submitted.
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)	A letter was received from the CQC relating to the Perinatal Mortality Surveillance programme that highlighted that the Trust is reporting over 10% higher than the average perinatal mortality rate. A formal response was returned to the CQC as requested. This confirmed that all cases received a root cause analysis review and upon further investigation four women chose to continue with pregnancies in the knowledge that the foetus had serious abnormalities. All of these babies were subsequently stillborn.
Major Trauma Audit: The Trauma Audit & Research Network (TARN)	All Major Trauma Centres are mandated to submit data to TARN. This oversees performance and is part of the best practice tariff. The Trust's Major Trauma Team are meeting the 25 day data submission to TARN target. The data shows that the case ascertainment is consistently 100% and that data completeness is 97% for core data fields.

PRIORITY 2: Corporate Must Do Audits	
Clinical Record Keeping	It is essential that a planned programme of audit of our clinical record keeping is undertaken across all specialties to ensure that the quality of the health record facilitates high quality treatment and care. It is also a mandatory requirement of the Department of Health to undertake an annual assessment (Information Governance Toolkit) which states that clinical record-keeping audits must be undertaken across at least 50% of specialties to assess the standard of record-keeping. The Trust achieved 58% compliance in 2017/18. Compliance is monitored through the Clinical Effectiveness Group In addition the Trust achieved 74% compliance against the Royal College of Physicians record keeping standards.
Ionising Radiation (Medical Exposure) Regulation (IRMER)	A rolling audit programme is being implemented across specialties where agreements have been made for clinicians to evaluate a patient's films within the patient's clinical record rather than awaiting a formal Radiologist report. All seven specialties required to undertake this audit have completed a baseline audit with five of those having completed a re-audit. The clinical evaluation is present in 93% of the audited records which has increased from 84% during 2016-17. Non-compliance is being monitored through the Radiation Safety Committee.
PRIORITY 3: Service line must do clinical audits	
A survey to investigate primary care follow up of patients with coeliac disease who are discharged from acute services: is follow up in line with present UK guidelines?	The aim of this audit was to investigate whether former patients who attended the Dietitian lead coeliac clinic (2004-2014) and were discharged back to the GP have been reviewed annually as recommended by NICE (QS135 and NG20). This audit also aimed to check that patients received routine blood tests and DEXA bone scans in line with the diagnosis and management of adult coeliac disease guidelines from the British Society of Gastroenterology. Royal Cornwall Hospital Trust is managing patients through a specialist nurse led telephone clinic whilst Plymouth Hospitals NHS Trust is returning patients to primary care. Only one third of patients who were discharged back to their GP in Plymouth had an annual review compared to 84% in Cornwall where many patients had nurse-led telephone clinic reviews. It was noted that patients having annual reviews were more likely to have follow-up tests and investigations in line with NICE guidance. A Gastroenterology Consultant is reviewing the provision of an annual review service for Coeliac patients and the results of this audit have been presented to the British Society of Gastroenterology (BSG) 2017 conference in Manchester. The Clinical Audit Team will continue to monitor the action relating to the creation of an annual review service.
Audit of Major Ear Surgery Readmissions	In February 2017 a report was published by NHS Improvement titled "Getting It Right First Time". It compared statistics from ENT services across the UK. Plymouth performed well in almost all the published metrics. One area that raised concern was the percentage of major ear surgery patients that were readmitted for further ENT surgery within 1 year. Plymouth Hospitals NHS Trust is an outlier on this metric, with a disproportionally large number of patients being readmitted. The audit reviewed 46 patient notes for those admitted for the following procedures: Atticotomy, Myringoplasty, Mastoidectomy and Tympanoplasty. The results found that four patients were incorrectly reported and that they were not readmitted within one year and another patient returned to the Trust for an unrelated procedure. under general anaesthetic (responsible for 13% of the readmissions).

	The audit highlighted one area where a change of practice may be considered; the use of absorbable packs in children to reduce the planned requirement to have the packs removed under general anaesthetic (responsible for 13% of the readmissions). Upon further review it was noted that for the categories of unexpected disease at first operation (1.1%) and recurrence/residual disease (2.7%) that the readmission rate was 3.8% for major ear surgery patients and not 13.5% as stated within the GIRFT report.
Are WHO checklists being completed during local anaesthetic procedures in the maxillofacial department?	The aim of this audit was to assess whether the Oral and Maxillofacial Department is meeting the Trust policy requirements on the completion of Surgical Safety Checklists for all local anaesthetic procedures. The initial audit found that 84% of surgical safety checklists were carried out and when re-audited six months later it was found that 85% of surgical safety checklists were undertaken. It was recommended that the checklist is printed on a different colour of paper as a visual prompt and reminder to notice the checklist and to complete it.
Audit of Omalizumab for chronic urticaria: Usage compared to NICE guidance and efficacy in current patient cohort	This audit was undertaken to review compliance against NICE Technology appraisal guidance [TA339]. The results demonstrated improved compliance with NICE guidance in the last six months since the introduction of Omalizumab two years ago. Re-audit in six months was proposed due to further changes made during the audit period that were not captured such as the creation of the Omalizumab patient database. Re-audit in 6 months will hopefully show the effect of these changes as they become more established.
Audit of Inpatient MRI waiting times for suspected occult femoral neck fracture	The aim of this audit was to review the inpatient MRI service for occult femoral neck fracture and produce an action plan for reducing waiting times. The audit was also designed to demonstrate compliance with NICE guidance which states that MRI should be offered for suspected occult femoral neck fracture within 24 hours if anteroposterior pelvis and lateral hip radiographs are negative. Of the 117 patients that had an indication of fracture, 61% were diagnosed with a fracture following MRI. The median time interval between X-ray and MRI was 48 hours. There were also noted delays between an MRI request submission to the scan being undertaken. A new rota for Musculoskeletal (MSK) Consultants for MRI reporting is in place and staff have been reminded to ensure that the vetting/changing priority of scans are set to urgent. An Occult Hip Fracture protocol has been implemented and a re-audit is now in progress. This is due to be completed by Summer 2018.

Audit Description	Comments
PRIORITY 1: Specialist Interest Audits	
Open shoulder stabilisation – service evaluation of complications and outcomes	The audit results showed that 94% of patients have returned to work following surgery. The audit did not capture if patients are returning to sport and it has been agreed that telephoning patients to assess Oxford Shoulder Instability Score (OSIS), re-dislocation and return to sport was within the remit of existing audit. This will be followed up.
Study of induction of labour using the Cook Cervical Ripening Balloon and delivery outcomes	This audit was requested by the Women's and Children's Clinical Effectiveness Committee to assess the effectiveness of Cook Cervical Ripening Balloons as a mechanical method of induction of labour. Additionally the audit reviewed both maternal and neonatal complications throughout both the intrapartum and immediate postnatal period with the aim to identify common themes or trends relating to their usage. Following completion of the audit it was demonstrated that Cook balloons as a mechanical induction of labour device are an acceptable and safe alternative to a prostaglandin method. The majority of women within the dataset reviewed were at a significantly increased risk of multiple complications including uterine rupture and there were no significant maternal or neonatal complications noted during data collection.
Frozen Section diagnostic accuracy in the diagnosis of ovarian neoplasms	This audit was undertaken due to the publication of the Cochrane Review of Frozen Sections in the diagnosis of ovarian masses. Results indicated that Frozen Section (FS) can drastically alter the operation a patient undergoes by providing immediate histology compared with paraffin section analysis. There is however an inherent error rate. This audit concluded that Frozen Section accuracy rates within the Trust are in line with nationally accepted limits and results demonstrated an improvement on previous results. This has resulted in fewer women being under/over treated with surgical interventions.
Service Evaluations	
Driving in insulin treated individuals with diabetes	The audit results showed that 96.8% of patients have informed DVLA about their diabetes and being on insulin with 96% of these patients reporting that they carry a blood glucose testing kit in their vehicle. 92% patients reported that they test their blood glucose before the start of a journey. It was disappointing to hear that only 22% of patients pull over, test blood glucose, treat hypoglycaemia appropriately and wait for the recommended 45 minutes before resuming a journey. The Service Line have agreed that the DVLA requirements will become part of the patients' annual clinical review process and that local teaching will include the requirements to ensure that all staff are kept up to date.
An Audit of the Induction of Labour Rate for August 2017	The induction of labour rate for August 2017 was 40% (an increase from the average induction of labour rate of 30-35%). The most common indications for induction were reduced fetal movements, prolonged pregnancy and gestational diabetes. The majority of women were induced in their 39th week of pregnancy. Of the 142 women who were induced; a total of 104 women (73%) had a normal vaginal delivery. There were no concerns or themes noted with regards to the unprecedented rise in the induction of labour rate.

Audit Description	Comments
National audit of tracheostomy usage and outcome in Motor Neurone Disease (MND)	This audit was developed within the Trust to ascertain the extent that tracheostomy ventilation is used in MND across the UK. It was hoped that the baseline data collected would be used to stimulate nationwide discussion and development of National Guidance on use of tracheostomy ventilation in MND patients. The initial pilot collected retrospective data from 4 centres. 38 patients had been set up on tracheostomy ventilation as a consequence of MND between January 1998 and December 2016. The audit found that the Mean length of life post tracheostomy ventilation was 3.7 years with longer life expectancy in the elective group of 5.1 years. Most patients (79%) had a tracheostomy as part of an acute deterioration. 75% of patients who had elective tracheostomy ventilation did so because they wanted to live as long as possible, whilst the others were struggling with continuous use of non-invasive interfaces. Interestingly length of hospital stay for planned admission is not as long as is anecdotally suggested. The Motor Neurone Disease Association is supportive of the results and is keen to see the national audit expanded and national guidance published. This will be led by Plymouth Hospitals NHS Trust. A shared folder and a generic NHSMail account has been created to hold the anonymous data received from participating centres and an audit protocol has been created. No patient identifiable information will be sent to the Trust and therefore it has been approved by the Trust's Caldicott Guardian. The results of this audit have been accepted for presentation at two prestigious international conferences, the British Thoracic Society Winter Conference in London (December 2017) and the International Tracheostomy Symposium in Dallas (February 2018).

Annex F - 2018/19 Priorities

Priority 1: Staffing – improve the patient experience by ensuring our wards and departments have the correct levels of staff with the appropriate skills.

Rationale
Having the right nursing staff in the right place at the right time is a fundamental element to delivery of safe high quality care for our patients. Patient survey results show us patients do not always feel the wards are adequately staffed. It is essential we build highly effective teams and provide assurance to patients and the public that staffing on the wards are at the right levels.

Current Position
We have reviewed our current position based on information from the past 12 months. We have then used this information to set targets for the coming year.

Description	2017/18 Performance	2018/19 Target
Maintain agreed staffing levels for all wards in line with Safer Staffing	Planned vs Actual Mar 18 – overall 86.2%	Planned vs Actual >90%
Reduce the overall staff vacancy factor	9.60%	tbc
Reduce the number of complaints which include an element relating to staff attitude and behaviour	171	<10%
Improve patients' perception of staffing on our wards - In your opinion, were there enough nurses on duty to care for you in hospital? (Q29 National Inpatient Survey 2017 – Always / Nearly Always)	51%	>78%
If you needed attention, were you able to get a member of staff to help you within a reasonable time? (Q43 National Inpatient Survey 2017)	74.50%	>83%

How we will do it
We will continue to adopt innovative approaches to the recruitment and retention of clinical staff but face national challenges in recruiting registered nurses.

The House of Commons Health Committee has published a report The Nursing Workforce which looks at the current and future scale of the shortfall of nursing staff. Further improvement resources have been published by the National Quality Board for urgent and emergency care, learning disability service, district nursing and maternity and neonatal care. The recommendations within this guidance will contribute to the workforce reviews that will take place this year.

Continue to build the hospital website in order to attract staff to the organisation and develop a prospectus to inform potential staff about our specialist areas and professional development opportunities.

Put in place a 6 monthly review process to ensure workforce plans remain in alignment with the Trust's financial and activity plans. This approach will ensure that we not only track delivery but that we also revise

our plans to meet our activity requirements by adapting roles and skills mix in light of changing recruitment market features.

Progress the reporting of all health roster metrics to enable real time monitoring of ward performance of rosters, including the Carter metrics on workforce efficiencies.

Build on the successes of previous recruitment open days and schedule future dates for 2018/19.

Measuring Progress
We will monitor staffing levels and incidents on a monthly basis to the Nursing and Midwifery Operational Committee, chaired by the Chief Nurse. In addition we will provide bi-annual updates to the Trust Management Executive and Public Trust Board. External reports monitoring progress against staffing levels will be provided to our commissioners, NHS Improvement (NHSI) and the Care Quality Commission.

Priority 2: Ensure that all patients receive high quality care by working with other providers to ensure that their care is provided by the right staff in the right place and at the right time

Rationale

Patients with complex care needs have the right to timely safe discharge care which is in line with best practice. The Trust has recently experienced difficulties with capacity which resulted in cancellations for patients and longer waits for treatment than we would like.

We recognise that good end of life care enables people to live in as much comfort as possible until they die and to make choices about their care and where to spend their last days.

Maternity Services should maximise the opportunity for women to be fully involved in making well informed decision about their care.

Current Position

We have reviewed our current position based on information from the past 12 months. We have then used this information to set targets for the coming year.

Description	2017/18 Performance	2018/19 Target
Number of patients who are cancelled	3.03%	0.80%
A&E four hour waiting time	84.34%	95% tbc
Referral to Treatment incomplete pathways Where there are over 52 week waiters, develop trajectories to eliminate all over 52week waiters as soon as possible	tbc	tbc
Over 6 week diagnostic waiting times Develop bespoke trajectories which as a minimum delivers 1% or below	tbc	tbc
Delayed transfers of care	tbc	tbc

How we will do it

We are committed to working to deliver the best possible care for local people all of the time, through integrated provision. We will support our staff in being able to do this.

Further detail to be confirmed setting out our plans for integration across the healthcare community.

Measuring Progress

We will monitor progress against the overall projects through the Quality Improvement Committee chaired by the Medical Director.

Priority 3: Reduce the overall number of patients who suffer harm whilst under the care of the hospital

Rationale
There is a chance that if patients in hospital deteriorate they may not receive the necessary response in a timely fashion. This may cause patients to be more unwell, affect their treatment, increase length of stay and alter their views about their experience in hospital. Patient falls and pressure ulcers are known to cause extended length stay and significant discomfort for patients. We will continue to improve falls prevention by focusing on planning specific care for the individual patient and working with our Tissue Viability Team on targeted areas to reduce the number of pressure ulcers.

Untreated sepsis can progress to severe sepsis, multi-organ failure, septic shock and ultimately death. Septic shock has a 50% mortality rate. The mortality rate for sepsis in children is estimated to be 10 – 15% and is the most common cause of direct maternal death. We will continue to implement systematic screening and treatment for these patients.

Current Position
Recognising and responding to patient deterioration relies on a whole systems approach and the revised National Early Warning Score (NEWS2), published by the Royal College of Physicians in December 2017, reliably detects deterioration in adults, triggering review, treatment and escalation of care where appropriate. NEWS2 is an improvement on the original NEWS, in use since 2012, in key areas including:
Better identification of patients likely to have sepsis
Improved scoring for patients with hypercapnic respiratory failure
Recognising the importance of new-onset confusion or delirium

Currently, around two-thirds of healthcare providers use the original NEWS for adult patients, with the rest using adapted versions or locally devised early warning scores (University Hospitals Trusts use a modified version). Harm could result from having different scoring systems in use across the NHS when patients or staff move between services.

The adoption of NEWS2 is vital to standardise how adult patients who are acutely deteriorating are identified.

Description	2017/18 Performance	2018/19 Target
Trustwide adoption of NEWS2	N/A	March 2019

How we will do it
Implementation of NEWS2 across as identified in Patient Safety Alert NHS/PSA/RE/2018/003.

Measuring Progress
We will monitor progress and drive changes in practice monthly via the Quality Improvement Committee chaired by the Medical Director.

Annex G - Sign up to Safety - Pressure Ulcers and Falls

Pressure Ulcers

Sign up to Safety is a national initiative to help NHS organisations achieve their patient safety aspirations and care for their patients in the safest way possible. We want to give patients confidence that we are doing all we can to ensure the care they receive will be safe and effective at all times.

Plymouth Hospitals NHS Trusts do not have a specific Sign up to Safety Project; we have chosen to embed key safety initiatives into our quality improvement initiatives which include.

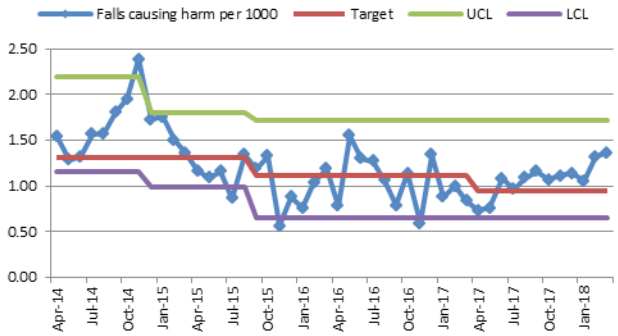
- Sepsis
- Pressure Ulcers
- Falls

Our Sign up to Safety pledges were derived from current programs of work identified from incidents, NHS Litigation Authority claims and patient and staff feedback as well as nationally recognised areas for improvement. The following programs of work have been included for the coming year:

Reduce falls leading to harm
We continue to work hard to reduce the number of falls that harm our patients, and to try and reduce the number of falls that do not result in harm for the patient. We take into account recommendations from national reports, and took part in the National Audit of Inpatient Falls in May 2017. We scrutinise our data and investigations in order to learn and put in place interventions that will help the work around reducing falls.

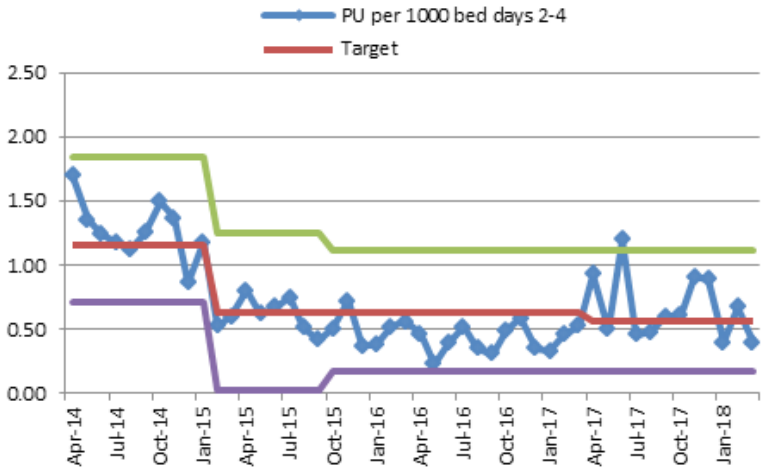
During 2017/18 our falls prevention work has focused on ensuring patients are able to mobilise safely and patients are encouraged to do so. We have introduced a new lying and standing blood pressure care plan and information for patients advising them of how they can recognise and manage the symptoms of a drop in blood pressure when they stand up.

#End Paralysis week on the Health Care of the Elderly wards encouraged patients to 'get up, get dressed. get moving'. Hembury Ward staff supported this by wearing pyjamas during their shift so they could understand more about how movement can be limited by 'nightwear'. We are also continuing to look at the reasons why a patient may fall on more than one occasion



Reducing Harm from Pressure Ulcers

We continue to learn from our investigations and data in order to reduce the occurrence of pressure ulcers. During 2017/18 we have continued work to improve the accuracy of pressure ulcer risk assessment, and put in place appropriate interventions in order to reduce the risk to our patients. The tissue viability team are part of a Pressure Ulcer Collaborative, and in March 2018 the team were acknowledged for their work on the use of the SNAP app which allows staff to capture an image of a wound or pressure damage. The Tissue Viability Nurses can review and ensure that the pressure damage is graded correctly and that there is an accurate image of the wound on admission. We continue to work in targeted areas to reduce the number of pressure ulcers occurring, and are promoting 'React to Red Skin' staff huddles in order to maintain momentum on the need to put in place measures to avoid any further damage



Annex H - Statement of Directors' Responsibilities

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Accounts) Amendments Regulations 2011 and 2012 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors should take steps to assure themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the reporting period;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice;
- the data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- the Quality Account has been prepared in accordance with any Department of Health guidance.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Richard Crompton
Chairman
Date: 30 June 2018

Ann James
Chief Executive
Date: 30 June 2018

Annex I - Statements from external stakeholders

Local Healthwatch (Plymouth, Cornwall, Devon and Torbay)
Local Healthwatch (Plymouth, Cornwall and Devon) continue to work with Plymouth Hospitals NHS Trust to ensure that the patient voice is heard at service design and decision making level.

Healthwatch acknowledges that the level of operational pressure felt by the Trust remains consistently high with the Emergency Department in particular seeing a higher volume of patients compared to previous years. As a result there remains an impact to delivery of elective procedures. Equally the number of people waiting for outpatient appointments beyond the NHS standard continues to increase. In turn this leads to patient frustration due to significant cancelations of operations and delays in accessing treatment. Whilst some of this is within the Trust's ability to resolve, the wider pressures in the local health and social care economy, particularly primary care, home support and care homes, will inevitably mean that progress will be slow in reducing waiting times.

Patient feedback received around Derriford Hospital and its services continues to be generally positive, with most commenting on the excellent level of care received and the way that staff positively go about delivering that care. However, of particular concern is the continuing upward trend of elective surgery cancellation and increasing wait for outpatient appointments. In the 2017/18 Quality account, Priority 2: Reduce the number of patients who are cancelled and ensure access to services within acceptable timeframes, aimed to tackle some of the issues around this. The opening of the Acute Assessment Unit adjacent to the Emergency Department is welcomed as is the increase in diagnostic capacity. We also note that the Putting Patients First programme will continue to drive other changes around this priority alongside work with partners in the wider health and social care economy in 2018/19; this is fully supported by local Healthwatch.

We note and support the Trust's priorities for 2018/19 around:

Staffing – Improve the patient experience by ensuring our wards and departments have the correct levels of staff with the appropriate skills
Ensure all patients receive high quality care by working with other providers to ensure that their care is provided by the right staff in the right place and at the right time
Reduce the overall number of patients who suffer harm whilst under the care of the hospital

Local Healthwatch continues to work with Plymouth Hospitals NHS Trust as a critical friend, where representatives from Healthwatch Plymouth and Cornwall attend the Patient Experience Committee. These meetings remain an effective way to allow health professionals to understand concerns of patients that use their services. Likewise Healthwatch Devon continues to liaise directly with the patient experience lead via the regional patient experience network.

Both Healthwatch Cornwall and Plymouth continue to have a monthly presence at Derriford Hospital gathering the views of patients, relatives and carers.

Northern, Eastern and Western Devon Clinical Commissioning Group
NHS Northern, Eastern and Western Devon Clinical Commissioning Group (the CCG) is pleased to provide feedback on the Quality Account for Plymouth Hospitals NHS Trust (UHPNT) 2017/18 and would like to offer the following commentary.

We review the quality of services throughout the year, including safety, effectiveness and experience and UHPNT has provided evidence of a commitment to high quality care. This Quality Account summarises and reflects the evidence. The CCG is pleased to see the continued progress with aspects of the 2016/17 quality priorities.

The Care Quality Commission (CQC)
The Trust has continued to make excellent progress against the actions designed to address the CQC requirement notices. The CCG is pleased to note that 93% of the actions are complete and that a significant proportion of the outstanding actions relate to A&E performance and follow-up backlog. This will require a sustained effort over the forthcoming year in order to ensure progress is maintained. Additionally, UHPNT were part of the CQC Plymouth System Review in December 2017 and the CCG acknowledges the Trust's continued efforts to deliver high quality care through an integrated model. The report recognised the good relationships at senior leadership level across the Plymouth system.

National Staff Survey
Despite extreme operational pressures, we commend the Trust's success in significantly improving the participation rate of the staff survey being able to demonstrate that they are in the top 20% of all acute trusts.

Maternity
The successful pilot from last year now has a dedicated team of 4 midwives working in the South West Ambulance Headquarters in Exeter, offering advice and triage to women and other healthcare professionals. This service is providing an innovative and effective response for women and their families and the Trust should be congratulated for its implementation and success. Additionally, the CCG is pleased to see that women now have better access to the specialist perinatal mental health care team.

Safe Care
There is recognition of areas within last year's quality priorities that were not fully achieved; indeed the position of cancellations and delayed treatments has deteriorated further. The CCG acknowledges that despite the significant operational pressures, the Trust has prioritised reducing cancellations and delayed treatments. The CCG will continue to support the Trust's initiatives to drive this agenda forward.

The CCG welcomes the Trust's quality improvement initiative Scan4Safety and we look forward to working closely with the Trust and supporting an innovative approach that will further enhance the quality of care that is being provided.

Leading Change, Adding Value
The CCG is delighted that the Trust will continue its work from 2016 to deliver the 6 C's in a new strategy that adds value to care delivery in order to achieve better outcomes for patients. Led by the Matrons and

Heads of Nursing, this is now encompassed into the Trust's 10 Commitments.

Cancer Services
The Trust continues to work with the CCG to improve cancer services and two areas that we would wish to highlight are the new pathway for prostate cancer that has been implemented, which will significantly optimise the care that those patients receive. Secondly, the design of a new innovative cancer nurse development post to develop specialist nurses. These two initiatives will bring huge benefits to patients who suffer from cancer.

Looking Forward
Looking ahead, the CCG welcomes the specific priorities for 2018/19 which are highlighted within the report and consider that they are the most appropriate areas to target for continued improvement. The CCG is assured that these priorities were developed in conjunction with key stakeholders, including staff and patients.

It is felt overall that the report is well considered and reflective of quality activity and the CCG looks forward to our continued collaborative working to deliver safe and high quality care across Devon.
Lorna Collingwood, Chief Nursing Officer

Plymouth Caring Plymouth Scrutiny Panel
Unfortunately due to a conflict between the deadline set by the Department of Health for the submission of Quality Accounts and the Council's municipal calendar the Wellbeing Plymouth Scrutiny Panel has been unable to consider these Quality Accounts as part of a standard committee meeting.

Cornwall Health and Adults Overview and Scrutiny Committee
Thank you for providing us with your quality account for the year 2017 - 2018.

It is confirmed that representatives of Plymouth Hospitals NHS Trust have attended meetings when needed and the organisation has provided reports and information to the Committee when asked.

Patient Council
As a Patient Council we are involved in many activities through the hospital year, including formal meetings on alternate months, with informal meetings in between. I particularly like the informal meetings which are sometimes attended by Richard Crompton, Chairman of the Trust Board and Ann James, Chief Executive. These occasions are fertile ground for lively discussion and debate of issue and policies like the car parking charges. Richard Crompton said that he valued our feedback and opinions as they provided the Trust Board with the patient perspective.

The relationships we are forging as individuals with our different service lines are proving fruitful in some cases with some members getting involved in projects on the wards or theatres. Our progress with our clinical alignments has been understandably hampered by winter pressures meaning that non-essential meetings and work was cancelled and contact with medical staff was reduced as they were so busy. We hope to pick this up again now that hopefully the hospital gets some breathing space.

As Chair of the Patient Council, I also enjoy being one of the patient council members on the Patient Experience Committee, contributing to discussion and again providing the patient perspective to senior hospital staff.
Jane Hitchings, Chair Patient Council

Lay Chair of the Patient Experience Committee
Hospital staff have continued to work under extreme operational pressure due to increasing numbers of patients and higher levels of acuity. I want to pay tribute to staff commitment to patient wellbeing, often to the detriment of their own wellbeing. One example of this commitment is demonstrated by the Trust's Friends and Family Test score for Emergency Services, especially when compared with the NHS England average score (annex B, 21.1). This achievement is remarkable, given that there are sometimes up to twice as many patients in the Emergency Department as there is clinical space available.

The updated Carers Policy provides considerable improvement in care for carers, who provide essential and valuable support for their vulnerable relatives when in hospital. The policy ensures better support and facilities for carers own wellbeing.

The Patient Experience Committee endorses and encourages numerous staff initiatives to improve patient experience. Patient diaries in Critical Care help patients to understand and manage the mental distress which sometimes accompanies the experience of treatment in that environment. New style bereavement bags give sensitive and compassionate care to the property of patients who die in hospital, and therefore to bereaved relatives also.

The Patient Experience Committee supports clinical initiatives to reduce the incidence of pressure ulcers, slips, trips and falls, and the Ten Commitments. It supports environmental initiatives to improve patient facilities and Making Mealtimes Matter, which improves both patient nutrition and the enjoyment of meals and mealtimes. Administrative processes are monitored to improve the quality of patient communication and information in all variety.

Disability Awareness Week highlighted issues which impact negatively on people with various kinds of disability. The Patient Experience Committee monitors the work of the Learning Disability Team, which improves the quality of care and experience for patients with a learning disability.

The Patient Experience Committee reviews both internal and external survey results. The data is used to make changes to the provision of care to increase patient satisfaction.

Every staff member of the Patient Experience Committee is actively involved in some aspect of patient wellbeing and experience. The lay members provide insight and perception on behalf of all patients. Together we work to enhance Plymouth Hospitals as a place in which it is good to be a patient. There is still much to do to manage the needs of the increasing numbers of patients. It is important that staff and patients share together in a compassionate experience of healing.

Vera Mitchell, Lay Chair Patient Experience Committee

Annex J - Independent auditor's report

Independent Practitioner's Limited Assurance Report to the Board of Directors of Plymouth Hospitals NHS Trust on the Quality Account

We have been engaged by the Board of Directors of Plymouth Hospitals NHS Trust to perform an independent assurance engagement in respect of Plymouth Hospitals NHS Trust's Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the following indicators:

- Rate of clostridium difficile infections (on page 39 of the Quality Account)
- Percentage of patient safety incidents resulting in severe harm or death (on page 39 of the Quality Account)

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and Practitioner
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health and NHS Improvement guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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 Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS

Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:
- Board minutes for the period April 2017 to June 2018;
- papers relating to quality reported to the Board over the period April 2017 to June 2018;
- feedback from commissioners dated 18 May 2018;
- feedback from local Healthwatch organisations dated 16 May 2018;
- feedback from the Overview and Scrutiny Committee dated 18 May 2018;
- feedback from other named stakeholders involved in the sign off of the Quality Account dated May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009;
- the national inpatient survey 2017;
- the 2017 national NHS staff survey;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 16 May 2018; and
- the annual governance statement dated 25 May 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

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 Directors of Plymouth Hospitals NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Plymouth Hospitals NHS 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 under the terms of the Guidance. 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 of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower 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 Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Plymouth Hospitals NHS Trust.

Our audit work on the financial statements of Plymouth Hospitals NHS 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 Plymouth Hospitals NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Plymouth Hospitals NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Plymouth Hospitals NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Plymouth Hospitals NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors 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 Plymouth Hospitals NHS Trust and Plymouth Hospitals NHS Trust's directors 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 Account is not prepared in all material respects in line with the criteria set out in the Regulations; the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and the indicators in the Quality Account identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Jon Roberts

Grant Thornton UK LLP
Chartered Accountants
Bristol

25 June 2018

Financial Statements and Notes

Annual Accounts for the year ended 31 March 2018

Finances

The Trust set itself a significant financial challenge in the year to deliver a Financial Improvement Plan (FIP) of £40m, equivalent to 8% of our total budget, so we could achieve the deficit control total set by NHS Improvement of £3.1m.

Through our own efforts; a combination ranging from constraints and restraint, through to innovation, improved efficiency and income generation schemes, we managed to deliver over £30m of that £40m target. The balance was then achieved through commissioner and partner support within the Devon STP, where there was recognition that further funding was required given the ever increasing pressure associated with the urgent care activity going through the hospital.

As a result of us over-achieving on our original financial plan, by around £1.3m, we then became entitled to receive a 'performance bonus'. In effect this is a redistribution of resources from other providers who were not successful in delivering their own targets. Our share of this bonus was nearly £6m. As a result of this we have therefore ended the year reporting a surplus (before impairments and other technical adjustments) of approximately £3.4m.

This is a significant achievement for the Trust and is the first time we have been in surplus since 2012/13. It represents a significant strengthening of our position in a year when many other NHS providers have moved in the opposite direction. To get to this position required huge efforts from all the Care Groups and many of the clinical service lines within, as well as many millions of savings achieved through areas such as estates, procurement and prescribing. We must also acknowledge that we would not have got across the line without such strong collaboration and support from our partners in the Devon STP. This performance puts the Trust in a stronger financial position which allows it to design and follow its own strategic path supported by local partners.

Overview of income and expenditure position

2017-18 Financial Plan

The Trust was set a financial deficit control total by NHS Improvement of £14.9m. If the Trust was able to achieve this then it would also have access to the Department of Health's Sustainability and Transformation Fund (STF) of £11.8m which would further reduce this deficit to £3.1m. Although acknowledging the delivery risk the Trust Board accepted this challenge based on a Financial Improvement Plan of £40m and with the support of its local partners within the Devon STP. The planned position reflected a significant improvement from the deficit recorded in the previous year of £39.9m (before the technical accounting impact of asset revaluations and impairments).

The Trust's income was forecast to increase by £31m. £11.8m of this directly relates to the planned receipt of STF for compliance with the financial control total and the A&E 4hr wait operational standard. The Trust also benefited from a £10.5m increase in tariff funding driven by the new HRG4+ tariff which better reflects the income due for some of the speciality procedures carried out by the Trust. Income was also expected

to increase by £12m for the growth in clinical activity. Other movements in tariff and a loss of non-recurrent income from the previous year reduced income by £3.5m.

As part of its Financial Improvement Plan the Trust targeted additional income of £10m through a range of measures including a tariff modification, increased clinical activity and a further increase in commissioner income for structural funding issues.

Costs were forecast to increase by £34m. This reflected the required investments in capacity to deliver the growth in contracted service levels of £13m, and required investments in workforce development, safety and regulatory compliance of £2m. Price increases were forecast to be £6m for pay inflation and incremental increases, and £1.3m for the new apprenticeship levy. Non-pay inflation increases were forecast to be £4.3m including an increased contribution fee of £1.5m (10%) for the NHS Litigation Authority's Clinical Negligence Scheme for Trusts (CNST). Additionally the Trust had increased costs in 2017-18 reflecting the full year costs of investments and workforce recruitment made the previous year of £7m. The Trust also made provision for a contingency fund of £1m.

As part of its Financial Improvement Plan the Trust targeted savings of £30m. This was to be delivered through a number of workstreams including agency reductions, procurement, savings against activity growth costs, alternative workforce models, estates, support services and drugs.

2017-18 Financial Results

The impact of impairments and the impact of movements in the donated assets reserve are not taken into account in the evaluation of the Trust's financial performance by the Department of Health or the Trust's financial plan. On this basis, the Trust's overall financial performance in 2017-18 is a surplus of £3.4m.

After impairments and movements in the donated assets reserve, the reported financial position at the end of March 2018 is adjusted to a surplus of £0.75m.

Although a surplus has been recorded in 2017-18, the Trust still has an overall cumulative deficit (taking each year to the next) of £78.3m. This means that as expected, and as in 2016-17, the Trust has broken its statutory duty to break-even. As reported last year, the Trust's auditors have notified the Secretary of State of this with a Section 30 Notice.

The surplus of £3.4m is £6.5m better than planned. This is made up of an overachievement of £1.7m against its pre-STF target of £14.9m and a £4.8m increase in STF funding above the planned allocation of £11.8m.

The financial improvement has been achieved by delivering a Financial Improvement Plan of £31m (6%) against a target of £40m (8%) with the shortfall made up from additional income from commissioners in recognition of the increased demand and operational pressures this causes. As part of its savings plans the Trust has reduced agency spend from £12m to £8m and met its agency expenditure ceiling set by NHSI this year. The Trust was able to exceed its plan with additional winter funding allocated by NHS Improvement of £1.2m to cover expenditure included in the Trust's plan. Further improvement of £0.5m was achieved primarily from additional commissioner CQUIN income received.

The Trust achieved STF of £9.5m against the planned allocation of £11.8m based on delivering the criteria set for both the financial compliance for the year and compliance with the 4 hour wait target across the STP in quarters 1 and 2. The difference of £2.3m was not earned because we did not meet the 4 hour target in quarters 3 or 4. This performance is in the context of further increasing non-elective demand that put the Trust under operational strain, especially over the winter months. Under NHS Improvement's STF incentive schemes the Trust also achieved STF funding of £1.3m to match the overachievement of its pre STF plan. Finally the Trust was then awarded a further STF bonus of £5.8m by NHS Improvement under its policy to distribute all remaining STF funds to Trusts that achieved their plans.

Although financial performance has improved, as seen in other Trusts across the country the operational performance around the 4 hour wait target has not improved as desired and the performance against the 18 week Referral to Treatment target has deteriorated during the year.

The Trust's final income and expenditure performance for the year is shown below;

Statement of Comprehensive Income	2017-8 £000s	2016-7 £000s	Diff £000s
Revenue from patient care activities	440,999	403,258	37,741
Other operating revenue	66,782	47,090	19,692
Total Income	507,781	450,348	57,433
Gross employee benefits	(296,090)	(283,034)	(13,056)
Other operating costs	(189,975)	(185,617)	(4,358)
Depreciation and Amortisation	(12,360)	(15,749)	3,389
Total Expenditure	(498,425)	(484,400)	(14,025)
Operating surplus/(deficit)	9,356	(34,052)	43,408
Investment revenue	42	27	15
Other gains and (losses)	(20)	(29)	9
Finance costs	(2,327)	(1,497)	(830)
Public dividend capital dividends payable	(3,526)	(4,360)	834
Impairments and reversals	(2,778)	1,719	(4,497)
Retained surplus/(deficit) for the year	747	(38,192)	38,939

Retained surplus/(deficit) for the year	747	(38,192)	38,939
Impairments/(Impairments Reversals)	2,778	(1,719)	4,497
Adjustments in respect of donated asset reserve elimination	(118)	11	(129)
Adjusted retained (deficit)	3,407	(39,900)	43,307

Income

The majority of revenue from patient care activities comes from NEW Devon and Kernow Clinical Commissioning Groups (services for the local population) and NHS England who commission specialist, dental and screening services. In 2017-18, the Trust treated 59,406, elective patients, 57,728 non elective patients and over half a million outpatients. The Emergency Department had 101,085 attendances. The level of emergency and non-elective patient increased by 4%, nearly 2% more than planned which had an impact on the level of elective patients that the Trust saw which was reduced from last year.

Revenue from patient care activities increased by £38m in 2017/18 (9%). As mentioned above, income was expected to increase by £19m from the tariff increase and increased service levels planned with an additional income of £10m from the financial improvement plan. The majority of these improvements were delivered and in addition the Trust received additional funding from commissioners and partner support within the Devon STP in recognition that further funding was required given the ever increasing pressure associated with the urgent care activity going through the hospital.

Other operating revenue includes £30.0m of income derived from education, training and research activities, including the training of junior doctors and nursing staff. The balance represents income

generated from clinical and general services provided by the Trust to other organisations and from charges for the use of Trust services and facilities. Also included in this category is the £16.6m of STF funding that the Trust was awarded which accounts for most of the increase from last year. The Trust also received £2.3m of winter funding from NHS England, £1.2 of which contributed the overachievement of the Trust's plan.

Expenditure
With over 6,100 permanently employed whole time equivalent staff, pay costs, including salaries, national insurance and pension contributions, comprise the majority of the Trust's operating expenses and account for over 60% of the Trust's total expenditure. Staff costs have increased by £13m from 2016-17. The primary reason for the increase is as forecast staff increments and inflation increased by £6m and £1m for the new apprenticeship levy. The average number of staff employed during the year also increased by 184 WTE. This reflects the investments in permanent staff made to treat the additional numbers of patients seen totalling £6m. This WTE movement also includes a small increase in temporary staff although expenditure on agency staff has reduced dramatically from £12m to £8m as the Trust increased its use of local bank staff and continued to reduce the rates paid.

Non pay costs incurred in 2017/18 totalled £190 million, an increase of £4m. The cost of clinical supplies increased by £1m reflecting the increased number of patients treated and inflation costs. As mentioned previously there was also the forecast increase of £1.5m in the contribution fee for the NHS Litigation Authority's Clinical Negligence Scheme for Trusts (CNST). Other increases across a number of expenditure categories total £1.5m which include inflation pressures on premises costs for utilities and rates.

Depreciation costs have reduced by £3.3m as the Trust reviewed and reassessed the useful life for accounting purposes of its buildings. This has extended the lives of the assets to be more in line with the building life the Trust expects to use these assets for. The charge also reduced as assets brought on line for use was slower than forecast.

Savings Plans
The Trust has delivered £31m of the £40m Financial Improvement Plan. This delivery was across a number of workstreams. Significant areas include £10m savings against the costs of growth and increased contribution from variable contracts, £3m workforce savings mainly around the reduction of agency costs, £3m from procurement including £1.7m from pharmacy savings, £3m of depreciation savings, over £1m on estates savings, and £6m on income from commissions for structural funding issues.

Cash and Working Capital
The Trust's cash plan for the year reflected the utilisation of the £4.8m brought forward balance on capital expenditure, to end the year with a reduced balance of £1m. The actual balance stands at £4.2m, a reduction of £0.6m which reflects later than planned capital spend in March for which cash payments have yet be processed.

The Trust originally planned to have a revenue support loan of £3.1m from the Department of Health to support the planned deficit of £3.1m. However at the year end the Trust had taken loans of £9.5m with the

increased amount taken in lieu of the receipt of STF funding. When all STF funding is transacted early in 2018-19 the Trust will repay this borrowing in full. The funding has allowed the Trust to continue a good performance against the Better Payment Practice Code with 95% of invoices paid within the required time. The Trust has paid the required 3.5% dividend on public assets employed.

Capital Investments

The Trust started the financial year with an initial capital programme of £21m focused on three aspects; the continued implementation of major IT developments including the electronic patient notes and electronic prescribing projects, the maintenance capital requirements for the Trust's buildings, infrastructure and equipment, and finally to progress strategic plans to re-provide the Trust's ageing Interventional Radiology theatres and develop the case for an extended Emergency Department.

At the beginning of the year the Trust was successful in a bid to NHS Improvement for £1m of funding to develop GP streaming services on the hospital site. The Trust utilised this funding to create a wider Acute Assessment Unit (AAU) which encompassed GP Streaming services along with an increased ambulatory care service and frailty unit. This project involved building a new orthopaedic outpatients unit to allow for these services to be transferred out of the main hospital to enable the new AAU to be collocated next to other urgent care services. The Trust supported the project with a further £1m of internal funds and the unit opened in November 2017. The Trust received a further allocation of £1m from NHS Improvement to enhance its cyber security arrangements which was also utilised during the year.

With the additional requirements of these new programmes and the extensive demands of the original programme there were some delays in the remaining capital plan resulting in an underspend of £2m. Therefore the final total capital spend remained at £21m, as summarised below.

Capital Spend	£M
Estates and Facilities	2.5
IM&T Replacement Programme and systems	1.6
Rolling Replacement Programme for Medical Equipment	1.9
Service Line Programme	1.2
eNotes	2.5
ePrescribing	1
Lightwell Development	0.1
CT in ED	1.6
Other Planning Schemes	0.9
General Contingency	3.5
Donated assets	0.4
GS1/Scan4Safety	0.6
DoH PDC Primary Care Streaming/Orthopaedic OP/AAU	2.2
DoH PDC Cyber Security	1
DoH PDC WiFi Allocation	0.2
Total	**21.2**

Future Plans
The Trust has a plan for 2018-19 that is in line with the financial control total set by NHS Improvement, that being a deficit of £3.8m. The Trust has another challenging Financial Improvement Programme of £33m to meet this target and maintain an underlying performance similar to this year's significant improvement.

Despite the current adverse trading position the Trust remains a going concern and this status is supported by both NHS Improvement and our External Auditors. It must be noted however that the Trust is reliant on further Department of Health loan funding included in our plan which totals £8m during the course of the year but, after in-year repayments, will be £3.8 at year end. Although we are confident that this funding will be forthcoming, as this has not yet been formally confirmed for the whole year ahead it does represent an uncertainty that may be considered to cast doubt about the Trust's ability to continue as a going concern. However, we are certain that the services currently provided by the Trust will continue to be provided in the foreseeable future and the Trust fully expects to receive this support as in previous years and therefore we are absolutely confident in adopting the going concern status.

The Trust continues to work within the wider health community to deliver key elements of the Financial Improvement Programme. The Devon Sustainability and Transformation Plan is supported by the Trust Board and the fellow trusts included in its geographical scope. This programme provides the strategic pathway to ensure that all partners work together to restore operational and financial stability. The current plans for this programme indicate that the Trust can return to financial balance in two years. Key plans being developed with the health system includes actions to reduce elective and outpatient referrals and actions to reduce and manage emergency admissions effectively including reducing the number of patients awaiting transfer to alternative care settings. The Trust will also supplement these workstreams with its own internal financial improvement plans including continuing to generate procurement savings, tackling high agency spend and developing alternative workforce models. The Trust is also using the NHS Improvement 'Model Hospital' and 'Getting it Right First Time' benchmarking tools to develop a number of clinical productivity programmes.

The Trust is confident that these actions will help to bring long-term financial viability whilst delivering safe and effective care for patients.

Plymouth Hospitals NHS Trust

Annual Accounts for the year ended 31 March 2018

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed: Ann James
Chief Executive

Date 25th May 2018

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Ann James	Chief Executive	25th May 2018
Neil Kemsley	Finance Director	25th May 2018

Independent auditor's report to the Directors of University Hospitals Plymouth NHS Trust in respect of Plymouth Hospitals NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Plymouth Hospitals NHS 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 Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

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 Department of Health and Social Care Group Accounting Manual 2017-18; 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 Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors 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 Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that the Directors intend to apply to the Department of Health and Social Care, supported by NHS Improvement, for additional cash funding in 2018/19. As stated in note 1.1.2, the Department of Health and Social Care has not, at the date of our report, confirmed this support.

This event, along with the other matters explained in note 1.1.2, 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.

Other information
The Directors are responsible for the other information. The other information comprises the information included in the Annual Report other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, 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 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 resource 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.

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 comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. 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.

Opinion on other matters required by the Code of Audit Practice

In our opinion:
- the parts of the Remuneration Report and 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 Department of Health and Social Care Group Accounting 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 Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the 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 Accountable Officer
As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable 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 Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to 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 Plymouth Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Jon Roberts
Partner

for and on behalf of Grant Thornton UK LLP

2 Glass Wharf
Bristol
BS2 0EL

25th May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3.1	440,999	403,258
Other operating income	4	66,782	47,090
Operating expenses	5.1, 7	(501,203)	(482,681)
Operating surplus/(deficit) from continuing operations		**6,578**	**(32,333)**
Finance income	10	42	27
Finance expenses	11	(2,327)	(1,497)
PDC dividends payable		(3,526)	(4,360)
Net finance costs		**(5,811)**	**(5,830)**
Other gains / (losses)	12	(20)	(29)
Surplus / (deficit) for the year from continuing operations		**747**	**(38,192)**
Surplus / (deficit) for the year		**747**	**(38,192)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	16	382	(863)
Total comprehensive income / (expense) for the period		**1,129**	**(39,055)**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	988	1,011
Property, plant and equipment	14	211,156	204,619
Trade and other receivables	18	3,200	2,937
Total non-current assets		**215,344**	**208,567**
Current assets			
Inventories	17	11,626	11,169
Trade and other receivables	18.1	31,088	20,182
Cash and cash equivalents	19	4,220	4,809
		46,934	**36,160**
Current liabilities			
Trade and other payables	20	(44,119)	(38,677)
Borrowings	22	(24,217)	(758)
Provisions	24	(287)	(317)
Other liabilities	21	(1,958)	(2,062)
Total current liabilities		**(70,581)**	**(41,814)**
Total assets less current liabilities		**191,697**	**202,913**
Non-current liabilities			
Borrowings	22	(60,885)	(75,423)
Provisions	24	(1,172)	(1,253)
Total non-current liabilities		**(62,057)**	**(76,676)**
Total assets employed		**129,640**	**126,237**
Financed by			
Public dividend capital		197,825	195,551
Revaluation reserve		7,663	7,456
Other reserves		652	652
Income and expenditure reserve		(76,500)	(77,422)
Total taxpayers' equity		**129,640**	**126,237**

The notes on pages 199 to 240 form part of these accounts.

Signed: Ann James

Position: Chief Executive

Date 25th May 2018

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**195,551**	**7,456**	**652**	**(77,422)**	**126,237**
Surplus for the year	-	-	-	747	747
Other transfers between reserves	-	(175)	-	175	-
Revaluations	-	382	-	-	382
Public dividend capital received	2,274	-	-	-	2,274
Taxpayers' equity at 31 March 2018	**197,825**	**7,663**	**652**	**(76,500)**	**129,640**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**189,551**	**8,591**	**652**	**(39,502)**	**159,292**
(Deficit) for the year	-	-	-	(38,192)	(38,192)
Other transfers between reserves	-	(272)	-	272	-
Revaluations	-	(863)	-	-	(863)
Public dividend capital received	6,000	-	-	-	6,000
Taxpayers' equity at 31 March 2017	**195,551**	**7,456**	**652**	**(77,422)**	**126,237**

Information on reserves

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

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

Other reserves
The balance on this reserve dates back many years and relates to the acquisition of property from a demising Community Trust.

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

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		6,578	(32,333)
Non-cash income and expense:			
Depreciation and amortisation	5.1	12,360	15,749
Net impairments	6	2,778	(1,719)
Income recognised in respect of capital donations	4	(538)	(422)
(Increase) in receivables and other assets		(10,941)	(2,497)
(Increase) in inventories		(457)	(807)
Increase / (decrease) in payables and other liabilities		3,252	(9,673)
(Decrease) in provisions		(112)	(145)
Net cash generated from / (used in) operating activities		**12,920**	**(31,847)**
Interest received		42	27
Purchase of intangible assets		(282)	(396)
Purchase of property, plant, equipment and investment property		(18,445)	(15,100)
Sales of property, plant, equipment and investment property		48	-
Net cash (used in) investing activities		**(18,637)**	**(15,469)**
Cash flows from financing activities			
Public dividend capital received		2,274	6,000
Movement on loans from the Department of Health and Social Care		8,815	49,868
Movement on other loans		133	225
Capital element of finance lease rental payments		(28)	-
Interest paid on finance lease liabilities		(28)	(28)
Other interest paid		(2,284)	(1,250)
PDC dividend (paid)		(3,754)	(3,936)
Net cash generated from / (used in) financing activities		**5,128**	**50,879**
Increase / (decrease) in cash and cash equivalents		**(589)**	**3,563**
Cash and cash equivalents at 1 April - brought forward		**4,809**	**1,246**
Cash and cash equivalents at 31 March	**19**	**4,220**	**4,809**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care 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 and Social Care. 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.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.
IAS 1 requires management 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 than, the dissolution of the Trust without the transfer of its services to another entity.
As directed by the 2017/8 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 directors also consider that the contracts it has agreed with commissioning bodies and anticipated support for any required application it makes to the Department of Health & Social Care, supported by NHS Improvement, for additional cash funding in 2018/9 are also evidence that the Trust will have adequate resources to continue in operational existence for the foreseeable future. It is, however, acknowledged that the additional cash funding requested in 2018/19 (which totals £8m during the course of the year, and is expected to be £3.8m at the end of the year following delivery of the Financial Improvement Plan) has not yet formally been approved by the Department of Health. Therefore, although we are confident that this funding will be forthcoming through the monthly request and approval process, as this has not yet been confirmed for the whole year ahead it does represent a material uncertainty that may be considered to cast significant doubt about the Trust's ability to continue as a going concern. However, as stated above, as we

are certain that the services currently provided by the Trust will continue to be provided in the foreseeable future, we are content with adopting the going concern status.

Note 1.2 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Judgement is required to assess whether or not there has been any impairment of assets over the period. In the case of land and buildings the advice of the District Valuer is sought annually. For plant and equipment an internal impairment review is completed annually.

Note 1.2.1 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Accruals for services received not yet invoiced are estimated on the basis of past experience.

Note 1.3 Income
Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

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 the 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 as income 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.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension 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. Therefore 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.

Note 1.5 Expenditure on other goods and services
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.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition
Property, plant and equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.6.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

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

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.
Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
ains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.
Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of

service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

Note 1.6.3 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.

Note 1.6.4 Donated assets
Donated property, plant and equipment assets are capitalised at their fair value on receipt. The donation is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Note 1.6.6 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	16	84
Plant & machinery	2	30
Transport equipment	7	7
Information technology	2	16
Furniture & fittings	5	20

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

Note 1.7 Intangible assets
Note 1.7.1 Recognition
Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
the project is technically feasible to the point of completion and will result in an intangible asset for sale or use

- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

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

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation - see Note 16. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

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

Note 1.7.3 Useful economic lives of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Licences & trademarks	4	11

Note 1.8 Inventories
Inventories are valued at current cost. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.9 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

Note 1.10 Carbon Reduction Commitment scheme (CRC)
The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that

have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Note 1.11 Financial instruments and financial liabilities

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

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

Financial assets are categorised as fair value through income and expenditure, loans and receivables or available-for-sale financial assets.

Financial liabilities are classified as fair value through income and expenditure or as other financial liabilities.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the statement of Comprehensive Income.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at fair value through income and expenditure are impaired. Financial assets are impaired and impairment losses are recognised if, and only 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.

Note 1.12 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 The Trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

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

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
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.

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

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

Note 1.12.2 The Trust as lessor

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although 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 24.2 but is not recognised in the Trust's accounts.

Note 1.14 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

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

Note 1.15 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 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.

Note 1.17 Foreign exchange
The Trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

Note 1.18 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing 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.

Note 1.19 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

- IFRS 9 Financial Instruments
  This standard becomes effective for the 2018/19 financial statements. No material impact is expected.
- IFRS 15 Revenue from Contracts with Customers
  This standard becomes effective for the 2018/19 financial statements. No material impact is expected.
- IFRS 16 Leases
  This standard becomes effective for the 2019/20 financial statements. The impact may be material. This impact is expected to be clarified following the issue of the 2019/20 HM Treasury Financial Reporting Manual which is expected to be published in December 2018.

Note 2 Operating Segments

The Trust has no material operating segments other than healthcare.

	2017-18 £000s	2016-17 £000s
Income	507,781	450,348
Operating surplus/ (deficit)	6,578	(32,333)
Net Assets	129,640	126,237

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	79,630	79,553
Non elective income	122,736	107,995
First outpatient income	37,389	35,388
Follow up outpatient income	20,512	23,940
A & E income	13,590	11,860
High cost drugs income from commissioners (excluding pass-through costs)	41,858	40,952
Other NHS clinical income	111,605	93,047
All services		
Private patient income	2,849	2,509
Other clinical income	10,830	8,014
Total income from activities	**440,999**	**403,258**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	163,604	149,164
Clinical commissioning groups	267,259	245,887
Other NHS providers	1,214	899
NHS other	156	82
Local authorities	2,917	2,541
Non-NHS: private patients	2,849	2,509
Non-NHS: overseas patients (chargeable to patient)	238	196
NHS injury scheme	1,887	1,715
Non NHS: other	875	265
Total income from activities	440,999	403,258
Of which:		
Related to continuing operations	440,999	403,258
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	238	196
Cash payments received in-year	200	139
Amounts added to provision for impairment of receivables	30	28
Amounts written off in-year	-	11

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	5,110	5,450
Education and training	23,380	23,513
Receipt of capital grants and donations	538	422
Charitable and other contributions to expenditure	857	883
Non-patient care services to other bodies	9,218	9,232
Sustainability and transformation fund income	16,636	-
Rental revenue from operating leases	998	681
Income in respect of staff costs where accounted on gross basis	2,762	369
Other income	7,283	6,540
Total other operating income	**66,782**	**47,090**
Of which:		
Related to continuing operations	66,782	47,090
Related to discontinued operations	-	-
Other income includes:		
Income generation activities	5,447	4,438
Other	1,836	2,102
	7,283	**6,540**

Note 4 Fees and charges - Income generation activities
The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care.

The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

	2017/18	2016/17
	£000	£000
Income	2,419	2,359
Full cost	(1,792)	(2,507)
Surplus / (deficit)	**627**	**(148)**

The only scheme with costs exceeding £1m was car parking. Much of the cost relates to the lease of the multi-storey car park, which is included in "rentals under operating leases" in note 5.1. The Trust has been actively working on reducing the cost of running its parking facilities and the MSCP lease was renegotiated during the year, resulting in a significant ongoing cost reduction and a one off additional benefit of £285k in 2017/18.

Note 5.1 Operating expenses

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	621	509
Purchase of healthcare from non-NHS and non-DHSC bodies	7,702	7,651
Staff and executive directors costs	296,090	283,034
Remuneration of non-executive directors	88	79
Supplies and services - clinical (excluding drugs costs)	55,826	54,449
Supplies and services - general	16,584	16,568
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	57,161	57,835
Inventories written down	165	77
Consultancy costs	603	189
Establishment	3,361	3,243
Premises	14,951	12,266
Transport (including patient travel)	513	2,397
Depreciation on property, plant and equipment	12,055	15,345
Amortisation on intangible assets	305	404
Net impairments	2,778	(1,719)
Increase/(decrease) in provision for impairment of receivables	56	130
Change in provisions discount rate(s)	18	110
Audit fees payable to the external auditor		
audit services- statutory audit	66	74
other auditor remuneration (external auditor only)	10	10
Internal audit costs	169	161
Clinical negligence	17,280	15,709
Legal fees	315	269
Insurance	451	477
Research and development	4,691	4,544
Education and training	1,510	1,267
Rentals under operating leases	3,381	4,037
Early retirements	21	43
Car parking & security	1,976	1,836
Hospitality	81	20
Losses, ex gratia & special payments	126	171
Grossing up consortium arrangements	215	245
Other services, e.g. external payroll	417	426
Other	1,617	825
Total	501,203	482,681
Of which:		
Related to continuing operations	**501,203**	**482,681**
Related to discontinued operations	-	-

Note: audit fees are shown gross of VAT. The net statutory audit fee was £55k (2016/17 £62k.)

Note 5.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	10	10
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**10**	**10**

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m.

Note 6 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	2,778	(1,719)
Total net impairments charged to operating surplus / deficit	**2,778**	**(1,719)**

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	233,820	221,049
Social security costs	23,403	22,110
Apprenticeship levy	1,136	-
Employer's contributions to NHS pensions	27,564	26,113
Temporary staff (including agency)	17,021	19,853
Total gross staff costs	**302,944**	**289,125**
Recoveries in respect of seconded staff	(1,091)	(1,546)
Total staff costs	**301,853**	**287,579**
Of which		
Costs capitalised as part of assets	2,152	1,442

Note 7.1 Retirements due to ill-health

During 2017/18 there were 4 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £219k (£211k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 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 FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the 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 Pension 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 revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Pension costs - other scheme

Under the terms of the Pensions Act 2008 the Trust is required to provide a pension scheme for employees who are not eligible for membership of the NHS Pension Scheme. Qualifying employees are enrolled in the National Employment Savings Trust (NEST) managed scheme. NEST is a defined contribution scheme managed by a third party organisation. It carries no possibility of actuarial gain or loss to the Trust and there are no financial liabilities other than payment of the 2% employers contribution of qualifying earnings. This contribution will increase to 3% in 2018. Employer contributions are charged directly to the Statement of Comprehensive Income and paid to NEST monthly. At 31st March 2018 there were 172 employees enrolled in the scheme (154 at 31 March 2017).
Further details of the scheme can be found at www.nestpensions.org.uk.

Note 9 Operating leases

Note 9.1 Plymouth Hospitals NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Plymouth Hospitals NHS Trust is the lessor.

Several items of medical equipment, some vehicles and some buildings used mainly for administrative functions but also some for service provision are held on operating leases. The Trust also leases land at the site of the haemodialysis unit and a multi-storey car park adjacent to the main Derriford site.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	998	681
Total	998	681

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
	513	300
- later than one year and not later than five years;	271	419
- later than five years.	338	455
Total	**1,122**	**1,174**

Note 9.2 Plymouth Hospitals NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Plymouth Hospitals NHS Trust is the lessee.

The Trust lets part of its estate to commercial organisations on operating leases.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	3,381	4,037
Total	3,381	4,037

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	3,762	3,821
- later than one year and not later than five years;	10,226	10,536
- later than five years.	33,119	2,057
Total	**47,107**	**16,414**

Note 10 Finance income

Finance income represents interest received in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	42	27
Total	**42**	**27**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,297	1,466
Finance leases	28	22
Other	1	6
Total interest expense	**2,326**	**1,494**
Unwinding of discount on provisions	1	3
Total finance costs	**2,327**	**1,497**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	1	6

Note 12 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Losses on disposal of assets	(20)	(29)
Total gains / (losses) on disposal of assets	**(20)**	**(29)**

Note 13.1 Intangible assets - 2017/18

	Licences & trademarks	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**2,339**	**2,339**
Additions	282	282
Gross cost at 31 March 2018	**2,621**	**2,621**
Amortisation at 1 April 2017 - brought forward	**1,328**	**1,328**
Provided during the year	305	**305**
Amortisation at 31 March 2018	**1,633**	**1,633**
Net book value at 31 March 2018	**988**	**988**
Net book value at 1 April 2017	**1,011**	**1,011**

Note 13.2 Intangible assets - 2016/17

	Licences & trademarks	Total
	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**2,269**	**2,269**
Additions	70	**70**
Valuation / gross cost at 31 March 2017	**2,339**	**2,339**
Amortisation at 1 April 2016 - as previously stated	**924**	**924**
Amortisation at 1 April 2016 - restated	**924**	**924**
Provided during the year	404	404
Amortisation at 31 March 2017	**1,328**	**1,328**
Net book value at 31 March 2017	**1,011**	**1,011**
Net book value at 1 April 2016	**1,345**	**1,345**

Note 14.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**4,802**	**142,837**	**18,617**	**109,931**	**192**	**25,657**	**4,710**	**306,746**
Additions	-	66	20,518	368	-	93	11	**21,056**
Impairments	-	(2,779)	-	-	-	-	-	**(2,779)**
Reversals of impairments	-	1	-	-	-	-	-	**1**
Revaluations	-	(4,410)	-	-	-	47	-	**(4,363)**
Reclassifications	-	6,967	(15,775)	6,562	46	1,909	291	**-**
Disposals / derecognition	-	-	-	(337)	(10)	-	-	**(347)**
Valuation/gross cost at 31 March 2018	**4,802**	**142,682**	**23,360**	**116,524**	**228**	**27,706**	**5,012**	**320,314**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**1,719**	**-**	**77,680**	**154**	**19,809**	**2,765**	**102,127**
Provided during the year	-	3,026	-	6,895	11	1,800	323	**12,055**
Revaluations	-	(4,745)	-	-	-	-	-	**(4,745)**
Disposals / derecognition	-	-	-	(275)	(4)	-	-	**(279)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**84,300**	**161**	**21,609**	**3,088**	**109,158**
Net book value at 31 March 2018	**4,802**	**142,682**	**23,360**	**32,224**	**67**	**6,097**	**1,924**	**211,156**
Net book value at 1 April 2017	**4,802**	**141,118**	**18,617**	**32,251**	**38**	**5,848**	**1,945**	**204,619**

Note 14.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**6,002**	**140,927**	**8,214**	**107,494**	**192**	**27,609**	**5,961**	**296,399**
Prior period adjustments	-	(4,825)	-	-	-	-	-	**(4,825)**
Valuation / gross cost at 1 April 2016 - restated	**6,002**	**136,102**	**8,214**	**107,494**	**192**	**27,609**	**5,961**	**291,574**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	-	17,597	871	-	111	14	**18,593**
Impairments	-	(164)	-	-	-	-	-	**(164)**
Reversals of impairments	-	1,883	-	-	-	-	-	**1,883**
Revaluations	(1,200)	337	-	-	-	-	-	**(863)**
Reclassifications	-	4,679	(7,194)	3,090	-	668	(1,243)	**-**
Disposals / derecognition	-	-	-	(1,524)	-	(2,731)	(22)	**(4,277)**
Valuation/gross cost at 31 March 2017	**4,802**	**142,837**	**18,617**	**109,931**	**192**	**25,657**	**4,710**	**306,746**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**-**	**-**	**72,116**	**146**	**20,468**	**3,125**	**95,855**
Prior period adjustments	-	(4,825)	-	-	-	-	-	**(4,825)**
Accumulated depreciation at 1 April 2016 - restated	**-**	**(4,825)**	**-**	**72,116**	**146**	**20,468**	**3,125**	**91,030**
Provided during the year	-	5,695	-	7,197	8	2,147	298	**15,345**
Reclassifications	-	849	-	(138)	-	(75)	(636)	**-**
Disposals/ derecognition	-	-	-	(1,495)	-	(2,731)	(22)	**(4,248)**
Accumulated depreciation at 31 March 2017	**-**	**1,719**	**-**	**77,680**	**154**	**19,809**	**2,765**	**102,127**
Net book value at 31 March 2017	**4,802**	**141,118**	**18,617**	**32,251**	**38**	**5,848**	**1,945**	**204,619**
Net book value at 1 April 2016	**6,002**	**140,927**	**8,214**	**35,378**	**46**	**7,141**	**2,836**	**200,544**

Note 14.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	4,802	140,605	23,360	30,662	67	5,910	1,819	**207,225**
Finance leased	-	-	-	544	-	-	-	**544**
Owned - donated	-	2,077	-	1,018	-	187	105	**3,387**
NBV total at 31 March 2018	**4,802**	**142,682**	**23,360**	**32,224**	**67**	**6,097**	**1,924**	**211,156**

Note 14.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	4,802	139,056	18,617	30,722	38	5,725	1,825	**200,785**
Finance leased	-	-	-	584	-	-	-	**584**
Owned - donated	-	2,062	-	945	-	123	120	**3,250**
NBV total at 31 March 2017	**4,802**	**141,118**	**18,617**	**32,251**	**38**	**5,848**	**1,945**	**204,619**

Note 15 Donations of property, plant and equipment
Donated assets totalling £538k were received during the year. Of these, £268k were received from the Trust's linked charity, and £270k from rganisations including the League of Friends, tHe Cavitron Fund, the Chestnut Appeal and Heartswell.

Note 16 Revaluations of property, plant and equipment
Land and property assets are carried at valuation on the Statement of Financial Position. All of the Trust's land and building assets are revalued annually by the District Valuer of the Valuation Office Agency who is a Member of the Royal Institution of Chartered Surveyors. Valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

Building asset lives are also reassessed annually by the District Valuer. During 2017/18 the Trust made the decision to move to an equated life approach which had the effect of lengthening building lives for accounting purposes.

Note 17 Inventories

	31 March 2018	31 March 2017
	£000	£000
Drugs	2,275	2,524
Consumables	9,178	8,504
Energy	173	141
Total inventories	**11,626**	**11,169**

Inventories recognised in expenses for the year were £102,301k (2016/17: £103,039k). Write-down of inventories recognised as expenses for the year were £165k (2016/17: £77k).

Note 18.1 Trade receivables and other receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	23,054	12,244
Provision for impaired receivables	(1,156)	(1,169)
Prepayments (non-PFI)	3,852	4,362
PDC dividend receivable	374	146
VAT receivable	1,788	960
Other receivables	3,176	3,639
Total current trade and other receivables	**31,088**	**20,182**
Provision for impaired receivables	(903)	(838)
Other receivables	4,103	3,775
Total non-current trade and other receivables	**3,200**	**2,937**
Of which receivables from NHS and DHSC group bodies:		
Current	18,172	8,705
Non-current	-	-

Note 18.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**2,007**	**1,902**
Increase in provision	56	129
Amounts utilised	(4)	(25)
Unused amounts reversed	-	1
At 31 March	**2,059**	**2,007**

The great majority of trade is with other NHS organisations. As NHS organisations are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Note 18.3 Credit quality of financial assets

	31 March 2018	31 March 2017
	Trade and other receivables	Trade and other receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	-	-
30-60 Days	-	-
60-90 days	27	23
90- 180 days	131	28
Over 180 days	240	74
Total	**398**	**125**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	473	902
30-60 Days	628	344
60-90 days	229	77
90- 180 days	83	201
Over 180 days	248	46
Total	**1,661**	**1,570**

Note 19 Cash and cash equivalents movements

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

	2017/18	2016/17
	£000	£000
At 1 April	**4,809**	**1,246**
Net change in year	(589)	3,563
At 31 March	**4,220**	**4,809**
Broken down into:		
Cash at commercial banks and in hand	30	27
Cash with the Government Banking Service	4,190	4,782
Total cash and cash equivalents as in SoFP	**4,220**	**4,809**
Total cash and cash equivalents as in SoCF	**4,220**	**4,809**

Note 20 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	16,699	16,208
Capital payables	7,133	5,060
Accruals	7,001	5,742
Social security costs	3,374	3,201
VAT payables	250	-
Other taxes payable	3,142	2,885
Accrued interest on loans	163	150
Other payables	6,357	5,431
Total current trade and other payables	**44,119**	**38,677**
Of which payables from NHS and DHSC group bodies:		
Current	3,940	1,549
Non-current	-	-

The payables note above includes amounts in relation to pensions as set out below:

	31 March 2018	31 March 2017
	£000	£000
- outstanding pension contributions	3,928	3,752

Note 21 Other liabilities

	31 March 2018	31 March 2017
	£000	£000
Current		
Deferred income	1,958	2,062
Total other current liabilities	**1,958**	**2,062**

Note 22 Borrowings

	31 March 2018	31 March 2017
	£000	£000
Current		
Loans from the Department of Health and Social Care	24,114	700
Other loans	73	30
Obligations under finance leases	30	28
Total current borrowings	**24,217**	**758**
Non-current		
Loans from the Department of Health and Social Care	60,083	74,682
Other loans	286	195
Obligations under finance leases	516	546
Total non-current borrowings	**60,885**	**75,423**

Note 23 Finance leases

The Trust holds modular accommodation for the Trust's Staff Health & Wellbeing facility on a finance lease.

Obligations under finance leases where Plymouth Hospitals NHS Trust is the lessee are as follows:

	31 March 2018	31 March 2017
	£000	£000
Gross lease liabilities	**748**	**804**
of which liabilities are due:		
- not later than one year;	56	56
- later than one year and not later than five years;	226	226
- later than five years.	466	522
Finance charges allocated to future periods	(202)	(230)
Net lease liabilities	**546**	**574**
of which payable:		
- not later than one year;	30	28
- later than one year and not later than five years;	136	129
- later than five years.	380	417

Note 24.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Total
	£000	£000	£000
At 1 April 2017	**863**	**707**	**1,570**
Change in the discount rate	7	11	**18**
Arising during the year	24	113	**137**
Utilised during the year	(93)	(121)	**(214)**
Reversed unused	(9)	(44)	**(53)**
Unwinding of discount	1	-	**1**
At 31 March 2018	**793**	**666**	**1,459**
Expected timing of cash flows:			
- not later than one year;	89	198	**287**
- later than one year and not later than five years;	356	131	**487**
- later than five years.	348	337	**685**
Total	**793**	**666**	**1,459**

Note 24.2 Clinical negligence liabilities

At 31 March 2018, £150,113k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Plymouth Hospitals NHS Trust (31 March 2017: £128,683k).

Note 25 Contingent assets and liabilities

	31 March 2018	31 March 2017
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(93)	(78)
Gross value of contingent liabilities	**(93)**	**(78)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(93)**	**(78)**
Net value of contingent assets	**-**	**-**

Note 26 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	2,482	4,640
Intangible assets	-	169
Total	**2,482**	**4,809**

Note 27 Financial instruments

Note 27.1 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 Trust has with commissioners and the way those commissioners are financed, the 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 the financial reporting standards mainly apply. The NHS 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 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. The Trust's 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 borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are
confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because most of the Trust's revenue 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 primary care organisations, 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.

Note 27.2 Carrying values of financial assets

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	23,240	23,240
Cash and cash equivalents at bank and in hand	4,220	4,220
Total at 31 March 2018	**27,460**	**27,460**

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	12,301	12,301
Cash and cash equivalents at bank and in hand	4,809	4,809
Total at 31 March 2017	**17,110**	**17,110**

Note 27.3 Carrying value of financial liabilities

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	84,556	84,556
Obligations under finance leases	546	546
Trade and other payables excluding non financial liabilities	37,353	37,353
Total at 31 March 2018	**122,455**	**122,455**

Note 27.3 Carrying value of financial liabilities (contd)

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	75,607	75,607
Obligations under finance leases	574	574
Trade and other payables excluding non financial liabilities	32,592	32,592
Total at 31 March 2017	108,773	108,773

Note 27.4 Fair values of financial assets and liabilities

The carrying value of financial assets and liabilities is not significantly different from fair value.

Note 27.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	61,570	33,349
In more than one year but not more than two years	10,915	24,204
In more than two years but not more than five years	49,588	50,803
In more than five years	382	417
Total	**122,455**	**108,773**

Note 28 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	16	1	19	4
Bad debts and claims abandoned	62	3	99	25
Stores losses and damage to property	16	165	22	15
Total losses	**94**	**169**	**140**	**43**
Special payments				
Ex-gratia payments	147	122	232	204
Total special payments	**147**	**122**	**232**	**204**
Total losses and special payments	**241**	**291**	**372**	**248**

Note 29 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust

The Department of Health is regarded as a related party. During the year the 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 Department. For example :

NHS New Devon CCG
NHS Kernow CCG
NHS South Devon & Torbay CCG
NHS England
Royal Devon & Exeter NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust
Health Education England
NHS Resolution
NHS Business Services Authority
NHS Pension Scheme
Other CCGs
Other foundation trusts
Other NHS trusts

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. It has also had a number of transactions with the University of Plymouth during the year; certain Trust Board members are also members of the University Board. The relationship was strengthened on 1 April 2018 when the Trust changed its name to University Hospitals Plymouth NHS Trust.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the Trust Board. In particular the Trust has received grants from the Plymouth Hospitals General Charity, of which the Trust is Corporate Trustee.

Note 30 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	88,212	214,533	88,653	218,097
Total non-NHS trade invoices paid within target	84,819	201,971	84,382	193,672
Percentage of non-NHS trade invoices paid within target	96.15%	94.14%	95.18%	88.80%
NHS Payables				
Total NHS trade invoices paid in the year	2,460	8,569	2,824	8,847
Total NHS trade invoices paid within target	2,238	7,758	2,451	7,069
Percentage of NHS trade invoices paid within target	90.98%	90.54%	86.79%	79.90%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 31 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	11,783	52,530
Finance leases taken out in year	-	600
External financing requirement	11,783	53,130
External financing limit (EFL)	16,153	55,439
Under spend against EFL	4,370	2,309

Note 32 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	21,338	18,663
Less: Disposals	(68)	(29)
Less: Donated and granted capital additions	(538)	(422)
Charge against Capital Resource Limit	20,732	18,212
Capital Resource Limit	22,531	22,026
Under spend against CRL	1,799	3,814

Note 33 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus (control total basis)	3,107
CQuin adjustment	300
Breakeven duty financial performance surplus	3,407

Note 34 Breakeven duty rolling assessment

	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance	2,010	18	15	49	(12,988)	(4,989)	(35,996)	(39,900)	3,407
Breakeven duty cumulative position	12,056	12,074	12,089	12,138	(850)	(5,839)	(41,835)	(81,735)	(78,328)
Operating income	376,990	391,499	391,862	405,822	410,207	430,817	432,771	450,348	507,781
Cumulative breakeven position as a percentage of operating income	3.20%	3.08%	3.09%	2.99%	-0.21%	-1.36%	-9.67%	-18.15%	-15.43%

Paragraph 2(1) of Schedule 5 of the National Health Service Act 2006 states that "Each NHS trust shall ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account". NHS trusts normally plan to meet this duty by achieving a balanced position on their income and expenditure account each and every year. The interpretation of the statutory financial duty for NHS trusts to break even was clarified in 1997/99 which recognised that although NHS trusts are expected to achieve a balanced position on their income and expenditure account each and every year, there may be reasons for the NHS trusts to report deficits in one year which may be offset by surpluses achieved in another year(s). This is particularly relevant to situations where NHS trusts must recognise costs in advance of cash outlay, for example for clinical negligence or pension costs, and when managing the recovery of an NHS trust with serious financial difficulties. A run of three years may be used to test the break-even duty, but in exceptional cases the Department of Health may agree to a five year time-scale.

Note 35 Events after the reporting period

On 1 April 2018 the Trust changed its name to University Hospitals Plymouth NHS Trust.

PROUD!

Peter Cantin, Consultant Sonographer and employee of the Trust since 1995, has been awarded his Doctorate in Clinical Research.

Six-years in the making, he started his pathway to becoming a doctor in 2011 and finally achieved his goal towards the end of 2017. "It has been hard, hard work," admitted Peter. "However the department has been brilliant in allowing me to work flexibly to achieve it, part-funding some of the early stages of the study."

"It was a part-taught, part-learned doctorate with a major research project contributing to 50,000 words at the end of it which took over two-years in itself. The whole thing has taken six years to complete and of course this was whilst working full-time and doing other things that you need to do in life!"

Alongside fellow Consultant Radiologists Catherine Gutteridge and Simon Freeman, Peter runs the Derriford Ultrasound Service which delivers high quality diagnostics for general, obstetric and muscular skeletal studies.

"Peter's success as a Consultant Sonographer, and getting his doctorate, is great news for him and of course the Trust, but also for the British Medical Ultrasound Society (BMUS)," said Simon, who is also President of the BMUS.

He added: "BMUS is the main ultrasound body in the UK and, alongside obtaining his doctorate, Peter chaired the organising committee for our latest annual scientific meeting. A lot of work for the organisation of the three day event all came through our department here at the Trust thanks to Peter.

"There are very few Consultant Sonographers in the country, and we are in need of more. Peter is a shining example of what they can achieve and is certainly a ground breaker in this context."


TAVISTOCK
Main Entrance


Cumberland Centre
Livewell
Supporting people to be Safe, We


Child Development Centre

#1bigteam