NHS
University Hospitals Plymouth
NHS Trust

#1BigTeam

Annual Report and Accounts 2018/19

Leading with excellence, caring with compassion

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 includes a link to our Quality Accounts. The structure of the report is as follows:

Foreword

There are not many organisations which receive thousands of good wishes and messages of support on their birthday. But when the NHS celebrated its 70th birthday in the summer of 2018, it was an occasion we celebrated with people throughout the city and beyond.

Our matrons organised cream teas with patients and families on our wards and in departments, we joined forces with schools and universities to hold our #NHS70 Open Day. Chris Pointon came to talk movingly about the #hellomynameis campaign started by his late wife at our Pride of Plymouth NHS70 Awards, when we celebrated some of our many fantastic staff in both our Trust and our neighbouring community organisation Livewell Southwest. And we created an online group in which people shared photos and memories from the NHS of yesteryear.

It was a moment to both look back and celebrate and look forward and contemplate. The NHS is indeed a national treasure but to maintain its beloved place in the nation's hearts it has to evolve and change, meeting our needs as a changing society. For example, deaths from smoking-related diseases are declining, but the incidence of obesity and associated health problems is on the rise.

We had much to celebrate in 2018/19, including:

- Significantly reducing the number of people who are subject to delays when leaving hospital (delayed transfers of care) from 8% to consistently 2%-3.5% since April 2018 (80-100 patients down to 18-25)
- Securing more than £50m of funding for a new Emergency Department, two new MRI scanners and new digital histopathology system
- Making more progress in providing a rewarding and supportive environment in which to work with the results of the National Staff Survey 2018
- Using #PeopleFirst lean methodology to drive team-driven improvement
- Helping lead the way nationally with Getting it Right First Time (GIRFT) clinical specialty work, which is making sure our services are the best they can be

But we also have much to do. Almost seven months to the day after the NHS marked its birthday, the **NHS Long Term Plan** was published, setting the direction of travel for services for the next ten years. It outlined a new service model, in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. The NHS is also seeking to do more to prevent ill health, address inequalities and focus on specific areas such as cancer, mental health, diabetes, healthy ageing including dementia, children's health, cardiovascular and respiratory conditions, and learning disability and autism, amongst others.

We are, of course, revising our own direction of travel and ambitions in light of the NHS Long Term Plan. There are areas of immediate concerns we have to address, including our CQC report from

August 2018. This rated us as 'Requires Improvement' overall and saw us receive two warning notices: for pharmacy and diagnostics respectively. At the time of writing, we are still working to address concerns raised by inspectors about our diagnostic service.

Then there are the longer-term challenges. Over recent years we have seen consistent growth in the number of people attending our hospital as emergencies and the people we are seeing and admitting are sicker, or, in healthcare terms, they have 'higher acuity'.

Whilst demand is growing, our workforce is not. It remains our biggest challenge – having enough of the right staff to care for patients and their families. Training staff takes time – it takes an average ten years for a doctor to become a consultant for example and three years to qualify as a registered nurse – as well as training places which we don't control. We work with other organisations to try to plan for the future and we remain as flexible and responsive as we can – for example we have been a pilot site for new roles such as the Physician Associate and Nursing Associates.

Our colleagues - those both paid and those who volunteer their time for free – are our NHS. The best facilities, equipment and medication in the world would be nothing without them. It is often the kind words, the touch on the arm in a moment when we are distressed, the reassurance of their knowledge and expertise when we are vulnerable and scared that we remember as patients.

And it is their achievements which make this Annual Report and Quality Account what it is – it is their compassion, commitment and professionalism 24 hours a day, 7 days a week, 365 days a year that shines through. On behalf of our leadership team, we would like to express our deepest gratitude to all our staff and volunteers for their continued dedication and incredible compassion.

Ann James
Chief Executive

Richard Crompton
Chairman

Our Year in Pictures

April 2018

1st April marks our first day as University Hospitals Plymouth NHS Trust, following approval for our name change by the Secretary of State for Health and Social Care. This cements our status as an organisation which is and has been intrinsically involved with teaching, education and research for decades. We work in close partnership with the University of Plymouth and the Plymouth University Peninsula Schools of Medicine and Dentistry. We also support the University of Exeter Medical School with the placement of medical imaging students and are developing closer relationships with Plymouth's Marjon University, a national leader in rehabilitation.

Her Royal Highness, Princess Anne, officially opens the University of Plymouth's multimillion pound Derriford Research Facility, at an event attended by a number of research clinicians from our Trust. Professor Simon Rule, Consultant Haematologist at Derriford Hospital is pictured above with HRH Princess Anne The University building, acting as the new headquarters of its Institute of Translational and Stratified Medicine, is located next to Derriford Hospital. It is hoped the facility will allow greater collaboration between medical, dental and biomedical researchers at the University, with research clinicians at the Trust.

May 2018

June 2018

We join forces with Livewell Southwest CIC to celebrate some of the particularly special members of staff and volunteers who are the Pride of Plymouth NHS. Chris Pointon, widower of Dr Kate Granger, who co-founded and championed the #hellomynameis campaign, presents the winners with their awards. He also delivers an emotional talk on the life of his late wife and how their campaign continues to inspire people across the world. The event was organised, as **part of the NHS' 70th birthday**, to celebrate some of the incredible people who go above and beyond in providing NHS services to patients in and around Plymouth.

July 2018

We celebrate the NHS 70th birthday on 5 July 2018 with a special Tea with Matron on our wards, a hotly-contested charity Bake-Off, a special Schwartz round themed 'Cradle to Grave Care'. On top of our Open Day, we also partnered with organisations across the city to create an NHS70 Facebook group part populated with old footage of yesterday's healthcare in Plymouth, sourced from the Box Plymouth Museum and the South West Film Archive.

Our Trust achieves its highest scores to-date since the introduction of patient-led annual assessments five years ago. The Patient-Led Assessment of the Care Environment (PLACE) is led by patient assessors, who offer a non-technical view across a range of environmental aspects and observe how standards are being met that support patient privacy and dignity, food, cleanliness and general maintenance, as well as disability and dementia. The results reveal that not only has University Hospitals Plymouth improved in all of the measured areas, but it has achieved its highest scores in all of the defined categories since the introduction of PLACE standards in 2013.

August 2018

September 2018

Children needing emergency care can look forward to an improved experience after it is announced Derriford Hospital will receive more than £2million to upgrade parts of the Emergency Department in time for winter. The investment will allow:

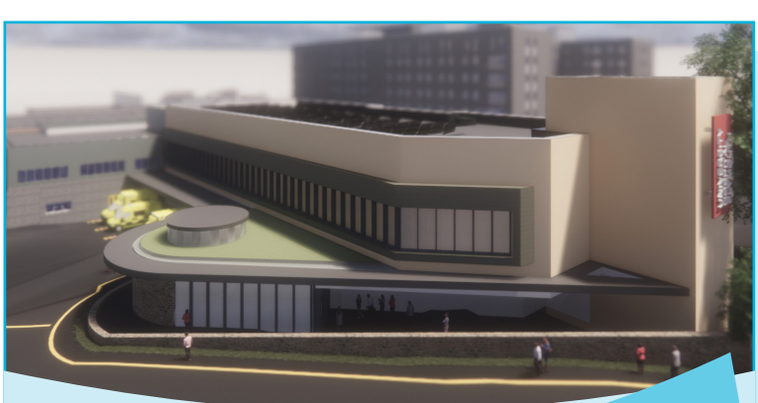
- An expansion of the paediatric area taking the unit from three children's consultation rooms up to five, plus a bigger waiting area and toilets for families to use
- An improved resuscitation unit which could increase the size from four bays to seven within the resuscitation unit.

October 2018

"Thank you to all the team on Pencarrow for saving lives every day" - wrote Secretary of State for Health and Social Care Matt Hancock on the Pencarrow comments board during his night shift in the hospital. The words could have applied to everyone he met.
Matt and MP Johnny Mercer asked if they could come and do a night shift with staff. They wanted to come without ceremony and witness the hospital at night as it is. They came with the aim of talking to and listening to staff and finding out what they think. They left blown away by how welcomed they felt they had been and how committed, professional and caring our #1bigteam is.

We celebrate the very first national Allied Health Professionals (AHPs) Day, which aims to recognise and appreciate the impact these professions have on healthcare. AHPs are the third largest workforce in health and care in England and have a huge impact on the health and wellbeing of our population. Many of us will know and recognise some of the work that our radiographers, paramedics and physiotherapists do. However, due to their small numbers and where they work, other roles such as Operating Department Practitioners, Orthoptists and Prosthetists are not so visible.

November 2018



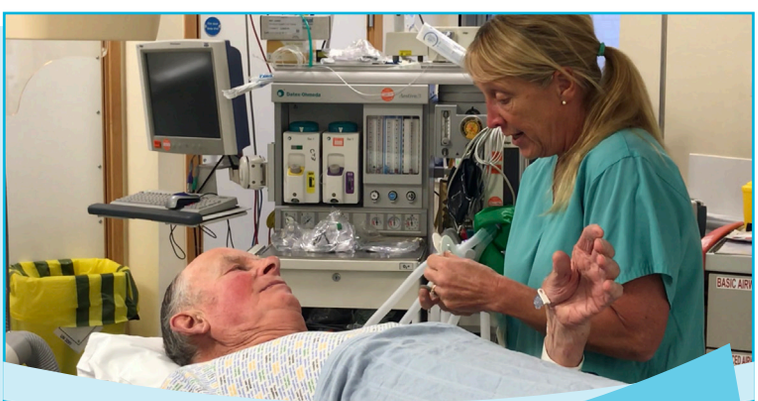
December 2018

We are delighted with an early Christmas present - news that Plymouth has been awarded £30 million to build a new Urgent and Emergency Care Hub. A further £12million is being invested in new diagnostic scanners and digital histopathology across Devon and Cornwall. The new Urgent and Emergency Care Hub will have dedicated areas for children, for patients with frailty, ambulatory care – patients who need urgent care but do not necessarily need to be admitted – and a dedicated area that offers privacy and dignity for ambulances to drop patients off.

January 2019

Our first cohort of Trainee Nursing Associates are registered with the Nursing and Midwifery Council (NMC). Following two years of training, Nursing Associates will work with Health Care Assistants and Registered Nurses to deliver care to patients. The role is intended to address a skills gap between health care assistants and registered nurses, opening a new entry point into a fully registered nursing career. Nursing associates are trained to work with people of all ages in a variety of settings in health and social care.

Good news - waiting times for patients needing cardiology diagnosis and treatment will fall with the opening of a third specialist lab at Derriford Hospital. Prior to the lab opening there were two cardiac catheterisation (cath) labs for cardiology patients which did not give sufficient space to see and treat all the patients needing planned procedures as well as those coming in as emergencies. Patients are currently having to wait 40 weeks for angiogram tests and up to 52 weeks for angioplasty. In a bid to secure extra capacity to treat patients in a timely way, Regent's Park Healthcare (RPH), is building a specialist centre at the back of the hospital.



February 2019

March 2019

A midwife at University Hospitals Plymouth NHS Trust recruits the 1,000th patient into a national clinical trial looking at whether a text messaging service can help pregnant women to quit smoking. The MiQuit 3 trial, led by Professor Tim Coleman at the University of Nottingham, is investigating whether pregnant women who smoke are interested in receiving support to stop smoking by text message and whether it can help them to quit. Heidi Hollands, a Research Midwife at Derriford Hospital and a National Research Champion for Reproductive Health, is the local Principal Investigator (PI) for the study.

About our Trust

University Hospitals Plymouth NHS Trust (UHP) is the largest hospital in the peninsula. We deliver a full range of general hospital services to around 500,000 people living in Plymouth, south and west Devon and Cornwall.

Where our patients come from:

Area	Number of distinct patients	%
North and East Cornwall	46,411	8
Plymouth	296,393	52
South and West Devon South Cornwall	128,018	22
	104,179	18
Total	**575,001**	**100**

We serve a diverse population with a wide variation in health and life expectancy, within which there are pockets of deprivation. For example, in Plymouth the life expectancy gap between those living in the most deprived areas and those in the least deprived areas remains signi¬ficant; life expectancy in the most deprived areas of Plymouth (at 78.4 years) is 4.4 years lower than in some of the least deprived areas (source: The Plymouth Report 2017).

As a specialist hospital, we operate at the heart of the south west peninsula providing specialist hospital services within a wider peninsula population of more than 1.5 million.

We are a teaching hospital in partnership with the University of Plymouth and working with Plymouth Marjon University. As host to the South West Medical Defence Group in a city with a strong military tradition, we have a tri-service staff of 200+ military doctors, nurses and allied health professionals fully integrated within the hospital workplace. Our Chief Executive sits on the Plymouth Growth Board, is a board member of the NHS South West Leadership Academy, Regional Chair for Talent Board and is a member of One Plymouth.

As such, we are ideally placed to support our local health and social care system acting as a lead partner, supporting new investments to ensure people are cared for as close to home as possible and developing new collaborative practices.

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. Services include emergency and major trauma, maternity, paediatrics, a full range of diagnostic, medical and surgical sub-specialties as well as many regional specialist services such as the south west peninsula cardiothoracic services, transplant services including kidneys and stem cells, and specialist neurosurgical services.

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 Estover.

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.

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

The Strategic Context

Integrated care
Health and care organisations and local authorities across Devon are working together with the aim of becoming an Integrated Care System (ICS), in line with the NHS Long Term Plan. This means agreeing a shared vision and collaborating more to meet the health and care needs of our population making sure our services are sustainable and affordable.

From competition to collaboration
The aim of the NHS Long Term Plan is to give everyone the best start in life; deliver world-class care for major health problems, such as cancer and heart disease, and help people age well. There are many references within the NHS Long Term Plan to the move towards collaboration over competition. Working together with all of our health and wellbeing partners, including those in the voluntary sector such as the Red Cross and St Luke's, we have to make best use of people's time and the funding available to achieve the best outcomes.

Local context
An ageing population is a recognised national trend, but the proportion of our local population in Plymouth, west Devon and south East Cornwall aged 85 or over is growing ahead of the national average by approximately 10 years. This requires us to innovate if we are to develop effective and sustainable services for older people.

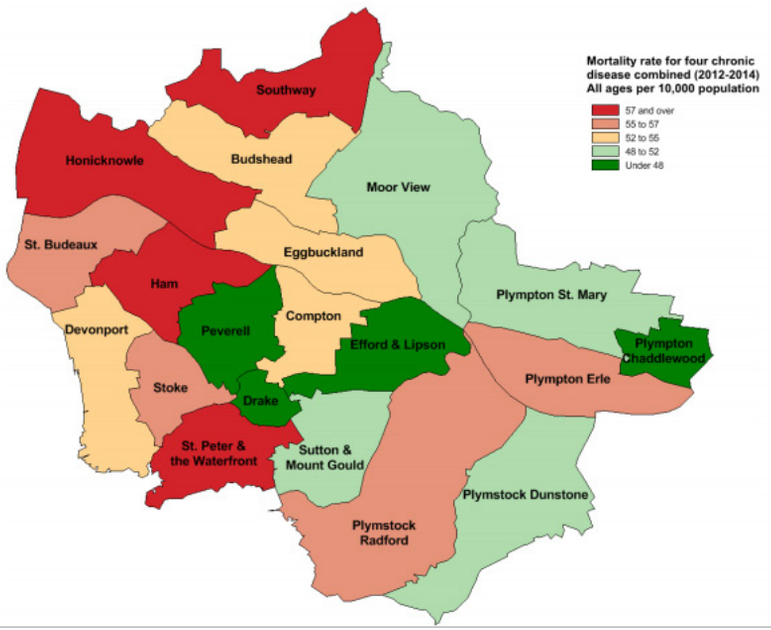
Pockets of deprivation within Plymouth drive higher demand for health and care services. Of local Plymouth people, 29% of the population are included in the most deprived in England and 15 out of 32 public health indicators in Plymouth are worse than the national average, including measures such as life expectancy, under 75 mortality rate, smoking prevalence, GCSEs achieved and children in low income families.

We are the largest single employer in Plymouth, employing more than 7,000 people. We are supplemented with a committed army of volunteers, 550+strong. This #1bigteam have a significant effect on the city of Plymouth, from how they choose to travel, their spending power and their own health and wellbeing. Our staff and volunteers are both contributors to the reality of Healthier Lives and advocates for it.

Our structure features four care groups which oversee 38 service lines covering all services, from emergency medicine and maternity to kidney transplant, neurosurgery, cardiothoracic surgery, upper GI surgery, cardiology and neurology to plastic surgery and trauma orthopaedics (amongst others).

More than 48,000 people pass through the main entrance of Derriford Hospital each week, without taking into account our other entrances or indeed other centres. Derriford Hospital has just over 900 beds in 36 wards, of which 167 are day-case beds, and 41 are for children.

Figure 26: All-age mortality rate for cancer, heart disease, respiratory disease, and stroke combined, 2012-14



Source: The Plymouth Report 2017

Devon Sustainability and Transformation Partnership

We joined forces with three local authorities, six other NHS organisations and one Community Interest Company in October 2016 to create a single Devon Sustainability and Transformation Partnership (STP). In July 2018, a two-year report was published highlighting the significant progress that has been achieved through joint working. It noted in particular:

Improved performance against national NHS standards, putting Devon in the top 30% nationally on urgent care and mental health
Reduced delays in transferring patients out of hospital, meaning Devon was on track to reach targets and to free 79 hospital beds for those needing them
High quality social care, with 86% of adult social care providers rated as either Outstanding or Good by the Care Quality Commission
Enhanced community services to support thousands more people to live independently at home, leading to 213 fewer acute and community hospital beds
Clinically appropriate referrals into hospitals, reducing unnecessary visits and seeing a 5.37% reduction in planned procedures and treatments
New clinical networks supporting "Best Care for Devon" standards in: • Urgent and emergency care • Stroke • Maternity services
Innovative mental health services including: • Liaison psychiatry in each acute hospital • Psychological support for people with long-term health conditions • Specialist support for women with postnatal depression
More than 100 ambassadors trained to promote careers in health and social care in schools.
Strengthening outcomes for children and young people, with children's community health services rated "Good" by the Care Quality Commission
In addition, historical overspending has been reduced from £95.4 million to £22.7 million in the past two years. This includes saving £25 million on agency staff. The Devon system is aiming for financial balance in 2019/20.

However, real challenges remain. These include health inequalities, social isolation, disadvantage for people with mental health problems, an ageing population and meeting the needs of carers. Recruitment of staff remains challenging, in primary care, in some medical specialties and in nursing and social care. The STP has proposed taking a more focused approach on fewer priorities for 2019/20. Over the next year, the STP focus will be on five areas:

- Accelerating the digital opportunities for the system to achieve integrated and interoperable care record systems, and improved access to care
- Developing an acute care strategy for Devon and Cornwall
- Addressing inequalities by moving resources to where they will be more effective in meeting need and improving outcomes
- Integrating mental health services, alongside development of inpatient services
- Promoting prevention and self-care, helping more people live healthy, well lives at home, with greater resilience in communities achieved through close working with charity and voluntary leaders.

These five priorities are accompanied by two other pieces of work:

- Implementation of the Integrated Care Model blueprint agreed in 2017
- Implementation of the workforce strategy

Integrating Care
Here are a few examples of how we have made good progress in joining up services so that people receive better all-round care:

Home First Approach
We have worked with Livewell Southwest, Plymouth Healthwatch, Plymouth City Council, care homes, the Red Cross and domiciliary care providers to design, develop and deliver integrated services for patient with more complex needs. A patient with complex needs is someone who needs support to keep them at home or to get them home post-discharge; they can be someone who needs reablement, occupational therapy or physiotherapy input or perhaps just a little help from careworkers to regain their confidence and independence at home. Equally they can be someone who needs to go to a care home after being in hospital, or support to die at home.
This has transformed the way we get patients home from hospital, switching us from bed-based care to a philosophy where home first is the default choice, what patients and their families want, wherever possible.

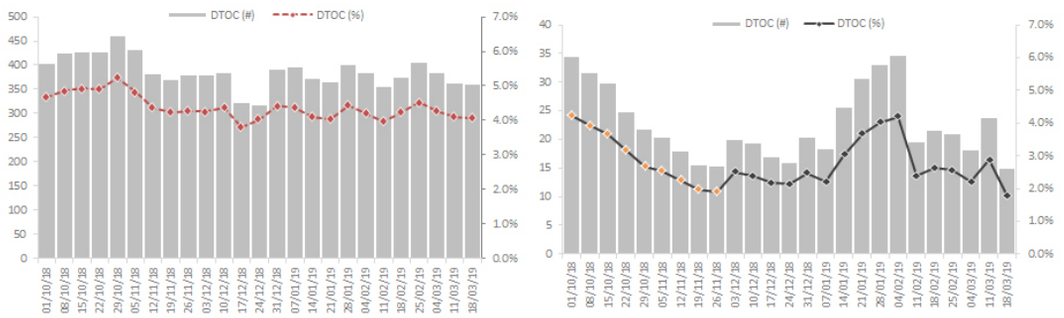
In Derriford Hospital, we have set up an integrated Command Centre in which a joint team have oversight of demand for hospital, community and social care services. This joint team is made up of hospital, community, council, intermediate care and ambulance service staff. The joint team means we can understand where demand is, what people need and use our resources to meet that, getting it right for patients first time.

These two things together, along with a rigorous daily effort looking at the needs of every complex patient, means we have achieved the national trajectory to reduce the number of patients subject to delayed transfers of care (DTOC).

DToC South

University Hospitals Plymouth NHS Trust

UHP

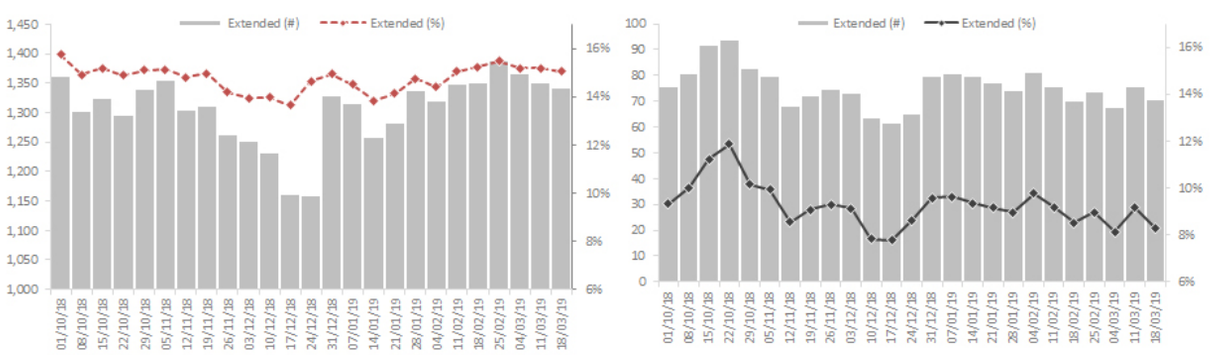


We are also in the top three performing trusts for the number of patients who have an extended length of stay (>21 days), which is linked to our efforts to minimise people deconditioning and our home-first philosophy.

Extended Length of Stay South

University Hospitals Plymouth NHS Trust

UHP



Our Acute Assessment Unit (AAU)

This unit offers patients needing urgent care a place to go for same day emergency care, a key plank of the NHS Long Term Plan. Patients are referred here to be seen by a GP (primary care streaming), for investigations and treatment within the same day (ambulatory care) and to be seen in a specialty frailty unit. Teams from our own trust and Livewell Southwest, the community provider, work together to support people to be treated and go home rather than be admitted. They can refer to a number of 'hot clinics' and call on colleagues within the Community Crisis Response Team to help do this. Our AAU sees 10% of our emergency patients.

Building relationships with GPs
We have an Associate Medical Director for Primary Care who is a GP and he is leading work to build stronger relationships between our hospital services and GPs. An example of this is a twinning programme between consultants and GPs. Eighty-four people – half GPs and half hospital consultants - spent time shadowing each other at the end of 2018. GPs shadowed hospital consultants at work and consultants went out to general practice to shadow GPs.

The main learning points for those involved were a mutual appreciation of each others' workloads and a desire to support each other to both deliver good clinical care and to make each others' professional lives easier. Everyone agreed that seeing things from a different perspective was enlightening, humbling, and valuable

Specific points for action were picked up around communication (quality of referrals and discharge) and improvements to specific clinical pathways. These are now being actioned by a joint Interface Working Group. This group consists of the Local Medical Committee members, GPs and consultants who look at feedback and action it. An early success for this group has been Fit Notes. GPs raised as an issue that patients were leaving hospital without them. We briefed our teams about what they should do to issue patients with Fit Notes on discharge, avoiding the patient leaving hospital and then having to visit their GP to get one.

We are also working with GPs on helping support people with long term conditions, for example those with diabetes or respiratory illness, so we are thinking about how our services work with theirs.

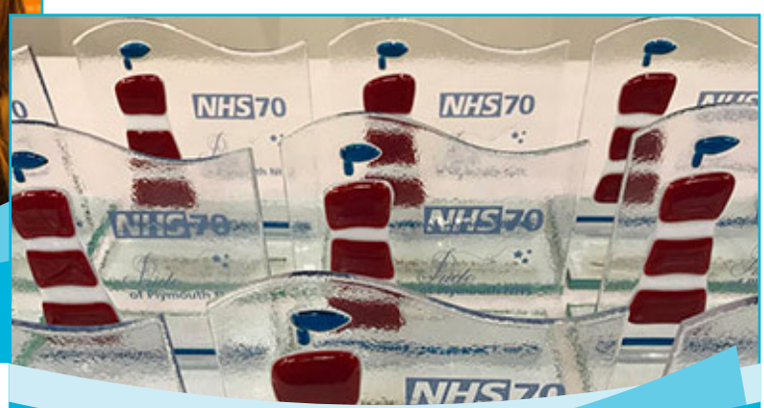
Extending diabetes expertise beyond hospital walls
We have a team of consultants and nurses in diabetes who would have traditionally seen patients in a hospital setting. Thanks to transformation funding, we have been able to do something different.

The aim of the transformation was to improve achievement of diabetes treatment targets (HbA1c, blood pressure and cholesterol) for patients across all local GP practices. To do this, we invested in more community specialist nurse sessions in GP practices and care homes and virtual consultant clinics. We developed a tool which works with the GP database, picks out blood test results, weight etc and uses an algorithm to highlight those patients the health professionals need to talk about.

By then giving advice and guidance to primary care colleagues, our specialists can support patient care in the community and patients don't need to come to hospital for an appointment.

As a result, we have seen a reduction in the number of people referred into the hospital and more discharges from our clinics. The advantage for patients is they get access to specialist advice without having to visit hospital and the patient feedback so far has been excellent.

Proud!



How we marked #NHS70

Within the Trust, celebrations for NHS70 started back in December 2017, when a hugely popular **advent calendar** recognised some of our longest serving members of staff and volunteers, taking a look back to where they started and where they are now.

The centrepiece of our NHS70 celebrations was our **Open Day** in June. The event saw over 700 visitors come along and learn about the changing history of services in the NHS, as well as get involved with some hands-on activities such as delivering a mock baby!

The Open Day was immediately followed by the **NHS70 Pride of Plymouth NHS Awards Ceremony**, a combined event with Livewell Southwest to celebrate some of the incredible people who go above and beyond in providing NHS services to patients in and around Plymouth.

The birthday was met with the news that Sian Dennison, our Head of Nursing for Cancer and End of Life, had won the 'Excellence in Cancer Care Award' at the **NHS70 Parliamentary Awards**. The national awards were created to recognise the massive contribution made by the individuals who work in and alongside the NHS and Sian was nominated by all three Plymouth MPs.

Meanwhile, staff across our sites brought out the bunting and got baking for the NHS Big7Tea. This included special NHS70 'Tea with Matron' events on each ward, which allowed patients and staff to share in the celebrations together. A small selection of photos from the many areas who took part can be found on the **Trust's Facebook Page**.

Staff from around the Trust took part in the Great NHS70 Bake. After much deliberation, the judges decided the winner was Student Nurse Tirion, who won with an NHS70-themed two-tier lemon and elderflower cake.

The day was particularly poignant for judge, Vera Mitchell MBE, as it marked 20 years since she underwent life-saving surgery at Derriford Hospital. This was the start of a long association with the Trust as a volunteer, which resulted in royal honours earlier this year.

The birthday was met by well-wishes from around the city:

- Plymouth Argyle's Ryan Edwards recorded a special message for staff at Derriford Hospital, after receiving treatment for testicular cancer earlier this year.
- Plymouth Herald featured "Plymouth's everyday heroes" explaining why they love working in the NHS.
  For all our #nhsheroes who save lives, fix us when we're broken, care for us when we need it most and deliver our babies, this one's for you #nhs70 #HappyBirthdayNHS #plymouth @Derriford_Hosp **https://t.co/NTmcLy0ZeA**
  - Plymouth Live (@Plymouth_Live) July 5, 2018
- Smeaton's Tower was even lit up blue in honour of NHS70.
  We are on Plymouth Hoe tonight, taking in the incredible view whilst we wait to see the iconic @SmeatonsTower#LightUpBlue tonight for #NHS70 - thanks to @plymouthcc for supporting the celebrations **pic.twitter.com/fcgFYcC2s0**
  - NHS England SW (@NHSEnglandSW) 5 July 2018
- **Plymouth Museums Galleries Archives** and the **South West Film and Television Archive** shared some old content from archives which documents the NHS of yesteryear, as part of our **NHS70 Plymouth Facebook Group**. You can still join up and tell your stories from years gone by.

Our Chairman and Chief Executive would like to extend a big thank you to our staff and volunteers. Ann James said: "As the NHS celebrates its 70th birthday, I would like to recognise and thank the many people here in Plymouth who make the NHS what it is. Not just now but all those who have done over the years."

Looking forward
In light of the new NHS Long Term Plan, we are currently revisiting and revising our 2013 strategy, At the Heart of the Peninsula.

Healthcare is funded by and belongs to us all. That's why it is so important that our strategy, Healthier Lives is drawn up by our staff, with input from their colleagues, patients, groups representing patients, our key partners including other providers and elected representatives. We are also drawing on the views of nearly 2,000 people across Plymouth.

With our strategy we are looking to build on our strengths, as identified by those who have shared their views with us: namely excellent clinical care, compassionate and professional staff and our open, collaborative approach which is helping build relationships right across our community.

But we also recognise there are areas we need to address, not least of which is having enough of the right staff with the right skills at the right time in the right place to provide care and advice. Working to recruit, train and retain the right number of staff will help us improve processes such as discharge, which stakeholders have told us is something we need to be better at.

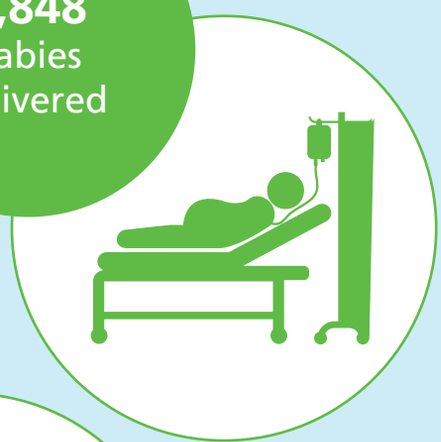
We are aiming to share our revised strategy in the summer of 2019.

Our Performance

137,674
patients cared for on our wards

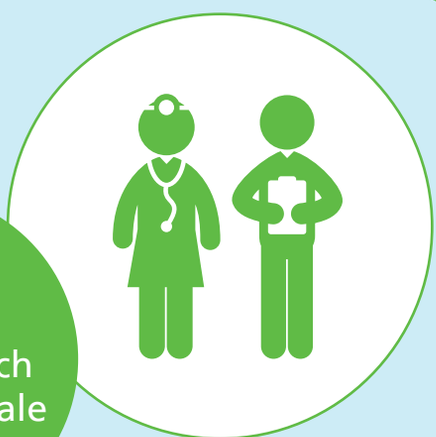
493,994
outpatient appointments

3,848
babies delivered



106,223
attendances including attendances at our Emergency Department, our Royal Eye Infirmary and our Minor Injuries Units

More than
4,500
people took part in research through UHP



7,415
staff, of which 75% are female

4.5 stars
on NHS Choices

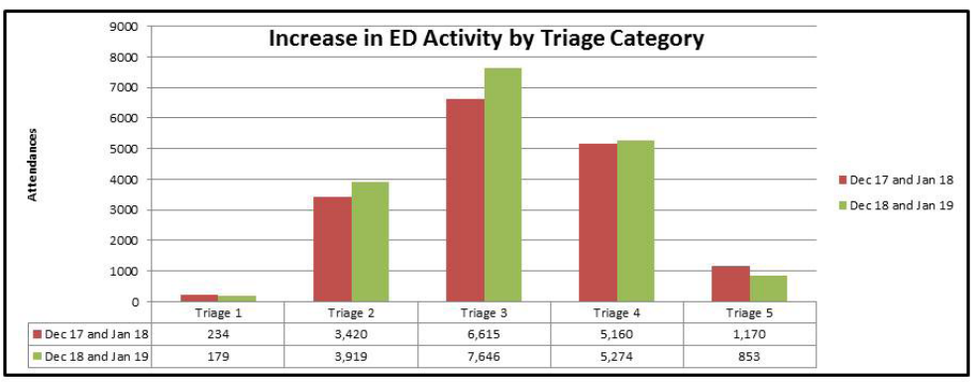
NHS Clinical Activity	2014/15	2015/16	2016/17	2017/18	2018/19
Elective Spells	62,321	62,774	62,877	59,446	66,756
Emergency + Non Elective Spells	53,152	54,623	56,752	58,726	70,911
Outpatient Attendances	485,423	487,435	492,968	485,812	493,994
Emergency Department Attendances	92,780	94,560	97,126	100,319	106,223
Babies delivered	4,555	4,570	4,180	4,166	3,848

*Emergency Department Attendances are inclusive of type one attendances and those streamed to Primary Care. They do not include type two attendances to the REI and Minor Injury Unit attendances (type three.)

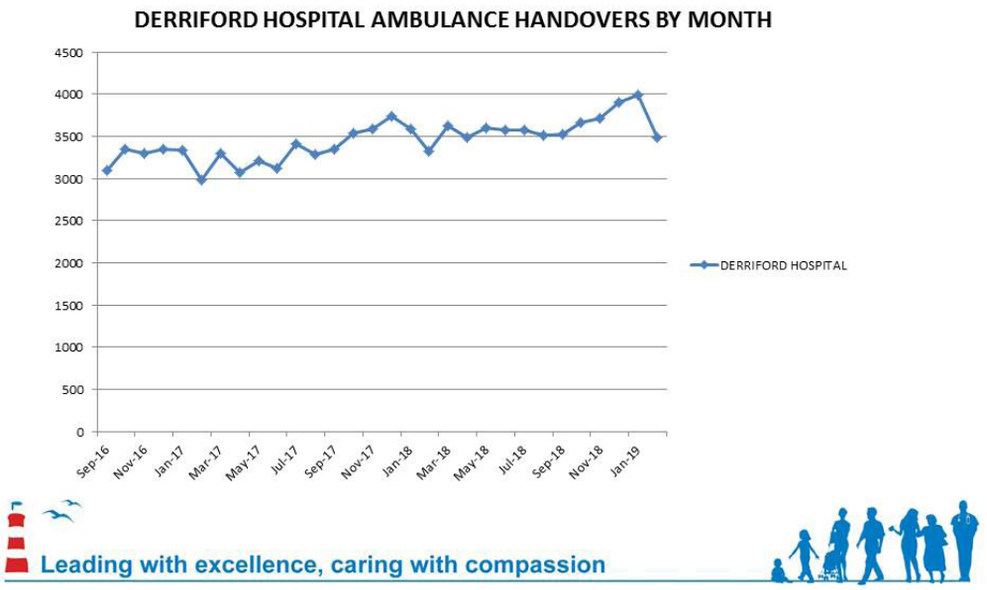
We have seen an increase in emergency demand, as shown by the graphs on the following pages. Overall, we admitted 200 more patients per month with 30 less beds than last year. But thanks to improved internal processes and huge effort from staff, the length of stay for medical patients reduced from 7.28 days to 6.50 days.

Comparing Winter 2018 and Winter 2019 – Triage

Largest movements in Triage categories 2 and 3 – Total movement of 1,530 in these two categories – 15% growth in triage 2 and 16% in triage 3 – 8% growth overall



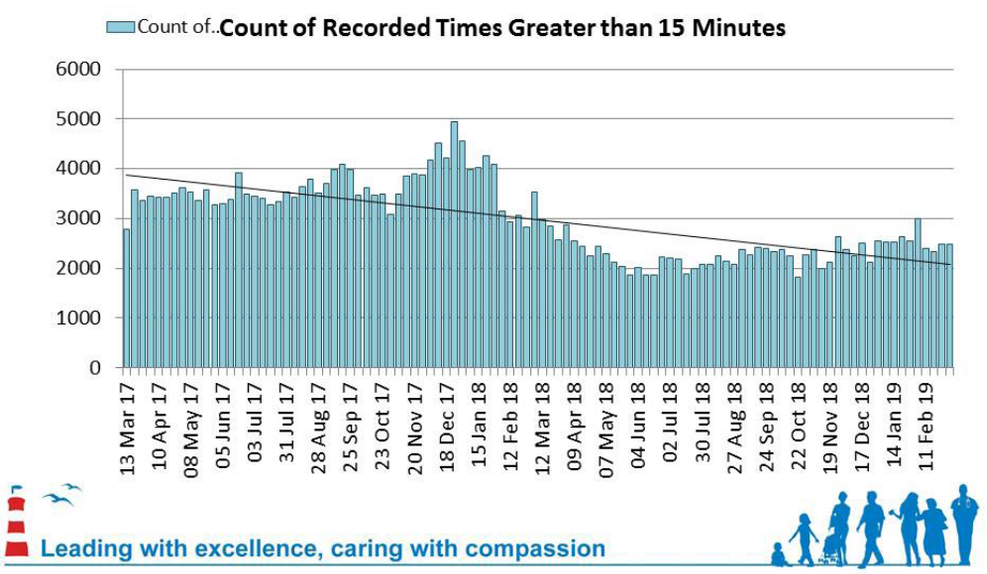
SWAST: Ambulance Handovers



An increase in the number of ambulances arriving at our Emergency Department doors.

But despite the increase in demand, our staff still managed to reduce delays for ambulance crews, so they could hand over their patients and get back out on the streets as soon as possible.

Ambulance Handover Trajectory



Comparing January 2019 to 2018 and 2017 – Attendances

	65+	75+	85+	Total Pts Aged 65+	Total Pts	% pts aged 65+
Jan-17	771	800	585	2,156	7,744	28%
Jan-18	887	888	649	2,424	8,099	30%
Jan-19	961	961	713	2,635	8,900	29%

Although there is no growth in the percentage of >65 attendances there is an obvious increase in volume so a proportionate increase in > 65s

We have also seen an increase in the number of older patients, who often have more complex needs.

	Standard Required	What did University Hospitals Plymouth achieve?
Infection Control		
Incidence of MRSA bacteraemia	0	6
Incidence of avoidable Clostridium difficile	<35	24
Referral to treatment times		
Incomplete pathways: Total number of pathways	26,347	27,922
Incomplete pathways %	92%	77.3%
52 week waits	0	48
Emergency Department		
Maximum time in ED of four hours from arrival to admission, transfer or discharge	95%	81.1%
Cancer urgent referral to first outpatient appointment waiting times:		
All cancer two week wait	93%	93.4%
Two week wait for symptomatic breast patients (cancer not initially suspected)	93%	87.1%
Cancer diagnosis to treatment waiting times:		
31 day (diagnosis to treatment) wait for first treatment: all cancers	96%	95.1%
31 day wait for second or subsequent treatment: surgery	94%	89.1%
31 day wait for second or subsequent treatment: anti-cancer drug treatments	98%	99.7%
31 day wait for second or subsequent treatment: radiotherapy treatments	94%	72.8%
Cancer urgent referral to treatment waiting times:		
62 day (urgent GP referral to treatment) wait for first treatment: all cancers	85%	73.8%
62 day wait for first treatment from consultant screening service referral: all cancers	90%	90.8%
62 day consultant upgrade wait for first treatment: all cancers	85%	72%
Diagnostic waits:		
Diagnostic test waiting times	<1%	5.89%
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%	17.1%
Cancelled operations by the hospital for non-clinical reasons on the day or after admission	No target	2.85%
Other key standards		
% stroke patients spending 90% of their stay on ASU	80%	81%
Mixed sex breaches	0	6
% patients receiving appropriate VTE risk assessment	95%	96.4%
* based on first 11 months of 18/19 as we report VTE one month in arrears to ensure we have all of the appropriate data sources available to get an accurate measure		

What the inspectors said:

In August, the Care Quality Commission (CQC) released findings from their planned inspection of our services during April and May 2018.

Overall, the Trust remains graded as Requires Improvement, however ratings in two of the sub-categories have deteriorated with Effective and Well-Led both moving from Good to Requires Improvement.

Previous ratings

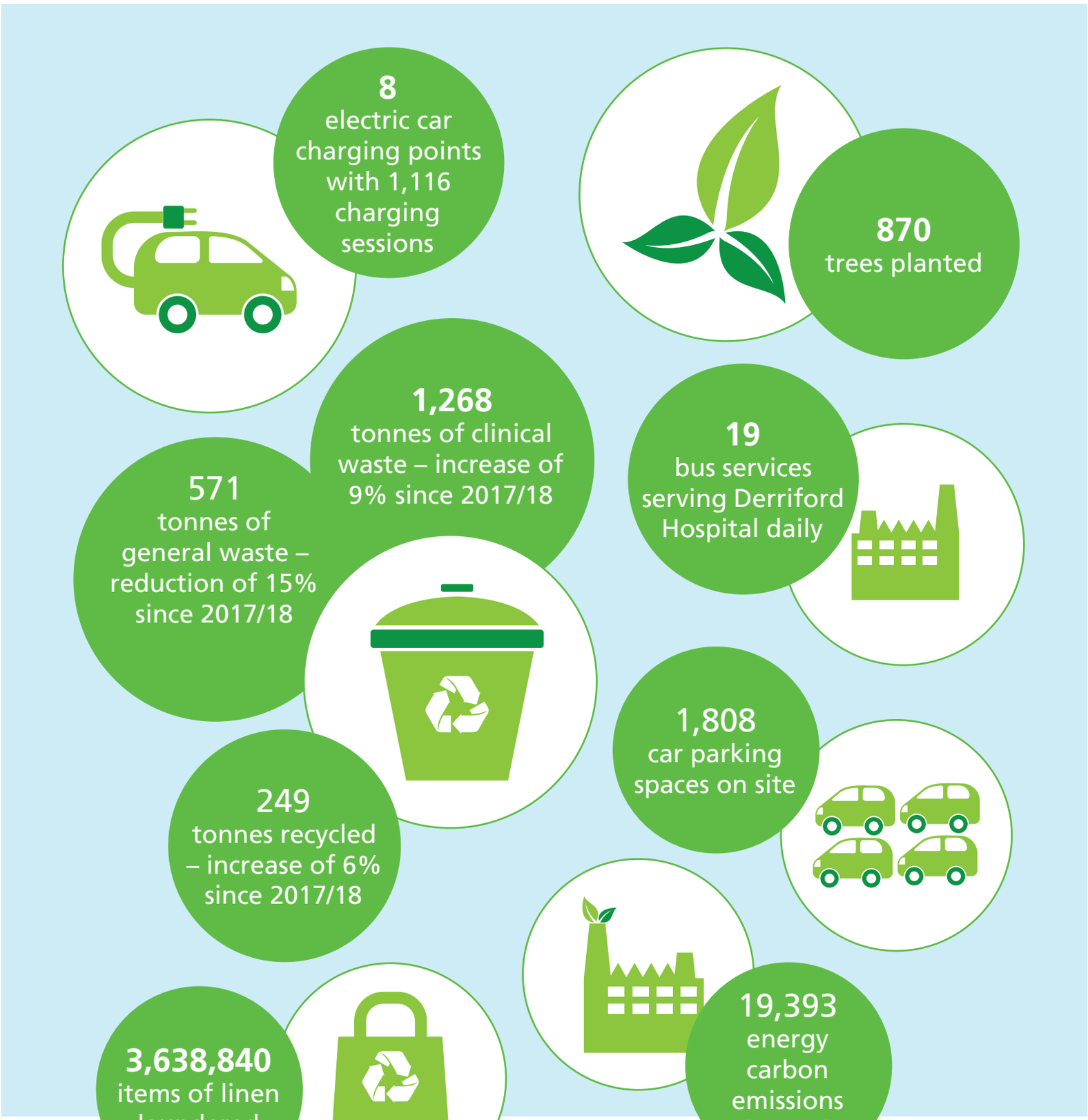
Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Good

New ratings

Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Outstanding
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

We remain rated Outstanding for Caring – one of only 36 out of 148 acute trusts nationally. Although this domain was not re-inspected during this visit, inspectors spoke of witnessing compassionate care from staff and volunteers across the service areas. Inspectors did have concerns and issued two warning notices, one for Pharmacy and one for Diagnostic Imaging. Improvement programmes were put in place to address the concerns raised and as of April 2019, one warning notice remains in place in diagnostics. The improvement work continues in this area.

Looking after our environment



Some of our achievements over the past year include:

Rollout of further recycling facilities across the Trust, including our retail areas
Contributing to Plymouth's Plastic Free Community Status where the Trust pledged to remove or replace plastics in the Trust's retail areas e.g. removal of plastic straws, plastic cutlery and single-use plastic cups from water fountains. All three have been achieved
Working on the development of a 'Green Champions' network - clinical and non-clinical staff who are passionate about being sustainable in the workplace
Refreshing the Trust's Green Travel Plan
Sowing the seeds to put Derriford's first gardening club in place. Planters have been positioned on site, where fruit and vegetables will be grown
Participating in Sustainable Health & Care Week in June 2018. The Trust focused on three areas - waste, travel and green space. Staff were encouraged to use a more sustainable method of transport such as bus, car share, cycling or walking across the week.
Continuing to promote Warp It, the Trust's online portal for staff to redistribute (give, loan or share) resources conveniently within the Trust.
Working closely with Warrens regarding takeaway packaging generated from the restaurant and cafe areas.They have now implemented compostable takeaway boxes, coffee cups and cups for water. They are also now using paper straws and compostable cutlery and selling reusable coffee cups.

Our Teams Driving Improvement
Together with Livewell Southwest, during 2018 we were successful in our joint bid to become one of just seven national hospitals to partner with NHS Improvement in a programme of work using lean methodology. We have called this our #PeopleFirst Programme.

With help and support from the national team we are changing the way we work to improve the quality of care we offer, making our services safer, more effective and more patient-centred. By removing waste, putting the best ideas of our frontline staff into practice and focusing on what our patients really want, we are delivering better services.

Our core principles are:
- Respect for staff
- Value to the person we care for
- Teams able to drive improvements

This programme continues to build on our strong existing Quality Improvement work which aims to implement ideas from all our staff, clinical and non-clinical, and also from our patients and service users.

We aim to:
- Ensure all our staff understand our clear and concise plan describing 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 – through spread of training and improvement huddles.
- Ensure the voice of patients is heard in all our changes, with the establishment of a dedicated group focusing on patient involvement in improvement.
- Provide our staff with the skills they require to bring about such change. Through training in local team-based improvement skills and coaching of teams.

Quality Academy & People First
Our Quality Academy team come from a variety of professional clinical and non-clinical backgrounds. This multi-disciplinary approach allows us to support and drive positive change across our organisation whilst truly understanding demands, pressures and challenges that our wards and departments are experiencing.

Sustainable team-driven improvement starts and ends with staff engagement. By working closely with ward and department teams, we

have been able to have open and honest conversations with staff and patients to identify areas for potential improvement.

Recent examples with our respiratory team show the benefit of team-driven change with consultants, juniors, nurses, therapists, pharmacists and managers all involved in developments to share handover and reduce patient time waiting for take home drugs.

We now hold a monthly 'Report Out' event, which is open to all staff. This provides a forum to share learning relating to improvements that are ongoing in all areas throughout the Trust, as part of the #PeopleFirst programme.

Creating an Exemplar
The Monkswell Ward team were selected to be a part of the #PeopleFirst programme by becoming the first 'Exemplar Area', this being somewhere that embodies the principles and values of the programme; putting the people at the heart of the service, respecting and valuing our staff and cultivating team-driven improvement.

With some coaching support from the programme staff, the ward team have really stepped-up to the challenge and embraced the #PeopleFirst methodology. This has helped the team to identify and implement smaller-scale improvements on a regular daily basis and also understand and work on their biggest challenges to providing outstanding care for every single patient.

Better every day
The Monkswell ward team now hold a daily 'improvement huddle' where members of the whole ward multidisciplinary team meet to identify how things could be better for patients, relatives, carers and staff. This focus has helped the team to make a number of gradual and incremental changes to ward processes for the better, including how patients are better assisted at mealtimes, helping patient handover to run smoothly and efficiently and testing ways to ensure that patient privacy and dignity is supported in the evenings and early mornings.

An eye on the big challenges
The team are working on the 'high impact' problems too and have selected to work on two big challenges that will reduce the length of time patients need to stay on the ward and release nursing time to care for patients. These two areas were identified as the key areas of focus by the team.

Team development
One of the aims of the #PeopleFirst programme is to help create a culture of 'continuous improvement', and as part of the Exemplar Ward some staff have had the opportunity to attend training courses provided by the programme, and others will have the opportunity to learn new skills and habits of daily improvement. The journey will not stop there – we hope to learn from this practice and impact further on patient care. Monkswell will continue we hope to develop its daily learning and work through more changes after the initial period of support.

Proud!

Named after the anaesthetist: baby Emily meets her namesake

It's not often we get to tell a story like this. Baby Emily is named after the kind-hearted anaesthetist who kept her promise and held her mum's hand during a traumatic birth. Mum Charlotte wanted to introduce baby Emily to her namesake, and to say a big thank you for her care. A reunion was on the cards, so we squeezed it in, just in time for Christmas …

"Back in February, I was in the hairdressers having a girly day with my eldest daughter Ellie, when suddenly I had a placental abruption," explains Charlotte Burgoyne, Assistant Practitioner in Radiotherapy Oncology at University Hospitals Plymouth NHS Trust. "I was rushed to Derriford Hospital, where I was examined and told I had to have an emergency C-section. I'd had two previously for my two older children and so I was fine about it.

"I met Emily (the anaesthetist) down in theatre when I was having the epidural. We were talking about baby names with my husband Peter and I suddenly realised that I didn't like any of the ones we'd picked. Emily joked that hers was a good name and we had a laugh about it.

"I knew something wasn't going according to plan when they called for another consultant. It was decided that, due to residual scar tissue, they would need to cut higher up, further than the epidural and into my chest, so it was urgent that I was put to sleep. Peter had to be rushed out and I felt utterly terrified. I grasped Emily's hand and begged her to stay with me, as I didn't want to be on my own.

"I woke up quite a few hours later and learnt that, not only did we have a beautiful baby girl, but Emily had kept her promise and stayed with me the entire time. After what happened, we knew there was only one name our baby could be called. And that was Emily."

At the time, Emily Howells was working as a Senior Registrar in Anaesthetics and Intensive Care at Derriford Hospital. She now works at the Royal Devon and Exeter Hospital.

“I think it’s always worth trying to get more Emilys in the world,” she says, “although I really didn’t expect Charlotte to take me seriously. Everyone forgets the anaesthetist after about 20 minutes. But it’s a very good name and a huge, major honour.”

After hearing Charlotte and Emily’s story as part of our #WhyILovetheNHS Advent Calendar, we decided to reunite the pair. On Friday 14 December, Charlotte surprised Emily with a visit with baby Emily.

“I thought it would be really wonderful for baby Emily to know who she is named after, and for Emily to meet our baby girl,” explains Charlotte, who is also a Freedom to Speak Up Guardian at University Hospitals Plymouth. “Looking back, it was such a scary situation made worse by my husband having to leave the room. I just wanted someone to stay with me and knowing that Emily did and that she kept her promise got me through all the horrible days and recovering from the trauma of it.

“A lot of people focus on the negatives of the story and say “I can’t believe that happened to you” but it’s so nice to be able to flip it and focus on the positives. We are so grateful to be where we are now.”

Emily adds: “It’s so important for patients to feel safe and looked after, and in the hands of someone that they know they can trust. Charlotte had all of us in the team taking care of her and making sure she was okay.

“I think that’s our job – being there for people’s best days and also their scariest days – is a huge privilege. It’s an amazing thing to be a part of people’s lives, and to know that you have had an effect on them is very moving and I appreciate it hugely. I’m so glad I got the opportunity to see Charlotte again and of course to meet baby Emily.”

GIRFT is a national clinical programme of work designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings. It is led by frontline clinicians who are expert in the areas they are reviewing, and importantly understand their specialty data. The data is presented to every Trust that delivers the clinical specialty through a national clinical-led visit to the organisation.

GIRFT covers a total of 32 separate specialities, of which Phase 1 encompassed 12 of the largest surgical specialties. Phase 2 was launched in mid-2018, covering a further 22 medical, smaller surgical areas, and cross cutting themes. We have received 23 national GIRFT visits to date, and are working closely with the recently established GIRFT South West hub, with their oversight of Devon STP variation.

Internally, the GIRFT programme of work is led by our Medical Director, Dr Phil Hughes, with the clinical lead for each specialty, and the divisional care group. We developed an approach to ensure the data is used to drive improvement, through a selected 5 metric approach for an initial six month focus. Clinical leads for each specialty are required to present their progress at three-month, and six-month check-in meetings with releasing benefits assessed against categories including improvements to patient access, capacity (bed days), cost avoidance, cost savings, and income opportunities.

Our approach has been nationally recognised by the GIRFT team and has been communicated through the GIRFT regional hubs as the blueprint of best practice approach in both structure, and governance. We have established an internal GIRFT Programme Board, to provide overarching visibility with the internal response, which underpins the role of GIRFT in our organisation.

In direct response to GIRFT, there have been a number of pilot projects which have commenced across the Trust including:

- Urology: A capacity-releasing project moving the treatment, where appropriate, of benign prostate from a surgical procedure requiring an in-patient two-day length of stay, to a laser-based treatment, undertaken as a day case.
- Ophthalmology: A cost-releasing project which releases the need for the Trust anaesthetist from appropriate cataract procedures (approximately 60% of total case volume) is becoming established as our standardised approach, without impacting on clinical outcomes, or theatre productivity.

A national GIRFT report is published for every specialty with explicit recommendations and actions with identified ownership. Our Trust was referenced as a best practice case study within the National Cardiothoracic Report, as having the lowest reported rate of blood transfusion after surgery (23%) which was half the national average (46%). This has been achieved, through both internal education to our surgical trainees, our clinical approach with the use of our Specialty Care Practitioners (SC`s) in carrying out off-site patient assessments, accompanying surgeons to outlying multi-disciplinary team meetings, and use of intravenous iron in anaemic patients pre-operatively. For patients, this results in lower length of stay, less complications, and mitigation of the need to use expensive blood products. **https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/07/CardiothoracicReportMar18-F.pdf**

Best practice case study

Attention to detail the key to low rates of blood transfusion

Plymouth Hospitals

SWCC has the lowest reported transfusion rate for blood products after surgery in England, with a rate of just 23%.

They put this down to surgical attention to detail and highlight the following key practices:

- stressing the importance of their blood transfusion practices to surgical trainees (28% of their cases are operated on by trainees as primary surgeon – the fourth highest in England)
- stopping pre-operative dual antiplatelet therapy
- observing a strict transfusion trigger (Hb of 8g/100ml)
- ensuring that surgical care practitioners carry out off-site patient assessments, accompany surgeons to outlying MDTs, and review in-house transfers
- using IV Iron in anaemic patients pre-operatively.

Proud!

Nurse Intervention Pilot showing signs of improving cardiac care

A nurse-led improvement project in Derriford Hospital's Emergency Department is changing the way patients with cardiac conditions experience urgent care.

The three-month pilot, devised by the Heart Failure Nursing Team, is examining the impact that earlier intervention from a specialist nurse could have on the outcomes of patients attending the Emergency Department with either heart failure, cardiac conditions or atrial fibrillation (as a primary or secondary diagnosis). Nobody wants to have to stay in hospital, but the nature of cardiac conditions means that there is a high likelihood a patient will have to be admitted, with 70% of emergency attendances requiring an inpatient admission and a subsequent referral to a Heart Failure Nurse.

The primary focus of the pilot is to assess the impact of quicker access to specialist nurse review and diagnostics, by providing Heart Failure Nurse support within the Emergency Department.

Lead Heart Failure Specialist Nurse, Becky Horne, said: "Early intervention from a specialist nurse is really beneficial to patients, as in many cases they can be sent home with a package of care and can avoid having to stay in hospital. In terms of patient experience, this is the best possible outcome." Over the first two-week period of the pilot (from 4 March), the Heart Failure Nurses assessed more than 30 patients in the Emergency Department and were able to provide 91% with advice or care packages allowing them to return home. The admission rate during this time was lowered to 9% (compared to 70% previously).

"In the reducing number of instances where admission is necessary, we are able to directly admit patients to the most appropriate specialist ward." explains Becky. "This is better for patients as it speeds up their onward journey, bypassing a transitional stay in an assessment unit and putting them straight into the care of our specialist team."

Having studied the initial impact of the pilot, the next stage is to understand the impact early intervention has on outcomes for patients admitted directly to the cardiology wards. This will involve monitoring length of stay amongst the patient group (previously 5.18 days on average).

This 'scientific learning' approach is based on the Trust's #PeopleFirst programme.

Improving Our Patients' Experience
We recognise the importance of putting the patient 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 experiences of our patients, we actively seek to engage with patients and members of the public.

Following receipt of the National Inpatient Survey results in 2018 a decision was made to focus improvement across the Trust through a new campaign 'Let's Talk about MEEE'. (Making Every Experience Excellent) @MeeeUhp.

The purpose of the campaign was to implement a process to actively listen to our staff and patients and act on their ideas for improvement. This would mirror the methodology and learning from the 'Big Conversation' staff engagement sessions used by our Learning and Organisational Development Team following receipt of the staff survey results.

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.

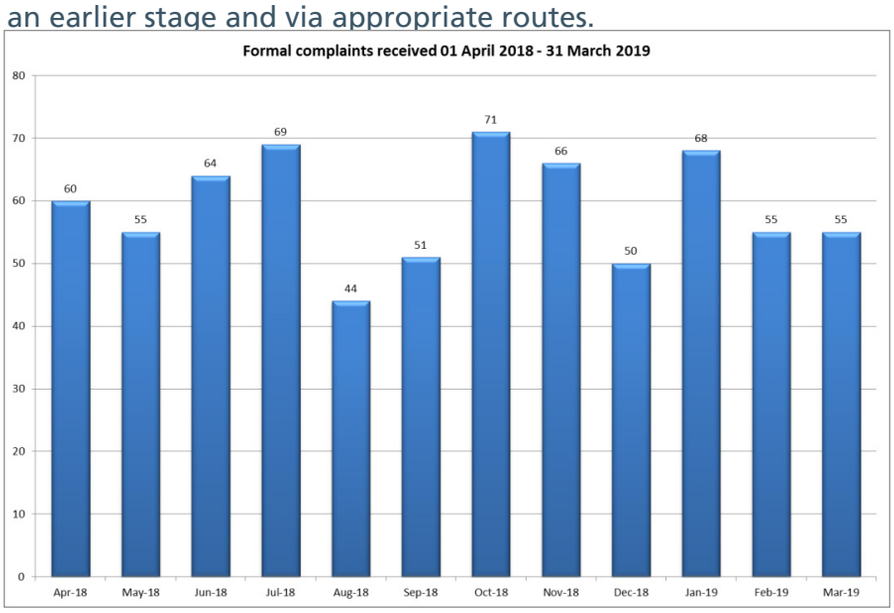
Patient Council
Our Patient Council, which was established in October 2014, is now well established with 10 members and a full schedule of both formal and informal meetings. Throughout 2018-19, the Council held six formal and three informal meetings. The Patient Council was established to embed the patient perspective into day-to-day activity and its strategy is to be the collective voice for patients and carers who use our services and act alongside the Trust as a critical friend. Our Patient Council are incredibly engaged and supportive of the work we do and members have actively been involved in a number of activities including PLACE assessments, Making Mealtimes Matter Week, Patient Experience Ambassadors and the Nursing Assessment Assurance Framework (NAAF) audits. See the Patient Council report on page 39.

Patient Feedback
We seek this through

The Friends and Family Test;
- Patient Surveys - for the period 01 April 2018 to 31 March 19 we received feedback from 893 patients, 97.21% rated their overall care as excellent, very good or good;
- Care Opinion and NHS (previously NHS Choices), websites where patients have the opportunity to register comments, anonymously if they choose to do so. During the past year 147 pieces of feedback were posted on the Care Opinion website relating to University Hospitals Plymouth 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;
- Learning from Excellence (LfE) - for the period 01 April 2018 to 31 March 19 we received 1,881 LfE nominations of which 407 came from patients, their family and friends.

Complaints
For the period 01 April 2018 to 31 March 2019, 708 formal complaints were received, which are detailed in the table below by month. This represents a 21.5% increase compared to the same period in 2017/18, which is a significant rise in activity.

On review, 4,982 PALS enquiries were received during 2018/19 which would indicate concerns are being managed at an earlier stage and via appropriate routes.



We improved accessibility and visibility of our Patient Advice & Liaison Service (PALS) by increasing the number of PALS Clinics, which involves members of the PALS team visiting wards to speak to patients and staff. 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

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 number of cases for each outcome.

Outcome	Definition	Number	Percentage
Upheld	Complaints in which the concerns were found to be correct on investigation	419	60%
Partially upheld	Complaints in which some of the concerns were found to be correct on investigation	181	26%
Not upheld	Complaints in which the concerns were not found to be correct on investigation	90	13%
Ongoing	Complaint investigation ongoing therefore, outcome has not yet been confirmed	1	N/A
Withdrawn	Complaint withdrawn	8	1.14%

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 01 April 2018 to 31 March 2019 the Trust received seven requests for information and investigation from the PHSO.

Of those seven cases, three were not taken forward by the PHSO; 1 complaint was re-opened as the complainant had been given new information at a recent outpatient appointment. This case is now closed following a further Chief Executive response letter. In two of the seven cases, we have shared information with the PHSO and are currently waiting for their decision as to whether or not they will investigate. One case has since gone forward for investigation.

Compliments
During the past year the Trust has worked with all areas to actively identify compliments received whether that be a formal thank you letter, card, box of chocolates or expression of thanks through the Friends and Family Test. We are pleased to report that for 2018/19 the Trust received 2,784 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.

Improving patient care
Throughout 2018/19 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 our Quality Account.

- ✓ Discharge Information Leaflet
  Discharges can be a stressful time for patients as not only have they been through a health crisis but they are now at the point where they need to continue on with their lives. Being discharged from hospital is a complex process involving a number of different people all working together to ensure that patients have transport home, medication to take away and the correct medical and onward care information. We trialled on one of our wards a new discharge information leaflet as a useful resource for patients to help them feel empowered, involved in and up-to-date with the discharge progress and this leaflet is now being rolled out Trust-wide.
- ✓ Development of the ICU Rehab Garden
  Phase one of the Critical Care Rehabilitation garden opened in December 2018. The garden has been designed to act as a space for both psychological and physical rehabilitation and has been already been transformed with plants and fairy lights and a basketball hoop which will provide further opportunities for physical activity for patients. The outdoor space supports the recovery of patients with ICU related delirium and the effects of staying in ICU can have on their psychological and physical health. The natural light from the garden helps patients reconnect with their natural sleep-wake cycles and helps to build resilience and independence.
- ✓ End of Life Care Boxes
  Our End of Life Care Boxes have been introduced in our Intensive Care Unit (ICU) for bereaved

families. These boxes include keep sakes such as a handprint; Forget-me-Not seeds, ICU patient diary, a bereavement booklet, organza bags for a lock of hair or jewellery, and a handwritten card for the family written by the nurse caring for the patient.

- ✓ Ward Noticeboards
  Following feedback from our PLACE assessments the Trust recognised the requirement to make improvements to the overall patient information available on each ward. As such, we are in the process of installing new ward noticeboards which advise patients, families and their carers' details of the ward manager, the person in charge and the matron. Other information also includes the number of nurses on duty for the day, safety information and the contact details for PALS.
- ✓ Improving Access to Sexual Health Services
  Our Women's and Children's Service Line wanted to improve the access to sexual health services for patients who might not otherwise attend clinic and avoid unnecessary trips for patients to hospital. We are now offering an online testing service to patients. Testing kits are sent in the post and these can be sent back and processed without the need for hospital attendance. The results are text or phoned through to patients with the appropriate treatment and support provided where necessary.

Our Patient Council Reports
In February 2019 we received a presentation and update from the Trust on its developing Strategy and following this, we have developed our Patient Council Strategy; the overall aim of which is to be the collective voice for Patients and Carers who use Trust services.

We've been extremely busy over the last 12 months and have continued to build on the strong relationships we have formed. We have been working on a number of key projects which include:

- Involvement with Let's Talk About Making Every Experience Excellent (MEEE) Campaign participating in the conversations with staff and patients
- Becoming Patient Experience Ambassadors – PEAS
- Review of all Patient Information leaflets prior to publication
- Involvement with the Making Mealtimes Matter Week
- Involvement with the Disability Awareness week and sensory awareness training
- Training for our hospital guides for patients with visual impairments
- Involvement with the Nursing Assessment Assurance Framework (NAAF) audits
- Involvement with the PLACE Assessments
- Involvement with Volunteers Week and the NHS 70th Birthday Celebrations
- Attendance at the Quality Improvement Workshops
- Representation at the Clinical Excellence Awards, the Planning and Building Group, the Equality, Diversity and Inclusivity Working group, the Nutritional Steering Group and at the Patient Experience Committee

It's really difficult to choose a favourite highlight from our involvement over the last 12 months, but if we had to, one of our top favourites would be our involvement with the Let's Talk About MEEE campaign. Having the opportunity to spend the week having meaningful conversations with patients and staff about key topics and even coming in for a night shift with the Chief Executive was so valuable and rewarding and we really felt as though we were making a difference.

Some of our key aims for coming year are to recruit more members to ensure all patient groups are actively represented and we are working with the Trust to create a Youth Patient Council.

We are becoming Patient Experience Ambassadors (PEAS) and we recently attended the launch event for this. We are very much enthused and focused for the year ahead and look forward to building our work as critical friends to the Trust.

Jane Hitchings
Chair

John Osborn
Vice Chair

Plymouth Healthwatch Reports

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

In addition, Healthwatch Plymouth are involved with this Trust and Livewell Southwest in the redesign of Discharge from Hospital Pathways to help improve patient involvement and service coordination. We have also been invited to sit on the Hotel Services Transition Board to review service delivery such as portering, cleaning and food delivery as these services transfer back to being delivered by Hospital staff.

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.

Patient-Led Assessments of the Care Environment (PLACE) 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 shave seen progress from previous years that saw the Trust achieve its highest scores in all areas. We found the hospital to be clean, most areas well maintained, and staff really engaged in the process. However, areas for further improvement were identified and presented to the hospital's PLACE working Group and we look forward to seeing the progress around these items at this year's annual assessment.

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

Nick Pennell,
Chair
Plymouth Healthwatch

Emergency Preparedness, Resilience and Response
We experienced a 1-in-10-year event with heavy snow over a protracted period in March 2018, when the Incident Control Centre was established to co-ordinate arrangements. This enabled us to support staff experiencing difficulties in getting to and from work, whilst minimising disruption to patient services. Having reviewed our incident response, arrangements for accessing 4x4 vehicle support were strengthened and put to the test again in February 2019 when further snow was experienced. Whilst demand was lower than the previous winter, it was recognised there was a marked improvement delivering 4x4 vehicle support for our staff through the revised multi-agency arrangements.

Command awareness training was delivered across the summer to all senior staff required to lead an incident response. This reinforced the need for a stepped change in managing incidents, standardised response arrangements and reiterated the national decision making and communication models.

In recognition of national security threats, we met with police colleagues to review plans and walk through arrangements in place to receive and care for high risk and VIP patients. Officers involved found the familiarisation tour beneficial and provided positive feedback on the extent of arrangements in place.

There has been a significant amount of activity since December 2018 in preparing for any disruption that leaving the European Union may present. Part of our EU Exit preparations also included undertaking a business continuity exercise.

In September 2018 we participated in a multi-agency exercise, to consider the capability of each acute hospital in Devon and Cornwall to receive casualties from a major incident or mass casualty event. Following this exercise, pre-determined response figures have been agreed, in support of casualties being distributed across the Devon and Cornwall peninsula.

Following our annual self-assessment against the EPRR Core Standards, NHS England and NEW Devon CCG reviewed the evidence provided and reported the Trust as 'substantially compliant' in meeting requirements. A further audit undertaken in March 2019 by Western Ambulance NHS Foundation Trust to specifically review arrangements in place to respond to a chemical, biological, radiological or nuclear (CBRN) incident. Their audit findings reported the organisation as 'fully compliant' in meeting the standards required.

A new training e-learning package has been developed, so staff are familiar with resilience arrangements in place and action to take during a major incident or periods of disruption to critical services. This will now be delivered to all staff in 2019/20 through the trust Update and Induction programmes.

Incidents Involving Data
Whilst we have strict information management policies, occasionally an incident occurs when information is not 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 (IG) element are recorded on the Trust Incident Reporting System (Datix). Guidance on how to report and score serious IG incidents via a scoring matrix has been provided by NHS Digital Guide to the Notification of Data Security and Protection Incidents.

In order to report the severity of incidents, scores are grouped into three categories:
- Low Impact incidents - very low in severity
- Local IG Investigation incidents - a thorough investigation by the IG team with recommendations and lessons learned
- IG Reportable Incidents – reported to the Information Commissioner's Office (ICO) and possibly the Department of Health

Incidents are scored by the Information Governance team in conjunction with the Caldicott Guardian and the Senior Information Risk Owner. Those scored as an IG Reportable Incident are reported to the Information Commissioner's Office (ICO – the regulators of Data Protection legislation) via the NHS Digital online reporting tool located on the Data Security & Protection Toolkit.

IG Reportable Incidents are also reported to NEW Devon CCG via STEIS by the Risk & Incident team. A full root cause analysis is conducted for these incidents. In the 2018/19 financial year there were two IG Reportable Incidents:

IG breach type	Details
Inappropriate Disclosure (error)	Patients' mothers received reminders for appointments that their adult children were due to attend.
Inappropriate Disclosure (error)	A number of patient letters were placed in one envelope several times and sent out to patients in error.

The Trust has co-operated 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.

Health and Safety
The specialist health and safety leads have continued with our 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. This has been done with the full support of the Health and Safety Committee.

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 ASW Assurance to provide a Local Counter Fraud Specialist (LCFS), who work with the Trust to help ensure risks are mitigated and that the Trust systems are resilient to fraud and corruption. The Audit Committee receive 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 2018/19 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 2018/19, the LCFS dealt with eight referrals which to date has led to Trust disciplinary action with the repayment of study leave taken and recovery action in respect of overclaimed locum shift payments.

Proud!

Our NHS70 Parliamentary Award Winner

A huge congratulations to our Head of Nursing (Cancer and End of Life), Sian Dennison, who won the 'Excellence in Cancer Care Award' at the NHS70 Parliamentary Awards.

The prestigious competition was the first of its kind to mark the 70th birthday of the NHS. Nominations for the awards were put forward by Mr Johnny Mercer MP, Mr Gary Streeter MP and Mr Luke Pollard MP, before a panel of regional judges chose the shortlist from nearly 800 nominations submitted.

Sian attended the awards ceremony held in Parliament's Terrace Pavilion, where she was announced the winner. Upon receiving the award, Sian said: "I'm utterly flabbergasted … absolutely thrilled. I feel so very lucky. But it's not just about me.

"To me, this award is about the team I work with. I couldn't have achieved all that has been delivered without their passion, dedication and their support to improve patient care and make a difference." Sian has been a nurse for over 30 years and has been described by her colleagues as "the voice for cancer services and cancer patients in the region."

Research, Development and Innovation

Research & Development's vision is to improve the health & wellbeing of the population we serve by conducting high quality, well-run research which is relevant to the needs of the local population. Our action plan is based on key strategic intents to:

- Reflect the priorities of local people.
- Reflect local transformation in healthcare delivery through integrated care systems
- Grow a Research Rich Climate, embedding research as part of core business.
- Involve a multidisciplinary workforce
- Ensure financial stability, including the achievement in the medium term of accreditation as an NIHR Clinical Research Facility

Local Collaborations

As a UK pioneer centre for the TriNetX Global and Trials Connect IT platforms this maintains our prominence with biopharmaceutical companies ensuring Plymouth is the site of choice for the new studies, giving patients early access to innovative treatments

In the past year we`ve been the first NHS Trust in the country to recruit patients into clinical studies who are having surgery at Care UK, the Independent Sector Treatment Centre.

We continue as an active partner in the IQVIA Peninsula Prime site, one of their best performing across the globe.

This year we reaffirmed our collaboration with Plymouth University`s Faculty of Health: Medicine, Dentistry & Human Sciences, Peninsula Clinical Trials Unit, South West Research Design Service and PenCLAHRC by launching a shared Research Hub which signposts the considerable amount of research advisory support available to prospective clinical & translational researchers . Finally, we are a key partner in the establishment of the Plymouth Health Innovation Alliance, a networking group centred on the Plymouth Science Park which supports rapid innovation and development in the life sciences industries.

Notable Successes

We celebrated outstanding local results for Mantle Cell Lymphoma, where research is embraced as part of everyday care, gaining access to cutting edge treatments for patients. We continue to be the first recruiting centre in the UK for several studies across our portfolio.

Awards during the year include:

- British Society for Haematology & NIHR Awards 2019: Researcher of the Year, Nursing & AHP
- South Devon Apprenticeship Awards 2019: Health Apprentice of the Year
- HSJ Awards 2018: Winner, using technology to improve efficiency

Innovation in 2018/19

Health technology and preventative medicine feature prominently in the NHS Long Term Plan, and our examples of this include include:

- A project to evaluate a home-based care pathway for Parkinson`s disease, based on digital technology
- Health trainers to help people cut down on smoking
- Accelerometers for assessing recovery after day surgery
- Prehabilitation using exercise bikes before major surgery
- Novel technology to adapt CT scans of the heart as a potential substitute for an invasive procedure

Research portfolio

- We currently have 360 (open to recruitment) research projects ongoing.
- We have recruited more than 4,500 patients into a research portfolio managed across 157 Principal Investigators (PIs) & 33 Chief Investigators and a growing number of non-medics PIs with our retention rate remaining above average.
- 127 new research projects opened during 2018/19, 41 commercial and the remainder non-commercial, a significant growth on 2017/18.
- In the year to March 2019 there were 350 Pubmed listed publications attributed to authors from our Trust.

We remain committed to our research agenda, and have just published our new 5 year strategy, to make available to patients the most innovative treatments at the earliest opportunity and further support the public health agenda through education and training.

Proud!

Mark completes Plymouth 10k race after accident leaves him barely able to walk

In June 2018, Mark 'Simmo' Simmons was only able to run ten steps after being involved in at accident at Falmouth Docks. Less than six months later, he ran over 14,000 steps, completing the Plymouth 10k race in an impressive 56 minutes.

On 20 August 2014, Mark was involved in an accident whilst at work. He was crushed by a large steel rack which contained heavy, flat steel bars. Pinned down by the steel unit, Mark was in immense pain and could hardly breathe, but says thinking of his family and young daughter kept him going.

Mark suffered breaks in his pelvis, arm, a vertebra in his back and suffered a catastrophic open fracture to his leg. He spent three months in three different hospitals. Unable to weight bear, he was confined to his hospital bed or wheelchair. "I was lucky; Derriford saved my life and the amazing Orthopaedic Team saved my leg from being amputated," said Mark.

"I was told that it was highly unlikely that I would ever run again. It's been just over four years since the accident and I have taught myself; with the help of Diarmuid from The Devery Practice, to begin to run again."

Mark spent 18 days on Shaugh Ward at Derriford Hospital and he sought to raise £1,800 for Plymouth Hospitals Charity; £100 for every day he spent on the ward.

"People don't really know how much a hospital does until they need it", said Mark. I just want to raise money for the hospital to say 'thank you' to all those who took care of me. They really were amazing."

Our Charity
Our donors told us they wanted their donations to make a difference!
We can tell you they really have.

So what has been going on?

- More than 300 people donated to Val's fund – funding future research at Derriford hospital into the side effects of chemotherapy for people with Advanced Malignant Melanoma.
- 46 Just Giving pages were opened across the year. Just Giving donations reached £42,584 with the average amount raised by an individual being £500.
- Neurosurgery Unit ran a successful fundraising campaign raising £60k to fund a new mobile scanner.
- We worked with Children's Happy Hospital Fund on SplashED fundraising appeal and jointly raised money for equipment for the new children's emergency department
- Snowdrop Appeal, raising money for a maternity bereavement suite, reached a total of £146,000 and held an event providing the opportunity for those who have supported the appeal to give their input before building starts on the unit later this year
- And more than 100 people remembered their loved one by making a lasting donation to the charity in memory of their partner and best friend.
- Lucy held a Ball
- Chris ran a marathon
- Kerry went to Mount Everest
- Jacky held a garden sale
- Kate and her friends flew down a zip wire
- Rosie walked on the wing of a plane

These are just a few of our 550 active fundraisers who, over the year, did something big or small, raised thousands or donated their pocket money.

Every one of our donors is amazing and we thank you so very much

To find out more about how you can fundraise or make a donation to University Hospitals Plymouth NHS Trust, please visit **https://www.plymouthhospitals.nhs.uk/fundraising**

Our Accountability 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. The Board comprises voting and non-voting members.

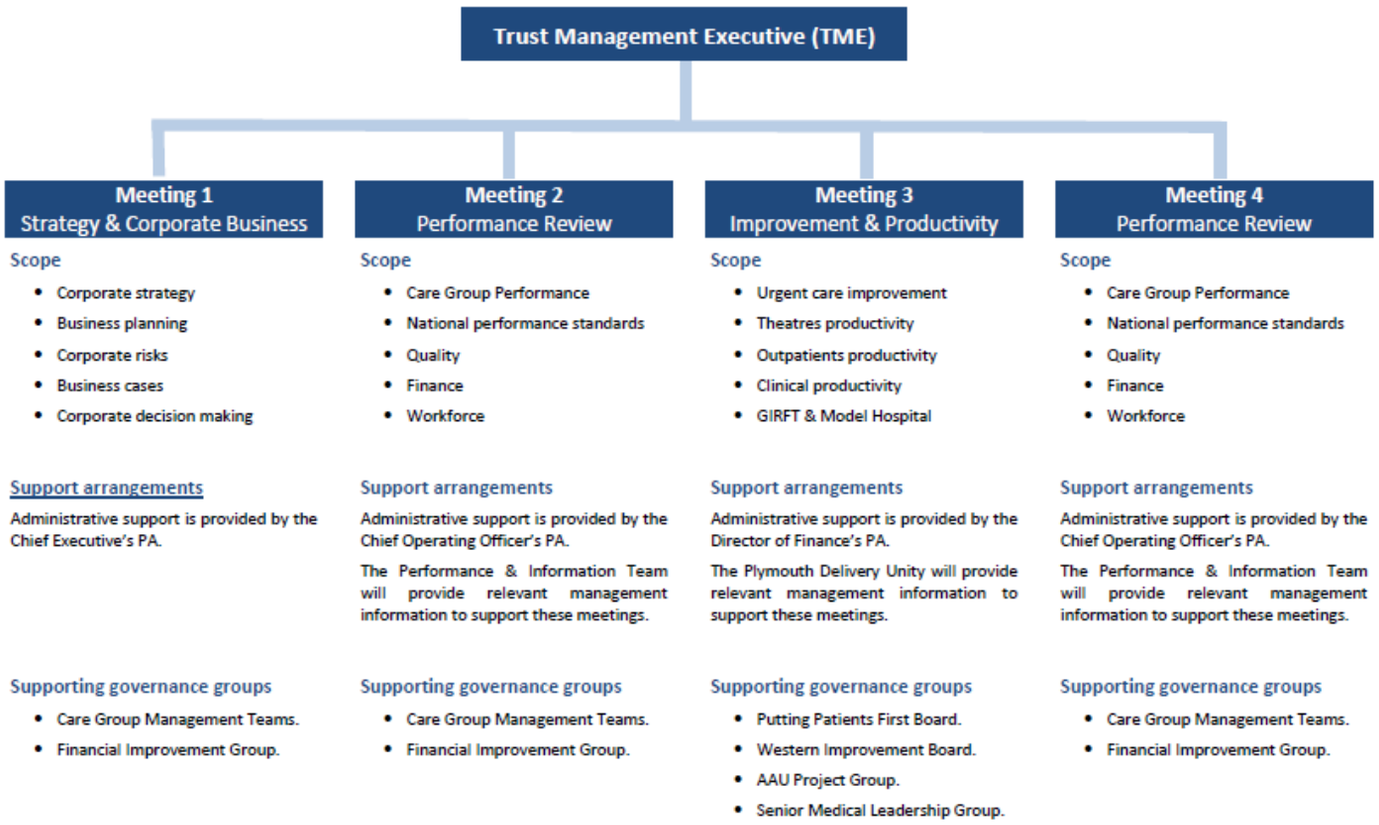
The Trust's Standing Orders set out the matters reserved to the Board and our Standing Financial Instructions and Scheme of Reservation and Delegation define our financial decision making framework.

Our 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 2018/19, the Trust Board approved an Operating Plan which identified four key areas of focus and five overarching strategic aims, as summarised in the following diagram.

Our plan was underpinned by our desire to maximise the system impact of culture change and continuous improvement using NHS Improvement's (NHSI) LEAN programme. We call this our *People First* programme (see page 27).

We established robust arrangements for overseeing and securing delivery of our 2018/19 Business Plan:



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

Members of the Board of Directors in 2018/19

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 January 2019 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.

We became a 'University Trust' in April 2018, having made a successful application to the Secretary of State for Health to change our name from Plymouth Hospitals NHS Trust to University Hospitals Plymouth NHS Trust. We did this because it more accurately reflects our status as an organisation with strong educational and research functions and our close relationship with the University of Plymouth. As a result of becoming a 'University Trust', the University was required to nominate a Non-Executive Director to serve on our Board.

NON-EXECUTIVE DIRECTORS

We have seven 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 2018/19:

V – voting Director
NV – non-voting Director

Richard Crompton, Chairman (V)
Richard was initially appointed in August 2012 and was re-appointed in 2016 and 2018. A former Chief Constable of Lincolnshire Police, Richard also served with the Metropolitan Police and the 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 was appointed to our Board in September 2016 for four years, having previously been Chief Executive of Rowcroft House Foundation Limited (Rowcroft Hospice). Giles brings to our Board considerable experience within the charity sector at leadership and board level and senior NHS management experience at an operational level having worked for the former National Blood Service and South Devon Healthcare NHS Trust.

- 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 thirty 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. Jacky was appointed in October 2016 for four years.

Declarations of interests:
- President 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.
- Director of Postgraduate Clinical Training University of Nicosia.

- Associate, General Medical Council.

Professor Elizabeth Kay, MBE (Associate, NV)
Liz was appointed Associate Non-Executive Director in September 2016 for a four year term. Formerly the Foundation Dean of the Peninsula Dental School, Liz 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 BUPA Oasis Healthcare.
- Chair of NICE Guideline Committee on Epilepsies
- British Dental Association Health and Sciences Committee member.
- Board member, South West Academic Health Science Network.
- Trustee and Vice Chair, British Medical and Dental Student Trust.

Hisham Khalil, (V)
Professor Khalil is a Consultant Ear, Nose and Throat Surgeon with the Trust and the Interim Dean of the University of Plymouth's Faculty of Medicine and Dentistry. He is the University's nominated Non-Executive Director on our Trust Board and took up this appointment in August 2018 for a period of two years.

Declarations of interests:
- Interim Dean, Faculty of Medicine & Dentistry, University of Plymouth.
- Consultant Surgeon, University Hospitals Plymouth NHS Trust.
- Consultant Surgeon, Nuffield Health Hospital, Plymouth.

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.

- Mike has declared no interests.

Elizabeth Raikes (V)
A chartered accountant by profession, Elizabeth was a Chief Executive in the public sector for twelve years before her appointment to our Board in September 2012. Elizabeth stepped down from the Board in September 2018 at the conclusion of her term of office.

During the period covered by this report, Elizabeth declared the following interest:

- Spouse is a governor of Plymouth Marjon University.

Graham Raikes, MBE (V)
With a public sector career spanning over forty years, Graham was formerly the Director of Resources at the Arts and Humanities Research Council. He had a successful military career with the Army and the Ministry of Defence, holding a number of staff and regimental appointments both at home, overseas and on operations and in 1997 was awarded an MBE. He also worked as the Deputy Vice Chancellor (Resources) and Director of Corporate Finance at the University of Plymouth for five years. He has been a Governor at Plymouth Marjon University since November 2017.

Declarations of interest:
- Chair of Governors, Plymouth Marjon University.

Rob Sneyd, (V)
Rob made an outstanding contribution across several fields as a doctor, teacher, academic and regional leader in medical education and training. His achievements included the development of the Plymouth Postgraduate Medical School and his successful leadership of the bid for a new Medical School in the South West, culminating in his appointment, in 2012, as Dean of the Plymouth University Peninsula School of Medicine and Dentistry. Rob attended our Board from 2012 and was Plymouth University's nominated Non-Executive Director on it from April 2018 until his retirement in July 2018.

Estelle Thistleton (V)
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 (Associate, NV)
Appointed as an Associate Non-Executive Director in April 2013, Henry has brought 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's, 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 in April 2017 and again in April 2019 for a further two year term.

Declarations of interests:
- Chairman and Director of Fluvial Innovations Ltd.
- Chair of Peninsula Dentistry Social Enterprise.
-

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:
- Chair, South West Leadership Academy.
- Chair, Southwest Talent Board.
- Member, One Plymouth.
- Chair, National Institute Health Research Peninsula Partnership Group.
- Member, Plymouth Growth Board.
- Vice Chair, Board of Governors, Devonport High School for Girls

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 Cornwall. Originally qualifying as a nurse in 1986, Kevin 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.

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.

Lenny Byrne, Interim Chief Nurse (V)
Lenny took up his appointment as Interim Chief Nurse on 25 March 2019.

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 and is the Board's Senior Information Risk Owner.

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 had previously 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. Greg resigned from the Trust in March 2019.

During the period covered by this report Greg declared the following 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. 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:
- Brother-in-law is Partner at PWC (but has no involvement in UK public sector).

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.
- Member of GS1 UK Healthcare Advisory Board.

DIRECTORS' ATTENDANCE OF PUBLIC BOARD MEETINGS IN 2018/2019

The Board met in public on seven 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	7 of 7
Giles Charnaud	6 of 7
Jacky Hayden	7 of 7
Liz Kay	6 of 7
Hisham Khalil	4 of 4
Mike Leece	4 of 7
Elizabeth Raikes	2 of 3
Graham Raikes	4 of 4
Rob Sneyd	3 of 3
Estelle Thistleton	5 of 7
Henry Warren	7 of 7

Executive Directors	Meetings attended
Ann James	7 of 7
Kevin Baber	6 of 7
Lenny Byrne	1 of 1
Lee Budge	5 of 7
Greg Dix	5 of 7
Phil Hughes	6 of 7
Steven Keith	6 of 7
Neil Kemsley	7 of 7
Nick Thomas	5 of 7

Board Evaluation and Effectiveness

The Board held regular development sessions during 2018/19 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 topics covered in Board Development during 2018/19 were:

- An externally facilitated session on the Care Quality Commission's Well Led Framework.
- The Trust's medium and long term Site Development Plan.
- Maternity Services.
- The development of the Trust's strategic direction and engagement with external stakeholders.
- Enhancing the Trust's governance arrangements.
- A commitment to a programme of 360 degree feedback and skills development.
- Leadership framework and behaviours.
- Strategic refresh and development of strategic intentions.
- The 'People First' Improvement Programme and the Board's role in this.
- The Medium Term Financial Plan.
- A facilitated session with senior leaders from across the organisation on the Trust's vision and values.
- Winter Planning.
- NHSI Undertakings.

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 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 was chaired by Elizabeth Raikes until she stepped down from the Board. From October 2018 it was chaired by Graham Raikes. Along with

the chair, Jacky Hayden, Mike Leece, and Henry Warren are core members; Jacky, Mike and Henry also chair other Committees of the Board. All other Non-Executive Directors, with the exception of the Chairman and the NED representing the University of Plymouth, 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 2018/19 was:

Non-Executive Directors	Meetings attended
Elizabeth Raikes, Chair until September 2018	3 of 3
Graham Raikes, Chair from October 2018	3 of 3
Giles Charnaud	5 of 6
Jacky Hayden	5 of 6
Liz Kay	0 of 6
Mike Leece	5 of 6
Estelle Thistleton	2 of 6
Henry Warren	6 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 was chaired by Elizabeth Raikes until she stepped down from the Board, then by Graham Raikes. It met on five occasions during 2018/19: in August 2018 to review the Chairman's appraisal of the Chief Executive; in October 2018 to consider an externally commissioned report and associated personnel matters; in November 2018 to review the Chief Executive's appraisals of her Executive team, and in January and March 2019 to consider recommendations for Executive portfolios and remuneration arrangements and guidance from NHS Improvement on Very Senior Managers' appointments and pay.

Members' attendance at Remuneration Committee meetings during 2018/19 was:

Non-Executive Directors	Meetings attended
Elizabeth Raikes, Chair until September 2018	0 of 1
Graham Raikes, Chair from October 2018	4 of 5
Giles Charnaud	4 of 5
Richard Crompton	5 of 5
Jacky Hayden	5 of 5
Liz Kay	5 of 5
Mike Leece	4 of 5
Estelle Thistleton	4 of 5
Henry Warren	5 of 5

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 Graham Raikes. This Committee met on thirteen occasions in 2018/19. Board members' attendance was:

Core NED/Executive Member	Meetings attended
Henry Warren, Chairman	11 of 13
Giles Charnaud	11 of 13
Mike Leece	12 of 13
Graham Raikes	5 of 8
Chief or Deputy Chief Executive	12 of 13
Director of Finance	13 of 13
Chief Operating Officer	6 of 13
Director of Corporate Business	2 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 safety and quality risks. It met six times in 2018/19 and is chaired by Jacky Hayden. Board members' attendance was:

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

On the occasion when the Chief Nurse was not present and Deputy Chief Nurse attended.

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 has oversight of HR policies. It met on five occasions during the year and is chaired by Mike Leece. Board members' attendance during 2018/9 was:

Core NED/Executive Member	Meetings attended
Mike Leece, Chair	5 of 5
Estelle Thistleton	4 of 5
Director of People	5 of 5
Chief Nurse or nominee	5 of 5
Medical Director's nominee	1 of 5

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	2 of 3
Chief Nurse	2 of 3
Medical Director	1 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 met four times in 2018/19 and is chaired jointly by Executive Directors Lee Budge and Kevin Baber. The corporate trustee has agreed, in principle, to introduce revisions to the charity's governance arrangements in order to separate the operational and strategic elements of its charitable governance. The Charitable Funds Management Committee will be disbanded and a new Charity Operational Group and Charity Strategic Group will be introduced. It is planned to seek the corporate trustee's approval of these new arrangements in 2019/20. More details on the work of Plymouth Hospital's Charity can be found in the **Charity's Annual Report**.

Annual Governance Statement 2018/19

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 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.

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 provide only 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 University Hospitals Plymouth NHS Trust for the year ended 31 March 2019 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:

- 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.

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.

The risk and control framework

Corporate governance arrangements

The Trust has had a fully constituted Board for 2018/19 and there were no major changes to the appointed Non-Executive or Executive Directors during the year. The Board held regular development sessions throughout 2018/19. 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.

The Board is in the process of reviewing the approach to assessing its effectiveness and will be updating its development plan accordingly in 2019/20.

Risk management arrangements
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 are 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. It 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.

Quality governance arrangements
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.
- A Clinical Effectiveness Group to oversee the introduction of new devices and procedures.
- 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.

We will continue to develop our quality governance arrangements throughout 2019/20.

Risk assessment
Key risks to the achievement of our objectives have been regularly reviewed and updated throughout the year. The key areas of focus have included:

Aim 1: Improve quality
Operational Pressures
Follow-up Backlogs
Quality Governance
Pharmacy
Medical Equipment
Infection Control
Clinical Administration
CQUINs
Aim 2: Develop our workforce
Safe Staffing
Culture & Staff Experience
Core Requirements
Clinical Education
Aim 3: Improve our financial position
Financial Performance
Capital Programme
Use of Resources
Financial Sustainability
Aim 4: Create a sustainable future
System Transformation
Physical Infrastructure
Aim 5 – Maintain strong governance
Health & Safety
Fire Safety
Emergency Planning
Cyber Security

Progress in mitigating these risks has been reviewed by the Trust Board and its committees throughout the year.

Care Quality Commission (CQC) assessment
The Trust was inspected by the CQC in April and May 2018. We have again been rated as 'Requires Improvement' overall for our services. Our rating for each of the five domains assessed by the CQC (including the well-led assessment) is shown below:

Safe	Requires improvement
Effective	Requires improvement
Caring	Outstanding
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

The Trust developed a comprehensive action plan in response to the CQC findings and has reported progress in delivering this plan to the Safety & Quality Committee and Trust Board.

In addition to the Inspection Report, the Trust received two Section 29A Warning Notices, one for Pharmacy and one for Diagnostic Imaging. The CQC inspectors had been alerted to problems we had identified in pharmacy prior to their inspection; as part of this we also told them what we were doing to address these.

The Trust was required to make the significant improvements identified in the Warning Notices by 26th October 2018. The CQC conducted a follow-up inspection on 11th and 18th December 2018. The key findings were as follows:

- *Pharmacy:* The CQC found that the Trust had not fully addressed some of their concerns in the Warning Notice. However, they recognised that the Trust was making some progress and that a cultural shift would take time.
- *Imaging:* The CQC felt that insufficient progress had been made in addressing the concerns in the 2018 Warning Notice and on 25th January 2019 they issued a new Section 29A Warning Notice.

Both Pharmacy and Diagnostic Imaging have made real progress in addressing the issues highlighted by the CQC. Whilst it is disappointing that the Trust has received a new Section 29A Warning Notice for Diagnostic Imaging, there has been significant improvement in our imaging performance since December 2018, as reported following a visit by colleagues from NHS Improvement and NHS England. It is acknowledged that there is a lot of work to do to improve the culture and wellbeing of staff and the team intend to prioritise actions to address these issues but, as acknowledged by the CQC, a cultural shift will take time.

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.

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 whether its 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.

Data quality
The Trust has continued to adopt a pro-active approach to data quality in 2018/19 by maintaining its 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.

Data security
The Trust recognises the importance of effective leadership in addressing the Cyber Security threat and has established a number of arrangements for ensuring that senior leaders drive this agenda. The Trust has conducted a number of reviews in order to test the adequacy of its Cyber Security arrangements. The Trust Board reviewed the Cyber Security Annual Report in January 2019 which gave assurance that the threats associated with cyber security were being appropriately managed.

Developing workforce safeguards
The Trust has a number of arrangements in place to assess whether staffing processes are safe, sustainable and effective. This includes:
- Daily ward staffing review meetings.
- Weekly forward look on ward rota gaps.
- Regular safe staffing reports to the Trust Board.
- Guardian of Safe Working Hours reports.

The Human Resources & Organisational Development Committee oversees workforce safeguards on behalf of the Trust Board. The Committee received a briefing on NHSI's 'Developing Workforce Safeguards' requirements in December 2018. This continues to be identified as a key risk with the Board Assurance Framework and, as such, will be reviewed by the Trust Board throughout 2019/20.

Managing conflicts of interest
Declarations of interest are recorded for all Trust Board meetings. The Trust has conducted a comprehensive review of the 'Managing Conflicts of Interest in the NHS' guidance and has updated its Standards of Business Conduct Policy to reflect this. An action plan is being developed to ensure that appropriate arrangements are in place to ensure compliance with the policy.

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 responsibilities
The Trust has undertaken risk assessments and has a draft sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of the use of resources
The Trust has established arrangements for reviewing and improving economy, efficiency and effectiveness in the use of our resources. We are actively engaged in the national Getting It Right First Time (GIRFT) and Model Hospital work programmes and continue to use benchmarking to identify variation in performance and/or practice. These arrangements are reviewed annually by the Trust's external auditors.

Information governance
All incidents with an Information Governance element are recorded on the Trust Incident Reporting System (DATIX). Incidents are scored by the Information Governance team in conjunction with the Caldicott Guardian and the Senior Information Risk Owner using guidance provided by NHS Digital. Incidents fall within one of the following three categories:

- Low impact incidents - very low in severity.
- Local IG Investigation incidents - a thorough investigation by the IG team with recommendations and lessons learned.
- IG Reportable Incidents – reported to the Information Commissioner's Office (ICO) and the NEW Devon CCG. A full root cause analysis is conducted for these incidents.

In the 2018/19 financial year there were two IG Reportable Incidents, as follows:

- Patients' mothers received reminders for appointments that their adult children were due to attend.
- A number of patient letters were placed in one envelope several times and sent out to patients in error.

The Trust has cooperated fully with the ICO who have welcomed the remedial actions taken. The Trust continues to actively raise Information Governance awareness and encourage the reporting of incidents.

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 2018/19 Quality Account will be provided by our external auditors.

Review of effectiveness
As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control.

My review of the effectiveness of the system of internal control is informed by the work of internal auditors, clinical audit and the executive managers and clinical leads who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee and committees of the Board.

Executive Directors who have responsibility for the development and maintenance of the system of internal control also 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 has been reviewed.

A plan to address weaknesses and ensure continuous improvement of the system is in place.

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. The most significant issues facing the Trust in 2018/19 may be summarised as follows:

- *Operational pressures:* The Trust continues to face significant pressure from a sustained increase in the number of emergency attendances and high levels of acuity. The hospital has been under operational distress for a considerable time which has had a major impact on our ability to achieve a number of key national performance standards and/or the improvement trajectories agreed with NHS Improvement.
- *Quality:* The Trust received Warning Notices from the CQC in respect of pharmacy and imaging services during 2018/19. Whilst I am pleased that the inspectors recognised that progress is being made, further work is required to address these issues on a sustainable basis. We have adopted a comprehensive approach to doing this which includes regular reports to the Trust Board.
- *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.
- *Financial position:* The Trust originally planned for a small deficit of approximately £3m in 2018/19. It became apparent early in the financial year that this outturn was not achievable and, after dialogue with NHS Improvement, a revised budget for the year was submitted in October 2019 which showed an increased deficit of approximately £30m for the year.

In last year's Annual Governance Statement I commented that fundamental system transformation was needed if we are to address these challenges and meet the increasing demands on health and social care within the finite resources available.

For our part, we will continue to work with other stakeholders within the wider health & social care community to do what is right for the people we serve by better integrating the services they need.

Conclusion
A number of significant internal control issues have been identified in this Annual Governance Statement. My review confirms that whilst many key components of an effective system of internal control are in place as at 31 March 2019, 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 Board in 2019/20.

Signed (on behalf of the Trust Board)

Ann James
Chief Executive

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 and Social Care'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.

Salaries and allowances (subject to audit)

2018/19	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		2,900			40-45
Michael Leece, Non-Executive Director	5-10					5-10
Elizabeth Raikes, Non-Executive Director (note 1)	0-5		100			0-5
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		4,100			10-15
Jacky Hayden, Non-Executive Director	5-10					5-10
Liz Kay, Associate Non-Executive Director (see note 2)	5-10					5-10
Hisham Khalil, Non-Executive Director (see note 3)	0-5	130-135				135-140
Graham Raikes, Non-Executive Director (see note 4)	0-5		100			0-5
Ann James, Chief Executive	185-190		100	500		185-190
Kevin Baber, Chief Operating Officer	140-145			500		140-145
Greg Dix, Director of Nursing (see note 5)	120-125		100			120-125
Neil Kemsley, Director of Finance	135-140		4,200	5,500	15-17.5	160-165
Steven Keith, Director of People	125-130		100		22.5-25	145-150
Nick Thomas, Deputy Chief Executive and Director of Planning & Site Services	110-115		100		7.5-10	115-120
Phil Hughes, Medical Director	110-115	75-80	300	500		190-195
Lee Budge, Director of Corporate Business	85-90			400	20-22.5	105-110
Lenny Byrne, Chief Nurse and Director of Clinical Professions (see note 6)	0-5					0-5

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 2)	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 7)	85-90			5,200	10-12.5	100-105
Lee Budge, Director of Corporate Business	80-85			600	22.5-25	105-110

Notes

1. Term of office completed 24 September 2018
2. Invoiced by the University of Plymouth until 31 January 2019; on Trust payroll from 1 February 2019
3. Existing Trust employee appointed as non-executive director from 31 July 2018. This note covers only the period from that date.
4. Appointed 25 September 2018
5. Left the Trust 31 March 2019
6. Appointed 25 March 2019
7. Comparative note covers period to 28 January 2018 only; on secondment to another organisation from 29 January 2018 and has now left the Trust.
8. 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.
9. Taxable benefits relate to mileage reimbursement outside standard HMRC allowances, including home to base mileage, and taxable removal expenses.

Pension Benefits (subject to audit)

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 1)							
Phil Hughes, Medical Director (see note 1)							
Kevin Baber, Chief Operating Officer (see note 1)							
Greg Dix, Director of Nursing	0	0	30,000-35,000	70,000-75,000	572	531	9
Nick Thomas, Director of Planning & Site Services	1-2,500	2,500-5,000	50,000-55,000	155,000-160,000	1,193	1,031	114
Lee Budge, Director of Governance (see note 2)	1-2,500	0	10,000-15,000	0	173	128	30
Neil Kemsley, Director of Finance	1-2,500	0	50,000-55,000	125,000-130,000	1,013	861	107
Steven Keith, Director of People	1-2,500	0	35,000-40,000	80,000-85,000	678	563	80
Lenny Byrne, Chief Nurse and Director of Clinical Professions (see note 3)	0	0	20,000-25,000	65,000-70,000	427	366	1

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 factors used to calculate CETV changed on 29 October 2018.

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. No lump sum shown for members of the 2008 scheme
3. Increase disclosures are adjusted for time in post

Fair Pay (subject to audit)
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 £188,925 (2017-18 £186,850.) This was 6.7 times (2017-18 7.0) the median banded remuneration of the workforce, which was £28,050 (2017-18 £26,614.) The range of banded remuneration was from £7,235 to £188,925 (2017-18 £6,844 to £186,850.)

In 2018-19 twenty one employees (2017-8 twenty) received total remuneration in excess of the Chief Executive's, with total remuneration ranging from £189,061 - £281,020 (2017-8 range £188,541 - £249,855.)

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 (not subject to audit)

Off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months

	Number
Number of existing engagements as of 31 March 2018	1
Of which the number that have existed	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	1
for between two and three years at the time of reporting	0
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 2018 and 31 March 2019, 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	5
Of which	
Number assessed as caught by IR35	5
Number assessed as not caught by IR35	0
Of which	
Number engaged directly (via PSC contracted to the Trust)	5
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.

21 individuals have been deemed "board members and/ or senior officers with significant financial responsibility" during the year.

Medical locum staff costing over £142,500 per annum (not subject to audit)
Reporting bodies are required to disclose details of agency medical staff whose total cost to the organisation was over £142,500 in the year.

Name	Role	Total cost to the organisation in 2018-19 (£)
T Usmani	Consultant Surgeon	219,317
A Abushaala	Consultant Surgeon	208,628

Sickness absence data (not subject to audit)
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 2018.

	2018 Number	2017 Number
Total Days Lost	o/s	57,788
Total Staff Years	o/s	6,124
Average working Days Lost	o/s	9

Exit packages (subject to audit)
There were no exit packages during the year

Analysis of staff costs (subject to audit)

	Permanent	Other	2018/9 Total	2017/18 Total
	£000	£000	£000	£000
Salaries and wages	246,006	1,666	247,672	233,820
Social security costs	24,784	-	24,784	23,403
Apprenticeship levy	1,208	-	1,208	1,136
Employer's contributions to NHS pensions	29,074	-	29,074	27,564
Temporary staff	-	18,447	18,447	17,021
Total gross staff costs	**301,072**	**20,113**	**321,185**	**302,944**
Recoveries in respect of seconded staff	(1,716)	-	(1,716)	(1,091)
Total staff costs	**299,356**	**20,113**	**319,469**	**301,853**
Of which				
Costs capitalised as part of assets	2,339	14	2,353	2,152

Average staff numbers (subject to audit)

	Permanent	Other	2018/9 Total	2017/18 Total
	Number	Number	Number	Number
Medical and dental	1,036	61	1,097	942
Ambulance staff	3	-	3	2
Administration and estates	1,403	65	1,468	1,410
Healthcare assistants and other support staff	969	142	1,111	1,083
Nursing, midwifery and health visiting staff	1,815	155	1,970	1,889
Nursing, midwifery and health visiting learners	1	-	1	2
Scientific, therapeutic and technical staff	1,213	7	1,220	1,155
Other	8	-	8	8
Total average numbers	**6,448**	**430**	**6,878**	**6,491**
Of which:				
Number of employees (WTE) engaged on capital projects	58	14	72	54

Consultancy (not subject to audit)
Expenditure on consultancy in 2018/19 was £489,000 (2017/8 £603,000.)

Proud!

Health Care Assistant Fiona Dilorenzo wins national award
Specialist Learning Disability Liaison Acute Health Care Assistant (HCA), Fiona Dilorenzo, has won a national award.

The Royal College of Nursing institute (RCNi) awards were held in London in July where Fiona was announced the winner in the HCA of the Year category.

Part of Fiona's role is to support patients who may otherwise find attending a hospital appointment a very difficult experience. Fiona was nominated by colleagues based on her ability to encourage even the most anxious patients to come into the hospital and attend their appointments.

One patient who is regularly supported by Fiona, Sean McCann, said: "Fiona is excellent. If I'm here, Fiona's here and it's a real help to have that. She helps with my health assessments and I think she's marvellous. It's nice to have help with medical things but she helps with other things as well. She really goes the extra mile."

Following the award ceremony Fiona said: "It was a great honour to be nominated for this award and I was even more overwhelmed and humbled to win especially after meeting the competition and hearing about the great work they do.

"I wish to thank my colleagues in the Learning Disability Hospital Team as it would not have been possible without their support. I love my job and helping our patients get the same access to hospital care as the general population gives me great satisfaction."

Our People

Roll Call of Honours

Hepatology nursing team
Winner of 'Liver Nurse of the Year' at the British Medical Journal Awards

ACE Mobile Dementia App
Finalist in 'Strengthening the Foundation' at Patient Experience National Network Awards

SALUS
Finalist in 'Innovative use of Technology at Patient Experience National Network Awards

Kelly Whitehorn
Winner of 'Patient Experience Transformer of Tomorrow' at Patient Experience National Network Awards

Defence Medical Welfare Service
Runner up of 'Working in Partnership at Patient Experience National Network Awards

Lewis Edwards
(Communications Team) in partnership with AHPs and HCSs Shortlisted for 'Communications Initiative' at Health Service Journal Value Awards

Fiona Dilorenzo
Winner of HCA of the Year at the RCNi Awards

vCreate
Finalist in 'Communicating Effectively with Patients and Families' at Patient Experience National Network Awards

Jamie Read
Care and Compassion Award in the NHS70 Parliamentary Awards

Sian Dennison
Winner of Excellence in Cancer Care in the NHS70 Parliamentary Awards

Immunology Team
Person-Centred Care Champion Award in the NHS70 Parliamentary Awards

Joe Rahamim
Lifetime Achievement Award in the NHS70 Parliamentary Awards

Staff numbers by Staff Group, figure as of 31st March 2019

Scientific and Technical Staff (inc ODPs)	280.89
Healthcare Assistants and Clinical Helpers	1286.54
Administrative and Clerical Staff	1406.95
Allied Health Professionals and Therapists	367.87
Estates and Ancillary Staff	129.90
Healthcare Scientists	252.55
Medical and Dental Staff	941.41
Nursing and Midwifery	1772.53
Total (wte)	6438.63
Total Headcount	7415
Annual Turnover	10.3%
Annual Sickness Absence	4.28%

Staff numbers by gender

Gender	Board	Senior Manager	Other	Grand Total
Female	4	95	5466	5565
Male	12	71	1768	1850
Grand Total	16	166	7234	7415

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

Staff Group	Total
Add Prof Scientific and Technic	43
Additional Clinical Services	227
Administrative and Clerical	225
Allied Health Professionals	63
Estates and Ancillary	16
Healthcare Scientists	15
Medical and Dental	307
Nursing and Midwifery Registered	276
Grand Total	1172

Creating a fair, diverse and inclusive workplace and healthcare service
Equality, diversity and inclusion are at the heart of the NHS strategy and recognize that a diverse workforce enables us to deliver a more inclusive service and improve the experience of our patients. We strive to continue to create a working environment where colleagues are treated fairly to enable them to reach their full potential. To do this we recognise the diversity that each of us has and we continue to build an environment where individuals' experience both in and out of work is valued and fosters a sense of inclusion.

We continue to ensure that inclusion is inherent in our policies, processes and decision making allowing for collaborate working and thinking by understanding the impact of our actions on our colleagues and patients. Whilst we understand and work within the legal framework of equality we recognise that policies alone are not enough to build an inclusive workplace and inclusion should not be a box-ticking exercise. How people feel when they are at work is important to us and everyone of us has a part to play in the how we deliver the care for our patients.

Our aims for the coming year include enabling our leaders to work in a compassionate, kind and inclusive way. This is supported by our leadership programme which enable leaders at all levels to understand the impact they have and how they can best create a positive and supportive culture where each individual is able to maximise their potential. A key element of our mandatory training for all our colleagues is our focus on the value of diversity, and includes understanding traits such as unconscious bias that may impact on how we treat others. We are listening to the experience of our colleagues so we can celebrate the good and understand what further work needs to be done to continually improve, taking action when we see behaviours that sit outside of our values. The impact of this will improve the experience of our patients as we continue to address healthcare inequalities through our understanding and learning.
Our Gender Pay Gap Report 2019 (snapshot data as at 31 March 2018) demonstrates that there could be greater female representation in senior clinical roles. Similarly, we acknowledge there could be greater male representation in less senior clinical and non-clinical roles. This position is consistent with the previous snapshot data taken on 31 March 2017.

We recognise that closing the gender pay gap will take some time and requires sustained commitment from the Trust. This year we have promoted our flexible working policies for all, focussed on inclusive leadership development, reviewed our recruitment and selection processes to ensure a gender balanced approach and have given practical support and encouragement to female clinicians and other under-represented groups to apply for national and local clinical excellence awards.

Listening to our people
We are constantly listening to our colleagues, through surveys, Big Conversations, feedback from touchpoints such as induction and exit interviews, when things go wrong and when things go right.

We have a Say **Thank You and Learn from Excellence** scheme which offers staff, patients and their families an easy way to say thanks and help us capture and learn from episodes of excellence. By completing a quick and easy online form, staff and patients or their families can generate a real card which contains their words of thanks. This is sent to the individual member of staff or team named and we know that staff really appreciate it when their Thank You card arrives in the post.

- In the last 12 months we have received **1,881** *Say Thank you and Learn from Excellence* nominations – double the number of nominations from the previous year.
- The learning from *Say Thank You and Learn from Excellence* nominations demonstrates that what matters most to colleagues, patients and their families is positive and supportive behaviour. Our staff are regularly thanked for being kind, giving time and supporting us in times of pressure or when we are feeling vulnerable. The seemingly little things - being friendly and approachable, smiling, helping out with 'no fuss', really do make the difference.

Some recent examples of the type of feedback sent to staff:

Thank you for the warm welcome following my operation. It was greatly received and quickly put me at ease

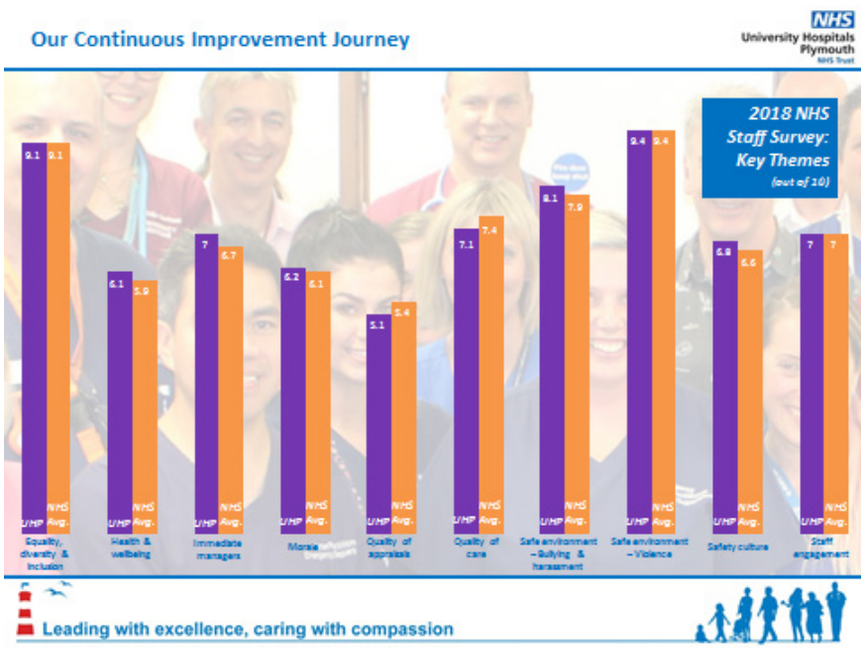
My wife had a lump checked out. The whole process from reception, very efficient lady, to seeing the reassuring consultant and being scanned and hearing the results took only about 40 minutes! Given the negative publicity the NHS sometimes receives for things, often outside their control, I thought the care was superb!

Mr .. was the first surgeon I met, on my first day in theatres. From that day, he has been warm and welcoming, patient with me while I learn new skills and coaching me to be a better healthcare professional.

We have loved having you join the ward family and we're grateful to know you will always be there if we need you. We want you to know how much we appreciate you.

Listening: Our Staff Survey
We continue to make improvements in our staff survey. The 2018 survey questions were grouped together into themes and out of the 10 themes:

- 2 statistically significantly improved for us between 2017/ 2018
- 7 stayed the same
- 1 was not comparable
- 5 were better than average in 2018
- 3 were the same as average
- 2 were lower than average

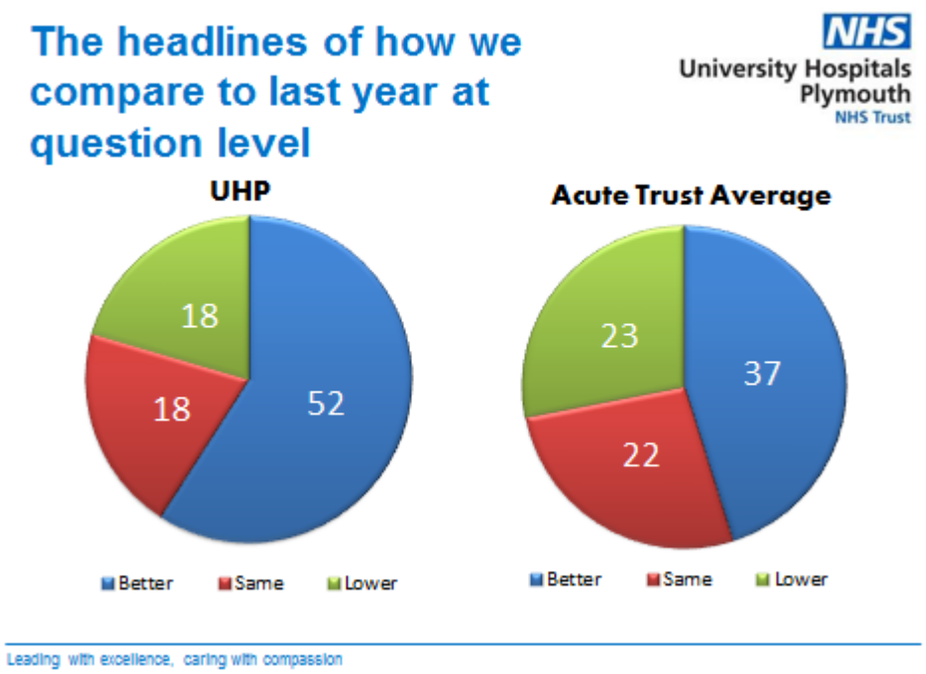


Top:

- Q17a. My organisation treats staff who are involved in an error, near miss or incident fairly (62% from 55%)
- Q5g. How satisfied are you with… your level of pay. (38% from 32%)
- Q5a. How satisfied are you with… the recognition you get for good work (58% from 53%)
- Q10c. On average, how many additional UNPAID hours do you work per week? (55% from 58%)
- Q19g. My manager supported me to receive this training, learning or development (55% from 50%)

Bottom:

- Q13c. In the last 12 months how often have you experienced harassment, bullying or abuse at work from… other colleagues: 19% (from 17%)
- Q10b. On average, how many additional PAID hours do you work per week?: 38% (from 34%)
- Q11a. Does your organisation take positive action on health and well-being?: 32% (from 35%)
- Q16b. In the last month have you seen any incidents that could have hurt… service users (31% from 29%)



Key quotes:

"I have always felt valued working in the NHS, yes sometimes as all jobs anywhere It has its pressures, but I have always felt supported and valued. I love working in the NHS."

"I am very lucky as I love my job and I feel that this is as a direct result of working within a department where I feel well supported and that the staff are focused on doing an excellent job."

"I feel positive changes are happening and the department is moving forwards."

"I feel privileged and proud to work for the NHS and in particular this organisation. I understand many of the pressures we face are due to increased demand and the current economic climate. The organisation faces enormous pressures to deliver care to our patients, which are always placed first. I am proud to play a small part in the fantastic service this organisation provides and to be part of a team with so many outstanding members."

Developing Our Managers
We have a Manager's Passport, bringing together a number of modules to help develop our managers in skills such as undertaking appraisals, having difficult conversations and service improvement. Currently 550 line managers are undertaking this passport.

Thank you!

Giving generously of their time… one of our many volunteers

Following early retirement, Debbie Walters (57), started volunteering in 2017, initially on a general surgical ward. Debbie admitted she "felt daunted" to start with, but got on well and enjoyed her time as a ward visitor.

About six months later, she attended an Open Day with her daughter on Lyd Ward, the Chemotherapy Day Ward, where she learned they had no volunteers, but were hoping to recruit some. It didn't take long for Debbie to sign up!

Lyd Ward is different from many of the other wards in the hospital and the role of a volunteer in this area is slightly different too. Patients on the ward attend on a regular basis, often on the same day and time each week, and can remain on the ward all day. Some bring friends or relatives, but some are unaccompanied.

As their first volunteer Debbie, along with the ward manager, Jane Ransome and other staff, identified tasks she could do including: befriending patients, spending time chatting and listening; shopping for patients; making drinks; tidying the area; and restocking cupboards with gloves, aprons and biscuits. This enabled a task description to be drawn up for this new role.

Debbie quickly settled in and is now an invaluable part of the team. She says of her voluntary work: "I love it, the staff are really friendly." She says her voluntary work gives her a "privileged insight" into the lives of some of the patients and she always looks forward to seeing them. Her role now also includes taking and collecting prescriptions from pharmacy, and can involve such diverse activities as helping a patient with a crossword or "comparing pictures of dogs".

Debbie, along with Lyd's other volunteer, Elaine, who is equally valued, finds it gives them a 'structure to their week' and provides an "extra service" for the staff and patients.

To encourage other new volunteers, Debbie is keen to reassure anyone interested that Lyd is a really "positive place" and she would be happy to help a newcomer settle in just as well as she has.

The Trade Union (Facility Time Publication Requirements) Regulations 2017
University Hospitals Plymouth NHS Trust Response for Period 1 April 2018 to 31 March 2019

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
54	49.52

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%	16
1-50%	37
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	£122,240
Provide the total pay bill (as defined by the Trade Union (Facility Time Publication Requirements) Regulations 2017)	£295,278,248
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*	**5.65%**

Our Financial Statements and Notes

Strategic Report 1 April 2018 to 31 March 2019

Finances

Although the Trust ended financial year 2017-18 with a surplus of £3.4m the requirements for 2018-19 required setting a plan that the Board accepted would be hugely challenging. This included a Financial Improvement Plan (FIP) of £33m, equivalent to 6% of our total budget, in order to achieve the deficit control total set by NHS Improvement of £3.8m. In approving the Operational and Financial Plan, the Trust Board recognised the scale of the challenge ahead, especially given the context of increasing urgent care activity and a requirement to improve national performance standards in the A&E 4 hour standard, cancer standards, referral to treatment waits over 52 weeks and diagnostic waits.

In October 2018 the Trust reported a forecast deficit for the year of £29.5m, £25.7m adverse to the control total of £3.8m. Of this £25.7m adverse variance: £10.0m related to a shortfall on FIP targets, £3.5m related to lower than planned performance on variable contract activity, £1.1m for a funding shortfall on the final agenda for change pay settlement and £11.1m in relation to non-achievement of Provider Sustainability Fund (PSF), which having missed the NHSI control total was no longer receivable.

The actual outturn for the year reflects a small improvement of £2.4m when compared to the forecast submitted in October. The final position reported is a deficit of £27.1m. The overall improvement in the position was due to the receipt of additional PSF funding of £4.8m.

Although it was disappointing not to achieve our original financial target, through a combination of improved efficiency, innovations, income generation and strict financial controls we delivered £19m of internal financial improvement plans against the £33m target. A further £4m 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 and the requirement for operational improvement in national standards. Overall we therefore delivered a FIP of £23m, equivalent to around 4% of our budget. This is an excellent achievement and all the more so, as it followed a £30m FIP delivery in the previous financial year.

As well as delivery of significant financial improvement plans, as described in more detail elsewhere in this report, the Trust was also able to improve performance in a number of standards including diagnostic waits, cancer targets and we reduced 52 week waiters by 50%.

Overview of income and expenditure position

2018-19 Financial Plan

The Trust was set a financial deficit control total by NHS Improvement of £16.2m. If the Trust was able to achieve this then it would also have access to the Department of Health's Provider Sustainability Fund (PSF) of £12.4m which would further reduce this deficit to £3.8m. This reflected an overall adverse movement of £7.2m from the previous year's outturn. This planned movement was accepted due to a significant loss of non-recurrent income from the previous year. This meant that with costs forecast to increase by £40m there was only a minimal increase in income to support this. The Trust

Board accepted this challenge based on the requirement to deliver a Financial Improvement Plan of £33m.

The Trust's limited movement in income was made up of reductions of £20m for non-recurrent income received in 2017-18 being offset by £20m of increases to deliver increased clinical activity as described below:

Planned Income Movements	£M
Loss of Non Recurrent Income	
Reduced level of PSF available for achieving compliance with the financial control total	-4
Income reductions of £16m for non-recurrent funding received in the previous year from its STP partners	-14
Loss of NHS England winter pressure funding	-2
Income Increases for 2018-19	
Contract tariff for increased clinical activity volumes	24
Reduction for a discount agreed with commissioners	-6
Growth in high cost drugs and devices	2
	0

Costs were forecast to increase by £40m as described below:

Planned Expenditure Movements	£M
Investments in capacity to deliver the growth in contracted clinical activity service levels	24
Increased high cost drugs and devices costs	2
Investments in workforce development, safety and regulatory compliance	2
Full year impact of investments of the previous year	2
Pay inflation and incremental increases	7
Non-pay inflation increases	3
	40

The Trust's £33m Financial Improvement Plan was made up of targeted additional income of £10m and cost savings of £23m. Income increases were targeted through a range of measures including an increased clinical activity and a further increase in commissioner income for structural funding issues. Cost savings were to be delivered through a number of workstreams including theatre and outpatient productivity programmes, agency reductions, procurement, savings against activity growth costs, alternative workforce models, estates, support services and drugs costs.

2018-19 Financial Results

The impact of revaluations 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 2018-19 is a deficit of £27.1m.

After technical adjustments for revaluations (which has led to a reversal of previous impairments) and movements in the donated assets reserve, the actual financial position at the end of March 2019 is adjusted to a deficit of £22.8m.

The Trust has an overall cumulative deficit (taking each year to the next) of £105.5m. This means that as expected, and as per the last three years, the Trust has broken its statutory duty to break-even. The Trust's auditors notified the Secretary of State of this with a Section 30 Notice to this effect in the 2016-17 financial year.

The deficit of £27.1m is £23.3m worse than originally planned but £2.5m better than the revised forecast submitted in October. The final gap is comprised of an under-achievement of £17m against its pre-PSF target of £16.2m and a £6.3m variance in its PSF funding below the planned allocation of £12.4m.

The variance to plan is primarily due to the following factors.

- A £10m shortfall in the delivery of our Financial Improvement Plan. We delivered £23m of the £33m efficiency target (delivery of a 4% improvement).
- Although we have increased our elective/planned activity by around 5% overall, we have not increased activity by as much as we intended in some of our specialised services. We have also spent more than planned delivering operational improvements in the diagnostic targets. The year-end variance on these issues is £6m compared to the original financial plan.
- Although Trusts received additional income to cover the costs of the national pay award for their own staff; this was insufficient to cover the costs of those staff working in hospitals for other non-NHS organisations. The adverse impact of this issue is another £1m.

The Trust achieved PSF funding of £6.1m against the original allocation of £12.4m. The Trust achieved its financial target in Quarter 1, earning £1.3m of PSF, but failed to meet the target in Quarters 2 to 4 and also failed to achieve the required performance in A&E to earn this element of the PSF fund. However, the Trust was awarded £4.8m through the year end general distribution of PSF funds. The Trust's final income and expenditure performance for the year is shown on the following page;

Statement of Comprehensive Income	2018-9 £000s	2017-8 £000s	Diff £000s
Revenue from patient care activities	452,530	440,999	11,531
Other operating revenue	57,771	66,782	(9,011)
Total Income	**510,301**	**507,781**	**2,520**
Gross employee benefits	(313,612)	(296,090)	(17,522)
Other operating costs	(205,605)	(189,975)	(15,630)
Depreciation and Amortisation	(12,778)	(12,360)	(418)
Total Expenditure	**(531,995)**	**(498,425)**	**(33,570)**
Operating surplus/(deficit)	**(21,694)**	**9,356**	**(31,050)**
Investment revenue	112	42	70
Other gains and (losses)	9	(20)	29
Finance costs	(2,313)	(2,327)	14
Public dividend capital dividends payable	(3,195)	(3,526)	331
Impairments and reversals	4,234	(2,778)	7,012
Retained surplus/(deficit) for the year	**(22,847)**	**747**	**(23,594)**

Retained surplus/(deficit) for the year	**(22,847)**	**747**	**(23,594)**
Impairments/(Impairments Reversals)	(4,234)	2,778	(7,012)
Adjustments in respect of donated asset reserve elimination	(85)	(118)	33
CQuin risk reserve adjustment		(300)	300
Adjusted retained (deficit)	**(27,166)**	**3,107**	**(30,273)**

Income

The majority of revenue from patient care activities comes from NEW Devon and Kernow Clinical Commissioning Groups (commissioning services for the local population) and NHS England who commission specialist, dental and screening services. In 2018-19, the Trust treated 63455, elective patients, 64573 non elective patients (including 7567 through our Acute Assessment Unit) and over half a million outpatients. The Emergency Department had 105,858 attendances.

Within planned care, elective activity was 4447 spells below plan for all commissioners at the end of the year. This is reflective of areas that have had delays in implementing additional capacity plans such as Neurosurgery, Cardiology and Orthopaedics, but also reflects the fact that elective capacity has been restricted during periods in the year as operational and staffing pressures have limited bed capacity. Cardiac surgery was also under plan due to workforce pressures in critical care and theatre staffing issues. Although below plan, total elective activity actually increased by 3000 spells (5%) compared to the previous year. At the end of the year outpatients was below plan by around

21000 attendances. There were various over and under performances in specialties but the most significant under-performance was within Hepatology. Again however this is an overall increase from the previous year of just under 25000 (5%).On a like-for-like basis, the absolute numbers on the 18-week waiting list has been broadly maintained. There has been an increase though in respect of the transfer of the Care UK orthopaedic activity onto the Trust's waiting list.

Within urgent care Emergency Department activity at the end of the year also reflects an increase of 5% from the previous year. Non-elective activity, excluding the Acute Admissions Unit (AAU) activity, is 4013 spells below plan but the Ambulatory Care Unit activity (ACU) activity is now separately recorded and at 7567 attendances is offsetting the underperformance in non-elective activity, giving an overall increase of 2043 or 6%.

Although operational improvements were achieved in Q1, Q2 was more difficult with increased urgent care pressures. Urgent Care 4-hour wait performance has continued to be very challenging with a very difficult January and February. Plans to increase staffing levels, clinical space and improve patient flow are currently being implemented.

Revenue from patient care activities increased by £11.5m in 2018/19 (2.6%). As mentioned above, income was not expected to increase significantly because of the reduction of non-recurrent income from the previous year. The final income achieved is close to plan, however, within this there was a significant under-performance on the NHS England Specialist contract reflecting underperformance on the elective activity plan as described above. This totalled £7m but was offset by other items including £4m of from the Department of Health to fund the final agenda for change pay award and £3m for additional income following the implementation of a strategic partnership with Care UK to deliver orthopaedic activity under a single combined contract. Contract income also increased by £3m with the transfer of Minor Injuries Unit services to the Trust from Livewell Southwest in June 2018. The Trust also received additional commissioner income during the year of £4m as part of its Financial Improvement plan, in recognition of 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 PSF funding that the Trust was awarded. This accounts for the majority of income reduction in this area, with £16.5m received in 2017-18 but only £6.1m in 2018-19, £4.1m lower as per the plan and £6.3m due to the non-achievement of the PSF criteria.

Expenditure
With circa 7,000 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 £17.5m from 2017-18. The primary reason for the increase is, as planned, staff pay increments and inflation increased by £11m upon the final agreement of the new Agenda for Change pay award. The average number of staff employed during the year also increased by 387 WTE. This reflects the £6.5m investment in additional permanent staff to treat the additional numbers of patients. This WTE

movement also includes a small increase in temporary staff although expenditure on agency staff has further reduced in 2018-19 from £8m to £5.6m as the Trust increased its use of local bank staff and continued to reduce the hourly rates paid.

Non-pay costs incurred in 2018-19 totalled £206 million, an increase of £15.6m. The most significant area of cost increases was for the purchase of healthcare services from non NHS bodies which increased by £7.7m. This included £4.2m for increased costs relating to the Care UK partnership. The partnership has helped to ensure that we were able to maintain elective Orthopaedic services during the winter period. There was also a significant increase in the costs related to outsourcing arrangements for diagnostic services with increased expenditure on imaging reporting and additional scanning capacity along with increased endoscopy capacity totalling £1.5m. This cost has helped the Trust to increase compliance against the diagnostic target to ensure that a greater proportion of diagnostic tests are carried out within 6 weeks of referral. There is also a full year impact of the subcontract agreement with Livewell Southwest to provide sexual health services that gives increased costs against last year of £0.6m and an increase of non-pay costs as part of the transfer of Minor Injury Unit services to the Trust from Livewell Southwest of £1.1m.

A further £4.8m of the increase is in high cost drugs reflecting increased use of Homecare Drugs. The Trust also had an increase of £0.9m in the Hotel Services contract that reflected the increased staff costs within this contract that increased in line with the agenda for change pay award. The funding received from the Department of Health did not cover this additional cost which formed a significant in year cost pressure for the Trust.

Other increases reflect expected inflation increases across non-pay areas of £2m although these were higher than expected in utilities.

Savings Plans
The Trust has delivered £23m of the £33m Financial Improvement Plan. This delivery was across a number of workstreams. Significant areas include £6m from organisational productivity programmes including theatre utilisation, outpatient productivity and reduced urgent care costs. £2.5m of workforce savings were delivered mainly around the reduction of agency costs, £2.8m from procurement including £0.8m from pharmacy savings and £1m on estates savings. The Trust also secured additional income of £4m from commissioners in recognition that further funding was required given the ever increasing pressure associated with the urgent care activity going through the hospital. The balance of savings is made up of various smaller service line plans including securing a £0.5m reduction in CNST premiums.

Cash and Working Capital
The Trust's cash plan for the year reflected the utilisation of the £4.2m brought forward balance on capital expenditure, to end the year with a reduced balance of £1m. The actual balance stands at £3m, an increase of £2m from plan 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 £3.8m from the Department of Health to support the planned deficit of £3.8m. However at the year end the Trust had taken loans of £25.7m in line with the revised forecast outturn deficit of £29.5m. 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's original capital plan was to spend £20.8m, funded from internal depreciation of £12.8m, capital loans of £3m, financial leases of £2m and £3m of additional cash resources generated from last year's surplus (earned last year but paid via a PSF debtor during this year).

The programme included £1.5m preparatory work on the Interventional Radiology Theatres project, the first stage of the £30m DoH funded development. Other key projects included £2m for a new relocatable MRI facility, £1.5m for energy efficiency projects, £3.5m for IT strategic development including e-prescribing, £0.7m for the ground work for the new Cath Lab facility and £0.8m for work up of a new Emergency Department. The remainder of the programme covered £3.5m for estates backlog maintenance, £1.5m for the rolling equipment replacement programme and £5.8m for other various projects across service lines.

The programme was reduced during the year by £1.5m as a planned loan for the Interventional Radiology Theatres project was not drawn down.. This expenditure has still occurred but was funded from internal resources created by slippage in other projects. Planned spend also reduced by £2m as the finance lease for the new relocatable MRI was deferred to early in 2019-20. A planned Salix energy loan of £1.5m was reduced to £0.5m as £1m was deferred to 2019-20 following a successful bid for alternative funding through the NHS Energy Efficiency Fund.

Spend was increased for an in year allocation from NHSE for an Emergency Department expansion of £2.5m. The Emergency Department extension was completed in March giving increased space for 4 additional resus beds, a dedicated paediatric ED area and improved ambulance handover space. Total spend was £3.8m with supplementary funds from further slippage on other programmes.

Other minor allocations and donated assets took the final capital plan to £19.5m as summarised below.

Capital Spend	**£M**
Equipment and minor works	7.5
Emergency Department improvements	3.8
IM&T	2.9
Estates	1.7
Hybrid Theatres	1.5
Other Planning schemes	1.2
Cardiac catheter labs	0.9
Total	**19.5**

Future Plans
The Trust has a planned breakeven position for 2019-20 that is in line with the financial control total set by NHS Improvement. The Trust has another challenging Financial Improvement Programme of £25.5m to meet this target.

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 £16m during the course of the year (but is planned to be repaid by the end of the year). 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, the Trust fully expects to receive this support and therefore we are absolutely confident in adopting the going concern status.

The Trust has a number of work streams within its financial improvement plans including continuing the productivity programmes in theatres and outpatients, procurement savings, tackling 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 other clinical productivity programmes.

The Trust continues to work within the wider health community to deliver key elements of a longer term sustainability plan. The Devon Sustainability and Transformation Plan (STP) 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. 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 is confident that these actions will help to bring long-term financial viability whilst delivering safe and effective care for patients.

University Hospitals Plymouth NHS Trust

Annual Accounts for the year ended 31 March 2019

NHS
University Hospitals Plymouth
NHS Trust

#1BigTeam

Annual Report and Accounts 2018/19

Leading with excellence, caring with compassion

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 includes a link to our Quality Accounts. The structure of the report is as follows:

Foreword

There are not many organisations which receive thousands of good wishes and messages of support on their birthday. But when the NHS celebrated its 70th birthday in the summer of 2018, it was an occasion we celebrated with people throughout the city and beyond.

Our matrons organised cream teas with patients and families on our wards and in departments, we joined forces with schools and universities to hold our #NHS70 Open Day. Chris Pointon came to talk movingly about the #hellomynameis campaign started by his late wife at our Pride of Plymouth NHS70 Awards, when we celebrated some of our many fantastic staff in both our Trust and our neighbouring community organisation Livewell Southwest. And we created an online group in which people shared photos and memories from the NHS of yesteryear.

It was a moment to both look back and celebrate and look forward and contemplate. The NHS is indeed a national treasure but to maintain its beloved place in the nation's hearts it has to evolve and change, meeting our needs as a changing society. For example, deaths from smoking-related diseases are declining, but the incidence of obesity and associated health problems is on the rise.

We had much to celebrate in 2018/19, including:

- Significantly reducing the number of people who are subject to delays when leaving hospital (delayed transfers of care) from 8% to consistently 2%-3.5% since April 2018 (80-100 patients down to 18-25)
- Securing more than £50m of funding for a new Emergency Department, two new MRI scanners and new digital histopathology system
- Making more progress in providing a rewarding and supportive environment in which to work with the results of the National Staff Survey 2018
- Using #PeopleFirst lean methodology to drive team-driven improvement
- Helping lead the way nationally with Getting it Right First Time (GIRFT) clinical specialty work, which is making sure our services are the best they can be

But we also have much to do. Almost seven months to the day after the NHS marked its birthday, the **NHS Long Term Plan** was published, setting the direction of travel for services for the next ten years. It outlined a new service model, in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. The NHS is also seeking to do more to prevent ill health, address inequalities and focus on specific areas such as cancer, mental health, diabetes, healthy ageing including dementia, children's health, cardiovascular and respiratory conditions, and learning disability and autism, amongst others.

We are, of course, revising our own direction of travel and ambitions in light of the NHS Long Term Plan. There are areas of immediate concerns we have to address, including our CQC report from

August 2018. This rated us as 'Requires Improvement' overall and saw us receive two warning notices: for pharmacy and diagnostics respectively. At the time of writing, we are still working to address concerns raised by inspectors about our diagnostic service.

Then there are the longer-term challenges. Over recent years we have seen consistent growth in the number of people attending our hospital as emergencies and the people we are seeing and admitting are sicker, or, in healthcare terms, they have 'higher acuity'.

Whilst demand is growing, our workforce is not. It remains our biggest challenge – having enough of the right staff to care for patients and their families. Training staff takes time – it takes an average ten years for a doctor to become a consultant for example and three years to qualify as a registered nurse – as well as training places which we don't control. We work with other organisations to try to plan for the future and we remain as flexible and responsive as we can – for example we have been a pilot site for new roles such as the Physician Associate and Nursing Associates.

Our colleagues - those both paid and those who volunteer their time for free – are our NHS. The best facilities, equipment and medication in the world would be nothing without them. It is often the kind words, the touch on the arm in a moment when we are distressed, the reassurance of their knowledge and expertise when we are vulnerable and scared that we remember as patients.

And it is their achievements which make this Annual Report and Quality Account what it is – it is their compassion, commitment and professionalism 24 hours a day, 7 days a week, 365 days a year that shines through. On behalf of our leadership team, we would like to express our deepest gratitude to all our staff and volunteers for their continued dedication and incredible compassion.

Ann James
Chief Executive

Richard Crompton
Chairman

Our Year in Pictures

April 2018

1st April marks our first day as University Hospitals Plymouth NHS Trust, following approval for our name change by the Secretary of State for Health and Social Care. This cements our status as an organisation which is and has been intrinsically involved with teaching, education and research for decades. We work in close partnership with the University of Plymouth and the Plymouth University Peninsula Schools of Medicine and Dentistry. We also support the University of Exeter Medical School with the placement of medical imaging students and are developing closer relationships with Plymouth's Marjon University, a national leader in rehabilitation.

Her Royal Highness, Princess Anne, officially opens the University of Plymouth's multimillion pound Derriford Research Facility, at an event attended by a number of research clinicians from our Trust. Professor Simon Rule, Consultant Haematologist at Derriford Hospital is pictured above with HRH Princess Anne The University building, acting as the new headquarters of its Institute of Translational and Stratified Medicine, is located next to Derriford Hospital. It is hoped the facility will allow greater collaboration between medical, dental and biomedical researchers at the University, with research clinicians at the Trust.

May 2018

June 2018

We join forces with Livewell Southwest CIC to celebrate some of the particularly special members of staff and volunteers who are the Pride of Plymouth NHS. Chris Pointon, widower of Dr Kate Granger, who co-founded and championed the #hellomynameis campaign, presents the winners with their awards. He also delivers an emotional talk on the life of his late wife and how their campaign continues to inspire people across the world. The event was organised, as **part of the NHS' 70th birthday**, to celebrate some of the incredible people who go above and beyond in providing NHS services to patients in and around Plymouth.

July 2018

We celebrate the NHS 70th birthday on 5 July 2018 with a special Tea with Matron on our wards, a hotly-contested charity Bake-Off, a special Schwartz round themed 'Cradle to Grave Care'. On top of our Open Day, we also partnered with organisations across the city to create an NHS70 Facebook group part populated with old footage of yesterday's healthcare in Plymouth, sourced from the Box Plymouth Museum and the South West Film Archive.

Our Trust achieves its highest scores to-date since the introduction of patient-led annual assessments five years ago. The Patient-Led Assessment of the Care Environment (PLACE) is led by patient assessors, who offer a non-technical view across a range of environmental aspects and observe how standards are being met that support patient privacy and dignity, food, cleanliness and general maintenance, as well as disability and dementia. The results reveal that not only has University Hospitals Plymouth improved in all of the measured areas, but it has achieved its highest scores in all of the defined categories since the introduction of PLACE standards in 2013.

August 2018

September 2018

Children needing emergency care can look forward to an improved experience after it is announced Derriford Hospital will receive more than £2million to upgrade parts of the Emergency Department in time for winter. The investment will allow:

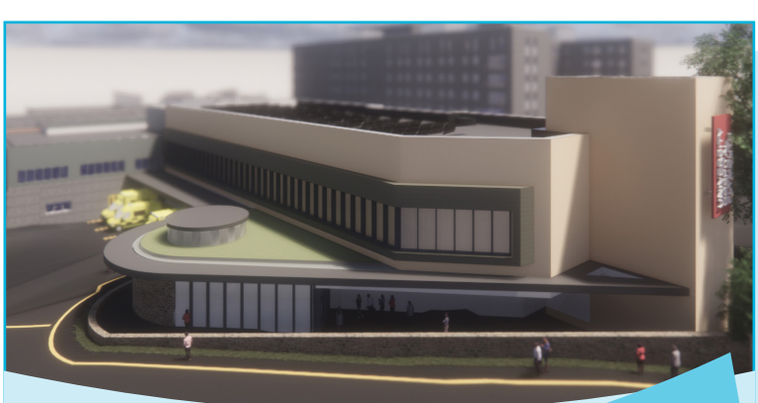
- An expansion of the paediatric area taking the unit from three children's consultation rooms up to five, plus a bigger waiting area and toilets for families to use
- An improved resuscitation unit which could increase the size from four bays to seven within the resuscitation unit.

October 2018

"Thank you to all the team on Pencarrow for saving lives every day" - wrote Secretary of State for Health and Social Care Matt Hancock on the Pencarrow comments board during his night shift in the hospital. The words could have applied to everyone he met.
Matt and MP Johnny Mercer asked if they could come and do a night shift with staff. They wanted to come without ceremony and witness the hospital at night as it is. They came with the aim of talking to and listening to staff and finding out what they think. They left blown away by how welcomed they felt they had been and how committed, professional and caring our #1bigteam is.

We celebrate the very first national Allied Health Professionals (AHPs) Day, which aims to recognise and appreciate the impact these professions have on healthcare. AHPs are the third largest workforce in health and care in England and have a huge impact on the health and wellbeing of our population. Many of us will know and recognise some of the work that our radiographers, paramedics and physiotherapists do. However, due to their small numbers and where they work, other roles such as Operating Department Practitioners, Orthoptists and Prosthetists are not so visible.

November 2018



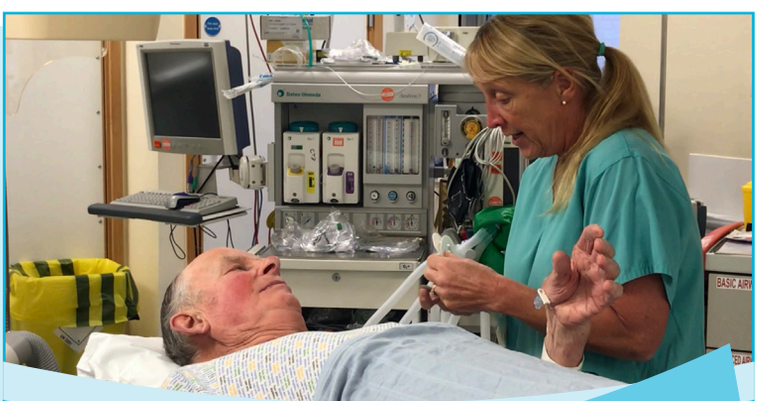
December 2018

We are delighted with an early Christmas present - news that Plymouth has been awarded £30 million to build a new Urgent and Emergency Care Hub. A further £12million is being invested in new diagnostic scanners and digital histopathology across Devon and Cornwall. The new Urgent and Emergency Care Hub will have dedicated areas for children, for patients with frailty, ambulatory care – patients who need urgent care but do not necessarily need to be admitted – and a dedicated area that offers privacy and dignity for ambulances to drop patients off.

January 2019

Our first cohort of Trainee Nursing Associates are registered with the Nursing and Midwifery Council (NMC). Following two years of training, Nursing Associates will work with Health Care Assistants and Registered Nurses to deliver care to patients. The role is intended to address a skills gap between health care assistants and registered nurses, opening a new entry point into a fully registered nursing career. Nursing associates are trained to work with people of all ages in a variety of settings in health and social care.

Good news - waiting times for patients needing cardiology diagnosis and treatment will fall with the opening of a third specialist lab at Derriford Hospital. Prior to the lab opening there were two cardiac catheterisation (cath) labs for cardiology patients which did not give sufficient space to see and treat all the patients needing planned procedures as well as those coming in as emergencies. Patients are currently having to wait 40 weeks for angiogram tests and up to 52 weeks for angioplasty. In a bid to secure extra capacity to treat patients in a timely way, Regent's Park Healthcare (RPH), is building a specialist centre at the back of the hospital.



February 2019

March 2019

A midwife at University Hospitals Plymouth NHS Trust recruits the 1,000th patient into a national clinical trial looking at whether a text messaging service can help pregnant women to quit smoking. The MiQuit 3 trial, led by Professor Tim Coleman at the University of Nottingham, is investigating whether pregnant women who smoke are interested in receiving support to stop smoking by text message and whether it can help them to quit. Heidi Hollands, a Research Midwife at Derriford Hospital and a National Research Champion for Reproductive Health, is the local Principal Investigator (PI) for the study.

About our Trust

University Hospitals Plymouth NHS Trust (UHP) is the largest hospital in the peninsula. We deliver a full range of general hospital services to around 500,000 people living in Plymouth, south and west Devon and Cornwall.

Where our patients come from:

Area	Number of distinct patients	%
North and East Cornwall	46,411	8
Plymouth	296,393	52
South and West Devon South Cornwall	128,018	22
	104,179	18
Total	**575,001**	**100**

We serve a diverse population with a wide variation in health and life expectancy, within which there are pockets of deprivation. For example, in Plymouth the life expectancy gap between those living in the most deprived areas and those in the least deprived areas remains signi¬ficant; life expectancy in the most deprived areas of Plymouth (at 78.4 years) is 4.4 years lower than in some of the least deprived areas (source: The Plymouth Report 2017).

As a specialist hospital, we operate at the heart of the south west peninsula providing specialist hospital services within a wider peninsula population of more than 1.5 million.

We are a teaching hospital in partnership with the University of Plymouth and working with Plymouth Marjon University. As host to the South West Medical Defence Group in a city with a strong military tradition, we have a tri-service staff of 200+ military doctors, nurses and allied health professionals fully integrated within the hospital workplace. Our Chief Executive sits on the Plymouth Growth Board, is a board member of the NHS South West Leadership Academy, Regional Chair for Talent Board and is a member of One Plymouth.

As such, we are ideally placed to support our local health and social care system acting as a lead partner, supporting new investments to ensure people are cared for as close to home as possible and developing new collaborative practices.

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. Services include emergency and major trauma, maternity, paediatrics, a full range of diagnostic, medical and surgical sub-specialties as well as many regional specialist services such as the south west peninsula cardiothoracic services, transplant services including kidneys and stem cells, and specialist neurosurgical services.

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 Estover.

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.

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

The Strategic Context

Integrated care
Health and care organisations and local authorities across Devon are working together with the aim of becoming an Integrated Care System (ICS), in line with the NHS Long Term Plan. This means agreeing a shared vision and collaborating more to meet the health and care needs of our population making sure our services are sustainable and affordable.

From competition to collaboration
The aim of the NHS Long Term Plan is to give everyone the best start in life; deliver world-class care for major health problems, such as cancer and heart disease, and help people age well. There are many references within the NHS Long Term Plan to the move towards collaboration over competition. Working together with all of our health and wellbeing partners, including those in the voluntary sector such as the Red Cross and St Luke's, we have to make best use of people's time and the funding available to achieve the best outcomes.

Local context
An ageing population is a recognised national trend, but the proportion of our local population in Plymouth, west Devon and south East Cornwall aged 85 or over is growing ahead of the national average by approximately 10 years. This requires us to innovate if we are to develop effective and sustainable services for older people.

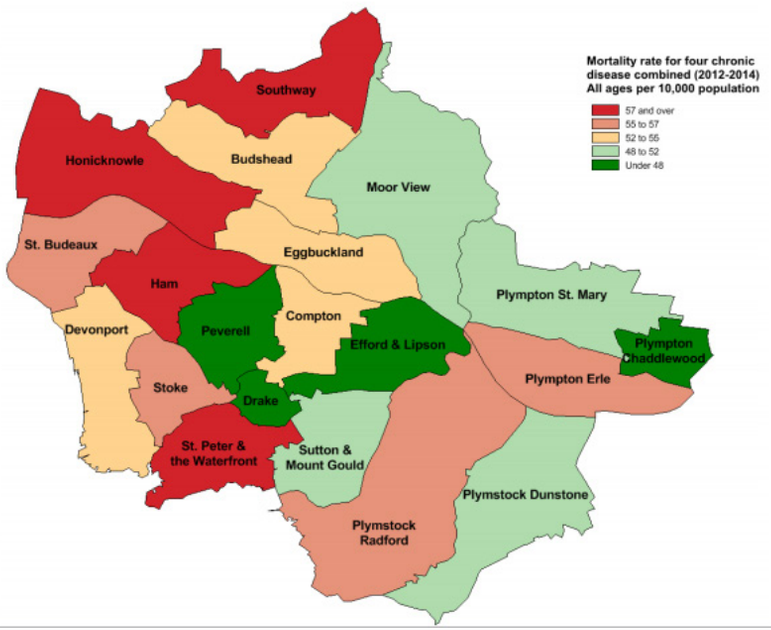
Pockets of deprivation within Plymouth drive higher demand for health and care services. Of local Plymouth people, 29% of the population are included in the most deprived in England and 15 out of 32 public health indicators in Plymouth are worse than the national average, including measures such as life expectancy, under 75 mortality rate, smoking prevalence, GCSEs achieved and children in low income families.

We are the largest single employer in Plymouth, employing more than 7,000 people. We are supplemented with a committed army of volunteers, 550+strong. This #1bigteam have a significant effect on the city of Plymouth, from how they choose to travel, their spending power and their own health and wellbeing. Our staff and volunteers are both contributors to the reality of Healthier Lives and advocates for it.

Our structure features four care groups which oversee 38 service lines covering all services, from emergency medicine and maternity to kidney transplant, neurosurgery, cardiothoracic surgery, upper GI surgery, cardiology and neurology to plastic surgery and trauma orthopaedics (amongst others).

More than 48,000 people pass through the main entrance of Derriford Hospital each week, without taking into account our other entrances or indeed other centres. Derriford Hospital has just over 900 beds in 36 wards, of which 167 are day-case beds, and 41 are for children.

Figure 26: All-age mortality rate for cancer, heart disease, respiratory disease, and stroke combined, 2012-14



Source: The Plymouth Report 2017

Devon Sustainability and Transformation Partnership

We joined forces with three local authorities, six other NHS organisations and one Community Interest Company in October 2016 to create a single Devon Sustainability and Transformation Partnership (STP). In July 2018, a two-year report was published highlighting the significant progress that has been achieved through joint working. It noted in particular:

Improved performance against national NHS standards, putting Devon in the top 30% nationally on urgent care and mental health
Reduced delays in transferring patients out of hospital, meaning Devon was on track to reach targets and to free 79 hospital beds for those needing them
High quality social care, with 86% of adult social care providers rated as either Outstanding or Good by the Care Quality Commission
Enhanced community services to support thousands more people to live independently at home, leading to 213 fewer acute and community hospital beds
Clinically appropriate referrals into hospitals, reducing unnecessary visits and seeing a 5.37% reduction in planned procedures and treatments
New clinical networks supporting "Best Care for Devon" standards in: • Urgent and emergency care • Stroke • Maternity services
Innovative mental health services including: • Liaison psychiatry in each acute hospital • Psychological support for people with long-term health conditions • Specialist support for women with postnatal depression
More than 100 ambassadors trained to promote careers in health and social care in schools.
Strengthening outcomes for children and young people, with children's community health services rated "Good" by the Care Quality Commission
In addition, historical overspending has been reduced from £95.4 million to £22.7 million in the past two years. This includes saving £25 million on agency staff. The Devon system is aiming for financial balance in 2019/20.

However, real challenges remain. These include health inequalities, social isolation, disadvantage for people with mental health problems, an ageing population and meeting the needs of carers. Recruitment of staff remains challenging, in primary care, in some medical specialties and in nursing and social care. The STP has proposed taking a more focused approach on fewer priorities for 2019/20. Over the next year, the STP focus will be on five areas:

- Accelerating the digital opportunities for the system to achieve integrated and interoperable care record systems, and improved access to care
- Developing an acute care strategy for Devon and Cornwall
- Addressing inequalities by moving resources to where they will be more effective in meeting need and improving outcomes
- Integrating mental health services, alongside development of inpatient services
- Promoting prevention and self-care, helping more people live healthy, well lives at home, with greater resilience in communities achieved through close working with charity and voluntary leaders.

These five priorities are accompanied by two other pieces of work:

- Implementation of the Integrated Care Model blueprint agreed in 2017
- Implementation of the workforce strategy

Integrating Care
Here are a few examples of how we have made good progress in joining up services so that people receive better all-round care:

Home First Approach
We have worked with Livewell Southwest, Plymouth Healthwatch, Plymouth City Council, care homes, the Red Cross and domiciliary care providers to design, develop and deliver integrated services for patient with more complex needs. A patient with complex needs is someone who needs support to keep them at home or to get them home post-discharge; they can be someone who needs reablement, occupational therapy or physiotherapy input or perhaps just a little help from careworkers to regain their confidence and independence at home. Equally they can be someone who needs to go to a care home after being in hospital, or support to die at home.
This has transformed the way we get patients home from hospital, switching us from bed-based care to a philosophy where home first is the default choice, what patients and their families want, wherever possible.

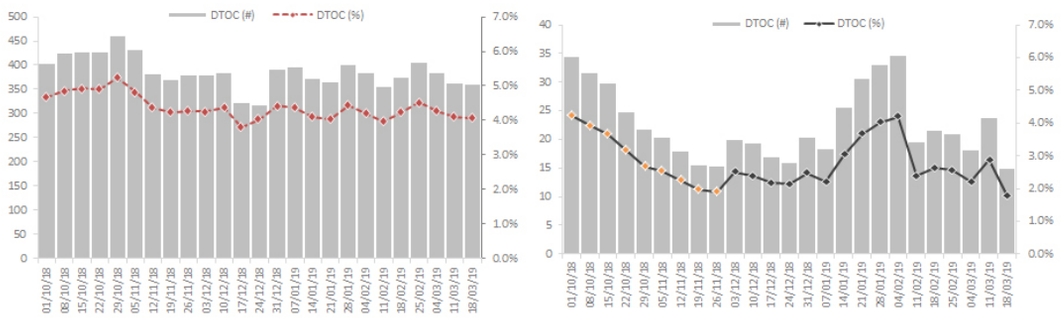
In Derriford Hospital, we have set up an integrated Command Centre in which a joint team have oversight of demand for hospital, community and social care services. This joint team is made up of hospital, community, council, intermediate care and ambulance service staff. The joint team means we can understand where demand is, what people need and use our resources to meet that, getting it right for patients first time.

These two things together, along with a rigorous daily effort looking at the needs of every complex patient, means we have achieved the national trajectory to reduce the number of patients subject to delayed transfers of care (DTOC).

DToC South

University Hospitals Plymouth NHS Trust

UHP

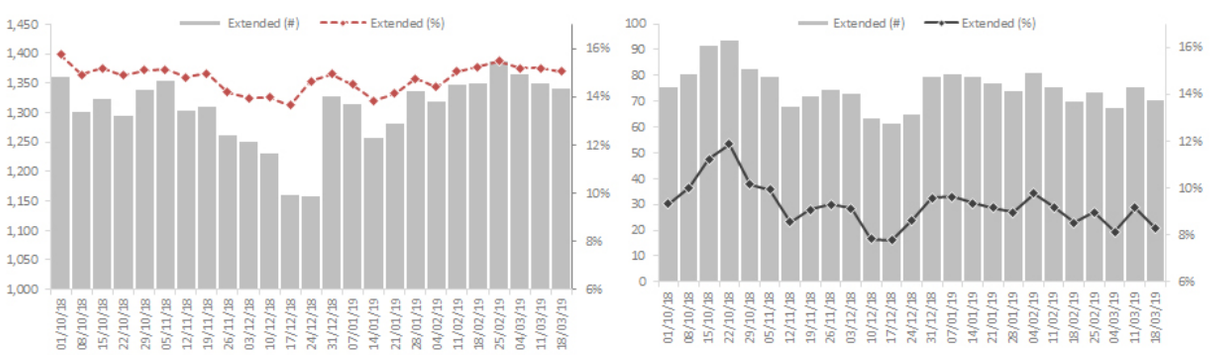


We are also in the top three performing trusts for the number of patients who have an extended length of stay (>21 days), which is linked to our efforts to minimise people deconditioning and our home-first philosophy.

Extended Length of Stay South

University Hospitals Plymouth NHS Trust

UHP



Our Acute Assessment Unit (AAU)

This unit offers patients needing urgent care a place to go for same day emergency care, a key plank of the NHS Long Term Plan. Patients are referred here to be seen by a GP (primary care streaming), for investigations and treatment within the same day (ambulatory care) and to be seen in a specialty frailty unit. Teams from our own trust and Livewell Southwest, the community provider, work together to support people to be treated and go home rather than be admitted. They can refer to a number of 'hot clinics' and call on colleagues within the Community Crisis Response Team to help do this. Our AAU sees 10% of our emergency patients.

Building relationships with GPs
We have an Associate Medical Director for Primary Care who is a GP and he is leading work to build stronger relationships between our hospital services and GPs. An example of this is a twinning programme between consultants and GPs. Eighty-four people – half GPs and half hospital consultants - spent time shadowing each other at the end of 2018. GPs shadowed hospital consultants at work and consultants went out to general practice to shadow GPs.

The main learning points for those involved were a mutual appreciation of each others' workloads and a desire to support each other to both deliver good clinical care and to make each others' professional lives easier. Everyone agreed that seeing things from a different perspective was enlightening, humbling, and valuable

Specific points for action were picked up around communication (quality of referrals and discharge) and improvements to specific clinical pathways. These are now being actioned by a joint Interface Working Group. This group consists of the Local Medical Committee members, GPs and consultants who look at feedback and action it. An early success for this group has been Fit Notes. GPs raised as an issue that patients were leaving hospital without them. We briefed our teams about what they should do to issue patients with Fit Notes on discharge, avoiding the patient leaving hospital and then having to visit their GP to get one.

We are also working with GPs on helping support people with long term conditions, for example those with diabetes or respiratory illness, so we are thinking about how our services work with theirs.

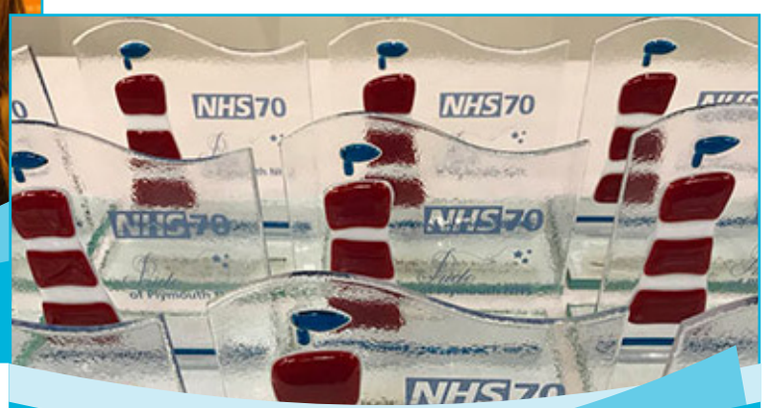
Extending diabetes expertise beyond hospital walls
We have a team of consultants and nurses in diabetes who would have traditionally seen patients in a hospital setting. Thanks to transformation funding, we have been able to do something different.

The aim of the transformation was to improve achievement of diabetes treatment targets (HbA1c, blood pressure and cholesterol) for patients across all local GP practices. To do this, we invested in more community specialist nurse sessions in GP practices and care homes and virtual consultant clinics. We developed a tool which works with the GP database, picks out blood test results, weight etc and uses an algorithm to highlight those patients the health professionals need to talk about.

By then giving advice and guidance to primary care colleagues, our specialists can support patient care in the community and patients don't need to come to hospital for an appointment.

As a result, we have seen a reduction in the number of people referred into the hospital and more discharges from our clinics. The advantage for patients is they get access to specialist advice without having to visit hospital and the patient feedback so far has been excellent.

Proud!



How we marked #NHS70

Within the Trust, celebrations for NHS70 started back in December 2017, when a hugely popular **advent calendar** recognised some of our longest serving members of staff and volunteers, taking a look back to where they started and where they are now.

The centrepiece of our NHS70 celebrations was our **Open Day** in June. The event saw over 700 visitors come along and learn about the changing history of services in the NHS, as well as get involved with some hands-on activities such as delivering a mock baby!

The Open Day was immediately followed by the **NHS70 Pride of Plymouth NHS Awards Ceremony**, a combined event with Livewell Southwest to celebrate some of the incredible people who go above and beyond in providing NHS services to patients in and around Plymouth.

The birthday was met with the news that Sian Dennison, our Head of Nursing for Cancer and End of Life, had won the 'Excellence in Cancer Care Award' at the **NHS70 Parliamentary Awards**. The national awards were created to recognise the massive contribution made by the individuals who work in and alongside the NHS and Sian was nominated by all three Plymouth MPs.

Meanwhile, staff across our sites brought out the bunting and got baking for the NHS Big7Tea. This included special NHS70 'Tea with Matron' events on each ward, which allowed patients and staff to share in the celebrations together. A small selection of photos from the many areas who took part can be found on the **Trust's Facebook Page**.

Staff from around the Trust took part in the Great NHS70 Bake. After much deliberation, the judges decided the winner was Student Nurse Tirion, who won with an NHS70-themed two-tier lemon and elderflower cake.

The day was particularly poignant for judge, Vera Mitchell MBE, as it marked 20 years since she underwent life-saving surgery at Derriford Hospital. This was the start of a long association with the Trust as a volunteer, which resulted in royal honours earlier this year.

The birthday was met by well-wishes from around the city:

- Plymouth Argyle's Ryan Edwards recorded a special message for staff at Derriford Hospital, after receiving treatment for testicular cancer earlier this year.
- Plymouth Herald featured "Plymouth's everyday heroes" explaining why they love working in the NHS.
  For all our #nhsheroes who save lives, fix us when we're broken, care for us when we need it most and deliver our babies, this one's for you #nhs70 #HappyBirthdayNHS #plymouth @Derriford_Hosp **https://t.co/NTmcLy0ZeA**
  - Plymouth Live (@Plymouth_Live) July 5, 2018
- Smeaton's Tower was even lit up blue in honour of NHS70.
  We are on Plymouth Hoe tonight, taking in the incredible view whilst we wait to see the iconic @SmeatonsTower#LightUpBlue tonight for #NHS70 - thanks to @plymouthcc for supporting the celebrations **pic.twitter.com/fcgFYcC2s0**
  - NHS England SW (@NHSEnglandSW) 5 July 2018
- **Plymouth Museums Galleries Archives** and the **South West Film and Television Archive** shared some old content from archives which documents the NHS of yesteryear, as part of our **NHS70 Plymouth Facebook Group**. You can still join up and tell your stories from years gone by.

Our Chairman and Chief Executive would like to extend a big thank you to our staff and volunteers. Ann James said: "As the NHS celebrates its 70th birthday, I would like to recognise and thank the many people here in Plymouth who make the NHS what it is. Not just now but all those who have done over the years."

Looking forward
In light of the new NHS Long Term Plan, we are currently revisiting and revising our 2013 strategy, At the Heart of the Peninsula.

Healthcare is funded by and belongs to us all. That's why it is so important that our strategy, Healthier Lives is drawn up by our staff, with input from their colleagues, patients, groups representing patients, our key partners including other providers and elected representatives. We are also drawing on the views of nearly 2,000 people across Plymouth.

With our strategy we are looking to build on our strengths, as identified by those who have shared their views with us: namely excellent clinical care, compassionate and professional staff and our open, collaborative approach which is helping build relationships right across our community.

But we also recognise there are areas we need to address, not least of which is having enough of the right staff with the right skills at the right time in the right place to provide care and advice. Working to recruit, train and retain the right number of staff will help us improve processes such as discharge, which stakeholders have told us is something we need to be better at.

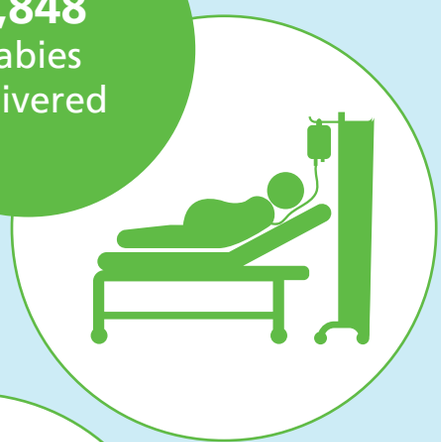
We are aiming to share our revised strategy in the summer of 2019.

Our Performance

137,674
patients cared for on our wards

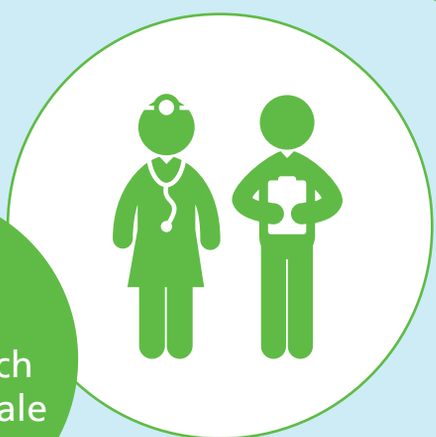
493,994
outpatient appointments

3,848
babies delivered



106,223
attendances including attendances at our Emergency Department, our Royal Eye Infirmary and our Minor Injuries Units

More than
4,500
people took part in research through UHP



7,415
staff, of which 75% are female

4.5 stars
on NHS Choices

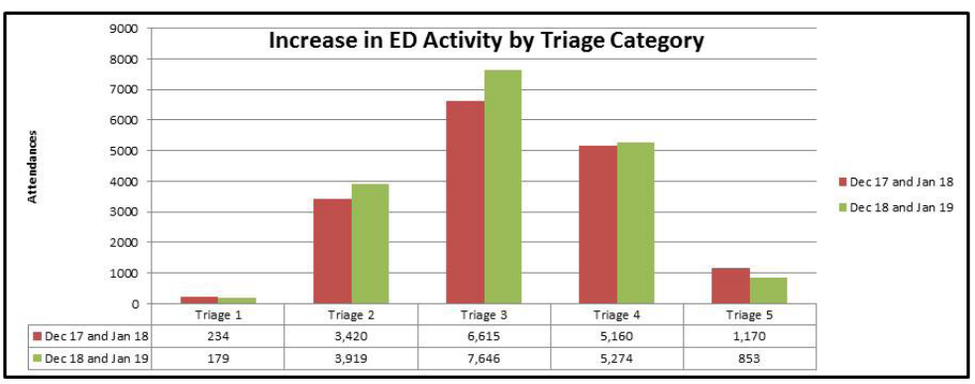
NHS Clinical Activity	2014/15	2015/16	2016/17	2017/18	2018/19
Elective Spells	62,321	62,774	62,877	59,446	66,756
Emergency + Non Elective Spells	53,152	54,623	56,752	58,726	70,911
Outpatient Attendances	485,423	487,435	492,968	485,812	493,994
Emergency Department Attendances	92,780	94,560	97,126	100,319	106,223
Babies delivered	4,555	4,570	4,180	4,166	3,848

*Emergency Department Attendances are inclusive of type one attendances and those streamed to Primary Care. They do not include type two attendances to the REI and Minor Injury Unit attendances (type three.)

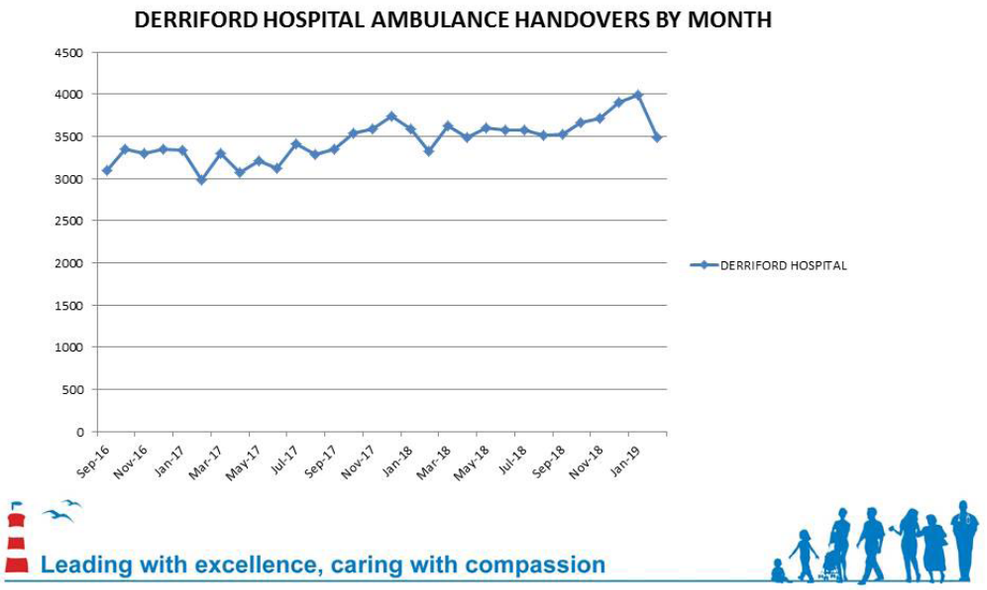
We have seen an increase in emergency demand, as shown by the graphs on the following pages. Overall, we admitted 200 more patients per month with 30 less beds than last year. But thanks to improved internal processes and huge effort from staff, the length of stay for medical patients reduced from 7.28 days to 6.50 days.

Comparing Winter 2018 and Winter 2019 – Triage

Largest movements in Triage categories 2 and 3 – Total movement of 1,530 in these two categories – 15% growth in triage 2 and 16% in triage 3 – 8% growth overall



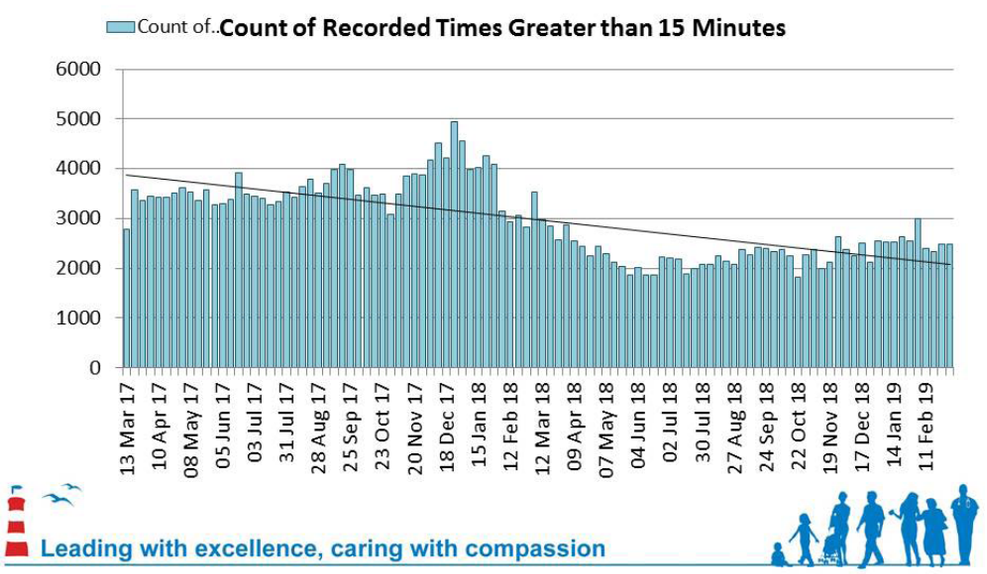
SWAST: Ambulance Handovers



An increase in the number of ambulances arriving at our Emergency Department doors.

But despite the increase in demand, our staff still managed to reduce delays for ambulance crews, so they could hand over their patients and get back out on the streets as soon as possible.

Ambulance Handover Trajectory



Comparing January 2019 to 2018 and 2017 – Attendances

	65+	75+	85+	Total Pts Aged 65+	Total Pts	% pts aged 65+
Jan-17	771	800	585	2,156	7,744	28%
Jan-18	887	888	649	2,424	8,099	30%
Jan-19	961	961	713	2,635	8,900	29%

Although there is no growth in the percentage of >65 attendances there is an obvious increase in volume so a proportionate increase in > 65s

We have also seen an increase in the number of older patients, who often have more complex needs.

	Standard Required	What did University Hospitals Plymouth achieve?
Infection Control		
Incidence of MRSA bacteraemia	0	6
Incidence of avoidable Clostridium difficile	<35	24
Referral to treatment times		
Incomplete pathways: Total number of pathways	26,347	27,922
Incomplete pathways %	92%	77.3%
52 week waits	0	48
Emergency Department		
Maximum time in ED of four hours from arrival to admission, transfer or discharge	95%	81.1%
Cancer urgent referral to first outpatient appointment waiting times:		
All cancer two week wait	93%	93.4%
Two week wait for symptomatic breast patients (cancer not initially suspected)	93%	87.1%
Cancer diagnosis to treatment waiting times:		
31 day (diagnosis to treatment) wait for first treatment: all cancers	96%	95.1%
31 day wait for second or subsequent treatment: surgery	94%	89.1%
31 day wait for second or subsequent treatment: anti-cancer drug treatments	98%	99.7%
31 day wait for second or subsequent treatment: radiotherapy treatments	94%	72.8%
Cancer urgent referral to treatment waiting times:		
62 day (urgent GP referral to treatment) wait for first treatment: all cancers	85%	73.8%
62 day wait for first treatment from consultant screening service referral: all cancers	90%	90.8%
62 day consultant upgrade wait for first treatment: all cancers	85%	72%
Diagnostic waits:		
Diagnostic test waiting times	<1%	5.89%
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%	17.1%
Cancelled operations by the hospital for non-clinical reasons on the day or after admission	No target	2.85%
Other key standards		
% stroke patients spending 90% of their stay on ASU	80%	81%
Mixed sex breaches	0	6
% patients receiving appropriate VTE risk assessment	95%	96.4%
* based on first 11 months of 18/19 as we report VTE one month in arrears to ensure we have all of the appropriate data sources available to get an accurate measure		

What the inspectors said:

In August, the Care Quality Commission (CQC) released findings from their planned inspection of our services during April and May 2018.

Overall, the Trust remains graded as Requires Improvement, however ratings in two of the sub-categories have deteriorated with Effective and Well-Led both moving from Good to Requires Improvement.

Previous ratings

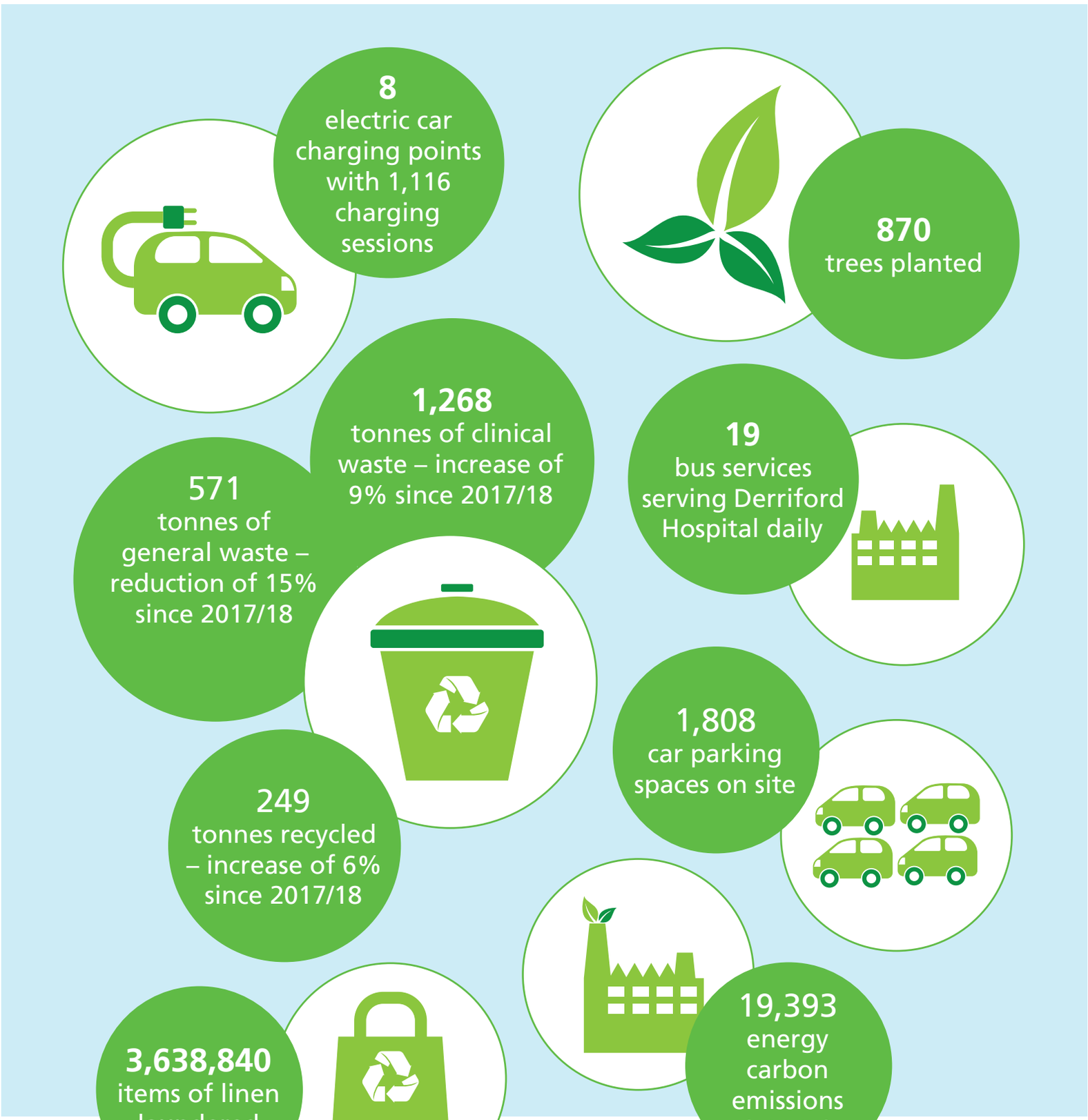
Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Good

New ratings

Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Outstanding
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

We remain rated Outstanding for Caring – one of only 36 out of 148 acute trusts nationally. Although this domain was not re-inspected during this visit, inspectors spoke of witnessing compassionate care from staff and volunteers across the service areas. Inspectors did have concerns and issued two warning notices, one for Pharmacy and one for Diagnostic Imaging. Improvement programmes were put in place to address the concerns raised and as of April 2019, one warning notice remains in place in diagnostics. The improvement work continues in this area.

Looking after our environment



Some of our achievements over the past year include:

Rollout of further recycling facilities across the Trust, including our retail areas
Contributing to Plymouth's Plastic Free Community Status where the Trust pledged to remove or replace plastics in the Trust's retail areas e.g. removal of plastic straws, plastic cutlery and single-use plastic cups from water fountains. All three have been achieved
Working on the development of a 'Green Champions' network - clinical and non-clinical staff who are passionate about being sustainable in the workplace
Refreshing the Trust's Green Travel Plan
Sowing the seeds to put Derriford's first gardening club in place. Planters have been positioned on site, where fruit and vegetables will be grown
Participating in Sustainable Health & Care Week in June 2018. The Trust focused on three areas - waste, travel and green space. Staff were encouraged to use a more sustainable method of transport such as bus, car share, cycling or walking across the week.
Continuing to promote Warp It, the Trust's online portal for staff to redistribute (give, loan or share) resources conveniently within the Trust.
Working closely with Warrens regarding takeaway packaging generated from the restaurant and cafe areas.They have now implemented compostable takeaway boxes, coffee cups and cups for water. They are also now using paper straws and compostable cutlery and selling reusable coffee cups.

Our Teams Driving Improvement
Together with Livewell Southwest, during 2018 we were successful in our joint bid to become one of just seven national hospitals to partner with NHS Improvement in a programme of work using lean methodology. We have called this our #PeopleFirst Programme.

With help and support from the national team we are changing the way we work to improve the quality of care we offer, making our services safer, more effective and more patient-centred. By removing waste, putting the best ideas of our frontline staff into practice and focusing on what our patients really want, we are delivering better services.

Our core principles are:
- Respect for staff
- Value to the person we care for
- Teams able to drive improvements

This programme continues to build on our strong existing Quality Improvement work which aims to implement ideas from all our staff, clinical and non-clinical, and also from our patients and service users.

We aim to:
- Ensure all our staff understand our clear and concise plan describing 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 – through spread of training and improvement huddles.
- Ensure the voice of patients is heard in all our changes, with the establishment of a dedicated group focusing on patient involvement in improvement.
- Provide our staff with the skills they require to bring about such change. Through training in local team-based improvement skills and coaching of teams.

Quality Academy & People First
Our Quality Academy team come from a variety of professional clinical and non-clinical backgrounds. This multi-disciplinary approach allows us to support and drive positive change across our organisation whilst truly understanding demands, pressures and challenges that our wards and departments are experiencing.

Sustainable team-driven improvement starts and ends with staff engagement. By working closely with ward and department teams, we

have been able to have open and honest conversations with staff and patients to identify areas for potential improvement.

Recent examples with our respiratory team show the benefit of team-driven change with consultants, juniors, nurses, therapists, pharmacists and managers all involved in developments to share handover and reduce patient time waiting for take home drugs.

We now hold a monthly 'Report Out' event, which is open to all staff. This provides a forum to share learning relating to improvements that are ongoing in all areas throughout the Trust, as part of the #PeopleFirst programme.

Creating an Exemplar
The Monkswell Ward team were selected to be a part of the #PeopleFirst programme by becoming the first 'Exemplar Area', this being somewhere that embodies the principles and values of the programme; putting the people at the heart of the service, respecting and valuing our staff and cultivating team-driven improvement.

With some coaching support from the programme staff, the ward team have really stepped-up to the challenge and embraced the #PeopleFirst methodology. This has helped the team to identify and implement smaller-scale improvements on a regular daily basis and also understand and work on their biggest challenges to providing outstanding care for every single patient.

Better every day
The Monkswell ward team now hold a daily 'improvement huddle' where members of the whole ward multidisciplinary team meet to identify how things could be better for patients, relatives, carers and staff. This focus has helped the team to make a number of gradual and incremental changes to ward processes for the better, including how patients are better assisted at mealtimes, helping patient handover to run smoothly and efficiently and testing ways to ensure that patient privacy and dignity is supported in the evenings and early mornings.

An eye on the big challenges
The team are working on the 'high impact' problems too and have selected to work on two big challenges that will reduce the length of time patients need to stay on the ward and release nursing time to care for patients. These two areas were identified as the key areas of focus by the team.

Team development
One of the aims of the #PeopleFirst programme is to help create a culture of 'continuous improvement', and as part of the Exemplar Ward some staff have had the opportunity to attend training courses provided by the programme, and others will have the opportunity to learn new skills and habits of daily improvement. The journey will not stop there – we hope to learn from this practice and impact further on patient care. Monkswell will continue we hope to develop its daily learning and work through more changes after the initial period of support.

Proud!

Named after the anaesthetist: baby Emily meets her namesake

It's not often we get to tell a story like this. Baby Emily is named after the kind-hearted anaesthetist who kept her promise and held her mum's hand during a traumatic birth. Mum Charlotte wanted to introduce baby Emily to her namesake, and to say a big thank you for her care. A reunion was on the cards, so we squeezed it in, just in time for Christmas …

"Back in February, I was in the hairdressers having a girly day with my eldest daughter Ellie, when suddenly I had a placental abruption," explains Charlotte Burgoyne, Assistant Practitioner in Radiotherapy Oncology at University Hospitals Plymouth NHS Trust. "I was rushed to Derriford Hospital, where I was examined and told I had to have an emergency C-section. I'd had two previously for my two older children and so I was fine about it.

"I met Emily (the anaesthetist) down in theatre when I was having the epidural. We were talking about baby names with my husband Peter and I suddenly realised that I didn't like any of the ones we'd picked. Emily joked that hers was a good name and we had a laugh about it.

"I knew something wasn't going according to plan when they called for another consultant. It was decided that, due to residual scar tissue, they would need to cut higher up, further than the epidural and into my chest, so it was urgent that I was put to sleep. Peter had to be rushed out and I felt utterly terrified. I grasped Emily's hand and begged her to stay with me, as I didn't want to be on my own.

"I woke up quite a few hours later and learnt that, not only did we have a beautiful baby girl, but Emily had kept her promise and stayed with me the entire time. After what happened, we knew there was only one name our baby could be called. And that was Emily."

At the time, Emily Howells was working as a Senior Registrar in Anaesthetics and Intensive Care at Derriford Hospital. She now works at the Royal Devon and Exeter Hospital.

“I think it’s always worth trying to get more Emilys in the world,” she says, “although I really didn’t expect Charlotte to take me seriously. Everyone forgets the anaesthetist after about 20 minutes. But it’s a very good name and a huge, major honour.”

After hearing Charlotte and Emily’s story as part of our #WhyILovetheNHS Advent Calendar, we decided to reunite the pair. On Friday 14 December, Charlotte surprised Emily with a visit with baby Emily.

“I thought it would be really wonderful for baby Emily to know who she is named after, and for Emily to meet our baby girl,” explains Charlotte, who is also a Freedom to Speak Up Guardian at University Hospitals Plymouth. “Looking back, it was such a scary situation made worse by my husband having to leave the room. I just wanted someone to stay with me and knowing that Emily did and that she kept her promise got me through all the horrible days and recovering from the trauma of it.

“A lot of people focus on the negatives of the story and say “I can’t believe that happened to you” but it’s so nice to be able to flip it and focus on the positives. We are so grateful to be where we are now.”

Emily adds: “It’s so important for patients to feel safe and looked after, and in the hands of someone that they know they can trust. Charlotte had all of us in the team taking care of her and making sure she was okay.

“I think that’s our job – being there for people’s best days and also their scariest days – is a huge privilege. It’s an amazing thing to be a part of people’s lives, and to know that you have had an effect on them is very moving and I appreciate it hugely. I’m so glad I got the opportunity to see Charlotte again and of course to meet baby Emily.”

GIRFT is a national clinical programme of work designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings. It is led by frontline clinicians who are expert in the areas they are reviewing, and importantly understand their specialty data. The data is presented to every Trust that delivers the clinical specialty through a national clinical-led visit to the organisation.

GIRFT covers a total of 32 separate specialities, of which Phase 1 encompassed 12 of the largest surgical specialties. Phase 2 was launched in mid-2018, covering a further 22 medical, smaller surgical areas, and cross cutting themes. We have received 23 national GIRFT visits to date, and are working closely with the recently established GIRFT South West hub, with their oversight of Devon STP variation.

Internally, the GIRFT programme of work is led by our Medical Director, Dr Phil Hughes, with the clinical lead for each specialty, and the divisional care group. We developed an approach to ensure the data is used to drive improvement, through a selected 5 metric approach for an initial six month focus. Clinical leads for each specialty are required to present their progress at three-month, and six-month check-in meetings with releasing benefits assessed against categories including improvements to patient access, capacity (bed days), cost avoidance, cost savings, and income opportunities.

Our approach has been nationally recognised by the GIRFT team and has been communicated through the GIRFT regional hubs as the blueprint of best practice approach in both structure, and governance. We have established an internal GIRFT Programme Board, to provide overarching visibility with the internal response, which underpins the role of GIRFT in our organisation.

In direct response to GIRFT, there have been a number of pilot projects which have commenced across the Trust including:

- Urology: A capacity-releasing project moving the treatment, where appropriate, of benign prostate from a surgical procedure requiring an in-patient two-day length of stay, to a laser-based treatment, undertaken as a day case.
- Ophthalmology: A cost-releasing project which releases the need for the Trust anaesthetist from appropriate cataract procedures (approximately 60% of total case volume) is becoming established as our standardised approach, without impacting on clinical outcomes, or theatre productivity.

A national GIRFT report is published for every specialty with explicit recommendations and actions with identified ownership. Our Trust was referenced as a best practice case study within the National Cardiothoracic Report, as having the lowest reported rate of blood transfusion after surgery (23%) which was half the national average (46%). This has been achieved, through both internal education to our surgical trainees, our clinical approach with the use of our Specialty Care Practitioners (SC`s) in carrying out off-site patient assessments, accompanying surgeons to outlying multi-disciplinary team meetings, and use of intravenous iron in anaemic patients pre-operatively. For patients, this results in lower length of stay, less complications, and mitigation of the need to use expensive blood products. **https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/07/CardiothoracicReportMar18-F.pdf**

Best practice case study

Attention to detail the key to low rates of blood transfusion

Plymouth Hospitals

SWCC has the lowest reported transfusion rate for blood products after surgery in England, with a rate of just 23%.

They put this down to surgical attention to detail and highlight the following key practices:

- stressing the importance of their blood transfusion practices to surgical trainees (28% of their cases are operated on by trainees as primary surgeon – the fourth highest in England)
- stopping pre-operative dual antiplatelet therapy
- observing a strict transfusion trigger (Hb of 8g/100ml)
- ensuring that surgical care practitioners carry out off-site patient assessments, accompany surgeons to outlying MDTs, and review in-house transfers
- using IV Iron in anaemic patients pre-operatively.

Proud!

Nurse Intervention Pilot showing signs of improving cardiac care

A nurse-led improvement project in Derriford Hospital's Emergency Department is changing the way patients with cardiac conditions experience urgent care.

The three-month pilot, devised by the Heart Failure Nursing Team, is examining the impact that earlier intervention from a specialist nurse could have on the outcomes of patients attending the Emergency Department with either heart failure, cardiac conditions or atrial fibrillation (as a primary or secondary diagnosis). Nobody wants to have to stay in hospital, but the nature of cardiac conditions means that there is a high likelihood a patient will have to be admitted, with 70% of emergency attendances requiring an inpatient admission and a subsequent referral to a Heart Failure Nurse.

The primary focus of the pilot is to assess the impact of quicker access to specialist nurse review and diagnostics, by providing Heart Failure Nurse support within the Emergency Department.

Lead Heart Failure Specialist Nurse, Becky Horne, said: "Early intervention from a specialist nurse is really beneficial to patients, as in many cases they can be sent home with a package of care and can avoid having to stay in hospital. In terms of patient experience, this is the best possible outcome." Over the first two-week period of the pilot (from 4 March), the Heart Failure Nurses assessed more than 30 patients in the Emergency Department and were able to provide 91% with advice or care packages allowing them to return home. The admission rate during this time was lowered to 9% (compared to 70% previously).

"In the reducing number of instances where admission is necessary, we are able to directly admit patients to the most appropriate specialist ward." explains Becky. "This is better for patients as it speeds up their onward journey, bypassing a transitional stay in an assessment unit and putting them straight into the care of our specialist team."

Having studied the initial impact of the pilot, the next stage is to understand the impact early intervention has on outcomes for patients admitted directly to the cardiology wards. This will involve monitoring length of stay amongst the patient group (previously 5.18 days on average).

This 'scientific learning' approach is based on the Trust's #PeopleFirst programme.

Improving Our Patients' Experience
We recognise the importance of putting the patient 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 experiences of our patients, we actively seek to engage with patients and members of the public.

Following receipt of the National Inpatient Survey results in 2018 a decision was made to focus improvement across the Trust through a new campaign 'Let's Talk about MEEE'. (Making Every Experience Excellent) @MeeeUhp.

The purpose of the campaign was to implement a process to actively listen to our staff and patients and act on their ideas for improvement. This would mirror the methodology and learning from the 'Big Conversation' staff engagement sessions used by our Learning and Organisational Development Team following receipt of the staff survey results.

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.

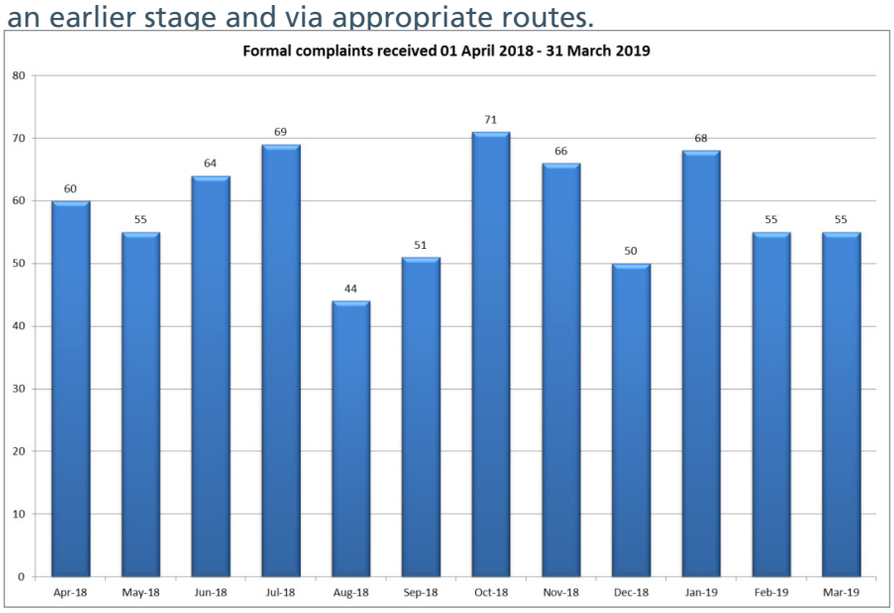
Patient Council
Our Patient Council, which was established in October 2014, is now well established with 10 members and a full schedule of both formal and informal meetings. Throughout 2018-19, the Council held six formal and three informal meetings. The Patient Council was established to embed the patient perspective into day-to-day activity and its strategy is to be the collective voice for patients and carers who use our services and act alongside the Trust as a critical friend. Our Patient Council are incredibly engaged and supportive of the work we do and members have actively been involved in a number of activities including PLACE assessments, Making Mealtimes Matter Week, Patient Experience Ambassadors and the Nursing Assessment Assurance Framework (NAAF) audits. See the Patient Council report on page 39.

Patient Feedback
We seek this through

The Friends and Family Test;
- Patient Surveys - for the period 01 April 2018 to 31 March 19 we received feedback from 893 patients, 97.21% rated their overall care as excellent, very good or good;
- Care Opinion and NHS (previously NHS Choices), websites where patients have the opportunity to register comments, anonymously if they choose to do so. During the past year 147 pieces of feedback were posted on the Care Opinion website relating to University Hospitals Plymouth 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;
- Learning from Excellence (LfE) - for the period 01 April 2018 to 31 March 19 we received 1,881 LfE nominations of which 407 came from patients, their family and friends.

Complaints
For the period 01 April 2018 to 31 March 2019, 708 formal complaints were received, which are detailed in the table below by month. This represents a 21.5% increase compared to the same period in 2017/18, which is a significant rise in activity.

On review, 4,982 PALS enquiries were received during 2018/19 which would indicate concerns are being managed at an earlier stage and via appropriate routes.



We improved accessibility and visibility of our Patient Advice & Liaison Service (PALS) by increasing the number of PALS Clinics, which involves members of the PALS team visiting wards to speak to patients and staff. 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

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 number of cases for each outcome.

Outcome	Definition	Number	Percentage
Upheld	Complaints in which the concerns were found to be correct on investigation	419	60%
Partially upheld	Complaints in which some of the concerns were found to be correct on investigation	181	26%
Not upheld	Complaints in which the concerns were not found to be correct on investigation	90	13%
Ongoing	Complaint investigation ongoing therefore, outcome has not yet been confirmed	1	N/A
Withdrawn	Complaint withdrawn	8	1.14%

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 01 April 2018 to 31 March 2019 the Trust received seven requests for information and investigation from the PHSO.

Of those seven cases, three were not taken forward by the PHSO; 1 complaint was re-opened as the complainant had been given new information at a recent outpatient appointment. This case is now closed following a further Chief Executive response letter. In two of the seven cases, we have shared information with the PHSO and are currently waiting for their decision as to whether or not they will investigate. One case has since gone forward for investigation.

Compliments
During the past year the Trust has worked with all areas to actively identify compliments received whether that be a formal thank you letter, card, box of chocolates or expression of thanks through the Friends and Family Test. We are pleased to report that for 2018/19 the Trust received 2,784 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.

Improving patient care
Throughout 2018/19 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 our Quality Account.

- ✓ Discharge Information Leaflet
  Discharges can be a stressful time for patients as not only have they been through a health crisis but they are now at the point where they need to continue on with their lives. Being discharged from hospital is a complex process involving a number of different people all working together to ensure that patients have transport home, medication to take away and the correct medical and onward care information. We trialled on one of our wards a new discharge information leaflet as a useful resource for patients to help them feel empowered, involved in and up-to-date with the discharge progress and this leaflet is now being rolled out Trust-wide.
- ✓ Development of the ICU Rehab Garden
  Phase one of the Critical Care Rehabilitation garden opened in December 2018. The garden has been designed to act as a space for both psychological and physical rehabilitation and has been already been transformed with plants and fairy lights and a basketball hoop which will provide further opportunities for physical activity for patients. The outdoor space supports the recovery of patients with ICU related delirium and the effects of staying in ICU can have on their psychological and physical health. The natural light from the garden helps patients reconnect with their natural sleep-wake cycles and helps to build resilience and independence.
- ✓ End of Life Care Boxes
  Our End of Life Care Boxes have been introduced in our Intensive Care Unit (ICU) for bereaved

families. These boxes include keep sakes such as a handprint; Forget-me-Not seeds, ICU patient diary, a bereavement booklet, organza bags for a lock of hair or jewellery, and a handwritten card for the family written by the nurse caring for the patient.

- ✓ Ward Noticeboards
  Following feedback from our PLACE assessments the Trust recognised the requirement to make improvements to the overall patient information available on each ward. As such, we are in the process of installing new ward noticeboards which advise patients, families and their carers' details of the ward manager, the person in charge and the matron. Other information also includes the number of nurses on duty for the day, safety information and the contact details for PALS.
- ✓ Improving Access to Sexual Health Services
  Our Women's and Children's Service Line wanted to improve the access to sexual health services for patients who might not otherwise attend clinic and avoid unnecessary trips for patients to hospital. We are now offering an online testing service to patients. Testing kits are sent in the post and these can be sent back and processed without the need for hospital attendance. The results are text or phoned through to patients with the appropriate treatment and support provided where necessary.

Our Patient Council Reports
In February 2019 we received a presentation and update from the Trust on its developing Strategy and following this, we have developed our Patient Council Strategy; the overall aim of which is to be the collective voice for Patients and Carers who use Trust services.

We've been extremely busy over the last 12 months and have continued to build on the strong relationships we have formed. We have been working on a number of key projects which include:

- Involvement with Let's Talk About Making Every Experience Excellent (MEEE) Campaign participating in the conversations with staff and patients
- Becoming Patient Experience Ambassadors – PEAS
- Review of all Patient Information leaflets prior to publication
- Involvement with the Making Mealtimes Matter Week
- Involvement with the Disability Awareness week and sensory awareness training
- Training for our hospital guides for patients with visual impairments
- Involvement with the Nursing Assessment Assurance Framework (NAAF) audits
- Involvement with the PLACE Assessments
- Involvement with Volunteers Week and the NHS 70th Birthday Celebrations
- Attendance at the Quality Improvement Workshops
- Representation at the Clinical Excellence Awards, the Planning and Building Group, the Equality, Diversity and Inclusivity Working group, the Nutritional Steering Group and at the Patient Experience Committee

It's really difficult to choose a favourite highlight from our involvement over the last 12 months, but if we had to, one of our top favourites would be our involvement with the Let's Talk About MEEE campaign. Having the opportunity to spend the week having meaningful conversations with patients and staff about key topics and even coming in for a night shift with the Chief Executive was so valuable and rewarding and we really felt as though we were making a difference.

Some of our key aims for coming year are to recruit more members to ensure all patient groups are actively represented and we are working with the Trust to create a Youth Patient Council.

We are becoming Patient Experience Ambassadors (PEAS) and we recently attended the launch event for this. We are very much enthused and focused for the year ahead and look forward to building our work as critical friends to the Trust.

Jane Hitchings
Chair

John Osborn
Vice Chair

Plymouth Healthwatch Reports

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

In addition, Healthwatch Plymouth are involved with this Trust and Livewell Southwest in the redesign of Discharge from Hospital Pathways to help improve patient involvement and service coordination. We have also been invited to sit on the Hotel Services Transition Board to review service delivery such as portering, cleaning and food delivery as these services transfer back to being delivered by Hospital staff.

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.

Patient-Led Assessments of the Care Environment (PLACE) 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 shave seen progress from previous years that saw the Trust achieve its highest scores in all areas. We found the hospital to be clean, most areas well maintained, and staff really engaged in the process. However, areas for further improvement were identified and presented to the hospital's PLACE working Group and we look forward to seeing the progress around these items at this year's annual assessment.

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

Nick Pennell,
Chair
Plymouth Healthwatch

Emergency Preparedness, Resilience and Response
We experienced a 1-in-10-year event with heavy snow over a protracted period in March 2018, when the Incident Control Centre was established to co-ordinate arrangements. This enabled us to support staff experiencing difficulties in getting to and from work, whilst minimising disruption to patient services. Having reviewed our incident response, arrangements for accessing 4x4 vehicle support were strengthened and put to the test again in February 2019 when further snow was experienced. Whilst demand was lower than the previous winter, it was recognised there was a marked improvement delivering 4x4 vehicle support for our staff through the revised multi-agency arrangements.

Command awareness training was delivered across the summer to all senior staff required to lead an incident response. This reinforced the need for a stepped change in managing incidents, standardised response arrangements and reiterated the national decision making and communication models.

In recognition of national security threats, we met with police colleagues to review plans and walk through arrangements in place to receive and care for high risk and VIP patients. Officers involved found the familiarisation tour beneficial and provided positive feedback on the extent of arrangements in place.

There has been a significant amount of activity since December 2018 in preparing for any disruption that leaving the European Union may present. Part of our EU Exit preparations also included undertaking a business continuity exercise.

In September 2018 we participated in a multi-agency exercise, to consider the capability of each acute hospital in Devon and Cornwall to receive casualties from a major incident or mass casualty event. Following this exercise, pre-determined response figures have been agreed, in support of casualties being distributed across the Devon and Cornwall peninsula.

Following our annual self-assessment against the EPRR Core Standards, NHS England and NEW Devon CCG reviewed the evidence provided and reported the Trust as 'substantially compliant' in meeting requirements. A further audit undertaken in March 2019 by Western Ambulance NHS Foundation Trust to specifically review arrangements in place to respond to a chemical, biological, radiological or nuclear (CBRN) incident. Their audit findings reported the organisation as 'fully compliant' in meeting the standards required.

A new training e-learning package has been developed, so staff are familiar with resilience arrangements in place and action to take during a major incident or periods of disruption to critical services. This will now be delivered to all staff in 2019/20 through the trust Update and Induction programmes.

Incidents Involving Data
Whilst we have strict information management policies, occasionally an incident occurs when information is not 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 (IG) element are recorded on the Trust Incident Reporting System (Datix). Guidance on how to report and score serious IG incidents via a scoring matrix has been provided by NHS Digital Guide to the Notification of Data Security and Protection Incidents.

In order to report the severity of incidents, scores are grouped into three categories:
- Low Impact incidents - very low in severity
- Local IG Investigation incidents - a thorough investigation by the IG team with recommendations and lessons learned
- IG Reportable Incidents – reported to the Information Commissioner's Office (ICO) and possibly the Department of Health

Incidents are scored by the Information Governance team in conjunction with the Caldicott Guardian and the Senior Information Risk Owner. Those scored as an IG Reportable Incident are reported to the Information Commissioner's Office (ICO – the regulators of Data Protection legislation) via the NHS Digital online reporting tool located on the Data Security & Protection Toolkit.

IG Reportable Incidents are also reported to NEW Devon CCG via STEIS by the Risk & Incident team. A full root cause analysis is conducted for these incidents. In the 2018/19 financial year there were two IG Reportable Incidents:

IG breach type	Details
Inappropriate Disclosure (error)	Patients' mothers received reminders for appointments that their adult children were due to attend.
Inappropriate Disclosure (error)	A number of patient letters were placed in one envelope several times and sent out to patients in error.

The Trust has co-operated 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.

Health and Safety
The specialist health and safety leads have continued with our 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. This has been done with the full support of the Health and Safety Committee.

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 ASW Assurance to provide a Local Counter Fraud Specialist (LCFS), who work with the Trust to help ensure risks are mitigated and that the Trust systems are resilient to fraud and corruption. The Audit Committee receive 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 2018/19 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 2018/19, the LCFS dealt with eight referrals which to date has led to Trust disciplinary action with the repayment of study leave taken and recovery action in respect of overclaimed locum shift payments.

Proud!

Our NHS70 Parliamentary Award Winner

A huge congratulations to our Head of Nursing (Cancer and End of Life), Sian Dennison, who won the 'Excellence in Cancer Care Award' at the NHS70 Parliamentary Awards.

The prestigious competition was the first of its kind to mark the 70th birthday of the NHS. Nominations for the awards were put forward by Mr Johnny Mercer MP, Mr Gary Streeter MP and Mr Luke Pollard MP, before a panel of regional judges chose the shortlist from nearly 800 nominations submitted.

Sian attended the awards ceremony held in Parliament's Terrace Pavilion, where she was announced the winner. Upon receiving the award, Sian said: "I'm utterly flabbergasted … absolutely thrilled. I feel so very lucky. But it's not just about me.

"To me, this award is about the team I work with. I couldn't have achieved all that has been delivered without their passion, dedication and their support to improve patient care and make a difference." Sian has been a nurse for over 30 years and has been described by her colleagues as "the voice for cancer services and cancer patients in the region."

Research, Development and Innovation

Research & Development's vision is to improve the health & wellbeing of the population we serve by conducting high quality, well-run research which is relevant to the needs of the local population. Our action plan is based on key strategic intents to:

- Reflect the priorities of local people.
- Reflect local transformation in healthcare delivery through integrated care systems
- Grow a Research Rich Climate, embedding research as part of core business.
- Involve a multidisciplinary workforce
- Ensure financial stability, including the achievement in the medium term of accreditation as an NIHR Clinical Research Facility

Local Collaborations

As a UK pioneer centre for the TriNetX Global and Trials Connect IT platforms this maintains our prominence with biopharmaceutical companies ensuring Plymouth is the site of choice for the new studies, giving patients early access to innovative treatments

In the past year we`ve been the first NHS Trust in the country to recruit patients into clinical studies who are having surgery at Care UK, the Independent Sector Treatment Centre.

We continue as an active partner in the IQVIA Peninsula Prime site, one of their best performing across the globe.

This year we reaffirmed our collaboration with Plymouth University`s Faculty of Health: Medicine, Dentistry & Human Sciences, Peninsula Clinical Trials Unit, South West Research Design Service and PenCLAHRC by launching a shared Research Hub which signposts the considerable amount of research advisory support available to prospective clinical & translational researchers . Finally, we are a key partner in the establishment of the Plymouth Health Innovation Alliance, a networking group centred on the Plymouth Science Park which supports rapid innovation and development in the life sciences industries.

Notable Successes

We celebrated outstanding local results for Mantle Cell Lymphoma, where research is embraced as part of everyday care, gaining access to cutting edge treatments for patients. We continue to be the first recruiting centre in the UK for several studies across our portfolio.

Awards during the year include:

- British Society for Haematology & NIHR Awards 2019: Researcher of the Year, Nursing & AHP
- South Devon Apprenticeship Awards 2019: Health Apprentice of the Year
- HSJ Awards 2018: Winner, using technology to improve efficiency

Innovation in 2018/19

Health technology and preventative medicine feature prominently in the NHS Long Term Plan, and our examples of this include include:

- A project to evaluate a home-based care pathway for Parkinson`s disease, based on digital technology
- Health trainers to help people cut down on smoking
- Accelerometers for assessing recovery after day surgery
- Prehabilitation using exercise bikes before major surgery
- Novel technology to adapt CT scans of the heart as a potential substitute for an invasive procedure

Research portfolio

- We currently have 360 (open to recruitment) research projects ongoing.
- We have recruited more than 4,500 patients into a research portfolio managed across 157 Principal Investigators (PIs) & 33 Chief Investigators and a growing number of non-medics PIs with our retention rate remaining above average.
- 127 new research projects opened during 2018/19, 41 commercial and the remainder non-commercial, a significant growth on 2017/18.
- In the year to March 2019 there were 350 Pubmed listed publications attributed to authors from our Trust.

We remain committed to our research agenda, and have just published our new 5 year strategy, to make available to patients the most innovative treatments at the earliest opportunity and further support the public health agenda through education and training.

Proud!

Mark completes Plymouth 10k race after accident leaves him barely able to walk

In June 2018, Mark 'Simmo' Simmons was only able to run ten steps after being involved in at accident at Falmouth Docks. Less than six months later, he ran over 14,000 steps, completing the Plymouth 10k race in an impressive 56 minutes.

On 20 August 2014, Mark was involved in an accident whilst at work. He was crushed by a large steel rack which contained heavy, flat steel bars. Pinned down by the steel unit, Mark was in immense pain and could hardly breathe, but says thinking of his family and young daughter kept him going.

Mark suffered breaks in his pelvis, arm, a vertebra in his back and suffered a catastrophic open fracture to his leg. He spent three months in three different hospitals. Unable to weight bear, he was confined to his hospital bed or wheelchair. "I was lucky; Derriford saved my life and the amazing Orthopaedic Team saved my leg from being amputated," said Mark.

"I was told that it was highly unlikely that I would ever run again. It's been just over four years since the accident and I have taught myself; with the help of Diarmuid from The Devery Practice, to begin to run again."

Mark spent 18 days on Shaugh Ward at Derriford Hospital and he sought to raise £1,800 for Plymouth Hospitals Charity; £100 for every day he spent on the ward.

"People don't really know how much a hospital does until they need it", said Mark. I just want to raise money for the hospital to say 'thank you' to all those who took care of me. They really were amazing."

Our Charity
Our donors told us they wanted their donations to make a difference!
We can tell you they really have.

So what has been going on?

- More than 300 people donated to Val's fund – funding future research at Derriford hospital into the side effects of chemotherapy for people with Advanced Malignant Melanoma.
- 46 Just Giving pages were opened across the year. Just Giving donations reached £42,584 with the average amount raised by an individual being £500.
- Neurosurgery Unit ran a successful fundraising campaign raising £60k to fund a new mobile scanner.
- We worked with Children's Happy Hospital Fund on SplashED fundraising appeal and jointly raised money for equipment for the new children's emergency department
- Snowdrop Appeal, raising money for a maternity bereavement suite, reached a total of £146,000 and held an event providing the opportunity for those who have supported the appeal to give their input before building starts on the unit later this year
- And more than 100 people remembered their loved one by making a lasting donation to the charity in memory of their partner and best friend.
- Lucy held a Ball
- Chris ran a marathon
- Kerry went to Mount Everest
- Jacky held a garden sale
- Kate and her friends flew down a zip wire
- Rosie walked on the wing of a plane

These are just a few of our 550 active fundraisers who, over the year, did something big or small, raised thousands or donated their pocket money.

Every one of our donors is amazing and we thank you so very much

To find out more about how you can fundraise or make a donation to University Hospitals Plymouth NHS Trust, please visit **https://www.plymouthhospitals.nhs.uk/fundraising**

Our Accountability 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. The Board comprises voting and non-voting members.

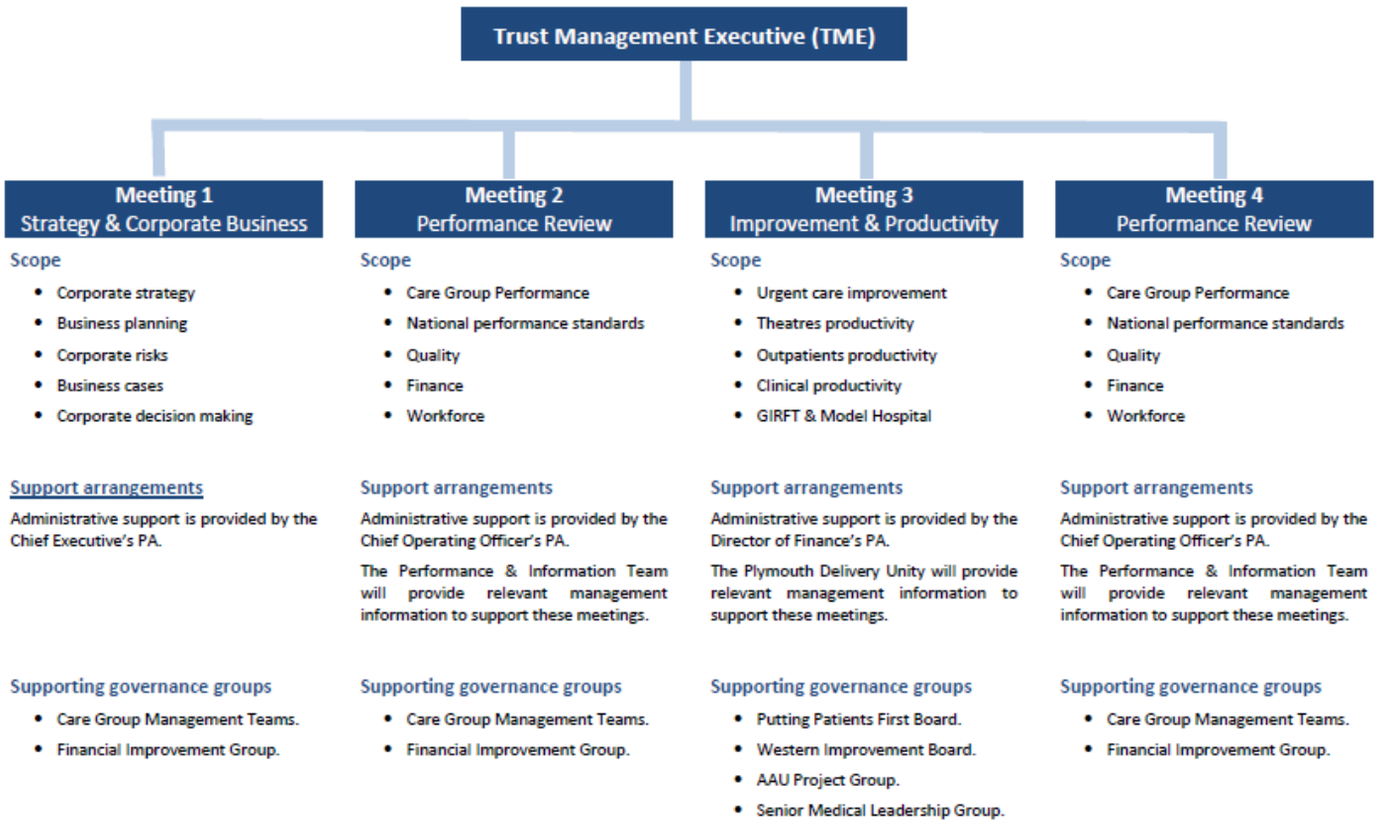
The Trust's Standing Orders set out the matters reserved to the Board and our Standing Financial Instructions and Scheme of Reservation and Delegation define our financial decision making framework.

Our 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 2018/19, the Trust Board approved an Operating Plan which identified four key areas of focus and five overarching strategic aims, as summarised in the following diagram.

Our plan was underpinned by our desire to maximise the system impact of culture change and continuous improvement using NHS Improvement's (NHSI) LEAN programme. We call this our *People First* programme (see page 27).

We established robust arrangements for overseeing and securing delivery of our 2018/19 Business Plan:



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

Members of the Board of Directors in 2018/19

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 January 2019 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.

We became a 'University Trust' in April 2018, having made a successful application to the Secretary of State for Health to change our name from Plymouth Hospitals NHS Trust to University Hospitals Plymouth NHS Trust. We did this because it more accurately reflects our status as an organisation with strong educational and research functions and our close relationship with the University of Plymouth. As a result of becoming a 'University Trust', the University was required to nominate a Non-Executive Director to serve on our Board.

NON-EXECUTIVE DIRECTORS

We have seven 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 2018/19:

V – voting Director
NV – non-voting Director

Richard Crompton, Chairman (V)
Richard was initially appointed in August 2012 and was re-appointed in 2016 and 2018. A former Chief Constable of Lincolnshire Police, Richard also served with the Metropolitan Police and the 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 was appointed to our Board in September 2016 for four years, having previously been Chief Executive of Rowcroft House Foundation Limited (Rowcroft Hospice). Giles brings to our Board considerable experience within the charity sector at leadership and board level and senior NHS management experience at an operational level having worked for the former National Blood Service and South Devon Healthcare NHS Trust.

- 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 thirty 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. Jacky was appointed in October 2016 for four years.

Declarations of interests:
- President 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.
- Director of Postgraduate Clinical Training University of Nicosia.

- Associate, General Medical Council.

Professor Elizabeth Kay, MBE (Associate, NV)
Liz was appointed Associate Non-Executive Director in September 2016 for a four year term. Formerly the Foundation Dean of the Peninsula Dental School, Liz 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 BUPA Oasis Healthcare.
- Chair of NICE Guideline Committee on Epilepsies
- British Dental Association Health and Sciences Committee member.
- Board member, South West Academic Health Science Network.
- Trustee and Vice Chair, British Medical and Dental Student Trust.

Hisham Khalil, (V)
Professor Khalil is a Consultant Ear, Nose and Throat Surgeon with the Trust and the Interim Dean of the University of Plymouth's Faculty of Medicine and Dentistry. He is the University's nominated Non-Executive Director on our Trust Board and took up this appointment in August 2018 for a period of two years.

Declarations of interests:
- Interim Dean, Faculty of Medicine & Dentistry, University of Plymouth.
- Consultant Surgeon, University Hospitals Plymouth NHS Trust.
- Consultant Surgeon, Nuffield Health Hospital, Plymouth.

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.

- Mike has declared no interests.

Elizabeth Raikes (V)
A chartered accountant by profession, Elizabeth was a Chief Executive in the public sector for twelve years before her appointment to our Board in September 2012. Elizabeth stepped down from the Board in September 2018 at the conclusion of her term of office.

During the period covered by this report, Elizabeth declared the following interest:

- Spouse is a governor of Plymouth Marjon University.

Graham Raikes, MBE (V)
With a public sector career spanning over forty years, Graham was formerly the Director of Resources at the Arts and Humanities Research Council. He had a successful military career with the Army and the Ministry of Defence, holding a number of staff and regimental appointments both at home, overseas and on operations and in 1997 was awarded an MBE. He also worked as the Deputy Vice Chancellor (Resources) and Director of Corporate Finance at the University of Plymouth for five years. He has been a Governor at Plymouth Marjon University since November 2017.

Declarations of interest:
- Chair of Governors, Plymouth Marjon University.

Rob Sneyd, (V)
Rob made an outstanding contribution across several fields as a doctor, teacher, academic and regional leader in medical education and training. His achievements included the development of the Plymouth Postgraduate Medical School and his successful leadership of the bid for a new Medical School in the South West, culminating in his appointment, in 2012, as Dean of the Plymouth University Peninsula School of Medicine and Dentistry. Rob attended our Board from 2012 and was Plymouth University's nominated Non-Executive Director on it from April 2018 until his retirement in July 2018.

Estelle Thistleton (V)
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 (Associate, NV)
Appointed as an Associate Non-Executive Director in April 2013, Henry has brought 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's, 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 in April 2017 and again in April 2019 for a further two year term.

Declarations of interests:
- Chairman and Director of Fluvial Innovations Ltd.
- Chair of Peninsula Dentistry Social Enterprise.
-

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:
- Chair, South West Leadership Academy.
- Chair, Southwest Talent Board.
- Member, One Plymouth.
- Chair, National Institute Health Research Peninsula Partnership Group.
- Member, Plymouth Growth Board.
- Vice Chair, Board of Governors, Devonport High School for Girls

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 Cornwall. Originally qualifying as a nurse in 1986, Kevin 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.

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.

Lenny Byrne, Interim Chief Nurse (V)
Lenny took up his appointment as Interim Chief Nurse on 25 March 2019.

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 and is the Board's Senior Information Risk Owner.

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 had previously 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. Greg resigned from the Trust in March 2019.

During the period covered by this report Greg declared the following 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. 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:
- Brother-in-law is Partner at PWC (but has no involvement in UK public sector).

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.
- Member of GS1 UK Healthcare Advisory Board.

DIRECTORS' ATTENDANCE OF PUBLIC BOARD MEETINGS IN 2018/2019

The Board met in public on seven 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	7 of 7
Giles Charnaud	6 of 7
Jacky Hayden	7 of 7
Liz Kay	6 of 7
Hisham Khalil	4 of 4
Mike Leece	4 of 7
Elizabeth Raikes	2 of 3
Graham Raikes	4 of 4
Rob Sneyd	3 of 3
Estelle Thistleton	5 of 7
Henry Warren	7 of 7

Executive Directors	Meetings attended
Ann James	7 of 7
Kevin Baber	6 of 7
Lenny Byrne	1 of 1
Lee Budge	5 of 7
Greg Dix	5 of 7
Phil Hughes	6 of 7
Steven Keith	6 of 7
Neil Kemsley	7 of 7
Nick Thomas	5 of 7

Board Evaluation and Effectiveness

The Board held regular development sessions during 2018/19 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 topics covered in Board Development during 2018/19 were:

- An externally facilitated session on the Care Quality Commission's Well Led Framework.
- The Trust's medium and long term Site Development Plan.
- Maternity Services.
- The development of the Trust's strategic direction and engagement with external stakeholders.
- Enhancing the Trust's governance arrangements.
- A commitment to a programme of 360 degree feedback and skills development.
- Leadership framework and behaviours.
- Strategic refresh and development of strategic intentions.
- The 'People First' Improvement Programme and the Board's role in this.
- The Medium Term Financial Plan.
- A facilitated session with senior leaders from across the organisation on the Trust's vision and values.
- Winter Planning.
- NHSI Undertakings.

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 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 was chaired by Elizabeth Raikes until she stepped down from the Board. From October 2018 it was chaired by Graham Raikes. Along with

the chair, Jacky Hayden, Mike Leece, and Henry Warren are core members; Jacky, Mike and Henry also chair other Committees of the Board. All other Non-Executive Directors, with the exception of the Chairman and the NED representing the University of Plymouth, 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 2018/19 was:

Non-Executive Directors	Meetings attended
Elizabeth Raikes, Chair until September 2018	3 of 3
Graham Raikes, Chair from October 2018	3 of 3
Giles Charnaud	5 of 6
Jacky Hayden	5 of 6
Liz Kay	0 of 6
Mike Leece	5 of 6
Estelle Thistleton	2 of 6
Henry Warren	6 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 was chaired by Elizabeth Raikes until she stepped down from the Board, then by Graham Raikes. It met on five occasions during 2018/19: in August 2018 to review the Chairman's appraisal of the Chief Executive; in October 2018 to consider an externally commissioned report and associated personnel matters; in November 2018 to review the Chief Executive's appraisals of her Executive team, and in January and March 2019 to consider recommendations for Executive portfolios and remuneration arrangements and guidance from NHS Improvement on Very Senior Managers' appointments and pay.

Members' attendance at Remuneration Committee meetings during 2018/19 was:

Non-Executive Directors	Meetings attended
Elizabeth Raikes, Chair until September 2018	0 of 1
Graham Raikes, Chair from October 2018	4 of 5
Giles Charnaud	4 of 5
Richard Crompton	5 of 5
Jacky Hayden	5 of 5
Liz Kay	5 of 5
Mike Leece	4 of 5
Estelle Thistleton	4 of 5
Henry Warren	5 of 5

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 Graham Raikes. This Committee met on thirteen occasions in 2018/19. Board members' attendance was:

Core NED/Executive Member	Meetings attended
Henry Warren, Chairman	11 of 13
Giles Charnaud	11 of 13
Mike Leece	12 of 13
Graham Raikes	5 of 8
Chief or Deputy Chief Executive	12 of 13
Director of Finance	13 of 13
Chief Operating Officer	6 of 13
Director of Corporate Business	2 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 safety and quality risks. It met six times in 2018/19 and is chaired by Jacky Hayden. Board members' attendance was:

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

On the occasion when the Chief Nurse was not present and Deputy Chief Nurse attended.

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 has oversight of HR policies. It met on five occasions during the year and is chaired by Mike Leece. Board members' attendance during 2018/9 was:

Core NED/Executive Member	Meetings attended
Mike Leece, Chair	5 of 5
Estelle Thistleton	4 of 5
Director of People	5 of 5
Chief Nurse or nominee	5 of 5
Medical Director's nominee	1 of 5

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	2 of 3
Chief Nurse	2 of 3
Medical Director	1 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 met four times in 2018/19 and is chaired jointly by Executive Directors Lee Budge and Kevin Baber. The corporate trustee has agreed, in principle, to introduce revisions to the charity's governance arrangements in order to separate the operational and strategic elements of its charitable governance. The Charitable Funds Management Committee will be disbanded and a new Charity Operational Group and Charity Strategic Group will be introduced. It is planned to seek the corporate trustee's approval of these new arrangements in 2019/20. More details on the work of Plymouth Hospital's Charity can be found in the **Charity's Annual Report**.

Annual Governance Statement 2018/19

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 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.

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 provide only 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 University Hospitals Plymouth NHS Trust for the year ended 31 March 2019 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:

- 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.

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.

The risk and control framework

Corporate governance arrangements

The Trust has had a fully constituted Board for 2018/19 and there were no major changes to the appointed Non-Executive or Executive Directors during the year. The Board held regular development sessions throughout 2018/19. 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.

The Board is in the process of reviewing the approach to assessing its effectiveness and will be updating its development plan accordingly in 2019/20.

Risk management arrangements
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 are 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. It 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.

Quality governance arrangements
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.
- A Clinical Effectiveness Group to oversee the introduction of new devices and procedures.
- 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.

We will continue to develop our quality governance arrangements throughout 2019/20.

Risk assessment
Key risks to the achievement of our objectives have been regularly reviewed and updated throughout the year. The key areas of focus have included:

Aim 1: Improve quality
Operational Pressures
Follow-up Backlogs
Quality Governance
Pharmacy
Medical Equipment
Infection Control
Clinical Administration
CQUINs
Aim 2: Develop our workforce
Safe Staffing
Culture & Staff Experience
Core Requirements
Clinical Education
Aim 3: Improve our financial position
Financial Performance
Capital Programme
Use of Resources
Financial Sustainability
Aim 4: Create a sustainable future
System Transformation
Physical Infrastructure
Aim 5 – Maintain strong governance
Health & Safety
Fire Safety
Emergency Planning
Cyber Security

Progress in mitigating these risks has been reviewed by the Trust Board and its committees throughout the year.

Care Quality Commission (CQC) assessment
The Trust was inspected by the CQC in April and May 2018. We have again been rated as 'Requires Improvement' overall for our services. Our rating for each of the five domains assessed by the CQC (including the well-led assessment) is shown below:

Safe	Requires improvement
Effective	Requires improvement
Caring	Outstanding
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

The Trust developed a comprehensive action plan in response to the CQC findings and has reported progress in delivering this plan to the Safety & Quality Committee and Trust Board.

In addition to the Inspection Report, the Trust received two Section 29A Warning Notices, one for Pharmacy and one for Diagnostic Imaging. The CQC inspectors had been alerted to problems we had identified in pharmacy prior to their inspection; as part of this we also told them what we were doing to address these.

The Trust was required to make the significant improvements identified in the Warning Notices by 26th October 2018. The CQC conducted a follow-up inspection on 11th and 18th December 2018. The key findings were as follows:

- *Pharmacy:* The CQC found that the Trust had not fully addressed some of their concerns in the Warning Notice. However, they recognised that the Trust was making some progress and that a cultural shift would take time.
- *Imaging:* The CQC felt that insufficient progress had been made in addressing the concerns in the 2018 Warning Notice and on 25th January 2019 they issued a new Section 29A Warning Notice.

Both Pharmacy and Diagnostic Imaging have made real progress in addressing the issues highlighted by the CQC. Whilst it is disappointing that the Trust has received a new Section 29A Warning Notice for Diagnostic Imaging, there has been significant improvement in our imaging performance since December 2018, as reported following a visit by colleagues from NHS Improvement and NHS England. It is acknowledged that there is a lot of work to do to improve the culture and wellbeing of staff and the team intend to prioritise actions to address these issues but, as acknowledged by the CQC, a cultural shift will take time.

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.

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 whether its 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.

Data quality
The Trust has continued to adopt a pro-active approach to data quality in 2018/19 by maintaining its 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.

Data security
The Trust recognises the importance of effective leadership in addressing the Cyber Security threat and has established a number of arrangements for ensuring that senior leaders drive this agenda. The Trust has conducted a number of reviews in order to test the adequacy of its Cyber Security arrangements. The Trust Board reviewed the Cyber Security Annual Report in January 2019 which gave assurance that the threats associated with cyber security were being appropriately managed.

Developing workforce safeguards
The Trust has a number of arrangements in place to assess whether staffing processes are safe, sustainable and effective. This includes:
- Daily ward staffing review meetings.
- Weekly forward look on ward rota gaps.
- Regular safe staffing reports to the Trust Board.
- Guardian of Safe Working Hours reports.

The Human Resources & Organisational Development Committee oversees workforce safeguards on behalf of the Trust Board. The Committee received a briefing on NHSI's 'Developing Workforce Safeguards' requirements in December 2018. This continues to be identified as a key risk with the Board Assurance Framework and, as such, will be reviewed by the Trust Board throughout 2019/20.

Managing conflicts of interest
Declarations of interest are recorded for all Trust Board meetings. The Trust has conducted a comprehensive review of the 'Managing Conflicts of Interest in the NHS' guidance and has updated its Standards of Business Conduct Policy to reflect this. An action plan is being developed to ensure that appropriate arrangements are in place to ensure compliance with the policy.

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 responsibilities
The Trust has undertaken risk assessments and has a draft sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of the use of resources
The Trust has established arrangements for reviewing and improving economy, efficiency and effectiveness in the use of our resources. We are actively engaged in the national Getting It Right First Time (GIRFT) and Model Hospital work programmes and continue to use benchmarking to identify variation in performance and/or practice. These arrangements are reviewed annually by the Trust's external auditors.

Information governance
All incidents with an Information Governance element are recorded on the Trust Incident Reporting System (DATIX). Incidents are scored by the Information Governance team in conjunction with the Caldicott Guardian and the Senior Information Risk Owner using guidance provided by NHS Digital. Incidents fall within one of the following three categories:

- Low impact incidents - very low in severity.
- Local IG Investigation incidents - a thorough investigation by the IG team with recommendations and lessons learned.
- IG Reportable Incidents – reported to the Information Commissioner's Office (ICO) and the NEW Devon CCG. A full root cause analysis is conducted for these incidents.

In the 2018/19 financial year there were two IG Reportable Incidents, as follows:

- Patients' mothers received reminders for appointments that their adult children were due to attend.
- A number of patient letters were placed in one envelope several times and sent out to patients in error.

The Trust has cooperated fully with the ICO who have welcomed the remedial actions taken. The Trust continues to actively raise Information Governance awareness and encourage the reporting of incidents.

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 2018/19 Quality Account will be provided by our external auditors.

Review of effectiveness
As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control.

My review of the effectiveness of the system of internal control is informed by the work of internal auditors, clinical audit and the executive managers and clinical leads who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee and committees of the Board.

Executive Directors who have responsibility for the development and maintenance of the system of internal control also 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 has been reviewed.

A plan to address weaknesses and ensure continuous improvement of the system is in place.

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. The most significant issues facing the Trust in 2018/19 may be summarised as follows:

- *Operational pressures:* The Trust continues to face significant pressure from a sustained increase in the number of emergency attendances and high levels of acuity. The hospital has been under operational distress for a considerable time which has had a major impact on our ability to achieve a number of key national performance standards and/or the improvement trajectories agreed with NHS Improvement.
- *Quality:* The Trust received Warning Notices from the CQC in respect of pharmacy and imaging services during 2018/19. Whilst I am pleased that the inspectors recognised that progress is being made, further work is required to address these issues on a sustainable basis. We have adopted a comprehensive approach to doing this which includes regular reports to the Trust Board.
- *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.
- *Financial position:* The Trust originally planned for a small deficit of approximately £3m in 2018/19. It became apparent early in the financial year that this outturn was not achievable and, after dialogue with NHS Improvement, a revised budget for the year was submitted in October 2019 which showed an increased deficit of approximately £30m for the year.

In last year's Annual Governance Statement I commented that fundamental system transformation was needed if we are to address these challenges and meet the increasing demands on health and social care within the finite resources available.

For our part, we will continue to work with other stakeholders within the wider health & social care community to do what is right for the people we serve by better integrating the services they need.

Conclusion
A number of significant internal control issues have been identified in this Annual Governance Statement. My review confirms that whilst many key components of an effective system of internal control are in place as at 31 March 2019, 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 Board in 2019/20.

Signed (on behalf of the Trust Board)

Ann James
Chief Executive

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 and Social Care'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.

Salaries and allowances (subject to audit)

2018/19	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		2,900			40-45
Michael Leece, Non-Executive Director	5-10					5-10
Elizabeth Raikes, Non-Executive Director (note 1)	0-5		100			0-5
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		4,100			10-15
Jacky Hayden, Non-Executive Director	5-10					5-10
Liz Kay, Associate Non-Executive Director (see note 2)	5-10					5-10
Hisham Khalil, Non-Executive Director (see note 3)	0-5	130-135				135-140
Graham Raikes, Non-Executive Director (see note 4)	0-5		100			0-5
Ann James, Chief Executive	185-190		100	500		185-190
Kevin Baber, Chief Operating Officer	140-145			500		140-145
Greg Dix, Director of Nursing (see note 5)	120-125		100			120-125
Neil Kemsley, Director of Finance	135-140		4,200	5,500	15-17.5	160-165
Steven Keith, Director of People	125-130		100		22.5-25	145-150
Nick Thomas, Deputy Chief Executive and Director of Planning & Site Services	110-115		100		7.5-10	115-120
Phil Hughes, Medical Director	110-115	75-80	300	500		190-195
Lee Budge, Director of Corporate Business	85-90			400	20-22.5	105-110
Lenny Byrne, Chief Nurse and Director of Clinical Professions (see note 6)	0-5					0-5

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 2)	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 7)	85-90			5,200	10-12.5	100-105
Lee Budge, Director of Corporate Business	80-85			600	22.5-25	105-110

Notes

1. Term of office completed 24 September 2018
2. Invoiced by the University of Plymouth until 31 January 2019; on Trust payroll from 1 February 2019
3. Existing Trust employee appointed as non-executive director from 31 July 2018. This note covers only the period from that date.
4. Appointed 25 September 2018
5. Left the Trust 31 March 2019
6. Appointed 25 March 2019
7. Comparative note covers period to 28 January 2018 only; on secondment to another organisation from 29 January 2018 and has now left the Trust.
8. 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.
9. Taxable benefits relate to mileage reimbursement outside standard HMRC allowances, including home to base mileage, and taxable removal expenses.

Pension Benefits (subject to audit)

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 1)							
Phil Hughes, Medical Director (see note 1)							
Kevin Baber, Chief Operating Officer (see note 1)							
Greg Dix, Director of Nursing	0	0	30,000-35,000	70,000-75,000	572	531	9
Nick Thomas, Director of Planning & Site Services	1-2,500	2,500-5,000	50,000-55,000	155,000-160,000	1,193	1,031	114
Lee Budge, Director of Governance (see note 2)	1-2,500	0	10,000-15,000	0	173	128	30
Neil Kemsley, Director of Finance	1-2,500	0	50,000-55,000	125,000-130,000	1,013	861	107
Steven Keith, Director of People	1-2,500	0	35,000-40,000	80,000-85,000	678	563	80
Lenny Byrne, Chief Nurse and Director of Clinical Professions (see note 3)	0	0	20,000-25,000	65,000-70,000	427	366	1

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 factors used to calculate CETV changed on 29 October 2018.

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. No lump sum shown for members of the 2008 scheme
3. Increase disclosures are adjusted for time in post

Fair Pay (subject to audit)
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 £188,925 (2017-18 £186,850.) This was 6.7 times (2017-18 7.0) the median banded remuneration of the workforce, which was £28,050 (2017-18 £26,614.) The range of banded remuneration was from £7,235 to £188,925 (2017-18 £6,844 to £186,850.)

In 2018-19 twenty one employees (2017-8 twenty) received total remuneration in excess of the Chief Executive's, with total remuneration ranging from £189,061 - £281,020 (2017-8 range £188,541 - £249,855.)

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 (not subject to audit)

Off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months

	Number
Number of existing engagements as of 31 March 2018	1
Of which the number that have existed	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	1
for between two and three years at the time of reporting	0
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 2018 and 31 March 2019, 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	5
Of which	
Number assessed as caught by IR35	5
Number assessed as not caught by IR35	0
Of which	
Number engaged directly (via PSC contracted to the Trust)	5
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.

21 individuals have been deemed "board members and/ or senior officers with significant financial responsibility" during the year.

Medical locum staff costing over £142,500 per annum (not subject to audit)
Reporting bodies are required to disclose details of agency medical staff whose total cost to the organisation was over £142,500 in the year.

Name	Role	Total cost to the organisation in 2018-19 (£)
T Usmani	Consultant Surgeon	219,317
A Abushaala	Consultant Surgeon	208,628

Sickness absence data (not subject to audit)
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 2018.

	2018 Number	2017 Number
Total Days Lost	o/s	57,788
Total Staff Years	o/s	6,124
Average working Days Lost	o/s	9

Exit packages (subject to audit)
There were no exit packages during the year

Analysis of staff costs (subject to audit)

	Permanent	Other	2018/9 Total	2017/18 Total
	£000	£000	£000	£000
Salaries and wages	246,006	1,666	247,672	233,820
Social security costs	24,784	-	24,784	23,403
Apprenticeship levy	1,208	-	1,208	1,136
Employer's contributions to NHS pensions	29,074	-	29,074	27,564
Temporary staff	-	18,447	18,447	17,021
Total gross staff costs	**301,072**	**20,113**	**321,185**	**302,944**
Recoveries in respect of seconded staff	(1,716)	-	(1,716)	(1,091)
Total staff costs	**299,356**	**20,113**	**319,469**	**301,853**
Of which				
Costs capitalised as part of assets	2,339	14	2,353	2,152

Average staff numbers (subject to audit)

	Permanent	Other	2018/9 Total	2017/18 Total
	Number	Number	Number	Number
Medical and dental	1,036	61	1,097	942
Ambulance staff	3	-	3	2
Administration and estates	1,403	65	1,468	1,410
Healthcare assistants and other support staff	969	142	1,111	1,083
Nursing, midwifery and health visiting staff	1,815	155	1,970	1,889
Nursing, midwifery and health visiting learners	1	-	1	2
Scientific, therapeutic and technical staff	1,213	7	1,220	1,155
Other	8	-	8	8
Total average numbers	**6,448**	**430**	**6,878**	**6,491**
Of which:				
Number of employees (WTE) engaged on capital projects	58	14	72	54

Consultancy (not subject to audit)
Expenditure on consultancy in 2018/19 was £489,000 (2017/8 £603,000.)

Proud!

Health Care Assistant Fiona Dilorenzo wins national award
Specialist Learning Disability Liaison Acute Health Care Assistant (HCA), Fiona Dilorenzo, has won a national award.

The Royal College of Nursing institute (RCNi) awards were held in London in July where Fiona was announced the winner in the HCA of the Year category.

Part of Fiona's role is to support patients who may otherwise find attending a hospital appointment a very difficult experience. Fiona was nominated by colleagues based on her ability to encourage even the most anxious patients to come into the hospital and attend their appointments.

One patient who is regularly supported by Fiona, Sean McCann, said: "Fiona is excellent. If I'm here, Fiona's here and it's a real help to have that. She helps with my health assessments and I think she's marvellous. It's nice to have help with medical things but she helps with other things as well. She really goes the extra mile."

Following the award ceremony Fiona said: "It was a great honour to be nominated for this award and I was even more overwhelmed and humbled to win especially after meeting the competition and hearing about the great work they do.

"I wish to thank my colleagues in the Learning Disability Hospital Team as it would not have been possible without their support. I love my job and helping our patients get the same access to hospital care as the general population gives me great satisfaction."

Our People

Roll Call of Honours

Hepatology nursing team
Winner of 'Liver Nurse of the Year' at the British Medical Journal Awards

ACE Mobile Dementia App
Finalist in 'Strengthening the Foundation' at Patient Experience National Network Awards

SALUS
Finalist in 'Innovative use of Technology at Patient Experience National Network Awards

Kelly Whitehorn
Winner of 'Patient Experience Transformer of Tomorrow' at Patient Experience National Network Awards

Defence Medical Welfare Service
Runner up of 'Working in Partnership at Patient Experience National Network Awards

Lewis Edwards
(Communications Team) in partnership with AHPs and HCSs Shortlisted for 'Communications Initiative' at Health Service Journal Value Awards

Fiona Dilorenzo
Winner of HCA of the Year at the RCNi Awards

vCreate
Finalist in 'Communicating Effectively with Patients and Families' at Patient Experience National Network Awards

Jamie Read
Care and Compassion Award in the NHS70 Parliamentary Awards

Sian Dennison
Winner of Excellence in Cancer Care in the NHS70 Parliamentary Awards

Immunology Team
Person-Centred Care Champion Award in the NHS70 Parliamentary Awards

Joe Rahamim
Lifetime Achievement Award in the NHS70 Parliamentary Awards

Staff numbers by Staff Group, figure as of 31st March 2019

Scientific and Technical Staff (inc ODPs)	280.89
Healthcare Assistants and Clinical Helpers	1286.54
Administrative and Clerical Staff	1406.95
Allied Health Professionals and Therapists	367.87
Estates and Ancillary Staff	129.90
Healthcare Scientists	252.55
Medical and Dental Staff	941.41
Nursing and Midwifery	1772.53
Total (wte)	6438.63
Total Headcount	7415
Annual Turnover	10.3%
Annual Sickness Absence	4.28%

Staff numbers by gender

Gender	Board	Senior Manager	Other	Grand Total
Female	4	95	5466	5565
Male	12	71	1768	1850
Grand Total	16	166	7234	7415

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

Staff Group	Total
Add Prof Scientific and Technic	43
Additional Clinical Services	227
Administrative and Clerical	225
Allied Health Professionals	63
Estates and Ancillary	16
Healthcare Scientists	15
Medical and Dental	307
Nursing and Midwifery Registered	276
Grand Total	1172

Creating a fair, diverse and inclusive workplace and healthcare service
Equality, diversity and inclusion are at the heart of the NHS strategy and recognize that a diverse workforce enables us to deliver a more inclusive service and improve the experience of our patients. We strive to continue to create a working environment where colleagues are treated fairly to enable them to reach their full potential. To do this we recognise the diversity that each of us has and we continue to build an environment where individuals' experience both in and out of work is valued and fosters a sense of inclusion.

We continue to ensure that inclusion is inherent in our policies, processes and decision making allowing for collaborate working and thinking by understanding the impact of our actions on our colleagues and patients. Whilst we understand and work within the legal framework of equality we recognise that policies alone are not enough to build an inclusive workplace and inclusion should not be a box-ticking exercise. How people feel when they are at work is important to us and everyone of us has a part to play in the how we deliver the care for our patients.

Our aims for the coming year include enabling our leaders to work in a compassionate, kind and inclusive way. This is supported by our leadership programme which enable leaders at all levels to understand the impact they have and how they can best create a positive and supportive culture where each individual is able to maximise their potential. A key element of our mandatory training for all our colleagues is our focus on the value of diversity, and includes understanding traits such as unconscious bias that may impact on how we treat others. We are listening to the experience of our colleagues so we can celebrate the good and understand what further work needs to be done to continually improve, taking action when we see behaviours that sit outside of our values. The impact of this will improve the experience of our patients as we continue to address healthcare inequalities through our understanding and learning.
Our Gender Pay Gap Report 2019 (snapshot data as at 31 March 2018) demonstrates that there could be greater female representation in senior clinical roles. Similarly, we acknowledge there could be greater male representation in less senior clinical and non-clinical roles. This position is consistent with the previous snapshot data taken on 31 March 2017.

We recognise that closing the gender pay gap will take some time and requires sustained commitment from the Trust. This year we have promoted our flexible working policies for all, focussed on inclusive leadership development, reviewed our recruitment and selection processes to ensure a gender balanced approach and have given practical support and encouragement to female clinicians and other under-represented groups to apply for national and local clinical excellence awards.

Listening to our people
We are constantly listening to our colleagues, through surveys, Big Conversations, feedback from touchpoints such as induction and exit interviews, when things go wrong and when things go right.

We have a Say **Thank You and Learn from Excellence** scheme which offers staff, patients and their families an easy way to say thanks and help us capture and learn from episodes of excellence. By completing a quick and easy online form, staff and patients or their families can generate a real card which contains their words of thanks. This is sent to the individual member of staff or team named and we know that staff really appreciate it when their Thank You card arrives in the post.

- In the last 12 months we have received **1,881** *Say Thank you and Learn from Excellence* nominations – double the number of nominations from the previous year.
- The learning from *Say Thank You and Learn from Excellence* nominations demonstrates that what matters most to colleagues, patients and their families is positive and supportive behaviour. Our staff are regularly thanked for being kind, giving time and supporting us in times of pressure or when we are feeling vulnerable. The seemingly little things - being friendly and approachable, smiling, helping out with 'no fuss', really do make the difference.

Some recent examples of the type of feedback sent to staff:

Thank you for the warm welcome following my operation. It was greatly received and quickly put me at ease

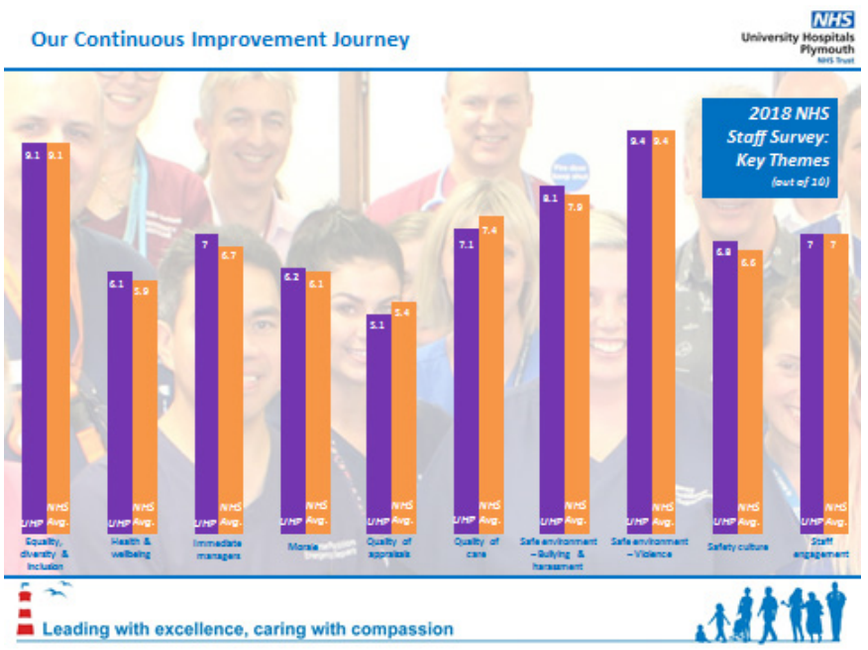
My wife had a lump checked out. The whole process from reception, very efficient lady, to seeing the reassuring consultant and being scanned and hearing the results took only about 40 minutes! Given the negative publicity the NHS sometimes receives for things, often outside their control, I thought the care was superb!

Mr .. was the first surgeon I met, on my first day in theatres. From that day, he has been warm and welcoming, patient with me while I learn new skills and coaching me to be a better healthcare professional.

We have loved having you join the ward family and we're grateful to know you will always be there if we need you. We want you to know how much we appreciate you.

Listening: Our Staff Survey
We continue to make improvements in our staff survey. The 2018 survey questions were grouped together into themes and out of the 10 themes:

- 2 statistically significantly improved for us between 2017/ 2018
- 7 stayed the same
- 1 was not comparable
- 5 were better than average in 2018
- 3 were the same as average
- 2 were lower than average

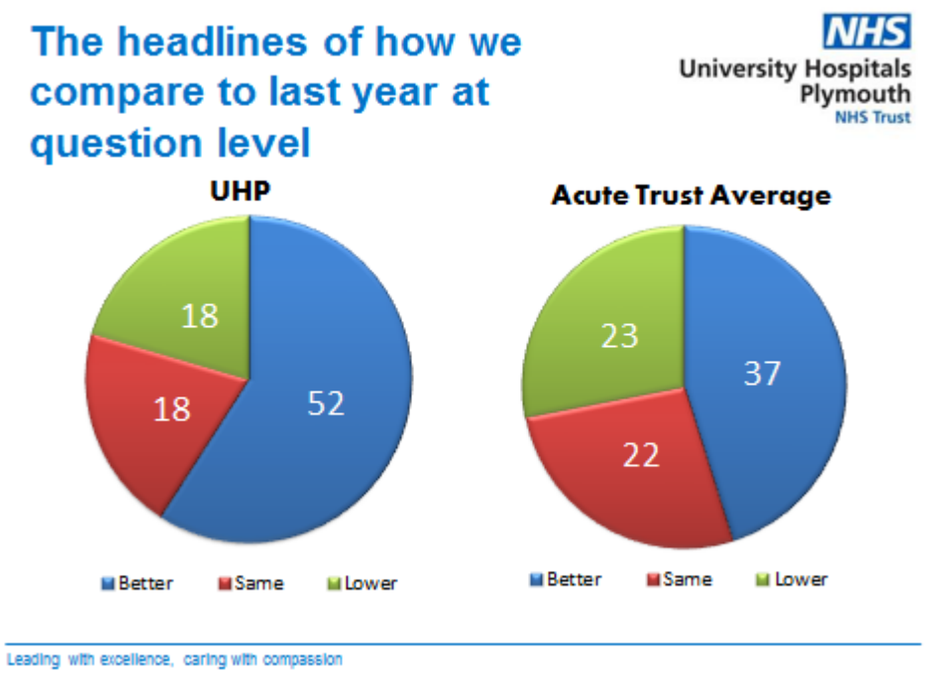


Top:

- Q17a. My organisation treats staff who are involved in an error, near miss or incident fairly (62% from 55%)
- Q5g. How satisfied are you with… your level of pay. (38% from 32%)
- Q5a. How satisfied are you with… the recognition you get for good work (58% from 53%)
- Q10c. On average, how many additional UNPAID hours do you work per week? (55% from 58%)
- Q19g. My manager supported me to receive this training, learning or development (55% from 50%)

Bottom:

- Q13c. In the last 12 months how often have you experienced harassment, bullying or abuse at work from… other colleagues: 19% (from 17%)
- Q10b. On average, how many additional PAID hours do you work per week?: 38% (from 34%)
- Q11a. Does your organisation take positive action on health and well-being?: 32% (from 35%)
- Q16b. In the last month have you seen any incidents that could have hurt… service users (31% from 29%)



Key quotes:

"I have always felt valued working in the NHS, yes sometimes as all jobs anywhere It has its pressures, but I have always felt supported and valued. I love working in the NHS."

"I am very lucky as I love my job and I feel that this is as a direct result of working within a department where I feel well supported and that the staff are focused on doing an excellent job."

"I feel positive changes are happening and the department is moving forwards."

"I feel privileged and proud to work for the NHS and in particular this organisation. I understand many of the pressures we face are due to increased demand and the current economic climate. The organisation faces enormous pressures to deliver care to our patients, which are always placed first. I am proud to play a small part in the fantastic service this organisation provides and to be part of a team with so many outstanding members."

Developing Our Managers
We have a Manager's Passport, bringing together a number of modules to help develop our managers in skills such as undertaking appraisals, having difficult conversations and service improvement. Currently 550 line managers are undertaking this passport.

Thank you!

Giving generously of their time… one of our many volunteers

Following early retirement, Debbie Walters (57), started volunteering in 2017, initially on a general surgical ward. Debbie admitted she "felt daunted" to start with, but got on well and enjoyed her time as a ward visitor.

About six months later, she attended an Open Day with her daughter on Lyd Ward, the Chemotherapy Day Ward, where she learned they had no volunteers, but were hoping to recruit some. It didn't take long for Debbie to sign up!

Lyd Ward is different from many of the other wards in the hospital and the role of a volunteer in this area is slightly different too. Patients on the ward attend on a regular basis, often on the same day and time each week, and can remain on the ward all day. Some bring friends or relatives, but some are unaccompanied.

As their first volunteer Debbie, along with the ward manager, Jane Ransome and other staff, identified tasks she could do including: befriending patients, spending time chatting and listening; shopping for patients; making drinks; tidying the area; and restocking cupboards with gloves, aprons and biscuits. This enabled a task description to be drawn up for this new role.

Debbie quickly settled in and is now an invaluable part of the team. She says of her voluntary work: "I love it, the staff are really friendly." She says her voluntary work gives her a "privileged insight" into the lives of some of the patients and she always looks forward to seeing them. Her role now also includes taking and collecting prescriptions from pharmacy, and can involve such diverse activities as helping a patient with a crossword or "comparing pictures of dogs".

Debbie, along with Lyd's other volunteer, Elaine, who is equally valued, finds it gives them a 'structure to their week' and provides an "extra service" for the staff and patients.

To encourage other new volunteers, Debbie is keen to reassure anyone interested that Lyd is a really "positive place" and she would be happy to help a newcomer settle in just as well as she has.

The Trade Union (Facility Time Publication Requirements) Regulations 2017
University Hospitals Plymouth NHS Trust Response for Period 1 April 2018 to 31 March 2019

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
54	49.52

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%	16
1-50%	37
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	£122,240
Provide the total pay bill (as defined by the Trade Union (Facility Time Publication Requirements) Regulations 2017)	£295,278,248
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*	**5.65%**

Our Financial Statements and Notes

Strategic Report 1 April 2018 to 31 March 2019

Finances

Although the Trust ended financial year 2017-18 with a surplus of £3.4m the requirements for 2018-19 required setting a plan that the Board accepted would be hugely challenging. This included a Financial Improvement Plan (FIP) of £33m, equivalent to 6% of our total budget, in order to achieve the deficit control total set by NHS Improvement of £3.8m. In approving the Operational and Financial Plan, the Trust Board recognised the scale of the challenge ahead, especially given the context of increasing urgent care activity and a requirement to improve national performance standards in the A&E 4 hour standard, cancer standards, referral to treatment waits over 52 weeks and diagnostic waits.

In October 2018 the Trust reported a forecast deficit for the year of £29.5m, £25.7m adverse to the control total of £3.8m. Of this £25.7m adverse variance: £10.0m related to a shortfall on FIP targets, £3.5m related to lower than planned performance on variable contract activity, £1.1m for a funding shortfall on the final agenda for change pay settlement and £11.1m in relation to non-achievement of Provider Sustainability Fund (PSF), which having missed the NHSI control total was no longer receivable.

The actual outturn for the year reflects a small improvement of £2.4m when compared to the forecast submitted in October. The final position reported is a deficit of £27.1m. The overall improvement in the position was due to the receipt of additional PSF funding of £4.8m.

Although it was disappointing not to achieve our original financial target, through a combination of improved efficiency, innovations, income generation and strict financial controls we delivered £19m of internal financial improvement plans against the £33m target. A further £4m 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 and the requirement for operational improvement in national standards. Overall we therefore delivered a FIP of £23m, equivalent to around 4% of our budget. This is an excellent achievement and all the more so, as it followed a £30m FIP delivery in the previous financial year.

As well as delivery of significant financial improvement plans, as described in more detail elsewhere in this report, the Trust was also able to improve performance in a number of standards including diagnostic waits, cancer targets and we reduced 52 week waiters by 50%.

Overview of income and expenditure position

2018-19 Financial Plan

The Trust was set a financial deficit control total by NHS Improvement of £16.2m. If the Trust was able to achieve this then it would also have access to the Department of Health's Provider Sustainability Fund (PSF) of £12.4m which would further reduce this deficit to £3.8m. This reflected an overall adverse movement of £7.2m from the previous year's outturn. This planned movement was accepted due to a significant loss of non-recurrent income from the previous year. This meant that with costs forecast to increase by £40m there was only a minimal increase in income to support this. The Trust

Board accepted this challenge based on the requirement to deliver a Financial Improvement Plan of £33m.

The Trust's limited movement in income was made up of reductions of £20m for non-recurrent income received in 2017-18 being offset by £20m of increases to deliver increased clinical activity as described below:

Planned Income Movements	£M
Loss of Non Recurrent Income	
Reduced level of PSF available for achieving compliance with the financial control total	-4
Income reductions of £16m for non-recurrent funding received in the previous year from its STP partners	-14
Loss of NHS England winter pressure funding	-2
Income Increases for 2018-19	
Contract tariff for increased clinical activity volumes	24
Reduction for a discount agreed with commissioners	-6
Growth in high cost drugs and devices	2
	0

Costs were forecast to increase by £40m as described below:

Planned Expenditure Movements	£M
Investments in capacity to deliver the growth in contracted clinical activity service levels	24
Increased high cost drugs and devices costs	2
Investments in workforce development, safety and regulatory compliance	2
Full year impact of investments of the previous year	2
Pay inflation and incremental increases	7
Non-pay inflation increases	3
	40

The Trust's £33m Financial Improvement Plan was made up of targeted additional income of £10m and cost savings of £23m. Income increases were targeted through a range of measures including an increased clinical activity and a further increase in commissioner income for structural funding issues. Cost savings were to be delivered through a number of workstreams including theatre and outpatient productivity programmes, agency reductions, procurement, savings against activity growth costs, alternative workforce models, estates, support services and drugs costs.

2018-19 Financial Results

The impact of revaluations 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 2018-19 is a deficit of £27.1m.

After technical adjustments for revaluations (which has led to a reversal of previous impairments) and movements in the donated assets reserve, the actual financial position at the end of March 2019 is adjusted to a deficit of £22.8m.

The Trust has an overall cumulative deficit (taking each year to the next) of £105.5m. This means that as expected, and as per the last three years, the Trust has broken its statutory duty to break-even. The Trust's auditors notified the Secretary of State of this with a Section 30 Notice to this effect in the 2016-17 financial year.

The deficit of £27.1m is £23.3m worse than originally planned but £2.5m better than the revised forecast submitted in October. The final gap is comprised of an under-achievement of £17m against its pre-PSF target of £16.2m and a £6.3m variance in its PSF funding below the planned allocation of £12.4m.

The variance to plan is primarily due to the following factors.

- A £10m shortfall in the delivery of our Financial Improvement Plan. We delivered £23m of the £33m efficiency target (delivery of a 4% improvement).
- Although we have increased our elective/planned activity by around 5% overall, we have not increased activity by as much as we intended in some of our specialised services. We have also spent more than planned delivering operational improvements in the diagnostic targets. The year-end variance on these issues is £6m compared to the original financial plan.
- Although Trusts received additional income to cover the costs of the national pay award for their own staff; this was insufficient to cover the costs of those staff working in hospitals for other non-NHS organisations. The adverse impact of this issue is another £1m.

The Trust achieved PSF funding of £6.1m against the original allocation of £12.4m. The Trust achieved its financial target in Quarter 1, earning £1.3m of PSF, but failed to meet the target in Quarters 2 to 4 and also failed to achieve the required performance in A&E to earn this element of the PSF fund. However, the Trust was awarded £4.8m through the year end general distribution of PSF funds. The Trust's final income and expenditure performance for the year is shown on the following page;

Statement of Comprehensive Income	2018-9 £000s	2017-8 £000s	Diff £000s
Revenue from patient care activities	452,530	440,999	11,531
Other operating revenue	57,771	66,782	(9,011)
Total Income	**510,301**	**507,781**	**2,520**
Gross employee benefits	(313,612)	(296,090)	(17,522)
Other operating costs	(205,605)	(189,975)	(15,630)
Depreciation and Amortisation	(12,778)	(12,360)	(418)
Total Expenditure	**(531,995)**	**(498,425)**	**(33,570)**
Operating surplus/(deficit)	**(21,694)**	**9,356**	**(31,050)**
Investment revenue	112	42	70
Other gains and (losses)	9	(20)	29
Finance costs	(2,313)	(2,327)	14
Public dividend capital dividends payable	(3,195)	(3,526)	331
Impairments and reversals	4,234	(2,778)	7,012
Retained surplus/(deficit) for the year	**(22,847)**	**747**	**(23,594)**

Retained surplus/(deficit) for the year	**(22,847)**	**747**	**(23,594)**
Impairments/(Impairments Reversals)	(4,234)	2,778	(7,012)
Adjustments in respect of donated asset reserve elimination	(85)	(118)	33
CQuin risk reserve adjustment		(300)	300
Adjusted retained (deficit)	**(27,166)**	**3,107**	**(30,273)**

Income

The majority of revenue from patient care activities comes from NEW Devon and Kernow Clinical Commissioning Groups (commissioning services for the local population) and NHS England who commission specialist, dental and screening services. In 2018-19, the Trust treated 63455, elective patients, 64573 non elective patients (including 7567 through our Acute Assessment Unit) and over half a million outpatients. The Emergency Department had 105,858 attendances.

Within planned care, elective activity was 4447 spells below plan for all commissioners at the end of the year. This is reflective of areas that have had delays in implementing additional capacity plans such as Neurosurgery, Cardiology and Orthopaedics, but also reflects the fact that elective capacity has been restricted during periods in the year as operational and staffing pressures have limited bed capacity. Cardiac surgery was also under plan due to workforce pressures in critical care and theatre staffing issues. Although below plan, total elective activity actually increased by 3000 spells (5%) compared to the previous year. At the end of the year outpatients was below plan by around

21000 attendances. There were various over and under performances in specialties but the most significant under-performance was within Hepatology. Again however this is an overall increase from the previous year of just under 25000 (5%).On a like-for-like basis, the absolute numbers on the 18-week waiting list has been broadly maintained. There has been an increase though in respect of the transfer of the Care UK orthopaedic activity onto the Trust's waiting list.

Within urgent care Emergency Department activity at the end of the year also reflects an increase of 5% from the previous year. Non-elective activity, excluding the Acute Admissions Unit (AAU) activity, is 4013 spells below plan but the Ambulatory Care Unit activity (ACU) activity is now separately recorded and at 7567 attendances is offsetting the underperformance in non-elective activity, giving an overall increase of 2043 or 6%.

Although operational improvements were achieved in Q1, Q2 was more difficult with increased urgent care pressures. Urgent Care 4-hour wait performance has continued to be very challenging with a very difficult January and February. Plans to increase staffing levels, clinical space and improve patient flow are currently being implemented.

Revenue from patient care activities increased by £11.5m in 2018/19 (2.6%). As mentioned above, income was not expected to increase significantly because of the reduction of non-recurrent income from the previous year. The final income achieved is close to plan, however, within this there was a significant under-performance on the NHS England Specialist contract reflecting underperformance on the elective activity plan as described above. This totalled £7m but was offset by other items including £4m of from the Department of Health to fund the final agenda for change pay award and £3m for additional income following the implementation of a strategic partnership with Care UK to deliver orthopaedic activity under a single combined contract. Contract income also increased by £3m with the transfer of Minor Injuries Unit services to the Trust from Livewell Southwest in June 2018. The Trust also received additional commissioner income during the year of £4m as part of its Financial Improvement plan, in recognition of 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 PSF funding that the Trust was awarded. This accounts for the majority of income reduction in this area, with £16.5m received in 2017-18 but only £6.1m in 2018-19, £4.1m lower as per the plan and £6.3m due to the non-achievement of the PSF criteria.

Expenditure
With circa 7,000 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 £17.5m from 2017-18. The primary reason for the increase is, as planned, staff pay increments and inflation increased by £11m upon the final agreement of the new Agenda for Change pay award. The average number of staff employed during the year also increased by 387 WTE. This reflects the £6.5m investment in additional permanent staff to treat the additional numbers of patients. This WTE

movement also includes a small increase in temporary staff although expenditure on agency staff has further reduced in 2018-19 from £8m to £5.6m as the Trust increased its use of local bank staff and continued to reduce the hourly rates paid.

Non-pay costs incurred in 2018-19 totalled £206 million, an increase of £15.6m. The most significant area of cost increases was for the purchase of healthcare services from non NHS bodies which increased by £7.7m. This included £4.2m for increased costs relating to the Care UK partnership. The partnership has helped to ensure that we were able to maintain elective Orthopaedic services during the winter period. There was also a significant increase in the costs related to outsourcing arrangements for diagnostic services with increased expenditure on imaging reporting and additional scanning capacity along with increased endoscopy capacity totalling £1.5m. This cost has helped the Trust to increase compliance against the diagnostic target to ensure that a greater proportion of diagnostic tests are carried out within 6 weeks of referral. There is also a full year impact of the subcontract agreement with Livewell Southwest to provide sexual health services that gives increased costs against last year of £0.6m and an increase of non-pay costs as part of the transfer of Minor Injury Unit services to the Trust from Livewell Southwest of £1.1m.

A further £4.8m of the increase is in high cost drugs reflecting increased use of Homecare Drugs. The Trust also had an increase of £0.9m in the Hotel Services contract that reflected the increased staff costs within this contract that increased in line with the agenda for change pay award. The funding received from the Department of Health did not cover this additional cost which formed a significant in year cost pressure for the Trust.

Other increases reflect expected inflation increases across non-pay areas of £2m although these were higher than expected in utilities.

Savings Plans
The Trust has delivered £23m of the £33m Financial Improvement Plan. This delivery was across a number of workstreams. Significant areas include £6m from organisational productivity programmes including theatre utilisation, outpatient productivity and reduced urgent care costs. £2.5m of workforce savings were delivered mainly around the reduction of agency costs, £2.8m from procurement including £0.8m from pharmacy savings and £1m on estates savings. The Trust also secured additional income of £4m from commissioners in recognition that further funding was required given the ever increasing pressure associated with the urgent care activity going through the hospital. The balance of savings is made up of various smaller service line plans including securing a £0.5m reduction in CNST premiums.

Cash and Working Capital
The Trust's cash plan for the year reflected the utilisation of the £4.2m brought forward balance on capital expenditure, to end the year with a reduced balance of £1m. The actual balance stands at £3m, an increase of £2m from plan 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 £3.8m from the Department of Health to support the planned deficit of £3.8m. However at the year end the Trust had taken loans of £25.7m in line with the revised forecast outturn deficit of £29.5m. 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's original capital plan was to spend £20.8m, funded from internal depreciation of £12.8m, capital loans of £3m, financial leases of £2m and £3m of additional cash resources generated from last year's surplus (earned last year but paid via a PSF debtor during this year).

The programme included £1.5m preparatory work on the Interventional Radiology Theatres project, the first stage of the £30m DoH funded development. Other key projects included £2m for a new relocatable MRI facility, £1.5m for energy efficiency projects, £3.5m for IT strategic development including e-prescribing, £0.7m for the ground work for the new Cath Lab facility and £0.8m for work up of a new Emergency Department. The remainder of the programme covered £3.5m for estates backlog maintenance, £1.5m for the rolling equipment replacement programme and £5.8m for other various projects across service lines.

The programme was reduced during the year by £1.5m as a planned loan for the Interventional Radiology Theatres project was not drawn down.. This expenditure has still occurred but was funded from internal resources created by slippage in other projects. Planned spend also reduced by £2m as the finance lease for the new relocatable MRI was deferred to early in 2019-20. A planned Salix energy loan of £1.5m was reduced to £0.5m as £1m was deferred to 2019-20 following a successful bid for alternative funding through the NHS Energy Efficiency Fund.

Spend was increased for an in year allocation from NHSE for an Emergency Department expansion of £2.5m. The Emergency Department extension was completed in March giving increased space for 4 additional resus beds, a dedicated paediatric ED area and improved ambulance handover space. Total spend was £3.8m with supplementary funds from further slippage on other programmes.

Other minor allocations and donated assets took the final capital plan to £19.5m as summarised below.

Capital Spend	**£M**
Equipment and minor works	7.5
Emergency Department improvements	3.8
IM&T	2.9
Estates	1.7
Hybrid Theatres	1.5
Other Planning schemes	1.2
Cardiac catheter labs	0.9
Total	**19.5**

Future Plans
The Trust has a planned breakeven position for 2019-20 that is in line with the financial control total set by NHS Improvement. The Trust has another challenging Financial Improvement Programme of £25.5m to meet this target.

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 £16m during the course of the year (but is planned to be repaid by the end of the year). 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, the Trust fully expects to receive this support and therefore we are absolutely confident in adopting the going concern status.

The Trust has a number of work streams within its financial improvement plans including continuing the productivity programmes in theatres and outpatients, procurement savings, tackling 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 other clinical productivity programmes.

The Trust continues to work within the wider health community to deliver key elements of a longer term sustainability plan. The Devon Sustainability and Transformation Plan (STP) 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. 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 is confident that these actions will help to bring long-term financial viability whilst delivering safe and effective care for patients.

University Hospitals Plymouth NHS Trust

Annual Accounts for the year ended 31 March 2019

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 24 May 2019

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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the Board

24 May 2019 *Ann James* Chief Executive

24 May 2019 *Sarah Brampton* Finance Director

University Hospitals Plymouth NHS Trust

Annual Accounts for the year ended 31 March 2019

Independent auditor's report to the Directors of University Hospitals Plymouth NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of University Hospitals Plymouth NHS Trust (the 'Trust') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in 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 International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 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 2018-19; 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.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which indicates that additional cash funding of £16m will be required in 2019/20 and that this funding has not been formally approved by the Department of Health and Social Care.

This event or condition indicates 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 2018-19, 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 audit 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 the 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 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 2018-19 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 issue a report 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 refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has 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 make 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 except on 17 May 2017 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to the Trust's expected breach of its statutory break-even duty for the three-year period ending 31 March 2019.

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 they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

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

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matter described in the basis for qualified conclusion section of our report we are satisfied that, in all significant respects University Hospitals Plymouth NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- In five of the last six years the Trust has not achieved its statutory break-even duty. The baseline position prior to financial support in 2017/18 was a £13.2 million deficit and at the end of 2017/18 the Trust recognised that its future financial viability could only be achieved through system re-design; The Trust set an initial budget surplus for 2018/19 of a £0.3 million surplus, after taking account of £16.6 million of anticipated funding from the Provider Sustainability Fund and £32.9 million of financial savings plans. This was revised by the Trust Board to a deficit budget of £3.8 million in April 2018;
- The Trust Board recognised that this was a challenging financial target, in the context of increasing demand and cost pressures. It quickly became clear that this budget was undeliverable and the Trust re-profiled its savings plans in June 2018;
- The Trust reported a £27.2 million deficit for 2018/19, after receipt of £6.1 million of PSF. The main reasons for the variance against budget were a £10.0 million under-delivery of savings plans and an £11.1 million reduction in PSF income. The original budget for 2018/19 was not realistic and the re-profiling of the savings plans during the year was insufficient to address the Trust's underlying financial pressures.

These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures and the delivery of financial savings plans. They are evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

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(1)(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 2019, and to report by exception where we are not satisfied.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of University Hospitals Plymouth NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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.

Jon Roberts, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

29 May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	452,530	440,999
Other operating income	4	57,771	66,782
Operating expenses	7, 9	(527,761)	(501,203)
Operating surplus/(deficit) from continuing operations		**(17,460)**	**6,578**
Finance income	12	112	42
Finance expenses	13	(2,313)	(2,327)
PDC dividends payable		(3,195)	(3,526)
Net finance costs		**(5,396)**	**(5,811)**
Other gains / (losses)	14	9	(20)
Surplus / (deficit) for the year from continuing operations		**(22,847)**	**747**
Surplus / (deficit) for the year		**(22,847)**	**747**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	18	3,334	382
Total comprehensive income / (expense) for the period		**(19,513)**	**1,129**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(22,847)	747
Remove net impairments not scoring to the Departmental expenditure limit		(4,234)	2,778
Remove I&E impact of capital grants and donations		(85)	(118)
CQUIN risk reserve adjustment (2017/18 only)		-	(300)
Adjusted financial performance surplus / (deficit)		**(27,166)**	**3,107**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	15	788	988
Property, plant and equipment	16	225,613	211,156
Receivables	20	2,878	3,200
Total non-current assets		**229,279**	**215,344**
Current assets			
Inventories	19	12,220	11,626
Receivables	20	27,475	31,088
Cash and cash equivalents	21	2,960	4,220
Total current assets		**42,655**	**46,934**
Current liabilities			
Trade and other payables	22	(46,011)	(44,119)
Borrowings	24	(30,156)	(24,217)
Provisions	26	(283)	(287)
Other liabilities	23	(2,502)	(1,958)
Total current liabilities		**(78,952)**	**(70,581)**
Total assets less current liabilities		**192,982**	**191,697**
Non-current liabilities			
Borrowings	24	(79,032)	(60,885)
Provisions	26	(1,100)	(1,172)
Total non-current liabilities		**(80,132)**	**(62,057)**
Total assets employed		**112,850**	**129,640**
Financed by			
Public dividend capital		200,548	197,825
Revaluation reserve		10,870	7,663
Other reserves		652	652
Income and expenditure reserve		(99,220)	(76,500)
Total taxpayers' equity		**112,850**	**129,640**

The notes on pages 6 to 50 form part of these accounts.

Name 

Position Chief Executive

Date **24 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**197,825**	**7,663**	**652**	**(76,500)**	**129,640**
Surplus/(deficit) for the year	-	-	-	(22,847)	**(22,847)**
Other transfers between reserves	-	(127)	-	127	**-**
Revaluations	-	3,334	-	-	**3,334**
Public dividend capital received	2,723	-	-	-	**2,723**
Taxpayers' equity at 31 March 2019	**200,548**	**10,870**	**652**	**(99,220)**	**112,850**

Statement of Changes in 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/(deficit) 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**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health 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	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(17,460)	6,578
Non-cash income and expense:			
Depreciation and amortisation	7.1	12,778	12,360
Net impairments	8	(4,234)	2,778
Income recognised in respect of capital donations	4	(476)	(538)
(Increase) / decrease in receivables and other assets		3,561	(10,941)
(Increase) in inventories		(594)	(457)
Increase in payables and other liabilties		3,543	3,252
(Decrease) in provisions		(79)	(112)
Net cash (used in) operating activities		**(2,961)**	**12,920**
Cash flows from investing activities			
Interest received		112	42
Purchase of intangible assets		(115)	(282)
Purchase of property, plant, equipment and investment property		(20,017)	(18,445)
Sales of property, plant, equipment and investment property		31	48
Net cash (used in) investing activities		**(19,989)**	**(18,637)**
Cash flows from financing activities			
Public dividend capital received		2,723	2,274
Movement on loans from the Department of Health and Social Care		23,481	8,815
Movement on other loans		409	133
Capital element of finance lease rental payments		(30)	(28)
Interest on loans		(2,206)	(2,283)
Other interest		(14)	(1)
Interest paid on finance lease liabilities		(27)	(28)
PDC dividend (paid)		(2,646)	(3,754)
Net cash generated from financing activities		**21,690**	**5,128**
(Decrease) in cash and cash equivalents		**(1,260)**	**(589)**
Cash and cash equivalents at 1 April - brought forward		**4,220**	**4,809**
Cash and cash equivalents at 31 March	21.1	**2,960**	**4,220**

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 2018/19 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 the 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 1.2 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 2018/19 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 2019/20 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 2019/20 (which totals £16m during the course of the year, and is expected to be £5.5m at the end of the year following delivery of the Financial Improvement Plan) has not yet formally been approved by the Department of Health & Social Care. 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 cast significant doubt about. the Trust's ability to continue as a going concern.

Note 1.3.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.3.2 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 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 1.3.3 Other income

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.

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 scheme is accounted for as though it is a defined contribution scheme.

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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful 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. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 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’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or 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 De-recognition

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 ie:

  - 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 abandoned 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 Donated and grant funded assets

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

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

Note 1.6.6 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	4	91
Plant & machinery	2	30
Transport equipment	7	14
Information technology	2	16
Furniture & fittings	5	20

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

Note 1.7 Intangible assets

Note 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Software

Software which is integral to the operation of hardware, eg 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, eg application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Note 1.7.3 Useful economic life of intangible assets

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

	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 assets and financial liabilities

Note 1.11.1 Recognition

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

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

Note 1.11.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

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

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.3 Derecognition

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

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

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 charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. 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 27 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

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 27 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 27, 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 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 (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health 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 functional and presentational currency of the Trust is sterling.

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

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.20 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 a rolling internal impairment review is carried out.

Note 1.20.1 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 1.20.2 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

● IFRS 16 Leases

It had been expected that this standard would become effective for the 2019/20 financial statements, but this has now been delayed to 2020/21. The impact may be material.

Note 2 Operating Segments

The Trust has no material operating segments other than healthcare.

	2018-19	2017-18
	£000s	£000s
Income	**510,301**	507,781
Operating surplus/ (deficit)	**(17,460)**	6,578
Net Assets	**112,850**	129,640

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Acute services		
Elective income	84,129	79,630
Non elective income	135,896	122,736
First outpatient income	40,538	37,389
Follow up outpatient income	21,072	20,512
A & E income	18,107	13,590
High cost drugs income from commissioners (excluding pass-through costs)	47,500	41,858
Other NHS clinical income	92,957	111,605
All services		
Private patient income	3,123	2,849
Agenda for Change pay award central funding	4,135	-
Other clinical income	5,073	10,830
Total income from activities	**452,530**	**440,999**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	166,067	163,604
Clinical commissioning groups	272,103	267,259
Department of Health and Social Care	4,135	-
Other NHS providers	985	1,214
NHS other	177	156
Local authorities	3,420	2,917
Non-NHS: private patients	3,123	2,849
Non-NHS: overseas patients (chargeable to patient)	539	238
Injury cost recovery scheme	1,641	1,887
Non NHS: other	340	875
Total income from activities	**452,530**	**440,999**
Of which:		
Related to continuing operations	452,530	440,999

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19	2017/18
	£000	£000
Income recognised this year	539	238
Cash payments received in-year	574	200
Amounts added to provision for impairment of receivables	104	30
Amounts written off in-year	33	-

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	4,844	5,110
Education and training (excluding notional apprenticeship levy income)	23,752	23,380
Non-patient care services to other bodies	8,024	9,218
Provider sustainability / sustainability and transformation fund income (PSF / STF)	6,091	16,636
Income in respect of employee benefits accounted on a gross basis	3,043	2,762
Other contract income	8,734	7,283
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	627	-
Receipt of capital grants and donations	476	538
Charitable and other contributions to expenditure	1,210	857
Rental revenue from operating leases	970	998
Total other operating income	**57,771**	**66,782**
Of which:		
Related to continuing operations	57,771	66,782

Note 5 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,958

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

Note 6 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018/19	2017/18
	£000	£000
Income	2,483	2,419
Full cost	(2,146)	(1,792)
Surplus	**337**	**627**

The only charging scheme with income 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 7.1 below.

Note 7.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,147	621
Purchase of healthcare from non-NHS and non-DHSC bodies	15,450	7,702
Staff and executive directors costs	313,612	296,090
Remuneration of non-executive directors	92	88
Supplies and services - clinical (excluding drugs costs)	56,718	55,826
Supplies and services - general	17,515	16,584
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	61,969	57,161
Inventories written down	52	165
Consultancy costs	489	603
Establishment	3,311	3,361
Premises	15,385	14,951
Transport (including patient travel)	583	513
Depreciation on property, plant and equipment	12,463	12,055
Amortisation on intangible assets	315	305
Net impairments (reversals)	(4,234)	2,778
Movement in credit loss allowance: contract receivables / contract assets	(95)	
Movement in credit loss allowance: all other receivables and investments	7	56
Change in provisions discount rate(s)	(16)	18
Audit fees payable to the external auditor		
audit services- statutory audit	67	66
other auditor remuneration (external auditor only)	10	10
Internal audit costs	172	169
Clinical negligence	15,812	17,280
Legal fees	486	315
Insurance	501	451
Research and development	4,940	4,691
Education and training	2,421	1,510
Rentals under operating leases	3,690	3,381
Early retirements	65	21
Car parking & security	2,341	1,976
Hospitality	54	81
Losses, ex gratia & special payments	157	126
Grossing up consortium arrangements	253	215
Other services, eg external payroll	461	417
Other	1,568	1,617
Total	**527,761**	**501,203**
Of which:		
Related to continuing operations	527,761	501,203

Note 7.2 Other auditor remuneration

	2018/19	2017/18
	£000	£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 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 8 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(4,234)	2,778
Total net impairments charged to operating surplus / deficit	**(4,234)**	**2,778**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**(4,234)**	**2,778**

Note 9 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	247,672	233,820
Social security costs	24,784	23,403
Apprenticeship levy	1,208	1,136
Employer's contributions to NHS pensions	29,074	27,564
Temporary staff (including agency)	18,447	17,021
Total gross staff costs	**321,185**	**302,944**
Recoveries in respect of seconded staff	**(1,716)**	(1,091)
Total staff costs	**319,469**	**301,853**
Of which		
Costs capitalised as part of assets	2,353	2,152

Note 9.1 Retirements due to ill-health

During 2018/19 there were 3 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £120k (£219k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 10 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 for Health 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 utilised 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 2019 is based on valuation data as at 31 March 2018 updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018, Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Pension

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 3% employers' contribution of qualifying earnings. Employer contributions are charged directly to the Statement of Comprehensive Income and paid to NEST monthly. At 31st March 2019 there were 188 employees enrolled in the scheme (172 at 31 March 2018). Further details of the scheme can be found at www.nestpensions.org.uk.

Note 11 Operating leases

Note 11.1 University Hospitals Plymouth NHS Trust as a lessor

This note discloses income generated in operating lease agreements where University Hospitals Plymouth 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.

	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	970	998
Total	**970**	**998**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	525	513
- later than one year and not later than five years;	1,335	271
- later than five years.	1,532	338
Total	**3,392**	**1,122**

Note 11.2 University Hospitals Plymouth NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where University Hospitals Plymouth NHS Trust is the lessee.

The Trust lets part of its estate to commercial organisations on operating leases.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	3,690	3,381
Total	**3,690**	**3,381**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	3,429	3,762
- later than one year and not later than five years;	8,078	10,226
- later than five years.	27,511	33,119
Total	**39,018**	**47,107**

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19	2017/18
	£000	£000
Interest on bank accounts	112	42
Total finance income	**112**	**42**

Note 13.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,269	2,297
Finance leases	27	28
Interest on late payment of commercial debt	14	1
Total interest expense	**2,310**	**2,326**
Unwinding of discount on provisions	3	1
Total finance costs	**2,313**	**2,327**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims under this legislation	14	1

Note 14 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	9	-
Losses on disposal of assets	-	(20)
Total gains / (losses) on disposal of assets	**9**	**(20)**
Total other gains / (losses)	**9**	**(20)**

Note 15.1 Intangible assets - 2018/19

	Licences & trademarks £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**2,621**	**2,621**
Additions	115	**115**
Valuation / gross cost at 31 March 2019	**2,736**	**2,736**
Amortisation at 1 April 2018 - brought forward	**1,633**	**1,633**
Provided during the year	315	**315**
Amortisation at 31 March 2019	**1,948**	**1,948**
Net book value at 31 March 2019	**788**	**788**
Net book value at 1 April 2018	**988**	**988**

Note 15.2 Intangible assets - 2017/18

	Licences & trademarks £000	Total £000
Valuation / gross cost at 1 April 2017	**2,339**	**2,339**
Additions	282	**282**
Valuation / gross cost at 31 March 2018	**2,621**	**2,621**
Amortisation at 1 April 2017	**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 16.1 Property, plant and equipment - 2018/19

	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 2018 - brought forward	**4,802**	**142,682**	**23,360**	**116,524**	**228**	**27,706**	**5,012**	**320,314**
Additions	-	149	18,898	222	-	15	90	**19,374**
Impairments	-	(99)	-	-	-	-	-	**(99)**
Reversals of impairments	-	4,333	-	-	-	-	-	**4,333**
Revaluations	-	315	-	-	-	-	-	**315**
Reclassifications	-	5,805	(12,689)	4,695	12	1,956	221	**-**
Disposals / derecognition	-	-	-	(1,208)	-	-	-	**(1,208)**
Valuation/gross cost at 31 March 2019	**4,802**	**153,185**	**29,569**	**120,233**	**240**	**29,677**	**5,323**	**343,029**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**-**	**84,300**	**161**	**21,609**	**3,088**	**109,158**
Provided during the year	-	3,019	-	6,932	13	2,162	337	**12,463**
Revaluations	-	(3,019)	-	-	-	-	-	**(3,019)**
Disposals / derecognition	-	-	-	(1,186)	-	-	-	**(1,186)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**90,046**	**174**	**23,771**	**3,425**	**117,416**
Net book value at 31 March 2019	**4,802**	**153,185**	**29,569**	**30,187**	**66**	**5,906**	**1,898**	**225,613**
Net book value at 1 April 2018	**4,802**	**142,682**	**23,360**	**32,224**	**67**	**6,097**	**1,924**	**211,156**

Note 16.2 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	**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	**-**	**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 16.3 Property, plant and equipment financing - 2018/19

	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 2019								
Owned - purchased	4,802	151,041	29,569	28,714	66	5,750	1,727	**221,669**
Finance leased	-	-	-	498	-	-	-	**498**
Owned - donated	-	2,144	-	975	-	156	171	**3,446**
NBV total at 31 March 2019	**4,802**	**153,185**	**29,569**	**30,187**	**66**	**5,906**	**1,898**	**225,613**

Note 16.4 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 17 Donations of property, plant and equipment

Donated assets totalling £476k were received during the year. Of these, £444k were received from the Trust's linked charity.

Note 18 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. Following advice from the Royal Institution of Chartered Surveyors, we have reassessed this decision in 2019/20.

Note 19 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	2,735	2,275
Consumables	9,310	9,178
Energy	175	173
Total inventories	**12,220**	**11,626**

Inventories recognised in expenses for the year were £102,114k (2017/18: £102,301k). Write-down of inventories recognised as expenses for the year were £64k (2017/18: £165k).

Note 20.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	22,888	
Trade receivables*		23,054
Allowance for impaired contract receivables / assets*	(1,106)	
Allowance for other impaired receivables	(5)	(1,156)
Prepayments (non-PFI)	3,726	3,852
PDC dividend receivable	-	374
VAT receivable	1,754	1,788
Other receivables	218	3,176
Total current trade and other receivables	**27,475**	**31,088**
Non-current		
Contract receivables*	3,685	
Allowance for impaired contract receivables / assets*	(807)	
Allowance for other impaired receivables	-	(903)
Other receivables	-	4,103
Total non-current trade and other receivables	**2,878**	**3,200**
Of which receivables from NHS and DHSC group bodies:		
Current	13,812	18,172

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 20.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**2,059**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	2,059	(2,059)
New allowances arising	-	7
Reversals of allowances	(95)	-
Utilisation of allowances (write offs)	(51)	(2)
Allowances as at 31 Mar 2019	**1,913**	**5**

Note 20.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format from the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**2,007**
Prior period adjustments	
Allowances as at 1 Apr 2017 - restated	**2,007**
Transfers by absorption	
Increase in provision	56
Amounts utilised	(4)
Allowances as at 31 Mar 2018	**2,059**

Note 21.1 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.

	2018/19	2017/18
	£000	£000
At 1 April	**4,220**	**4,809**
Net change in year	(1,260)	(589)
At 31 March	**2,960**	**4,220**
Broken down into:		
Cash at commercial banks and in hand	31	30
Cash with the Government Banking Service	2,929	4,190
Total cash and cash equivalents as in SoFP	**2,960**	**4,220**
Total cash and cash equivalents as in SoCF	**2,960**	**4,220**

Note 22 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	20,632	16,699
Capital payables	6,014	7,133
Accruals	5,624	7,001
Social security costs	3,612	3,374
VAT payables	150	250
Other taxes payable	3,313	3,142
PDC dividend payable	175	-
Accrued interest on loans*		163
Other payables	6,491	6,357
Total current trade and other payables	**46,011**	**44,119**
Of which payables from NHS and DHSC group bodies:		
Current	2,214	3,940

Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 24. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 23 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	2,502	1,958
Total other current liabilities	**2,502**	**1,958**

Note 24 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	29,954	24,114
Other loans	170	73
Obligations under finance leases	32	30
Total current borrowings	**30,156**	**24,217**
Non-current		
Loans from the Department of Health and Social Care	77,950	60,083
Other loans	598	286
Obligations under finance leases	484	516
Total non-current borrowings	**79,032**	**60,885**

Note 24.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**84,197**	**359**	**546**	**85,102**
Cash movements:				
Financing cash flows - payments and receipts of principal	23,481	409	(30)	**23,860**
Financing cash flows - payments of interest	(2,206)	-	(27)	**(2,233)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	163	-	-	**163**
Application of effective interest rate	2,269	-	27	**2,296**
Carrying value at 31 March 2019	**107,904**	**768**	**516**	**109,188**

Note 25 Finance leases

Note 25.2 University Hospitals Plymouth NHS Trust as a lessee

The Trust holds modular accommodation for the Trust's Staff Health & Wellbeing facility on a finance lease.

Obligations under finance leases where University Hospitals Plymouth NHS Trust is the lessee.

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**692**	**748**
of which liabilities are due:		
- not later than one year;	57	56
- later than one year and not later than five years;	225	226
- later than five years.	410	466
Finance charges allocated to future periods	(176)	(202)
Net lease liabilities	**516**	**546**
of which payable:		
- not later than one year;	32	30
- later than one year and not later than five years;	142	136
- later than five years.	342	380

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Legal claims	Total
	£000	£000	£000
At 1 April 2018	**793**	**666**	**1,459**
Change in the discount rate	(8)	(8)	**(16)**
Arising during the year	44	168	**212**
Utilised during the year	(90)	(169)	**(259)**
Reversed unused	-	(16)	**(16)**
Unwinding of discount	2	1	**3**
At 31 March 2019	**741**	**642**	**1,383**
Expected timing of cash flows:			
- not later than one year;	90	193	**283**
- later than one year and not later than five years;	354	134	**488**
- later than five years.	297	315	**612**
Total	**741**	**642**	**1,383**

Note 26.2 Clinical negligence liabilities

At 31 March 2019, £150,755k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of University Hospitals Plymouth NHS Trust (31 March 2018: £150,113k).

Note 27 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(91)	(93)
Gross value of contingent liabilities	**(91)**	**(93)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(91)**	**(93)**
Net value of contingent assets	**-**	**-**

Note 28 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	5,347	2,482
Total	**5,347**	**2,482**

Note 29 Financial instruments

Note 29.1 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 and Social Care
(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 2019 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 29.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ from those in the current year analyses.

	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non financial assets	24,382	**24,382**
Cash and cash equivalents at bank and in hand	2,960	**2,960**
Total at 31 March 2019	**27,342**	**27,342**

	Loans and receivables	Assets at fair value through the I&E	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**
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**

Note 29.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ from those in the current year analyses.

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	107,904	**107,904**
Obligations under finance leases	516	**516**
Other borrowings	768	**768**
Trade and other payables excluding non financial liabilities	38,270	**38,270**
Total at 31 March 2019	**147,458**	**147,458**

	Other financial liabilities £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	84,197	**84,197**
Obligations under finance leases	546	**546**
Other borrowings	359	**359**
Trade and other payables excluding non financial liabilities	37,353	**37,353**
Total at 31 March 2018	**122,455**	**122,455**

Note 29.4 Fair values of financial assets and liabilities

The carrying value of financial assets and liabilities is not significantly different from fair value.

Note 29.5 Maturity of financial liabilities

	31 March 2018 £000
In one year or less	61,570
In more than one year but not more than two years	10,915
In more than two years but not more than five years	49,588
In more than five years	382
Total	**122,455**

Note 30 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	17	3	16	1
Bad debts and claims abandoned	179	51	62	3
Stores losses and damage to property	83	64	16	165
Total losses	**279**	**118**	**94**	**169**
Special payments				
Ex-gratia payments	187	156	147	122
Total special payments	**187**	**156**	**147**	**122**
Total losses and special payments	**466**	**274**	**241**	**291**

Note 31.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £163k, and trade payables correspondingly reduced.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £5,408k.

Note 31.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need retrospectively to restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 32 Related parties

During the year none of the Department of Health and Social Care 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 and Social Care 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 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 33 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	90,637	226,671	88,212	214,533
Total non-NHS trade invoices paid within target	86,182	215,067	84,819	201,971
Percentage of non-NHS trade invoices paid within target	95.1%	94.9%	96.2%	94.1%
NHS Payables				
Total NHS trade invoices paid in the year	2,762	10,681	2,460	8,569
Total NHS trade invoices paid within target	2,564	9,868	2,238	7,758
Percentage of NHS trade invoices paid within target	92.8%	92.4%	91.0%	90.5%

The Better Payment Practice code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 34 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Cash flow financing	27,843	11,783
External financing requirement	**27,843**	**11,783**
External financing limit (EFL)	28,439	16,153
Under spend against EFL	**596**	**4,370**

Note 35 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	19,489	21,338
Less: Disposals	(22)	(68)
Less: Donated and granted capital additions	(476)	(538)
Charge against Capital Resource Limit	**18,991**	**20,732**
Capital Resource Limit	19,506	22,531
Under spend against CRL	**515**	**1,799**

Note 36 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance (deficit) (control total basis)	(27,166)
Breakeven duty financial performance (deficit)	**(27,166)**

Note 37 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		2,010	18	15	49	(12,988)	(4,989)	(35,996)	(39,900)	3,407	(27,166)
Breakeven duty cumulative position	10,046	12,056	12,074	12,089	12,138	(850)	(5,839)	(41,835)	(81,735)	(78,328)	(105,494)
Operating income		376,990	391,499	391,862	405,822	410,207	430,817	432,771	450,348	507,781	510,301
Cumulative breakeven position as a percentage of operating income		3.2%	3.1%	3.1%	3.0%	(0.2%)	(1.4%)	(9.7%)	(18.1%)	(15.4%)	(20.7%)

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.

The Trust has reported a deficit position for the five out of the last six years and and the cumulative deficit now stands at £105.5m.
It plans to break even in 2019/20.

University Hospitals Plymouth NHS Trust

Quality Account

2018/19

Contents

1 Chief Executive Statement

It gives me great pleasure to present University Hospitals Plymouth NHS Trust's annual Quality Account, representing our report on the quality of services we provided in 2018/19 and our key quality priorities for improvement in 2019/20.

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 2017/18 showed that most people receive a good quality of care, people's experiences are often determined by how well different parts of local systems work together.

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 need 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 2018/19. 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 significant additional funds for capital investment in a new Emergency Department, new diagnostic scanners and digital histopathology which will benefit patients across Devon and Cornwall. This comes on top of funding already received and used to upgrade our resuscitation and children's areas in the existing Emergency Department.
- Rollout of the #PeopleFirst programme, a national scheme which we applied to be part of jointly with Livewell Southwest, our colleagues providing community care. The #PeopleFirst methodology brings a scientific approach to team-driven improvement and is already making an impact, through projects such as changes to our heart failure service.
- Joining up care for people, particularly those with more complex needs on leaving hospital. By working more closely with other organisations providing NHS services, care homes and the voluntary sector, among others, we have been able to significantly reduce the number of patients who are subject to delayed transfers of care.

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

All of this has been achieved against a background of growing demand, which puts pressure both on services and the staff who provide them. We have seen particular increases in patients attending as emergencies and those referred under the two week wait pathway for some specialties.

We know we have more work to do to reduce waits for patients, particularly those waiting too long for planned care and this is a key focus for us in 2019/20.

We continue to work hard to support staff in a number of ways, from promoting team-driven improvement, to specific health and wellbeing initiatives, often run from our Derriford Centre for Health and Wellbeing.

Our thousands of staff and hundreds of volunteers remain our greatest asset and we remain committed to supporting them in their working lives, through training, development and wellbeing. In doing so, we enable and support them to provide the best possible care to patients and families, and if they are not frontline staff themselves, to support their colleagues who do so.

We remain, as ever, appreciative of all they do and I would like to take this opportunity to say a formal 'Thank You' for their continued dedication and incredible compassion.

I am therefore pleased to present our annual Quality Account for 2018/19, which I believe to be a fair and accurate report of our quality and standards of care.

Ann James
Chief Executive

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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.

We aspire to make a difference as the major provider of acute and specialist services in the south west peninsula. We will invest in the future through teaching, research and continual improvement and work within a highly collaborative and integrated health and social care system.

Our mission is to play our part in an inclusive society which addresses the social causes of ill health and empowers people to live healthy independent lives. We will support people to take responsibility for their own health, wherever possible, and provide access to high quality medical care.

We do many amazing things yet sometimes we do not always achieve the high standards to which we aspire. We deliver highly complex, specialist treatment every day but we do not always get the simple things right.

During 2018/19 we finalised our strategic direction for 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.

In terms of our more specific priorities for 2019/20, 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 priorities including our Operational Plan 2019/20, Board Assurance Framework, Quality Improvement Strategy, Care Quality Commission Report and NHS Improvement areas of focus.

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

Building Capability

University Hospitals Plymouth and Livewell Southwest continue to work together to improve patient care, support closer working and provide better outcomes for patients.

In 2018 University Hospitals Plymouth NHS Trust and Livewell SW were successful in our joint bid to become one of seven national hospitals to partner with NHS Improvement in a programme of work we have termed our People First Programme.

With help and support from the national team we are changing the way we work to improve the quality of care we offer, making our services safer, more effective and patient centred. By removing waste, putting the best ideas of our front line staff into practice and by focusing on what our patients really want, we will deliver better services.

Using a single approach to build quality improvement right through our organisations is helping us create a common purpose which we are all working towards and provides the opportunity for our staff at all grades to make a contribution.

Our executive team has been trained to use this approach and we have started a programme of training for our staff which will run over the next

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three years. This training will focus on how our staff can work to continuously improve how we deliver care. More detail can be found in **Annex G**.

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 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 its own observations during periodic, planned and unannounced inspections.

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

Planned Inspection

We were the subject of a planned CQC inspection in April-May 2018. During this inspection we were rated as 'Requires Improvement' overall.

The inspection report contained a number of Requirement Notices (Must Do actions). 56% of the actions designed to address these Requirement Notices are now complete. The significant ongoing open actions relate to redesign and rebuild of the Emergency Department; mandatory training; ensuring that patients presenting with possible sepsis are recognised, started on a treatment pathway and administered antibiotics within 60 minutes; and delivery of operational performance standards.

In addition to the Requirement Notices, the Trust received two Section 29A Warning Notices, one for Pharmacy and one for Diagnostic Imaging. These Warning Notices stated that:

- Significant improvement was required to ensure that patients suspected of having cancer had timely access to initial assessment, test results and diagnosis in diagnostic imaging.
- Significant improvement was required to ensure that systems and processes for safely managing medicines were operating correctly both within the pharmacy services and across the Trust, and were effectively governed so that people are given the medicines they need, when they need them and in a safe way.

We were required to make these significant improvements by Friday 26 October 2018. The key work streams to address these areas of concern had already started before receipt of the report, and in a number of cases had started before the inspection itself.

Follow up inspection

The CQC conducted a follow-up inspection in December 2018 focused solely on the improvements required within the two warning notices.

In Diagnostic Imaging the CQC found that:

- There was improving performance for patients waiting longer than six weeks for a routine scan.
- There were plans to improve process and efficiency with booking appointments.
- There was improved management of governance within the Imaging Department.
- There had been an internal review of risks on the risk registers and actions were progressing well.
- Improvements had been made in the management structure for senior staff in the Imaging Department.
- In CT the most urgent scans were reported on in a timely way.

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However, the CQC felt that insufficient progress had been made in addressing the concerns in the 2018 Warning Notice and on 25 January 2019 they reassessed the existing notice stating that; "significant improvement is required to ensure patients suspected of having cancer have timely access to initial assessment, test results and diagnosis in diagnostic imaging".

The key three areas of concern highlighted by the CQC are as follows:

- The Diagnostic Imaging Service was not meeting the seven-day internal target for the imaging of patients suspected of having cancer in CT, MRI or ultrasound.
- Radiographers consistently told inspectors that managers within diagnostic imaging were not addressing poor behaviour or attitudes displayed by some modality leaders.
- Band five radiographers consistently felt unable to speak with departmental managers and / or freedom to speak up guardians to escalate their concerns due to fear of repercussion.

The Trust was required to make the significant improvements in relation to the first point by 24 April 2019 and for the other issues by 24 July 2019.

Pharmacy: The CQC recognised the clinical pharmacy service had improved its access to clinical areas for routine pharmacy input. The service had been reinstated on 1 October 2018, reducing several risks identified in the Warning Notice from a previously restricted service. They also recognised that governance structures for pharmacy had been changed since the last inspection, although not yet embedded to enable the CQC to evidence their effectiveness.

One area of concern highlighted by the CQC was the limited assurance that sufficient priority or resources had been allocated by the Board to address and rectify issues in pharmacy, or that adequate support had been provided to the interim chief pharmacist to ensure a continued presence of support in the department. This has now been addressed following the appointment of a former chief pharmacist who now provides senior leadership support 2-3 days per week.

The CQC found we had not fully addressed or sufficiently acted on some of their concerns in the warning notice and the full warning notice, noting actions taken needed better executive oversight. However, they recognised some progress was being made and that a cultural shift would take time.

We were therefore not issued with a further warning notice for pharmacy; instead the report set out a number of requirement notices which do not have a specified time limit in which they should be addressed.

Our actions to improve both services are set out in the tables below.

Core Service	CQC required that we:	What are we doing to put this right?
Diagnostic Imaging	Ensure that 85% of patients suspected of having cancer are scanned within seven days as per the Trust target.	• We have implemented daily cancer admin huddles to improve booking scans and introduced an escalation in-box for admin staff. • We will appoint a 2 week wait co-ordinator. • We are reviewing admin cover by day of the week and considering options to deliver an extended working day. • We are auditing reasons for breaching the 7 day scanning standard. • We will review and improve booking processes for the Planned Investigation Unit/Lynd. • We will identify complex booking issues.

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Core Service	CQC required that we:	What are we doing to put this right?
	Ensure the management team addresses poor leadership and manages attitudes and behaviours shown by some of the team.	For band 7 and 8 staff we have: • Met to discuss behaviours and responsibilities and will send an open letter to the band 7 and 8 radiographers reinforcing expectations. • Implemented enhanced management arrangements for plain film. • Transferred the management of the rota into the service line office. • Clarified arrangements for rota swaps and reduced band 7 on call duties. In addition: • We will conclude current formal Investigation/s. For band 5 staff: We arranged a meeting to inform staff about the actions we are taking following the meeting in December 2018 and are arranging regular meetings to update them about progress and provide an opportunity to give feedback.
	Ensure that staff satisfaction improves, and that staff are confident to raise concerns with managers.	For radiographers we are: • Arranging to meet with Freedom to Speak up Guardians to discuss how they can support staff. • Securing support from Financial Improvement Group to uplift the radiographic establishment to improve capacity to lead. • Developing a leadership development plan for radiographers with leadership responsibilities, in conjunction with organisational development. • Moving CT and plain film teams to Agenda for Change contracts, terms and conditions. • Developing a team based approach to improvement with support from the 'PeopleFirst' programme. For consultants we are: • Securing support for recruitment into approved and projected vacancies in advance. • Co-ordinating feedback and actions to the stress survey. • Agreeing which additional consultant posts will be appointed following the business planning process. For administration staff we are: • Addressing the leadership structure. • Reviewing staff survey actions (All staff). • Using group meetings with modality leads to inform improvement actions. • Arranging for feedback from SCORE Survey.

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Core Service	CQC required that we:	What are we doing to put this right?
Pharmacy	Ensure there is a clear process within wards, pharmacy and transport, to safeguard patients receiving their critical medicines at discharge. Ensure patients are being appropriately counselled on their medicines.	• We are rolling out set criteria for discharge for all patients who do not have their medicines to take home i.e. not just critical medicines. • We are setting up a task and finish group with Heads of Nursing, Director of Winter & Communications to ensure the required action plan has been shared with care group clinical and operational leads.
	Ensure that we have assurance and can evidence processes, through review of data, that patients being discharged without their critical medicines receive them in a timely manner.	A process is now in place and data is reported to the executive team weekly.
	Review staffing establishment and skill mix for the pharmacy department to ensure staffing meets capacity and demand.	We are undertaking a workforce review as part of a broader project including service review (development) across the Trust.
	Review training and competency of staff and ensure staff are not working above their role and competencies.	• Senior education and training lead commences in post 1 April 2019. • We are reviewing requirements for part-time technician training post. • We are reviewing competencies and training. • Human resources to undertake review of banding for staff.
	Ensure capacity for leadership and ongoing support is available in the pharmacy department.	• Experienced pharmacist started in March to support the medication safety and governance work streams. • Communications describing the new structures and proposed reporting lines will be circulated to staff.
	Ensure risks are identified, recorded and mitigated, with a clear record for this.	• We will review and update the risk register in full. • We will ensure regular review of the risk register by Pharmacy Board. • We will review the work programme generated by the gap analysis against the Royal Pharmaceutical Society Standards and ensure that this links to risk management.
	Ensure there is robust oversight of governance for pharmacy and medicines trust-wide.	• Pharmacy Board now meets monthly. Fortnightly oversight meetings to be held with the lead executive director. • Terms of reference for Medicines Utilisation and Assurance Committee (MUAC) have been reviewed and we are establishing relevant sub-groups to focus

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Core Service	CQC required that we:	What are we doing to put this right?
		more effectively on medicines management, new medicines and medicines safety. • We are implementing key performance indicators and reporting structures. • Quality Management System meetings will feedback to the chief pharmacist on a fortnightly basis. • Pharmacy will report to Trust Management Executive on a regular basis • Internal pharmacy incidents will be reviewed at fortnightly Pharmacy Quality Management Group and monthly Pharmacy Board. • Trust wide medicines related incidents will be reviewed and monitored by appropriate senior pharmacy staff and reported through MUAC via the Medicines Management Sub Group.

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.

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Inspection

CQC inspectors conducted a short-notice announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the radiology service at Derriford Hospital in December 2018. The inspection was focused on the action plan produced following a full comprehensive inspection which took place in November 2017.

The inspection reviewed the reasons why some of the actions around revision and ratification of the employer's procedures required under schedule 2 of IR(ME)R 2017 had not been undertaken. However, the team were able to demonstrate that a new action plan was in place with a final date for implementation of March 2019.

Since December, all of our procedure documents have been reviewed and updated to IR(ME)R 2017 and an extensive training programme has commenced. We were re-inspected in April 2019 in response to the recommendations made by the CQC during their December 2018 inspection. The Trust received confirmation from the CQC on 29 April 2019 that they were now satisfied that their concerns regarding compliance with IR(MER) were met and the inspection file was closed as now fully compliant.

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

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Our overall performance in 2018/19

The Trust has found the Emergency Department 4 hour standard difficult to achieve for several years. Following external reviews it has now been recognised that the infrastructure to manage the workload is inadequate both in terms of space and workforce.

Work to expand and reconfigure the paediatric and the resuscitation areas was completed in March 2019. Work is also in progress to increase the workforce numbers enabled by £2.5m investment.

Demand and acuity of patients presenting at the Emergency Department continues to increase. To help address this increase improvements to support patient flow through the hospital, such as reduced delayed transfers of care and patients with extended lengths of stay, have helped us to reduce the number of patients who are cancelled.

During the first quarter of 2018/19, our diagnostic waiting times deteriorated considerably largely driven by lack of capacity and increased demand for imaging. Actions were put in place including additional scanning facilities and improved patient treatment management, plus successful recruitment to vacancies resulted in the reduction of patients waiting for diagnostic appointments. Performance improved from 24% of patients waiting over 6 weeks in July 2018 to 7% in March 2019.

Demand for elective care has continued to exceed our capacity, with the number of patients referred for treatment increasing by 4.2%, resulting in longer waits for treatment. Plans designed to improve our performance have been successful, including increased use of outpatient clinics, the Care UK partnership which started in November 2018, improved administration functions and a reduction in diagnostic waiting times.

Disappointingly other plans have not had the desired effect. These include the delayed opening of our third cath lab and recruitment of medical consultants, new appointments were successful but other staff have resigned since resulting in no increase.

Despite the pressure of increasing demand, we have made progress in reducing the number of patients waiting over 52 weeks for treatment. We have reduced the number of patients waiting over 52 weeks from 167 in June 2018 to 48 at the end of March 2019.

Cancer Standards

Performance against our cancer standards was variable in 2018/19.

Our 2 week wait performance recovered from August 2018 onwards following an in depth review of demand and capacity, booking processes and pathways.

62 day performance continues to be a challenge for the Trust and our plan to improve the position has been unsuccessful. Whilst the number of patients waiting had reduced during the autumn, mainly due to improving 2 week waits and diagnostic performance, with the onset of winter and surgical cancellations, the backlog soon started to grow again. Key pressure areas are in urology and colorectal services. Recruitment is underway to increase the consultant workforce manage the increasing activity going forward.

The core quality metrics we have used and reported throughout 2018/19 are shown in **Annex A**.

Review of Services

During 2018/19, University Hospitals Plymouth NHS Trust continued to provide (or sub contract) 64 NHS services. The Trust has reviewed all of the data available to them on quality of care in all these NHS services.

The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by University Hospitals Plymouth NHS Trust for 2018/19.

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Goals agreed with Commissioners

An element of University Hospitals Plymouth NHS Trust income in 2018/19 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 2018/19 on the basis of good levels of achievement of milestones.

A number of CQUIN schemes will continue into 2019/20 with others becoming part of normal contractual requirements. There are a number of new CQUIN schemes for 2019/20. 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 standardised code-set. The accuracy of clinical coding is a fundamental indicator of the accuracy of patient records and drives the income received for each patient's stay in addition to providing data 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 and regret for the 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 2018/19 the Trust participated in 100% of open, relevant national audits as defined by Healthcare Quality Improvement Partnership (HQIP). These audits are detailed in **Annex D**.

During 2018/19 hospitals were eligible to enter data for five National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies,

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which are detailed in **Annex D**. University Hospitals Plymouth NHS Trust submitted data for two studies. The remaining studies are ongoing.

In 2018/19 we also completed 23 planned Priority 2 audits including clinical record keeping and Ionising Radiation (Medical Exposure) Regulation (IRMER), 57 Priority 3 audits, 40 Priority 4 audits and 36 Service Evaluations. A number of improvements have been made as a result of these audits, examples of audits and 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 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 such as physiotherapy, speech and language therapy, occupational therapy and care from a dietician.

Despite the fact the hospital completed around 400,000 follow up consultations in 2018-19 there were still a large number of patients who did not receive their follow up appointment by the appropriate date clinically indicated. Timely appointments are important to avoid associated risks when delaying to a date later than originally deemed appropriate. It also represents a commitment made to the patient that has not been met by the hospital.

At the end of March 2019 the number of patients who had not received their appointment by the date indicated was 35,260 compared to 34,867 in March 2018. We have an electronic system of 'flagging' patients as being 'time critical' for follow up, which includes a date by which the patient should be seen or may be at risk of harm if they wait longer. 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 7,698 at the end of March 2019. The services that account for the largest number of patients are ophthalmology, neurology, gastroenterology, hepatology and rheumatology. A combination of competing clinical priorities, including pressure to achieve waiting times for new patients and reduced clinic capacity, means current arrangements need to be reviewed as a priority.

The number of ophthalmology patients in the higher risk categories has reduced by approximately 1,000 in the past 12 months, and accounts for 33% of the overall at risk numbers, compared to 43% at the end of March 2018. 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 release capacity the service line continues to work through the 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 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 hospital

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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 by the NHS 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 trust boards to keep deaths in their care under review and share learning from these

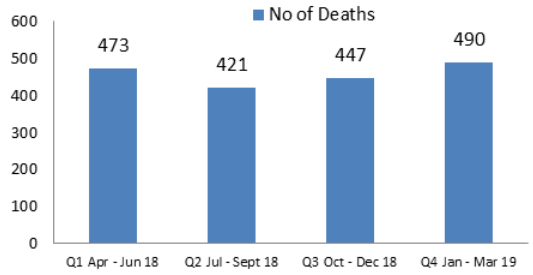
The CQC's recommendations have been translated into seven national work streams. The Department of Health (DH) has set up the Learning from Deaths Programme Board to support their implementation. Each work stream is led by the relevant healthcare body. The first step in this programme was the publication of the new Learning from Deaths Framework in March 2017. The new guidance identifies how NHS providers should learn from the deaths of people in their care. 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.

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 1831 inpatient deaths for the year April 1st 2018 – 31st March 2019 including patients who have died in the Emergency Department

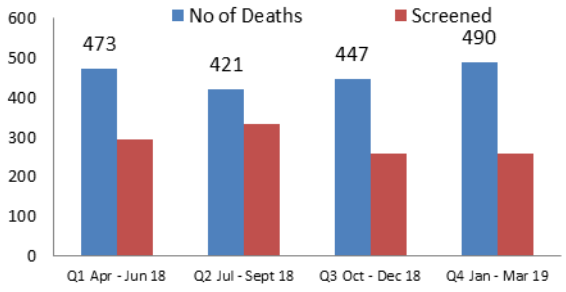


During 2018/19, 1831 patients died, (of which 7 were neonatal deaths, 18 were still births, 6 were people with learning disabilities).

This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 473 in the first quarter (of which 0 were neonatal death, 3 were still births, 3 were people with learning disabilities).
- 421 in the second quarter (of which 4 were neonatal death, 6 were still births, 1 was people with learning disabilities).
- 447 number in the third quarter (of which 0 were neonatal death, 3 were still births, 2 were people with learning disabilities).
- 490 number in the fourth quarter (of which 3 were neonatal death, 6 were still births, 0 number were people with learning disabilities).

The Trust has a process to screen deaths to help identify problems in service delivery, during the same period a total of 1145 deaths have been investigated using the Trust's screening tool.



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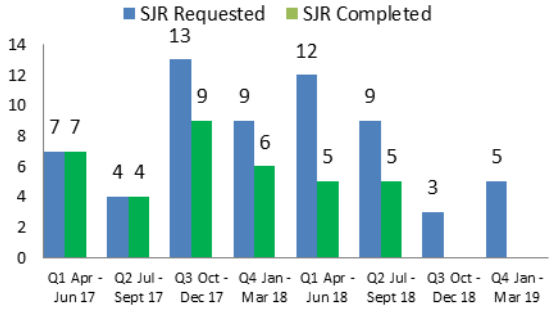
- 295 deaths screened in quarter 1
- 332 deaths screened in quarter 2
- 259 deaths screened in quarter 3
- 259 deaths screened in quarter 4

Of the total number of deaths in 2018/19 a further 29 have been subject of a case record review using the Royal College of Physicians Structured Judgement Review (SJR)

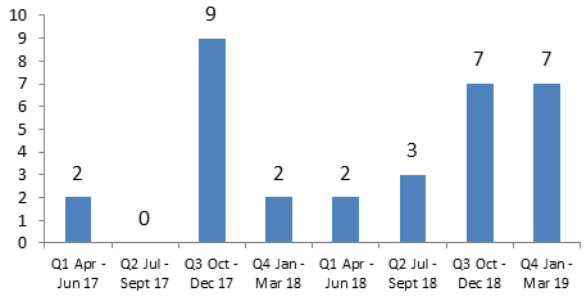


Statement from the Royal College of Physicians

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.

Deaths with associated incident investigations

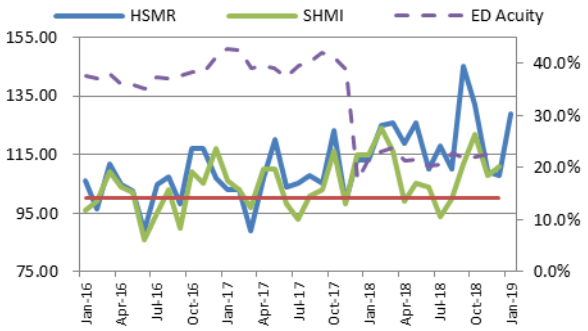
During 2018/19 a total of 19 deaths for University Hospitals Plymouth NHS Trust have been reported on the Strategic Executive Information System (StEIS) as a serious incident requiring further investigation.



Summary Hospital-Level Mortality Indicator (SHMI) & Hospital Standardised Mortality Ratio (HSMR)

SHMI - The number of deaths in hospital is captured through the Summary Hospital-level Mortality Indicator (SHMI). SHMI is the ratio between the actual number of patients who die following admission to hospital and the number who would be expected to die, based on average figures for England, given the characteristics of the patients treated there. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days of discharge.

HSMR - The HSMR scoring system works by taking the hospital's base mortality rate and adjusting it for a variety of factors such as population size, age profile, level of poverty, range of treatments and operations provided, etc. The idea is that by taking these factors into account for each hospital, it is possible to calculate two scores, the mortality rate that would be expected for any given hospital and its actual rate. It is the difference between these two rates that is important when it comes to HSMR.



Reviewing and understanding our performance

Given our headline indicators for SHMI and HSMR were higher than expected, we established two specific work streams to review and improve our understanding of the reasons for the variance.

- Increased number of consultant episodes
- Variation in capturing mortality information, e.g. clinical coding

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As part of this work we identified a number of areas that we believed where affecting our HMSR and SHMI figures.

Episodes of Care Coding

The new information system Salus made it easier to transfer a patient from consultant to consultant.

The effect of this has been additional coded episodes of care for each patient, which affected how each death is coded. In some cases this resulted in an increase in deaths coded against the initial diagnosis as opposed to the definitive diagnosis.

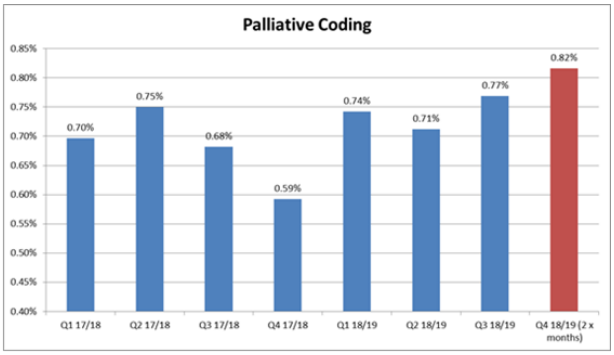
We believe this has negatively impacted on our mortality data and are working with an external company to see if any analysis is possible to understand the effect and compensate for it.

Palliative Care Coding

Patients on palliative care are normally excluded from the HSMR data. The palliative care team provide a list of patients each month to ensure that the coding team accurately reflect palliative care team contact. This will ensure that this cohort of patients is excluded from the data submission each month.

The Trust is working with the clinical coding teams from other organisations to ensure similar practice across the wider health community in Devon is being followed.

The graph below shows the latest quarter's rate has increased which we believe will improve our HMSR position, this will need to be monitored over the coming months.



Ambulatory Care

Previously some patients would be admitted for a limited period, of less than one day. These patients are now treated through our new Acute Assessment Unit (AAU) which is not included in the national data set. The introduction of our AAU resulted in this cohort of patient being removed from our data submission which was previously diluting/concentrating our mortality ratios.

In 2018/19 the patients treated in our AAU was not submitted onto the national system a plan to resubmit this data in 2019/20 is in place. It takes 2-3 months for the data to be reflected on the national mortality tools.

Learning from Reviews

- Transferring patients to wards that are not optimum for the patients' needs due to volume of demand for services.
- Delayed imaging for inpatients.
- Poor documentation – notes are disorganised.
- Timely escalation of deteriorating patient

Quality Improvement Projects resulting from Learning from Reviews of Deaths

We continue to identify and act upon learning from deaths, for example:

- Abscess management: We have produced a new pathway to ensure timely imaging in cases where an abscess is present or uncertainty exists. Teaching has been provided regarding management in situations where uncertainty of diagnosis exists in cases of mastitis/abscess formation.
- National Early Warning Score (NEWS): Recognising and responding to patient deterioration relies on a whole system approach and the revised National Early Warning Score (NEWS2), published by the Royal College of Physicians in December 2017, and 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

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identification of patients likely to have sepsis, improved scoring for patients with hypercapnia respiratory failure and recognising the importance of new-onset confusion or delirium. News 2 has been fully implemented at UHP.

- Discharging Patients without Critical Medications: Following two serious incidents in 2017/18 we have reviewed the actions taken to prevent a patient leaving the hospital without a critical medication. We have introduced improved processes for monitoring returned critical medications to pharmacy as well as improved ward processes.

Patient Feedback

Friends and Family Test Patients

Our Inpatient & Daycase results have remained steady throughout 2018/19, although Emergency Services were less consistent. 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 2018	97.57%	94.60%
May 2018	96.66%	94.61%
June 2018	96.66%	91.43%
July 2018	95.47%	94.07%
August 2018	96.22%	93.41%
September 2018	96.63%	90.99%
October 2018	96.58%	98.91%
November 2018	96.09%	91.07%
December 2018	97.35%	94.34%
January 2019	97.16%	95.16%
February 2019	97.17%	94.65%
March 2019	97.24%	96.32%

Patient Reported Outcome Measures (PROMs)

A summary of our PROMs results in 2018/19 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 hips and knees, but have reduced for hernia and varicose veins. The latest figures at March 2019 are shown below:

Participation Rate Hernia	Participation Rate Hip	Participation Rate Knee	Participation Rate Vein
0%	89%	97%	33%

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.

Every 6 months, the Trust is required to self-assess its performance against the four priority national standards and report this to Trust Board.

The latest report was submitted on 1st March 2019 with the following results;

Standard 2 – Time to first consultant review
88% of sampled patients were seen by a consultant within 14 hours of admission during the week and 75% on the weekend. The target standard is 90% which the Trust did not meet.

Standard 5 – Access to diagnostics tests
Hospital inpatients have access to seven-day emergency diagnostic tests and the Trust meets the standard.

Standard 6 – Access to consultant directed interventions
Patients have access to 24/7 emergency interventions and the Trust meets the standard.

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Standard 8 – Ongoing review by consultant twice daily if high dependency, daily for others

97% of sampled patients were reviewed daily by a consultant during the week and 73% on the weekend. The target standard is 90% and the Trust did not meet the standard for the weekend.

A Senior Working Group, chaired by the medical director, continues to meet to identify and implement improvements.

Staff Feedback

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

We are working hard to understand the experience of our staff – both when things are going well and when things require improvement. 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.

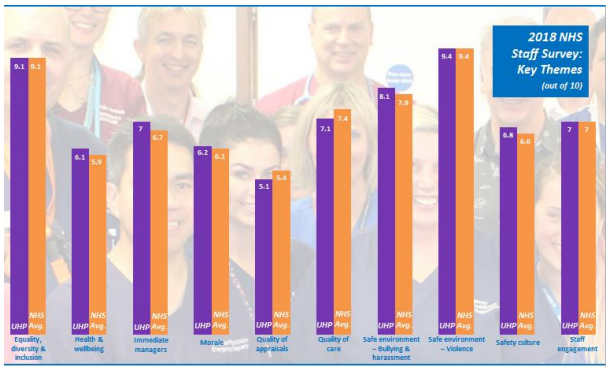
The Human Resources & Organisational Development Team (HR & OD) have worked closely with colleagues across various teams throughout the Trust, including service improvement, communications and the Learning from Excellence Team to build a culture that helps staff make changes through their ideas and feedback. 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 helps the Trust to understand the experience of staff in our organisation. In 2018, 3577 out of 6817 staff responded, equating to 52.5% response rate, providing highly reliable data.

Nationally, the survey data from NHS Employers shows a service struggling to provide care against increasing demands. Staff in our Trust have reported improvements in a number of areas when compared to 2017.

The survey is now reported in 10 themes and our performance is shown below:

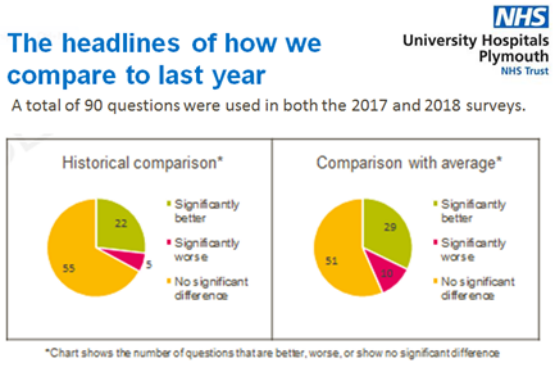


Out of the 10 themes for University Hospitals Plymouth NHS Trust:

- 2 statistically significantly improved between 2017/ 2018
- 7 stayed the same between 2017/ 2018
- 1 not comparable between 2017/2018
- 5 better than average in 2018
- 3 same as average in 2018
- 2 lower than average

Although a number of aspects of the survey have improved, such as the sense of being valued and the supprt from line managers there are still areas of significant concern from staff about the quality of care they can give and that they aspire to.

Our rate of improvement remains greater than the average of acute trusts.



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Staff have told us things such as :

"I find my managers very supportive and professional, the whole multi-disciplinary team are inspiring to work with."

"I have always felt valued working in the NHS, yes sometimes as all jobs anywhere It has its pressures, but I have always felt supported and valued. I love working in the NHS."

"I am very lucky as I love my job and i feel that this is as a direct result of working within a department where I feel well supported and that the the staff are focused on doing an excellent job."

"I feel positive changes are happening and the department is moving forwards."

Your Voice

Your Voice is the opportunity for staff to take part in conversations with the senior leaders and leaders within their teams.

Your Voice has developed this year to be the method for hosting local conversations as well as those with senior leaders. Staff have been sharing their views and local leaders taking forward plans to work on the solutions and actions arising.

Valuing our staff and Learning from Excellence

Our 'Say Thank you and Help us Learn from Excellence' programme of work has continued to grow.

In the last 12 months we have received 1881 Say Thank you and Learn from Excellence nominations, the number of nominations has doubled over the last 12 months and this is now over 3000 since we started.

This year, a fifth of our Say Thank You and Learn from Excellence nominations have come from patients, their family and friends.

Learning from these nominations demonstrates that what matters most to colleagues, patients and their families is positive and supportive behaviour.

Our staff are regularly thanked for being kind, giving time and supporting us in times of pressure or when we are feeling vulnerable. The seemingly little things such as being friendly and approachable, smiling, helping out with 'no fuss', really do make the difference.

Included below are some recent examples of feedback sent to staff:

"Thank you for being so friendly and approachable but also pushing us to be the best we can be. We have loved having you join the ward family and we're grateful to know you will always be there if we need you. We want you to know how much we appreciate you."

"Thank you for the warm welcome following my operation. It was greatly received and quickly put me at ease."

The work is progressing to inform our approaches to leadership development and creating a culture where compassion and civility play a key part.

Big Conversations

Following on from the previous years' successes, the Big Conversations took place for a third year.

Keeping the appreciative tone of the previous years' style of questioning, we again focused on a small number of specific areas for improvement. Working collaboratively with teams across the Trust we visited departments and wards, giving staff the opportunity to share good practice and specifically, what works well.

Nearly 700 staff participated in the conversations focusing on the following areas:

- Equality and Diversity:
  ensuring a 'just' culture through a diverse workforce that approaches processes, particularly career progression, in a fair manner

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- Feeling Safe to Speak Up:
  understanding how to continue supporting staff in feeling safe to speak up and what a 'safe' route looks and feels like
- Staff Wellbeing:
  understanding how best to support staff with their wellbeing; be it accessibility or determining what is actually needed, whilst also continuing our focus on supporting stress
- Quality of Care:
  understanding the ability to give good care. With a particular focus on resourcing (people and physical)

The focus areas are determined through the National Staff Survey data, and include areas that require improvement or areas where we want to continue to improve.

Three of the four of these areas of focus, when grouped together as a theme, sit above the national average in the 2018 National Staff Survey.

Freedom to Speak Up Guardian

Following the publication of Sir Robert Francis's recommendations in the Freedom to Speak Up Review in 2015, the NHS contract 2016/2017 specified that NHS Trusts should appoint a nominated Freedom to Speak Up Guardian (F2SUG) by 1 October 2016.

The purpose of the F2SUG role is to work alongside the leadership team to support a more open and transparent place to work, where all colleagues are actively encouraged and enabled to speak up safely. The Trust has now appointed four F2SUGs who continue working across all staff groups to raise awareness and report directly to the chief executive and Trust Board.

Our Guardian Team

Our F2SUGs have varying experience and professional backgrounds, each operates independently, impartially and objectively to support all staff within our organisation to raise any genuine concerns they may have. Our diverse team work one day a week as a guardian and the rest of the week in other roles in the Trust. .

Accessibility

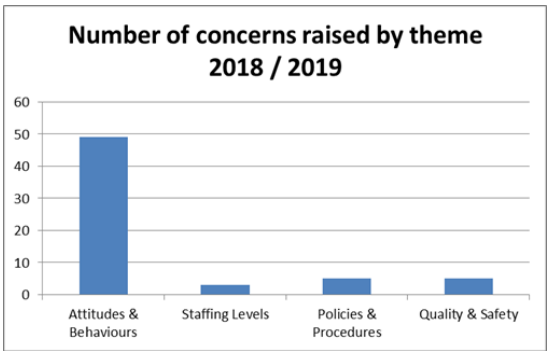
The F2SUG Team have been allocated a dedicated space which allows staff the opportunity to share their concerns in a safe space. In addition to this there are a number of different methods allowing staff to make contact with the Guardian team, including:

- Drop-in to the office or a pre-arranged meeting
- Telephone, with voicemail facility
- Email
- Staffnet page – this option allows for staff to record a concern anonymously or to leave their contact details

All concerns raised are confidential.

Concerns Raised

During 2018/19, 62 concerns were received by the F2SUG Team, an average of 16 concerns per quarter, which is an additional 3 per month from 2017/18. This indicates that more staff are aware of the role and feel confident in raising their concerns to the team.



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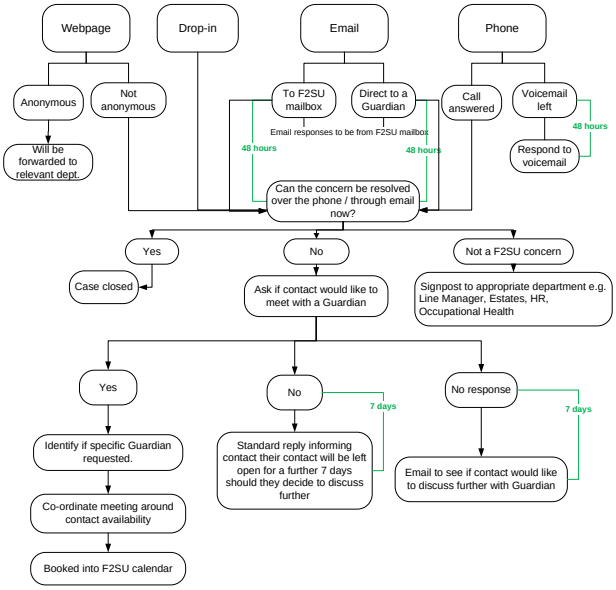
Response Times

The team has a clear process for how quickly it respond when somebody wishes to share their concern with us.

We want to ensure access to the F2SUG Team is equitable and responsive, and this is something we are able to measure.



If an **immediate** threat to patient / staff safety identified this will receive a response the same working day

The Guardian team are available to support you with your concerns Monday – Thursday 8:30 – 16:30, with ad-hoc cover available on a Friday.

Please note for concerns received outside of the core Guardian hours the initial response time, of 48 hours, will start from the next working day

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. The size of the financial challenge remains considerable and 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 effort has been made to reduce 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 high level 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 impact of the loss of the nursing bursary.

3 Progress against 2018/19 priorities

During 2018/19 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 continue 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: Working with other providers to ensure patients are treated in the right place at the right time
- Priority 3: Reduce the number of patients who suffer harm while under our 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 have continued our work to consider 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.

Nursing and midwifery staffing levels are monitored and reported monthly via NHS Choices and the Trust website. This information will continue to be submitted and inform our nursing dashboards and shared with matrons and senior nurses. Staffing reports are produced and presented at our Nursing and Midwifery Operational Committee with key performance indicators included from our ward dashboards and model hospital data.

We publish our staffing levels for each shift on a patient and visitor information board at the entrance to our wards and a poster in each bay stating the name of the nurse responsible for each patient's care and the nurse in charge of each shift. The information displayed also includes information on key quality metrics such as falls, infection rates and pressure ulcer incidents as well as Friends and Family Test scores and comments. This helps to demonstrate transparency in terms of the relationship between the care and experience our patients receive.

Ward dashboards are available monthly for each ward to review the quality metrics against workforce measures. The dashboards are RAG rated (red, amber and green), and cover the domains of the CQC assessments of Safe, Well Led and Effective Care.

The E-rostering system which interfaces with our Safe Care System continues to enable us to effectively redeploy nursing hours across the adult wards in the hospital. Patient acuity and dependency scores are recorded in real time. This ensures we accurately match staffing levels to the needs of the patients in our care. This is calculated in the form of Care Hours per Patient Day (CHPPD) and helps to inform the decision making when moving staff from one ward to another.

A new approach to daily staffing meetings has been adopted within the adult inpatient areas. Matrons for medicine and surgery care groups meet separately to oversee their own staffing needs, helping to reduce the number of cross care group redeployments whilst still supporting the organisation in balancing staffing risk.

3 Progress against 2018/19 priorities

Daily safety brief sessions introduced in 2017, in our admission areas, are now in place across the Trust. These sessions provide an opportunity for staff to be aware of times when we have not provided patients with the best care and also to celebrate and learn from those occasions when we get it right.

Within maternity an adaptation of the Trust's safe care acuity tool has been developed for the central delivery suite (CDS).

The Neonatal Unit staffing model is delivered using standards from the British Association of Perinatal Medicine (BAPM), which defines care levels and staffing requirements.

Within paediatrics a care level assessment is used to measure acuity of each patient which is mapped against the establishment. This gives an overview of the CHPPD. There is a new tool for acuity developed by the Shelford Group for Paediatrics. This will be implemented over the coming months.

We actively continue to train band 3 staff into band 4 assistant practitioner (AP) and nursing associate (NA) roles as part of developing our workforce. The first NA cohort successfully qualified in January 2019 and these members of staff are now on the NMC register and are in substantive positions across the organisation. Three of the NAs have commenced the Nurse Degree Apprenticeship course; as have four APs.

The Degree Nurse Apprenticeship programme started at the University of Plymouth in September 2018. These posts will be funded by the Trust for 18 months to 2 years and on qualifying the individuals will work as Band 5 registered nurses.

Levy funded apprenticeships started in 2017 for nursing associates, assistant practitioners and degree nurses. A recent OFSTED monitoring visit relating to the Healthcare Support Worker level 2 apprenticeship programme was undertaken in February 2019. The findings report "reasonable progress" across all 3 themes reviewed, indicating a high level of quality of training is being delivered. Apprentices have learning placements in various services within the trust, including paediatrics.

The hospital website nursing and midwifery pages, launched in 2017/18, continues to be published. The website is 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.

What we need to work on

An annual nurse staffing establishment review was undertaken in October 2018 and an assurance report was published in March 2019. Both recorded occasions when although the wards are suitably established, due to the number of vacancies across the Trust and the high bed occupancy rate they are not necessarily staffed to the required demand. Bed occupancy does exceed 100% during periods of high demand.

The trend in CHPPD data over the past 6 months for both registered nurses and care support workers has seen a narrowly fluctuating picture with only a slight downturn overall during 2018/19. The overall monthly fill rate ranges from 83.6% to 89% (Sept 18 to Feb 19). We continue to be supported by bank and agency staff and a recent incentive scheme has helped to maintain a degree of stability during the winter period.

Nurse vacancies remain a challenge and recruitment continues to be a priority with a greater focus on our retention strategies; including international recruitment. We already provide a high quality 12 month preceptorship programme and in partnership with our military partners, are developing a pilot for an 18 months rotation offer to band 5 nurses. In addition we continue to work with our wider STP regional programmes to address nursing shortages.

Next steps

We recognise the importance of ensuring that we have the right staff, in the right place and at the right time. 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 which includes:

3 Progress against 2018/19 priorities

- Undertaking a review of rostering practices
- Developing the preceptees rotation plan
- Engaging with the Strategic Transformation Plan (STP) in relation to a rolling programme of recruitment in India, United Arab Emirates and the Philippines. There is an ambition to recruit 70 registered nurses, with the first 20 expected to start with us by the end of 2019
- Continued development of the nursing associate role, which has been designed to bridge the gap between our healthcare assistant workforce and registered nurses. This is a stand alone role which will also provide a progression route into graduate level nursing

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

Background

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.

What we did well

We have much to be proud of in the quality of care that we give to our patients. We continue to perform well in many areas but face a significant challenge in providing responsive services and improving our performance against a number of key national standards.

Both University Hospitals Plymouth and our community partner, Livewell Southwest, have joined the national NHS Improvement Lean Transformation Programme which is branded locally as 'People First'.

People First is a cultural change programme with people and improvement at its heart. It brings people together in small groups called 'huddles' to define and solve problems and make improvements, big and small.

Visual Metrics and Plans

Our staff are using visual metrics and plans as a mechanism to track improvements. An example of which is the new Weekly Improvement of Safety Huddle (WISH) led by our Head of Quality Governance, which brings together some of the important safety topics to ensure we learn weekly and apply learning to improve care.

Building Improvement from the Frontline

A growing number of areas now have direct practice support from the People First team. The team have been working with Monkswell Ward who now hold a daily multi-disciplinary team improvement huddle including plans to improve care.

3 Progress against 2018/19 priorities

Another example is the great work being done on shared handover 'clinician patient list' and ward-based prescribing on respiratory wards from their weekly huddle. Pharmacy and the ward team have been working together to understand patient waits for medications and test some solutions. Both topics will make a big impact on patient care, flow and how we work together.

We continued to improve the process for referring complex discharge patients and for reviewing patients care requirements post-discharge.

Next steps

We have further developed our improvement strategy and associated programmes into a main workstream 'Peoplefirst'.

Our recent CQC inspection highlighted that we still have significant challenges in providing responsive services, but also highlighted significant concerns across Imaging and Pharmacy.

- In 2019 we will move into our first full year of our 'People First Improvement Practice, our quality improvement programme working with NHSI as part of the national Lean Transformation Programme.
- The Trust's quality improvement plan is focused on addressing the risks associated with operational pressures, safe staffing and medicines management.
- The Trust continues to make good progress in meeting national 7 day service standards.
- The Trust is proactively engaging in other national quality priorities such as learning from deaths, infection control and national early warning scores.
- Our existing Quality Impact Assessment process is being replaced with a new Quality Equality Impact Assessment (QEIA) process and we have an ongoing piece of work to further develop this approach

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

Background

We take patient safety as a key priority in the hospital setting and our aim is to keep patients safe and avoid increasing their length of stay.

There are some key incidents which can occur during a patient's admission to hospital such as falls and pressure ulcers. Having knowledge of this allows us to apply our best practice efforts to reduce the incidence of harm.

In addition infection can lead to a more serious condition called sepsis which can make the patient very unwell and in rare cases lead to death. We will continue to implement systematic screening and treatment for these patients.

What we did well

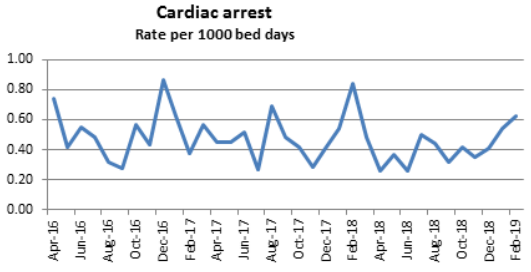
Sepsis

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.

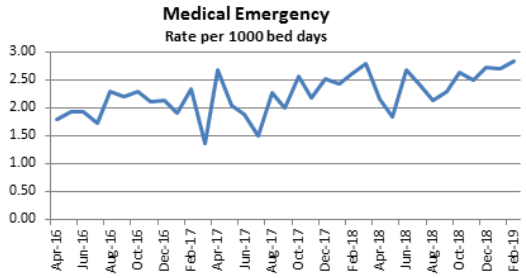
Over the last 12 months it has become increasingly apparent that our focus in acute admission areas needs to continue on ensuring effective care delivery when the system is hard pressed.

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.



3 Progress against 2018/19 priorities



We have a policy that sets out the minimum standards for patient observations and monitoring, which we regularly audit. We have implemented NEWS2 as our escalation tool, in-line with national guidance.

Scan4Safety

In January 2016, the Department of Health announced that University Hospitals Plymouth 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 new global standards for traceability, known as GS1 standards.

How are GS1 standards making a difference in Plymouth?

Using barcodes will lead to safer patient care and improved processes. By providing our patients with barcoded identity wristbands, which are then scanned along with any products linked to their care we are able to accurately track all elements of a patient's care in a more efficient way, saving time and reducing errors. These include product recall, catalogue management and paying suppliers electronically.

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

- Location Coding (Place) - defined by a Global Location Number (GLN) being assigned to all locations across the Trust both physically and in the electronic property management system is now complete.
- 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 and is now complete
- 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 – ongoing

The Trust continued with its implementation of Scan4Safety. All hospital areas are now identified using barcodes.

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.

A barcode has now been added to the existing identity wristbands which then enable it to positively identify a patient within systems that have been enabled to electronically capture patient details. In no way is patient confidentiality compromised.

Next steps

- Scan4Safety: continues to work on implementation of plans to use standards created for Product, Patient & Place (location) within new systems. We are working with clinical staff to ensure every inpatient area complies with 100% printed patient identity band on admission
- Build on 2018 achievements in the management of sepsis and improve the reliability of our data collection
- Further reduction of pressure ulcers and falls by 20%

4 Celebrating our successes

Whilst we faced a number of key challenges in 2018/19 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.

Cancer services

University Hospitals Plymouth NHS Trust continues to work across all areas to ensure the best quality, timely and efficient care and treatment in line with local need and national guidance. Throughout the last 12 months there have been a number of key improvements within cancer services including:

- Implementation of the new lung pathway in 2018, which has demonstrated a reduction in length of wait from referral to diagnosis and improved patient experience for those with lung cancer
- Continued improvement of our National Cancer Patient Experience Survey results
- Successful implementation of the recovery package in line with national taskforce objectives for 2018/19 such as holistic needs assessment and health and wellbeing events
- Working with St Mark and St John University we have implemented exercise programmes for patients preoperatively and pre radiotherapy
- Implementation of a new triage pathway, by our Oncology Advanced Clinical Practitioner, to support patients contacting the hospital out of hours and keep patients dealing with cancer safe and reduce emergency admissions.

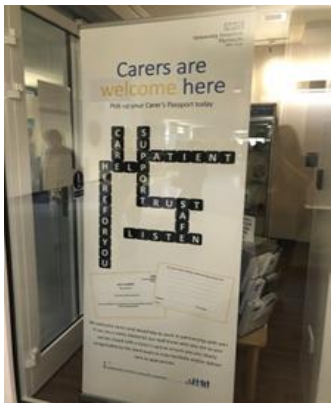
The Mustard Tree Cancer Support Service was also awarded national recognition for its outreach cancer care service to the prison service.

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

At University Hospitals Plymouth NHS Trust we recognise the important role carers have 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 hospital setting. We have been working hard to identify, involve and support carers in hospital in order to get the care of the patient right.

We promote the patient carer relationship; ensuring the carer is able to continue in the caring role to improve patients wellbeing. 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.



Caring for Carers Plymouth Service

In liaison with Plymouth Caring for Carers, a member of their team works closely with our Integrated Hospital Discharge Team attending discussions which identify patients who are due for discharge. Patients who have a carer are identified to ensure appropriate support is in place and that they have access to information and guidance as required.

In addition, we are working with the Defence Medical Welfare Service (DMWS). A liaison officer is available on site to visit our militay veteran patients and their carers five days per week. Working with Caring for Carers Plymouth staff they ensure early identification, signposting and appropriate support is available for our veterans.

4 Celebrating our successes

Carers Card

The Carers Card has been developed to distinguish and identify informal carers on the ward. Once a carer is identified and their role agreed, the ward sister will issue a Carers Card to ensure they are clearly recognisable by the ward team.

Meal Vouchers

Ward staff can provide meal vouchers for informal carers who are contributing to the delivery of care whilst in hospital.

Parking Arrangements

Free car parking is available for informal carers who have agreed to contribute to the care of the patient (cared for person) during their hospital stay.

Our Patient Council is committed to the overall improvement of carer support whilst in hospital and as such have included this within their Patient Council Strategy and annual work plan.

Children's Services

The children's wards continue to improve the environment for children and young people with the donation of a bubble machine to entertain the children whilst they wait for treatment or assessment on the Children's Assessment Unit.

We are privileged to have been given a vein viewer which aids medical staff in identifying suitable veins for cannulation. This means children are treated quickly and accurately.

Welcome Bags have been introduced for all new patients on the wards. The bag contains a parent information leaflet, age appropriate reading materials, activity books, a small toy for young children and some mindfulness information for our older children. The trial has been well received and will now be rolled out to all paediatric wards.

The Children's Community Nursing Team have also been working with our clinical commissioning group (CCG) to promote Personal Health Budgets for eligible families so they can have a more responsive care service at home for their children. These are children who require either 24 hour or overnight care due to complex health needs.

Our paediatric consultant team are providing electronic advice and guidance to GPs which helps to ensure referrals are timely and appropriate. GPs can now contact a paediatrician with a query or a request for guidance on how to manage a paediatric condition. Appropriate referrals to the hospital can be facilitated, or guidance given to prevent unnecessary referrals and manage the condition in the community.

A huge number of our staff were nominated and received Paediatric Awards for Training Achievements (PAFTA), which are awarded by the Royal College of Paediatrics and Child Health (Devon and Cornwall). These awards provide a welcome opportunity to reward those who work tirelessly to improve the care of children and are a fabulous boost to morale:

Defence Medical Welfare Service (DMWS)

DMWS is an independent charity providing practical and emotional support to the armed forces community when they receive medical treatment.

Any hospital treatment whether planned or unplanned can be stressful and brings 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 military family goes through the worry of

4 Celebrating our successes

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.

The DMWS have specialist knowledge, rooted in operational experience, which means the welfare officers have a deep understanding of working with Armed Forces personnel, veterans and their families.

Since May 2018, they have supported around 70 patients admitted to Derriford Hospital and the Royal Devon and Exeter Hospital and 60 additional family members from the armed forces community that have benefited from support in hospital and at home.

The team is working closely with the Veterans Mental Health (TIL) Service to refer patients who are showing signs or symptoms of post traumatic stress disorder (PTSD), which has resulted in faster diagnoses and support.

By working closely with volunteering projects in the community, DMWS have reduced the amount of alcohol related injuries through engaging patients in volunteering projects to reframe the mind and in turn reduce boredom, isolation and depression.

Bereavement support is also in place for patients or family members, DMWS have been able to secure funding for funeral costs and referred patients onto further support groups during an upsetting time filled with grief, anger, depression.

Dementia friendly award

University Hospitals Plymouth NHS Trust is 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 an accreditation scheme for dementia friendly wards and departments including a range of ways in which to make care in hospital more person-centred and help improve the environment. This year we have awarded dementia accreditation to seven departments.

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.

We are also is involved with the National Audit of Dementia Care in Hospital programme and 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.

Emergency Department - Resuscitation Unit

In early March building work began to improve the resuscitation unit within our Emergency Department. The work doubled the size of the resuscitation unit, increasing it from four to seven resus bays. This forms part of a £2m upgrade to the existing Emergency Department announced in September last year.

4 Celebrating our successes

#EndPJparalsis

From 17 April 2018 onwards, we took part in a 70 day national campaign, led by Professor Brian Dolan, to get one million patients dressed in their own clothes and up and moving.

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

We asked 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

The campaign was a huge success and we managed to achieve a remarkable 14,948 patients up, dressed and mobile during the 70-day challenge. Going forward, we remain committed to ensuring patients maintain independence as we know this reduces the risks associated with deconditioning and the need for ongoing or long-term care outside of the hospital.

Making Every Experience Excellent

Following review of the 2017 National Inpatient Survey results we decided to focus attention on three core areas where there had been a negative shift of 5% or more:

- I was bothered by noise at night by hospital staff
- My discharge from hospital was delayed for more than 2 hours
- During my hospital stay I was asked to give my views on the quality of care

In addition, patients scored us below the average when compared to other Trusts, in relation to discharge from hospital and information given to patients on discharge, for 14 of the 15 related questions. We decided that these concerns should become the focus for improvement across the Trust and the Making Every Experience Excellent – Let's Talk About MEEE campaign was launched @MeeeUhp.

The purpose of the campaign was to actively listen to our staff and patients and act on their ideas for improvement. This would mirror the methodology and learning from the 'Big Conversation' staff engagement sessions used by our Learning and Organisational Development Team.

Groups of staff and patient volunteers conducted the MEEE face to face survey 21 to 25 January 2019. People wore bright green t-shirts and armed with their tea trollies visited every inpatient area to ask three simple questions. The survey collected 284 feedback forms which held in excess of 850 streams of intelligence from which a review was compiled.

Following the thematic review of the data from both staff and patients several similarities emerged which would make overall experience better, more efficient and safer for patients, visitors and staff.

Whilst the MEEE survey did not reveal any new areas for improvement, it did show the similarities in ideas which operational staff and patients share to improve our services and conditions. Staff and patients recognised areas where significant improvements could be made to improve inpatient conditions, particularly overnight and to the discharge process.

4 Celebrating our successes

We have been working to implement a number of improvements:

- Information banners are now on display across the hospital, which detail the findings of each project and maintain momentum
- Patients sleep at night is moving forward. The Trust has agreed to fund sleep packs for patients which will include eye masks and ear plugs. The packs will be tested shortly on Torcross and respiratory wards
- A wider sleep group has been established to support the roll out, look at good work in other organisations that we could replicate and start working on a patient and staff charter to promote behaviours and conditions to allow for a peaceful night's sleep
- Discharge working group established and a discharge leaflet for patients is being trialled on Bickleigh Ward
- Patient Experience Ambassadors (PEAs) have been identified in each service line and from our Patient Council to champion improvements and share good practice
- Patient Experience Ambassador enamel pin badges will be available shortly for staff to wear with pride

Learning Disabilities Team

We believe people with learning disabilities (LD) have an equal right to healthcare. It is important to provide services and staff which enable people with learning disabilities to use our services. Through the Derriford User Group (DUG) we aim to provide those with learning disabilities a greater say on improving the patient experience in an acute care setting.

Hospital Passport

The Learning Disability Liaison Team together with our Independent Learning Disability Advocate hosted three focus groups around Plymouth to gather feedback on the new hospital passport add on pages. The hospital passport is a document that holds vital information about the person that is useful for staff to read when they come into hospital. Examples of the hospital passport can be found in the learning disability section of the Trust website.

Self-advocates from Pluss Plymouth reviewed a draft passport for patients with epilepsy, Yourway Support looked at a passport for people with Autism and The Regard Partnership surveyed a passport for people with mental health issues.

Feedback is vital to ensure we use terminology that patients with a learning disability can understand. A few simple suggestions and changes can make one document so much more accessible.

In addition the new passport will be shared throughout the community by our colleagues in the Community Learning Disability Team .

Annual Champion and DUG Awards

Another exciting Champions and DUG annual event was held in November 2018, attended by members of the Derriford User Group (DUG) and the Learning Disability Link Practitioners.

The event was organised to provide an opportunity to say thank you to hospital staff, wards and

4 Celebrating our successes

departments who have provided an exemplary service for patients with a learning disability, or specifically to an individual who has made a significant contribution to their care.

DUG members themselves were also given special 'thank you' awards for their excellent work during 2018.

Celebrating 100 years of Learning Disabilities

In February 2019 the Learning Disabilities Liaison Team celebrated 100 years of learning disability nursing by hosting a stand outside the Goodness at Greens restaurant, level 7, Derriford Hospital to share information about the work the team do in hospital and the wider range of other roles they have in the community.

Making mealtimes matter

The hospital embarked on the annual Making Mealtimes Matter (MMM) campaign to coincide with the national Nutrition & Hydration Week 11 - 17 March, which aims to raise awareness of the importance of nutrition to aid patients' recovery.

This year, the campaign ran alongside the work to implement the new International Dysphagia Diet Standardisation Initiative (IDDSI) regulations. The IDDSI have published international standardised terminology and definitions for texture modified foods and thickened liquids for people with dysphagia. The framework consists of a continuum of eight levels (0-7) and includes descriptors, testing methods and evidence for both liquid thickness and food texture levels. The MMM campaign was a timely opportunity to highlight the work to implement the new regulations.

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 nutrition & hydration to patients' recovery. The Speech & Language team were on hand to raise the profile of the care of patients with dysphagia, discuss the new regulations and the provision of modified texture food and fluids. The campaign was generously supported by a number of our local suppliers and retailers in order to illustrate our partnership working. The event was a huge success, even busier than in previous years and the feedback was extremely positive.

All wards were invited to join in with the fun and important messages of the week starting on the Monday with an invite to all ward managers to lead out the lunch trolley. Throughout the week, ward staff were encouraged to use the trust social media to post photos of their meal service, nominate members of the team who went the extra mile to ensure a positive patient meal experience and generally ensure the message of the week was widely shared. During the week, manual handling visited wards to raise awareness for the correct sitting position at mealtimes and providing guidance around the correct use of hoist scales. Once again both our student nurses, staff and mealtime volunteers provided sterling support to the initiative.

The MMM campaign was well supported by our suppliers and retail partners. A generous donation of clotted cream enabled our patients to enjoy a Devonshire cream tea on Global Tea Party afternoon, an annual event in the nutrition and hydration calendar. Likewise, another supplier kindly donated bottled water to support the campaign to highlight the importance to patients of keeping hydrated to aid recovery from illness and treatment.

The hydration theme was also extended to staff with the provision of a tea trolley round to all wards on the Thursday, highlighting the importance of hydration in maintaining good health and supporting our staff who really seemed to value this opportunity to have a breather and a cup of tea made just for them to enjoy.

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To complete the week, several prizes, some donated by one of our retail partners, were awarded, categories included best team mealtime selfie, individual award for the person who goes the extra mile to help with the patient meal service and ward of the week based on our data (Friends & Family, Nutrition audit and PLACE).

This year's campaign was a huge success which very clearly illustrated the trust's commitment to strive for excellence in this area and also our staff's commitment to embrace wholeheartedly opportunities improve patient care and the overall patient experience through their resounding participation in what proved to be a joyful week. This serves as a huge motivator to continue identifying and pressing for improvements through the continued work of our Nutritional Steering Group.

Maternity Services

Argyll Ward Champions

Midwifery Ward Champions have commenced on Argyll Ward. This is a developmental band 6 position for midwives and will ensure the antenatal and postnatal area is staffed with a senior midwife to lead each shift. The Champions will offer a long term commitment to improving care and facilitate learning on the ward. The focus is very much centred on the principles of continuity of carer, to ensure sufficient numbers of midwifery champions are available in key areas to maintain high standards by cascading skills and good practice.

Professional Midwifery Advocacy (PMA)

The A-Equip model (Advocating for Education and Quality Improvement), supports a continuous improvement process that aims to build personal and professional resilience of midwives, enhance quality of care for women and babies and support preparation for appraisal and professional revalidation. Alongside these components is the important element Restorative Clinical Supervision, which has been shown to have a positive impact on the immediate wellbeing of staff, influence a significant reduction in stress, and help staff feel 'valued 'by their employers for investing in them and their wellbeing.

Our midwives are offered restorative clinical supervision either on a one to one basis or as part of a group session. Feedback has been good and there is an appreciation of the benefits of staff having time to share and understand each other's job roles, impacting positively on patient care and job satisfaction.

Plymouth currently has four trained PMAs and one midwife currently undergoing the PMA course at Plymouth University. They represent University Hospital Plymouth NHS Trust at national and regional events.

Plymouth Obstetric Anal Sphincter Injury (OASI) Project

The implementation of the OASI project has had a consistent positive impact upon the women for whom we provide care. An audit of OASI rate completed in December 2018 demonstrated Plymouth has a low OASI rate compared to national figures and local figures have also reduced.

The introduction of OASI patient information leaflets and education tools for midwives and obstetricians will continue to improve care and reduce the number of women who experience this type of trauma.

Midwifery and obstetric training relating to the use of and evidence base for episcissors has been incorporated as part of the mandatory training schedule. The addition of a weekly postnatal perineal clinic launched in November 2018 supports the on-going work for all women sustaining perineal trauma or postnatal complications not exclusive to those sustaining OASI.

Better Births

The report of the National Maternity Review set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving.

4 Celebrating our successes

At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth. This continuity of care and relationship has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience; and was the single biggest request of women of their services that was heard during the review.

We are due to commence our plans to support all women booking onto a pathway to receive Continuity of Care on 24 June 2019.

We have appointed some specialist midwifery posts. A midwifery led care Implementation Lead Midwife was appointed to lead on all aspects of the maternity agenda supporting the matrons and the Director of Midwifery with the implementation of the relevant aspects of "Better Births", as mentioned above.

An Infant Feeding Lead who will work within the maternity service to promote excellence in the provision of infant feeding advice and support. In addition to working directly with patients, staff and volunteers, they will work at a strategic level to ensure that the UNICEF UK Baby Friendly Initiative standards are successfully implemented and our commitment to the Plymouth City Council's Breastfeeding Strategy remains high on our public health agenda.

Finally, a Specialist Mental Health Midwife was appointed who will act as the link professional between maternity services and other services involved in mental health care, provide additional support to women with severe mental health problems and act as a point of contact for health professionals involved in the care of women who are pregnant or have recently given birth.

Snowdrop Launch

February saw the launch of the plans for the Snowdrop Suite. Doctors, midwives and families who have used the current bereavement suite were able to view the new plans. Families were able to have their say on the colours, layout, design, signage and furniture that will all go some way to providing a homely environment for women and their families whilst in the Snowdrop Suite. Families also articulated how we could improve the care to them whilst experiencing bereavement.

Neonatal Services

ATAIN

ATAIN (avoiding term admissions into neonatal units) is a programme of work led by clinical experts to reduce harm leading to avoidable admission to a Neonatal Unit for infants born at 37 weeks or more. This project was led by NHS England due to increased numbers of term babies being separated from their mothers at birth and resulted in a patient safety alert. We have worked with maternity teams to achieve below the 6% target ensuring babies are not separated from their mothers.

Kaiser Permanente Early Onset Sepsis Calculator

Our Neonatal Intensive Care Unit (NICU) subscribed to antimicrobial stewardship which hoped to reduce the number of new-born babies receiving antibiotics in hospital. After liaising with NHS England we received permission to deviate from NICE guidelines, and demonstrated that we could reduce antibiotic administration to new-born babies by 80%. This resulted in a change in practice and guidelines. NICU implemented the Kaiser

4 Celebrating our successes

Permanente Early Onset Sepsis Calculator and developed an 'EOS sticker' which is included in the patient's notes.

vCreate

It is recognised that one the highest moments of stress for parents are when they are not with their baby which is what happens when their baby is admitted to NICU. vCreate is a free secure video messaging service that allows NICU staff to keep families up to date with their babies progress when they are away from the unit. Parents can share the videos with family and friends which supports the involvement of family and siblings to ensure wellbeing and support attachment with their sick new-born baby.

PReCePT

NICU hosts the specialist neonatal service for Devon and Cornwall, caring for the most preterm and sick new-born babies. NHS Improvement implemented a project to administer magnesium sulphate to mothers at risk of delivering extreme preterm babies to reduce the incidence of cerebral palsy. NICU in collaboration with maternity services have achieved 100% compliance which is evidenced on a national database.

Enhanced Neonatal Nurse Practitioners (ENNP)

We established a partnership with the University of Plymouth to deliver advanced practice neonatal nursing including Enhanced Neonatal Nurse Practitioners (ENNP) and Advanced NNP (ANNP). The first cohort of ENNPs qualified in September 2018 and has had a positive impact on the service enhancing the assessment of sick and preterm new-born babies. The partnership will ensure succession planning for our neonatal services and has attracted candidates from all over the country.

Neonatal Transitional Care

In 2018, NHS England requested all hospitals in England demonstrate they had an established Neonatal Transitional Care as part of the Clinical Negligence Scheme for Trust (CNST). University Hospital Plymouth NHS Trust achieved all 10 required actions, thereby securing funding to develop services. We continue to attract other health professionals from all over the world and are seen as an exemplar for excellent service 'keeping right baby in the right cot at the right time'.

Patient Experience National Network Awards (PENNA) 2018

At the end of January 2019 the Trust submitted six applications to the Patient Experience National Network Awards (PENNA). In February 2019 we were very pleased to discover that all six applications had been shortlisted.

4 Celebrating our successes

We had even more to celebrate when we won one and was runner up two further categories.

Winners
PENNA Category: Patient Experience Transformer of the Year

Runner up
SALUS Patient Care Manager
PENNA Category: Innovative Use of Technology, Social and Digital Media

Caring for Those who Serve
PENNA Category: Partnership Working to Improve the Experience

Shortlisted
vCreate
PENNA Category: Communicating Effectively with Patients and Families category

Mealtime Staff Volunteers
PENNA Category: Staff Engagement and Improving Staff Experience

ACEMobile App
PENNA Category: Using Insight for Improvement – Staff Feedback

Safeguarding

Our safeguarding service continued to improve and evolve in 2018/19 and a think family approach is promoted within the Trust. The new Physical Interventions Team is now part of the safeguarding team and plans are in place to grow this service to support staff and patients. This service aims to increase availability of conflict resolution and physical interventions support. Training for all staff is increasing to meet the need to offer reliable and adequate support for staff under pressure from physical and verbal patient challenge.

Safeguarding training is revised annually and 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 safeguarding children level 3 training. Safeguarding Adult and Children level 1 and 2 training complies with the skills for health and intercollegiate document recommendations, plans are developing to offer safeguarding adult level 3 training.

The process for referral into the safeguarding team continues to be revised and improved to ensure it is evolving with service need. Further simplification of referral processes are in development. The team is available to offer support and advice Monday-Friday 08:30 – 16.30 and is based within the hospital alongside multi-agency partners to ensure children and adults at risk are safe.

Revision of referral processes and further training in implementation of DoLS (deprivation of liberties) have resulted in continued increase in both safeguarding adult at risk and DoLS applications to the local authority.

This year has seen the implementation of the Child Protection - Information Sharing project (CP-IS), which enables health and social care staff to share information securely to protect the most vulnerable children. The CP-IS project links IT systems used across health and social care to help organisations share information securely.

The safeguarding team continues to support our staff and collate information to identify themes and trends. It works closely with colleagues from other agencies, including Local Safeguarding Adult and Children's Boards (Partnerships) to ensure compliance with standards.

4 Celebrating our successes

Moving Forward 2019/2020

Our new strategy is based on the five year forward plan and works towards health and social care integration. We also have a new Nursing Midwifery Framework which sets out vision for nursing and midwifery and the principles to support its delivery. We aim to continuously develop ourselves and seek to improve the quality of care and services we deliver.

Carers Booklet

Development of a new Carers Pack will be pivotal in providing additional information about the support we can provide for our carers. This will help to ensure they are treated as equal partners in care delivery for patients.

Maternity Voices

Our Maternity Voices group is being launched in spring 2019 and will provide a forum for staff and women to work together, ensuring that health professionals listen to and take account of the views and experiences of those who use our maternity services.

Better Birth Focus Group

Better Births focus groups are held once a quarter. The first group met in January and gave an overview of the local maternity system and work stream priorities, including new ways of working to provide a service that meets the Continuity of Care agenda and delivery of recommendations on the Better Births agenda.

Group Antenatal Care

Last year a number of women opted to receive their antenatal care in a group setting, giving vital space and time for women to form relationships with others who were at a similar point in their pregnancy. As well as receiving the antenatal check, each session provides plenty of time to find out about how to keep well during pregnancy and prepare for childbirth and parenthood. There was also time for women to meet with their midwife individually to answer any personal questions or concerns. Following evaluation of the pilot we hope to adopt a similar model for all women.

Facebook launch

This spring sees the launch of Derriford's Maternity Services Facebook page. We aim to be able to share news and information to women and their families.

Support at mealtimes project

Our Mealtime Volunteering Campaign provides our non-clinical staff, who do not normally work in patient facing roles, an opportunity to undertake interesting and rewarding duties to support patients a mealtimes,. We aim to continue the project with the aim of developing the role further to actively include carers and relatives at mealtimes.

A member of the PALS team joined the mealtime volunteer project in 2018 and continues to visit Braunton Ward every week to support patient need assistance. The campaign increases social interaction for patients who may not have visitors as well as encouraging them to eat, thereby supporting the patient's wellbeing and recovery.

The feedback from patients has been very positive, and they enjoy speaking to different members of staff and appreciate the extra support at mealtimes.

5 Our Plans for 2019/20

In order to deliver our improvement priorities we must be an organisation which embraces continuous improvement and is fully committed to greater staff and patient 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:

- Put patients first
- Take ownership
- Respect others
- Be 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.

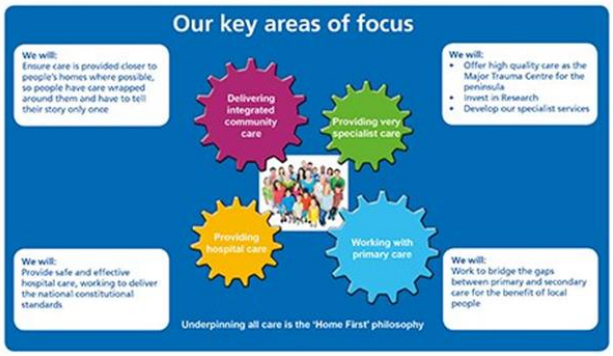
As defined within our strategic direction, our key areas of focus will be:

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 2019 we will move into our first full year of our 'People First Improvement Practice'.

University Hospitals Plymouth NHS Trust and Livewell SW were jointly chosen as one of seven NHS organisations to take part in the National Health Service Improvement Service (NHSi) Programme, the aim of which is to create a culture of continuous improvement by empowering staff to develop their own improvement ideas and lead on their own projects.

This programme will continue to 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 aim to:

- Ensure all our staff understand our clear and concise plan that describes our common goal and improvements in the services we will provide over the next three years and their role in it. We have revised our strategy and focus which we will be using to guide us.
- Provide the support and conditions that will enable that to happen at every level in the community and in the hospital – through spread of training and improvement huddles.
- Strive to ensure the patient's voice is integral to all our improvement work, with the establishment of a dedicated group focusing on patient involvement in improvement.

5 Our Plans for 2019/20

- Provide our staff with the skills they require to bring about such change. Training in local team based improvement skills, and coaching of teams.

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 2019 and identified three specific areas on which to focus our attention in 2019/20. These priorities link directly to those set out in our Operational Plan 2019/20.

Priority 1 – Staffing – Maintain safe staffing by ensuring that the right staff, are in the right place, at the right time.

Having the right 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 - Improve Responsiveness - Ensure all patients receive timely, high quality care by working with other providers to ensure care is provided by the right staff in the right place at the right time.

The Trust has recently experienced difficulties with capacity which resulted in cancellations for patients and longer waits for treatment than we would like. We aim to improve performance in a number of areas including:

- Increasing our ability to treat patients quickly in the Emergency Department
- Treatment within 18 weeks
- Cancer treatment in line with national standards
- Reduce the discharge delays from critical care beds to wards
- Reduce patient cancellations
- Reduce waits for diagnostic procedures

We recognise that arrangements for leaving the hospital are just as important and will focus on improving discharge care for those patients with complex care needs to ensure they have a timely safe discharge care which is in line with best practice. This will include a focus on good end of life care which 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.

Priority 3 - Patient communication and information – improve the quality of communication and information provided before, during and after their care

Patients frequently leave hospital uninformed about the details of their hospital stay, limited ability to accurately state their diagnosis and their ongoing management after discharge. We will enable patients to understand key aspects of their care by providing accurate and understandable information enabling them to take greater control, potentially reducing readmission rates and unplanned visits to secondary care, whilst providing safer care and improving patient experience.

5 Our Plans for 2019/20

Carers have an important role in the effective and safe delivery of treatment and care of patients in hospital. It is important to identify, involve and support carers in the clinical setting in order to get the care of the patient right.

We recognise there can be adverse consequences resulting from delays in diagnostic reporting and we will drive forward improvements to eradicate delays.

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

Safety Initiatives

The national Sign up to Safety initiative to help NHS organisations achieve their patient safety aspirations and care for their patients in the safest way possible has now been fully embedded into the organisations safety initiatives.

We will now continue working on our safety initiatives to give patients reassurance and confidence that we are doing all we can to ensure the care they receive will be safe and effective at all times. Our work will continue to be around the following key areas:

- Creating lasting change so that patients, and those who care for them, are free from avoidable harm?
- Creating a safety culture that leads to lasting change? We will continue to focus on how we work together, how we lead, make decisions, how we adjust and adapt and behave every day. We will continue to work towards a balanced approach to safety, creating 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
- Capturing data and learning from incidents and investigations effectively. If we do this we will have a good chance of preventing things from going wrong in the future?
- Learn from what is going well by capturing those moments that make a difference to patients, and the staff that care for them, then share what makes a difference.

Additional detail is described in **Annex G**.

Annex A Quality Metrics

National metrics

Description	2015/16	2016/17	2017/18	2018/19	Target	What this means
Incidence of C-Diff (patients aged 2 years and over)	42^	37	43	30	<34	*Lower is better*
Incidence of MRSA	2	2	3	6	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*
RTT - 52 week wait – at year end	36	89	108	48	20 by Mar 20	*Lower is better*
Maximum time in ED of four hours from arrival to admission, transfer or discharge	85.2%	84.3%	83.8%	81.14%	95%	*Higher % is better*
All cancer two week wait	89.8%	93.2%	92.2%	93.4%	93%	*Higher % is better*
Two week wait for symptomatic breast patients (cancer not initially suspected)	44.5%	77.5%	27.7%	87.1%	93%	*Higher % is better*
31 day (diagnosis to treatment) wait for first treatment: all cancers	96.9%	95.8%	95.7%	95.1%	96%	*Higher % is better*
31 day wait for second or subsequent treatment: surgery	92.9%	90.9%	92.5%	89.1%	94%	*Higher % is better*
31 day wait for second or subsequent treatment: anti-cancer drug treatments	99.6%	99.3%	99.4%	99.7%	98%	*Higher % is better*
31 day wait for second or subsequent treatment: radiotherapy treatments	93.5%	96.7%	87.3%	72.8%	94%	*Higher % is better*
62 day (urgent GP referral to treatment) wait for first treatment: all cancers	81.1%	79.2%	79.3%	73.8%	85%	*Higher % is better*
62 day consultant upgrade wait for first treatment: all cancers	80.8%	78.6%	77.3%	72.0%	85% Local Target	*Higher % is better*
62 day wait for first treatment from consultant screening service referral: all cancers	90.6%	86.9%	86.9%	90.2%	90%	*Higher % is better*
Access to genito-urinary medicine clinics (48 hours)	100%	100%	99.92%	100%	100%	*Higher % is better*
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	3.51%	3.03%	3.24%	2.85%	0.80%	*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	16.1%	15.3%	14.3%	17.1%	5%	*Lower % is better*

Annex A Quality Metrics

Other local metrics

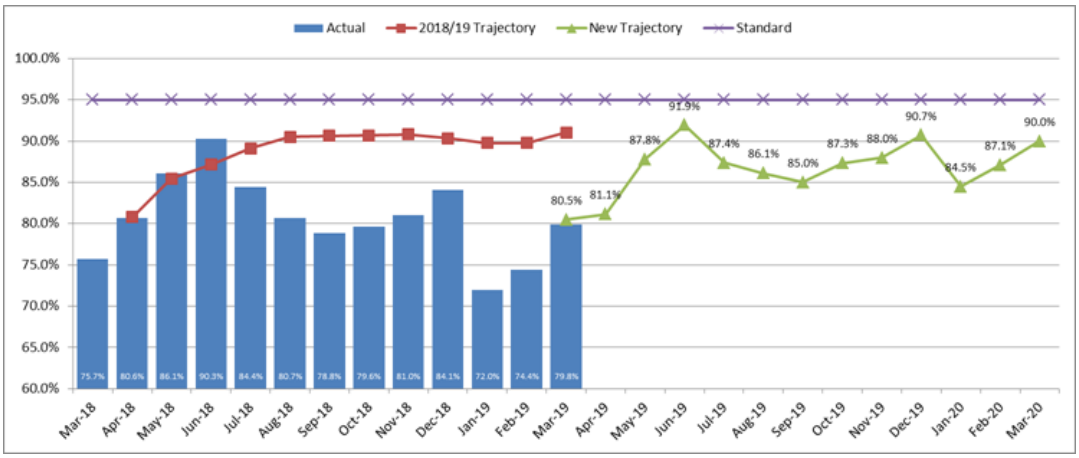
Description	2015/16	2016/17	2017/18	2018/19	Target	What this means
Rate of C-diff per 100,000 bed days (patients aged 2 years and over)	14.3	12.3	14.4	9.37	-	*Lower is better*
Hand hygiene compliance rates	97%	97%	97%	94%	95%	*Higher % is better*
Patient falls resulting in harm or death (moderate harm and above)	36	39	44	36	Reduce by 10%	*Lower is better*
Incident reporting rate – per 100 admissions	11.6	11.1	11.07	12.50	-	*Higher is better*
Percentage of reported patient safety incidents resulting in severe harm or death	0.43%	0.24%	0.31%	0.35%	-	*Lower is better*
Total Number of patient Safety Incidents reported to NRLS (includes No Harm through to Serious Harm & Death)	13,591	13,169	14,936	15,619	-	*Higher is better*
Number of Never events	2	4	3	7	0	*Lower is better*
Number of complaints	646	609	563	709	Reduce by 10%	*Lower is better*
Number of PALS enquiries	4672	4127	4432	4982	-	*Lower is better*
Grade 2, 3 & 4 pressure Ulcers	181	135	174	199	Reduce by 20%	*Lower is better*
% stroke patients spending 90% of their stay on Acute Stroke Unit	72%	74%	73.3%	81%	80%	*Higher is better*
Fractured NOF – delays to surgery < 36hrs	71%	71%	68%	69%	85%	*Higher is better*
Delayed transfers of care	-	-	6.73%	3.41%	3.5%	*Lower is Better*

2019/20 Performance Trajectories

We are mindful of the importance of developing and agreeing robust improvement trajectories for the each our key operational standards. The graphs below detail our improvement trajectories for the coming year, including our performance for the previous year.

Emergency Department 4hr standard

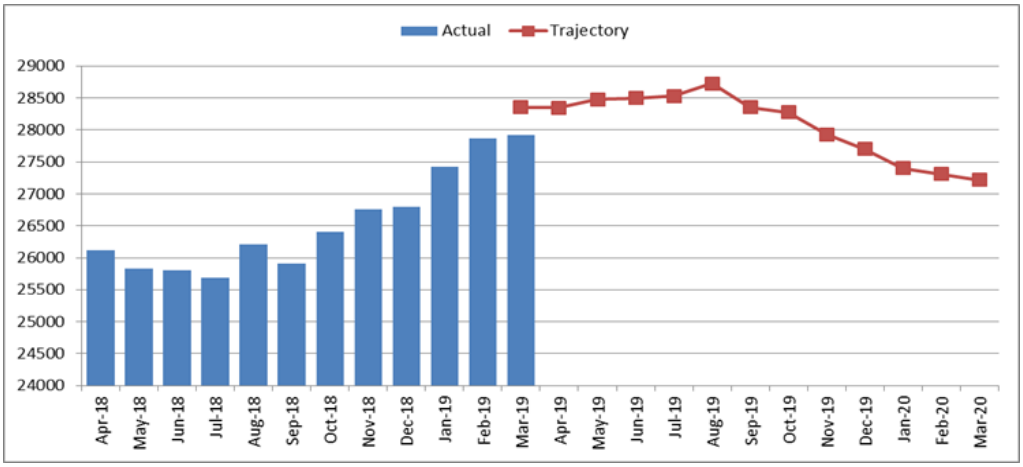
We have developed an initial improvement trajectory for the 4 hour A&E wait standard, shown in the graph below.



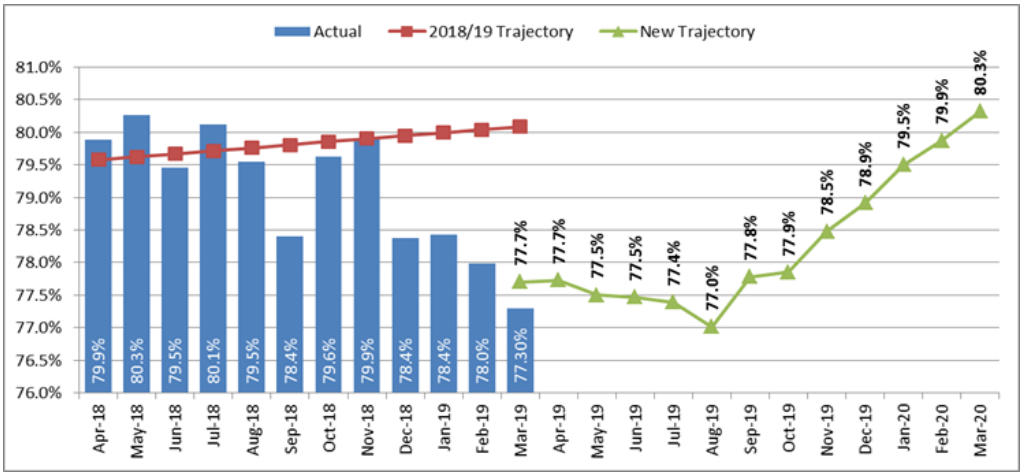
Annex A Quality Metrics

RTT Incomplete Pathways

We are planning to reduce the number of patients waiting longer than 18 weeks for treatment and achieve a standard of 79% by March 2020. Our planned improvement trajectory is shown in the graph below:

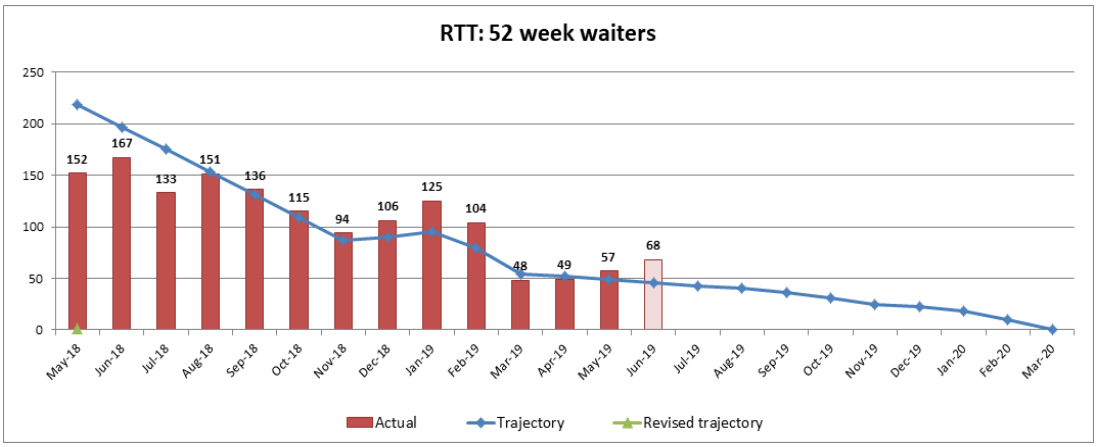


The graph below shows the expected number of incomplete pathways:



52-Week Waits

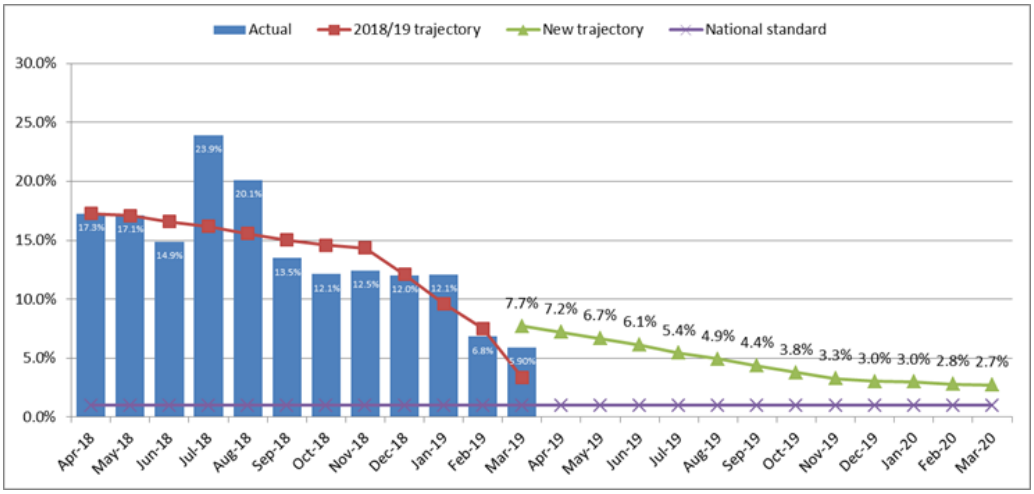
We are also committed to reducing the number of 52 week waits.



Annex A Quality Metrics

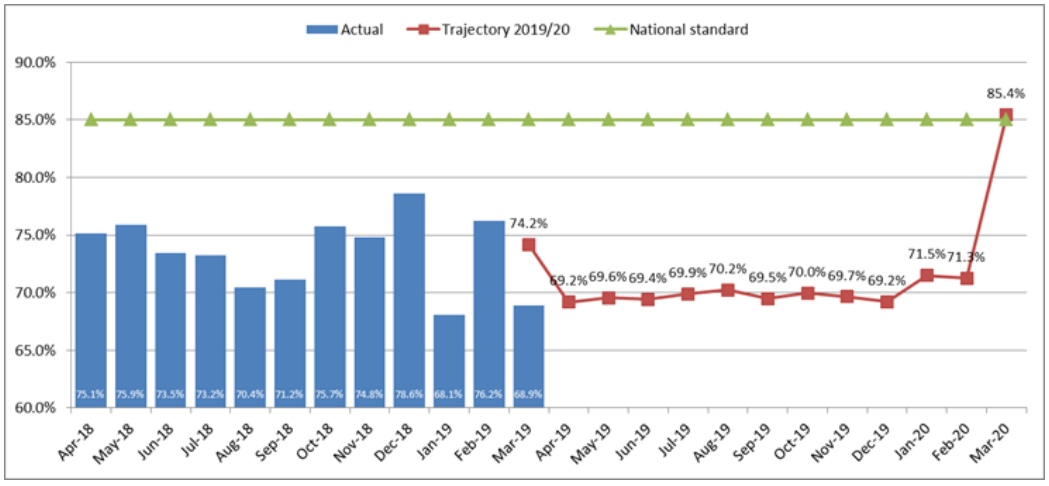
Diagnostic Waits

Our planned improvement trajectory achievement will be dependent on a number of critical factors including equipment developments, continued outsourcing and productivity improvements.

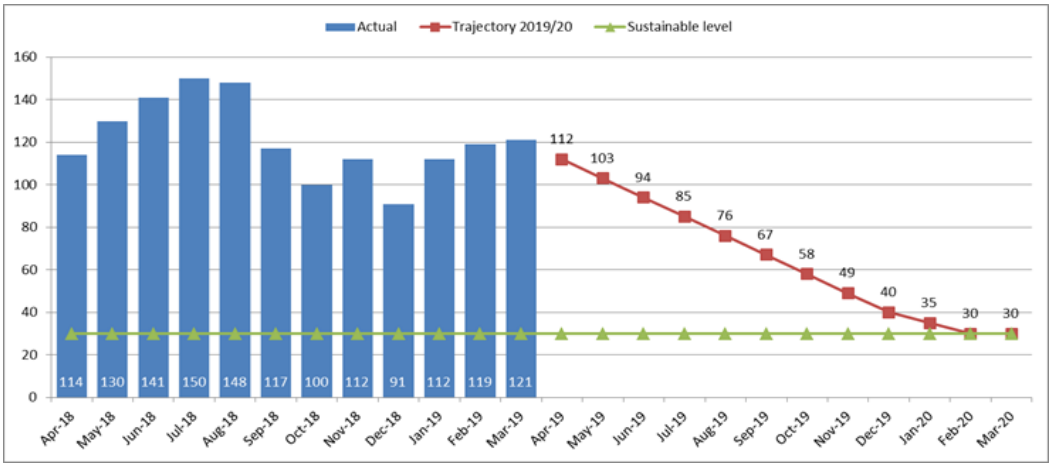


Cancer 62-Day Standard

We are planning to meet the national standard of at least 93% of patient seen within 2 weeks following a referral for suspected cancer and also for breast symptomatic patients in every month.



This trajectory is based on reducing the backlog of 62 day patients in line with the reduction levels experienced since August 2018.



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 15 – Sep 16	Oct 16 – Sep 17	Oct 17 – Sep 18
Plymouth - SHMI Value	0.9866	1.0306	1.08
Banding	2	2	2
National highest – SHMI Value	1.1638	1.2473	1.26
Banding	1	1	1
National lowest - SHMI Value	0.6897	0.7270	0.69
Banding	3	3	3
NHS trust average - SHMI Value	1.0034	1.0050	1.00

% of patient deaths with palliative care coded at either diagnosis or speciality level	Oct 15 – Sep 16	Oct 16 – Sep 17	Oct 17 – Sep 18
Plymouth	20.7	20.2	18.6
National highest	56.3	59.8	59.5
National lowest	0.4	11.5	14.3
NHS trust average	29.7	31.5	33.6

*The palliative care indicator is a contextual indicator.

Core indicator 18 - Patient Reported Outcome Measures (PROMS)

(i) hip replacement surgery

(ii) knee replacement surgery

Pre-operative participation and linkage
Participation from April 2017 – March 2018

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	620	580	93.5%	386	66.6%
Hip Replacement	297	279	93.9%	185	66.3%
Knee Replacement	323	301	93.2%	201	66.8%

Post-operative issue and return
Participation from April 2017 – March 2018

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate
All Procedures	580	577	99.5%	390	67.6%
Hip Replacement	279	276	98.9%	184	66.7%
Knee Replacement	301	301	100%	206	68.4%

Annex B Core Indicators

PROMS Total Health Gain *Participation from April 2017 – March 2018*								
Procedure	**Measure**	**Modelled Records**	**Average Pre-Op Q Score**	**Average Post-Op Q Score**	**Health Gain**	**Improved**	**Unchanged**	**Worsened**
Hip Replacement Primary	EQ-5D Index	141	0.26	0.74	0.482	124	11	6
	Oxford Hip Score	153	14.17	39.02	24.85	151	0	2
	EQ VAS	134	61.76	70.77	9.01	83	8	43
Knee Replacement Primary	EQ-5D Index	197	0.37	0.72	0.36	161	17	19
	Oxford Knee Score	209	18.41	35.98	17.57	196	4	9
	EQ VAS	185	64.79	71.97	7.18	110	20	55

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

- Continue to monitor response rates
- 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.

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?

Annex B Core Indicators

- 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	2017/18
University Hospitals Plymouth NHS Trust	69.1	68.9	65.1	67.5	64.8
National highest	84.2	86.1	86.2	85.2	85.0
National lowest	54.4	59.1	58.9	60.0	60.5
NHS trust average	68.7	68.9	69.6	68.1	68.6

University Hospitals Plymouth 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 started in 2018/19 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, the trust for quarter 2 of 2018/19 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 No Recommended	Percentage Recommended	Percentage No Recommended
University Hospital Plymouth NHS Trust	192	7,004	47%	27%	75%	11%
NHS Trust Average - England	130,555	1,149,726	64%	17%	81%	6%
National highest	3,493	20,502	61%	19%	82%	5%
National lowest	7	6,030	57%	14%	86%	0%

University Hospitals Plymouth NHS Trust monitors the recommended scores for all Friends and Family test areas.

Core indicator 21.1 – Friends and Family Test Patients

Percentage of patients discharged following an inpatient stay or emergency treatment for February 2019 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
University Hospitals Plymouth NHS Trust	42.39% (2.449)	97.14%	0.69%	8.9% (1,196)	94.65%	0.59%
NHS Trust Average -England (excluding Independent Sector Providers)	24.24%	95.51%	1.73%	12.15%	85.25%	8.76%
National highest	100%	100%	0%	35.62%	100%	0%
National lowest	1.86%	76.33%	14.50%	0.0%	56.99%	32.35%

The Friends and Family Test is 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.

Annex B Core Indicators

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

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 board to display results in 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 2018-19.

Description	University Hospitals Plymouth	National highest	National lowest	NHS trust average
Quarter 1 *April 2018 to June 2018*	95.91%	100%	67.04%	95.18%
Quarter 2 *July 2018 to September 2018*	97.10%	100%	75.84%	95.62%
Quarter 3 *October 2018 to December 2018*	96.23%	100%	68.67%	95.44%
Quarter *4 January 2019 to March 2019*	95.87%	100%	54.85%	95.60%

** 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
University Hospitals Plymouth NHS Trust	12.3	14.3	12.3	14.4
National highest	62.6	67.2	82.6	91.0
National lowest	0*	0*	0*	0*
NHS Trust average	15.0	14.9	13.2	13.7

**The Trust is advised by NHS Digital that zero recorded here may be due to missing data from other trusts reported to the centre.*

Core Indicator 25 – Patient Safety Incidents* (Comparison data against all Acute non specialist / 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	71.8	12.1	40.8
Patient safety incident: number	6246	13485	1485	4955

Annex B Core Indicators

Patient safety incidents: Rate per 1,000 bed days *Oct 2016 to March 2017*	41.4	69	23.1	41.1
Patient safety incident: number	6245	14506	1301	5122
Patient safety incidents: Rate per 1,000 bed days Apr 2017 to Sep 2017	42.5	111.7	23.5	42.8
Patient safety incident: number	6339	15228	1133	5226
Patient safety incidents: Rate per 1,000 bed days Oct 2017 to Mar 2018	47.7	124	24.2	42.6
Patient safety incident: number	7379	19897	1311	5449

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	0.01	0.16
Patient safety incident: number	25	98	1	19
Patient safety incidents: Rate per 1,000 bed days *Oct 2016 to March 2017*	0.13	0.53	0.01	0.16
Patient safety incident: number	19	92	1	19
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	18
Patient safety incidents: Rate per 1,000 bed days Oct 2017 to Mar 2018	0.24	0.55	0	0.15
Patient safety incident: number	37	99	0	19

** UHP has an open reporting system which allows any member of staff to report an incident and we do not want to discourage incident reporting. UHP 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 26 – Percentage of staff personally experiencing harassment, bullying or abuse at work from managers in the last 12 months

Description	Total Percentage			
	2015	2016	2017	2018
Acute Trusts Average	13.6%	12.9%	13.2%	13.7%
National Best	6.5%	6.8%	7.3%	8.0%
National Worst	27.3%	22.6%	23.8%	24.1%
University Hospitals Plymouth NHS Trust	13.1%	11.6%	11.7%	11.7%

Core Indicator KF 26 – Percentage of staff personally experiencing harassment, bullying or abuse at work from other colleagues in the last 12 months

Description	Total Percentage			
	2015	2016	2017	2018
Acute Trusts Average	19.3%	18.6%	19.0%	20.0%
National Best	12.5%	12.2%	13.6%	11.7%
National Worst	30.1%	27.6%	27.4%	28.4%
University Hospitals Plymouth NHS Trust	19.0%	16.9%	16.5%	19.3%

Annex C Assurance Statements

Clinical Administration Programme

The Clinical Administration Programme has been established for some time now and has a remit to support the service lines with the delivery of a high quality and cost effective clinical administration service. 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

A recent review of the remit of the programme has confirmed its focus as:

1. Implementing new technologies to help develop more efficient services
2. Agreeing the clinical office model in light of the pilots and further feedback from clinical areas
3. Ensuring an active programme of training and development for our staff, particularly around the leadership of our administration teams
4. Establishing clearly defined and well communicated service standards so that administration teams know what is expected of them
5. Stabilising some of our corporate departments to make them more responsive to service line needs

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. Utilisation currently sits in excess of 100% of clinic attendances. Next steps will be to enhance our mobile device functionality and speech recognition capabilities.

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.

Electronic-outcomes

Our electronic clinic outcome system is now live across all areas in the Trust. To date in excess of 8,500 clinic outcomes are being processed weekly through this system. There are now only a handful of clinicians that are not yet trained on the system. Feedback to date from clinicians using the system has been generally positive though there remains concern such as business support and the number of electronic systems and supporting IT infrastructure.

This project is now being prepared for closure with a number of benefits being realised including:

- Improved level of data quality therefore contributing positively to the management of the patient journey
- Reduction in paper usage for paper copy forms

- Minimises missing information so improving patient safety
- Reduced waiting times
- Reduced time needed on reception
- Improved Referral to Treatment (RTT) times

Electronic Communication to GPs

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. The pilot also evidenced a reduction in delivery times of clinic letters to GPs of up to five days. All specialties are now sending their clinic letters to the relevant GP practices.

Paper copies of letters to GP practices, in Devon and Cornwall were officially "switched off" on 1 September 2018 for all specialties that produce their correspondence via the Trust standard digital dictation system. To date over 133,000 letters have now been sent electronically to GP practices this generates not only savings in terms of stationary but also in staff time and in the courier service.

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. In terms of correspondence with patients we intend to give patients the choice of email, web based or paper copy depending on their individual requirements.

The Trust has completed the necessary work to identify a suitable patient portal-hybrid mail solution. This approach will significantly improve patient choice in terms of being able to choose the method of communication to suit their needs. This solution will also support compliance with national requirements to support accessible communication for all and to include patients in our clinical correspondence.

The web-portal element will also offer the Trust and its patients an opportunity to manage follow-up appointments differently. It will allow the remote management of stable routine patients either with chronic long term conditions or through the minimisation of post-operative follow-up. This will reduce the demand in our follow-up clinics and therefore support the programme of reducing our follow up backlog and ensuring that available capacity is used for more clinically urgent patients.

As a reminder these are the qualitative and clinical benefits:

- Patients have the ability to communicate at a time that suits them
- Patients can be seen when they need to be seen and not offered an appointment when they are well
- Patients' are empowered with the confidence and knowledge to control their own condition better
- Enables early recognition of flare-ups by patients and clinicians
- Provide an early alert system with instant management advice
- Allow early intervention, aimed at preventing urgent outpatient appointments/hospitalisation
- Allow remote management by the specialist clinical teams
- Allow pre-emptive and directed individualised therapy
- Improves patient satisfaction

Annex C Assurance Statements

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. Last year we introduced 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 agreed a corporate training strategy which significantly broadens capacity and capability to deliver effective training and education to our staff.

During the last year a significant number of staff attended training sessions across the modules being offered. These modules include Elective Access Policy, RTT Basics, RTT Masterclass. Primary Target Lists (PTLs), the Data Quality Handbook and Administrative Process Notes (APNs).

The team also provide support for the development of workplace tools such as a resource page on our internal website, e-learning to supplement the class room based training and the development of a dedicated e-mail inbox to support staff with queries.

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 and drives the Trust's income.

University Hospitals Plymouth NHS Trust was subject to a successful Information Governance Clinical Coding audit, undertaken in February 2018, by Rosalind Ward for the period Apr-Oct 2017. The error rates reported in the latest published audit for that period for diagnoses and treatment coding are 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 and October 2016. 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%

Annex C Assurance Statements

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 & Information Management 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 champion, usually 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 2018 internal audit completed a data quality audit pertaining to the RTT Performance Standard. This audit and previous audits on the A&E 4 hour standard, stroke and cancer waiting times provide assurance against these essential performance indicators.

In 2018/2019, the Performance Information Team and Patient Access Team held a number of data quality training sessions for administrative support managers and team leaders. This covered the rationale behind why good data quality is essential for patient care, patient safety, operational performance standards and income. Over the next few months training to all administration posts will be completed.

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 2018/2019 for two key indicators:

Patient Pathway	Valid NHS Number	Valid GP Practice
Admitted patient care	99.1%	100%
Outpatients	99.5%	100%
Accident & emergency care	98.4%	100%

The Trust remains top in the peninsula for data quality assurance on the SUS Data Quality Dashboards with a total combined score of 99.4.

Annex C Assurance Statements

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 occurrence.

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 harm and distress caused

Duty of Candour Diagram

Annex C Assurance Statements

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.

Progress towards achieving key targets for 2018/19 was as follows:

- Reduce MRSA bacteraemias in line with agreed local and national targets. Between April 2018 and March 2019, there were 6 MRSA bacteraemias (Target: no cases for the year).
- Reduce Clostridium difficile in line with agreed local and national targets. Between April 2018 and March 2019, 30 cases of hospital-apportioned Clostridium difficile were recorded, of which one was considered avoidable and 29 non-avoidable (Target: fewer than 34 avoidable infections).
- Achieve a 5% reduction in all cases of MRSA. Between April 2018 and March 2019, there were 31 new cases of MRSA compared to 22 the previous year.
- Achieve a 5% reduction in all MSSA bacteraemias. Between April 2018 and March 2019, there were 39 MSSA bacteraemias compared to 25 the previous year.
- Maintain the mean ward closure time due to epidemic gastroenteritis below 7 days. Between April 2018 and March 2019, there were no ward closures due to norovirus.
- Reduce other infections according to national and local priorities. The Trust recorded 68 E. coli bacteraemias, 18 Klebsiella bacteraemias and 2 Pseudomonas aeruginosa bacteraemias.
- 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 2018 and March 2019, the overall Trust hand hygiene compliance was 94%.
- 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 2018 and March 2019, the availability of alcohol hand gel in clinical areas was 95%.
- Continue to develop and update the IPC website. Completed.

Annex C Assurance Statements

- 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 - Data Security & Protection Toolkit

In May 2018, NHS Digital launched a new assurance framework to replace the Information Governance Toolkit. The new Data Security and Protection Toolkit (DSPT) is based on the National Data Guardian's ten data security standards recommended by Dame Fiona Caldicott and endorsed by the Government in July 2017.

The ten data security standards are:

- Personal Confidential Data
- Staff responsibilities
- Training
- Managing Data Access
- Process Reviews
- Responding to Incidents
- Continuity Planning
- Unsupported Systems
- IT Protection
- Accountable Suppliers

Within these standards, there are 32 mandatory assertions and eight non mandatory assertions. Each of these contains a number of statements the Trust must record compliance against.

The Trust has published the 2018/19 Data Security and Protection Toolkit with all standards met in March 2019.

Research and Development

Plymouth has had a very challenging financial year partly due to a significant cut in the National Institute for Health Research (NIHR) budget. However despite these challenges, and managing a higher than usual number of staff changes, we have managed to exceed our recruitment target to non-commercial portfolio badged studies. This has left an imbalance to commercial recruitment which is reflected in the commercial drop in income and will be a key work stream to be addressed in the coming year.

There are currently 360 research projects (open to recruitment) ongoing in the Trust. We have recruited 4896 patients into research projects this financial year with our retention rate remaining above average. 127 new research projects opened in the year, 41 commercial and 86 non-commercial, a significant growth on the previous period.

We continue 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 saving to the Trust which will support the New Excess Treatment cost arrangements. Plymouth

continues to build collaborations within the healthcare community, particularly successes have been with Care UK and Livewell SW

Our highly skilled research delivery and administration workforce continues to streamline the setup of studies to ensure that we are able to deliver to the NIHR high level objectives and bring the most up-to-date treatments to patients at the earliest opportunity. This year the delivery of research on the Lind Research Unit has benefitted from the support of 2 Clinical research doctors that has helped manage the challenge of sharing the research accommodation with the Planned Investigation Unit in support of winter pressure delivery. This collaborative working has built relationships and helped to further embed research in the core business of the Trust.

We continue to add to commercial research as an active member of the IQVIA Peninsula Prime Site Consortium and now part of the Pfizer Inspire SW Prime site. The Peninsula Prime Site has received IQVIA's Certificate of Achievement for the last three years. 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 with the wider healthcare community including Livewell, primary care, public health, Peninsula Clinical Research Network, Peninsula Academic Health Science Network continue to be recognised. The launch of the Research College, a joint initiative with the University of Plymouth and University Hospitals Plymouth NHS Trust sees the two organisations building stronger links to deliver both early phase translation medicine projects and delivery of late phase programme grant funded research. Research and development continues to take advantage of all research opportunities available for the benefit of our patients, the Trust and the wider healthcare community.

In 2018/19 we extend the remit of the department to incorporate Research, Development and Innovation (RD&I), building on the significant innovation growth and success the 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 the patient bridge for use in imaging. Innovation continues to be a key theme harnessing staff innovation for the benefit of the healthcare environment, and the wider NHS audience.

Plans are moving forward at a pace to convert the Lind Research Centre to a 24/7 facility which will support an application in 2019 to be a High Throughput Centre for late phase 3 and 4 studies. An overnight facility will further support an application in 2020 to become an accredited clinical research facility attracting new research particularly early Phase 1 and first in to man studies.

<u>Conclusion</u>

University Hospitals Plymouth NHS Trust remains committed to its research agenda, and has just published its new 5 year strategy, to make available to its patients the most innovative treatments at the earliest opportunity and further support the public health agenda through education and training.

Annex C Assurance Statements

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 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 2018.

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 and Director of Clinical Professions 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 individual's 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 arrangnments 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	N/A
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme • COPD • Adult asthma	 Continuous data collection Continuous data collection	 N/A N/A
National Lung Cancer Audit	Continuous data collection	N/A
National GastroIntestinal Cancer Programme • Oesophago-gastric Cancer • Bowel Cancer	 Continuous data collection Continuous data collection	 N/A N/A
National Prostate Cancer Audit	Continuous data collection	N/A
National Cardiac Audit Programme • Cardiac Rhythm Management (CRM) • Acute Coronary Syndrome or Acute Myocardial Infarction • Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions • Adult Cardiac Surgery • National Heart Failure Audit	 Continuous data collection Continuous data collection Continuous data collection Continuous data collection Continuous data collection	 N/A N/A N/A N/A N/A
National Vascular Registry	Continuous data collection	N/A
Diabetes (Paediatric) (NPDA)	Completed	N/A
National Diabetes Audit (NDA) – Adults - National Inpatient Audit (NaDIA, NDIP)	Continuous data collection	N/A
Falls and Fragility Fractures Audit programme (FFFAP) • Inpatient Falls • National Hip Fracture Database	Continuous data collection	N/A
Sentinel Stroke National Audit programme (SSNAP)	Continuous data collection	N/A
National Ophthalmology Audit	In progress	N/A
National Audit of Breast Cancer in Older People	Continuous data collection	N/A
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	In progress	N/A
National End of Life audit	Completed	100%
Medical and Surgical Clinical Outcome Review Programme • Cancer in Children, Teens and Young Adults • Perioperative Diabetes • Pulmonary Embolism • Acute Bowel Obstruction • Long Term Ventilation (includes children and young people as part of the Child Health Clinical Outcome Review Programme)	 Completed Completed In progress In progress In progress	 100% 100% N/A N/A N/A
National Audit of Dementia	Completed	100%
National Maternity and Perinatal Audit	Continuous data collection	N/A
Learning Disability Mortality Review Programme	Continuous data collection	N/A
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Continuous data collection	N/A
Neonatal Intensive and Special Care (NNAP)	Continuous data collection	N/A

Annex D National Clinical Audits

Non NCAPOP audits		
Case Mix Programme (CMP)	Continuous data collection	N/A
Adult Community Acquired Pneumonia	In progress	N/A
Adults Non-Invasive Ventilation -	In progress	N/A
BAUS Urology Audits • Radical Prostatectomy Audit • Nephrectomy audit • Percutaneous Nephrolithotomy (PCNL) • Cystectomy	 Continuous data collection Continuous data collection Continuous data collection Continuous data collection	 N/A N/A N/A N/A
RCEM – Feverish Children	Completed	100%
National Bariatric Surgery Registry	Continuous data collection	N/A
RCEM – Vital Signs in Adults	Completed	100%
RCEM – VTE risk in lower limb immobilisation	Completed	100%
Neurosurgical National Audit Programme	Continuous data collection	N/A
Major Trauma Audit	Continuous data collection	N/A
National Comparative Audit of Blood Transfusion programme • Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children • Management of massive haemorrhage • Management of Maternal Anaemia	 Completed Completed Completed	 N/A N/A N/A
National Cardiac Arrest Audit (NCAA)	Continuous data collection	N/A
Elective Surgery (National PROMs Programme) • Unilateral Hip Replacement • Unilateral Knee Replacement	Continuous data collection	N/A
National Joint Registry (NJR)	Continuous data collection	N/A
Serious Hazards of Transfusion (SHOT)	Continuous data collection	N/A
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Continuous data collection	N/A
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) – NHS England CQUIN • Antibiotic Consumption • Antimicrobial Stewardship	Quarterly data collection	N/A
Inflammatory Bowel Disease (IBD) Programme/ IBD Registry	Continuous data collection	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Completed	N/A
National Mortality Case Record Review Programme	Continuous data collection	N/A
Seven Day Hospital Services	Completed	100%
Surgical Site Infection Surveillance Services	Continuous data collection	N/A
UK Cystic Fibrosis Registry - Adult	Continuous data collection	N/A

Annex D National Clinical Audits

Category
National Confidential Enquiries
During 2018/19 hospitals were eligible to enter data into five NCEPOD studies. The Trust submitted data for two studies, equating to 100% participation for completed studies. 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
Cancer in Children, Teens and Young Adults	Completed	100%	The Cancer in Children, Teens and Young Adults report was published on the 13th December 2018. The responsible leads reviewed the report recommendations and stated full compliance with all relevant recommendations.
Perioperative Diabetes	Completed	100%	The Perioperative Diabetes report was published on the 13th December 2018. The responsible leads reviewed the report recommendations and stated full compliance with all relevant recommendations.
Pulmonary Embolism	In progress	N/A	All cases have been reviewed and now awaiting the final report publication.
Acute Bowel Obstruction	In progress	N/A	The selected cases are currently under review.
Long Term Ventilation	In progress	N/A	The selected cases are currently under review.

Annex E Example Outcomes from Clinical Audits

Audit Description	Comments
PRIORITY 1: Mandatory National Audits	
The National Neonatal Audit Programme (NNAP)	All metrics are within expected ranges with the exception of the following being within the top quartile or a positive outlier for the following: • Mothers who deliver babies below 30 weeks gestation given Magnesium Sulphate in the 24 hours prior to delivery. • Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission. • Babies with gestation at birth less than 30 weeks who had received documented follow-up at 2 years gestationally corrected age.
National Diabetes Audit	The score for patients visited by a member of the Diabetes Team dropped during winter pressures when the team were encompassed within the general medical work rota. In addition, the data collection for the foot care assessment was adversely affected by the transition to a new podiatrist which meant that less data was submitted. However the overall results demonstrate that the Trust is a positive outlier, scoring below the national average for medication and insulin errors. The Insulin Safety Group has contributed to this pleasing score and helped to reduce errors by reviewing incidents and providing education.
PRIORITY 2: Corporate Must Do Audits	
Clinical Record Keeping – Surgical Notes Audit	The purpose of this audit was to assess the standard of clinical record-keeping on surgical wards and measure the time taken to find the current clinical entry. Baseline data revealed a poor standard of filing and record-keeping: 94% of notes contained loose pages; 60% were not in chronological order; 59% did not have the required patient identifiers; and 23% had no date/time recorded. During ward rounds, up to 12 minutes was spent looking for clinical notes. A new filing system was introduced on Wolf ward, using a separate folder to hold the current clinical admission. A subsequent re-audit revealed significantly improved standards (only 5% with loose pages, 13% not chronologically ordered, 30% without required patient identifiers, and 10% with no date/time recorded). Access to notes was also significantly improved, with the average time to find the current clinical entry per patient being only 20 seconds. This simple and cost-effective intervention was welcomed by medical and nursing staff alike, and was adopted by another surgical ward, via the Matron, due to the visible success.
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 patients' clinical record rather than awaiting a formal radiologist report. All relevant specialties required to undertake this audit are in the process of completing this audit. Current results indicate that the clinical evaluation is present in 93% of the audited records. Non-compliance is being monitored through the Radiation Safety Committee.
PRIORITY 3: Service line must do clinical audits	
Prospective Audit of use Kaiser Permanente Neonatal Sepsis calculator tool as an aid to clinical decision making	Since the introduction of National Institute for Health and Care Excellence (NICE) guidance CG149 (Neonatal Infection (early onset); antibiotics for prevention and treatment) in August 2012, there has been a substantial increase in term admissions to Neonatal Intensive Care Units (NICU) in the UK. The extended hospital stay for this population of new-born term infants has resulted in babies being exposed to early antibiotic therapy which interferes with normal gut flora, and separation from mother after birth, leading to delayed breast feeding. Audits undertaken by clinicians identified that of those babies, treated with antibiotics for risk factors only (and not clinically unwell) there was no proven infection. The Kaiser Permanente Calculator was proposed as an alternative decision-making tool as it takes into consideration antenatal septic risk factors and the infant's clinical condition.

Annex E Example Outcomes from Clinical Audits

Audit Description	Comments
	This audit assessed 100 infants after the introduction of the "Changing approach" pathway in combination with the new sepsis calculator. Results indicated that there was a significant (87%) reduction in term babies routinely receiving antibiotics, with no blood culture positive results or late onset sepsis identified. There was also a reduction in hospital stay for the babies who were not treated with antibiotics (35 days over three months). Based on these results the NICU team requested to derogate from the NICE guidance; this decision was supported by NHS England and subsequently agreed by the Trust's Clinical Effectiveness Group.
An Audit of the Assessment and Management of Paediatrics and Adults Burns Patients (re-audit)	The reviews of burns patients presenting to the Plastics department in Derriford Hospital in May 2017 were audited against the standards of the Royal College of Surgeons' Good Surgical Practice, and the International Burns Injury Database. After the first audit cycle, a burns assessment proforma was designed and introduced. Further audits were completed a month and three months later, and a questionnaire was utilised to evaluate the response of staff to the new proforma. Results demonstrated that Advanced nurse practitioners (ANPs), Plastics senior house officers (SHOs) and non-Plastics junior doctors were the main users of the proforma, while Plastics registrars and consultants primarily used free-text documentation. The burns assessment proforma was found to facilitate high-quality assessment of patients and their injury, despite time of day and clinical experience. SHOs and Plastics ANPs found the burns proforma to be an effective learning tool that improved the efficiency and quality of their clerking. The success of the proforma was felt to be dependent on it being easily accessible in the Emergency Department, Trauma room and Outpatients, and that regular staff input and modification would enhance engagement and use. The lead noted that given the complexities of burn care, and the potential medico-legal ramifications of burns injuries, this tool helps to optimise the quality of burns reviews and documentation of the assessment.
PRIORITY 4: Specialist Interest Audits	
Audit of Patient Satisfaction and Complications in patients who underwent Muscle or a Nerve and Muscle biopsy	The muscle and nerve biopsy service at Derriford hospital is attended by patients from across Devon and Cornwall and from further afield, meaning that patients often have to travel long distances to attend for a biopsy. In contrast with other hospitals where patients have their biopsy undertaken after general anaesthesia and stay 2-3 nights in hospital, the biopsies at Derriford are performed under local anaesthesia as day case procedures. As well as assessment of patient satisfaction with the biopsy service, this audit also assessed the complication rate for patients undergoing muscle biopsy or nerve and muscle biopsy. Results from 41 patient questionnaires, from 108 sent out, identified a generally positive response: all patients had confidence in the neuropathologist and had adequate explanation for the biopsy and its risks; all patients rated the service good or better, with 50% (muscle biopsy) and 63% (nerve and muscle biopsy) giving the top rating of excellent; and post-operative complications such as wound infection and excessive bruising were rare. Based on these findings, the lead noted that undertaking biopsies as day case procedures under local anaesthesia appears to be safe. No significant concerns were raised but some areas for improvement were identified, including ensuring that patients receive the information sheet and detailed travel directions in advance of the appointment, choices are offered for the operation date, results are clearly explained in a timely manner, and that nursing staff warn all patients of danger signs before discharge. The service will be re-audited in 6-12 months as part of a rolling audit plan.
Nationwide audit of delirium assessment and prevalence in older people admitted acutely to hospital	As part of a national audit on World Delirium Awareness Day (14th March 2018) participating hospitals were asked to screen all patients who met a set criteria using the 4AT screening tool, proceeding to a full delirium assessment with a 4AT score of 4 or greater. Results indicated a delirium prevalence at Derriford of 19.2%, in line with the expected 20-30%, with demographics (age, gender, frailty) being comparable to national data. A key success was that delirium is being correctly identified at Derriford in 60% of patients versus 36.5% nationally. However, this means that it is likely that approximately 40% of cases of delirium are missed in

Annex E Example Outcomes from Clinical Audits

Audit Description	Comments
	acute admissions. Additionally, the Trust was found to only be communicating delirium to primary care in 25% of cases, which is significantly short of the NICE guidance (CG103) which states that all diagnoses should be relayed to primary care on discharge. The lead also noted that there is no robust method for identifying high risk patients and ensuring that screening takes place. As a consequence, a comprehensive action plan has been put in place, including the introduction of a delirium bundle, the set-up of a delirium steering group and the implementation of routine inpatient screening for high risk patients during their hospital stay.
Service Evaluations	
Pre-pectoral implant breast reconstruction with BRAXON mesh at Derriford Hospital; an evaluation of a new technique	This audit evaluated the outcomes and safety of the first twenty-one pre-pectoral implant breast reconstructions using BRAXON Acellular Dermal Matrix at Derriford Hospital. The decision to launch the service was driven by the evidence of outcomes comparable, if not better than, the gold standard sub-pectoral reconstruction, and the introduction of BRAXON. The surgeon's experience with BRAXON-based pre-pectoral reconstruction was found to be largely successful. The procedure was judged to be safe and associated with high levels of patient satisfaction. Complication rates met the required standard and all parameters represented an improvement from the national average. Patient selection was found to be important, as a higher complication rate is expected in smokers and patients with thin skin or very dense breasts where modification of the technique may become necessary. The experience of the only patient who had had a previous sub-pectoral implant, was that this procedure, combined with chest wall re-construction, can be ideal for salvage surgery. Going forward, there is a plan to set-up a prospective database and to re-audit the subsequent 30 pre-pectoral reconstructions, including an objective measure of cosmetic outcome and patient satisfaction.
• **ED Physiotherapy audit (7 day service)** • **Physiotherapy Late shift Audit (re-audit)** • **AAU Rapid Response Team Audit** • **Rapid Response Team (RRT) Outreach Pilot**	The Emergency Care Team was nominated for a thank you card through the learning from excellence scheme due to their dedication to making positive change and continuously reviewing outcomes. The key achievements from undertaking these audits are as follows: • The Community Crisis Response Team (CCRT) will only see patients in crisis and the Community Rehab Team (CRT) has a waiting list of approximately 6-12 weeks. Patients needing therapy input but not yet in crisis situation were not seen by CCRT or CRT. This lead to the creation of the Rapid Response Team Outreach service for the trial period which filled a gap in the services available within the community and saved the Trust approximately 54 bed days which equates to £7,400. Of the 22 patients seen during the 4 month period, 85% remained at home and were not readmitted under a medical specialty within 3 months of discharge. • Acute Assessment Unit (AAU) Rapid Response Team audit assessed the effectiveness of using Physiotherapists and Occupational Therapists to reduce the length of stay for patients admitted to the AAU. Out of 338 patients referred, 294 patients (88%) were discharged on the same day and 44 patients (13%) were admitted to hospital for medical reasons. • A total of 496 patients were seen following the introduction of the Physiotherapy late shifts from December 2016 and December 2017. Of these, 368 patients (74%) were discharged from the hospital. The discharge destination included the patient's home, placement or a community hospital. This means only 128 patients (26%) across the year were admitted to the main hospital to long-stay wards. There were 248 patients (50%) out of the total 496 who were discharged on the same day.

Annex F 2019/20 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 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. From a workforce planning perspective we need to ensure all staff proactively meet patient requirements in the most efficient and productive way possible.

Current Position

We have reviewed our current position based on information from the past 12 months and used this to set targets for the coming year.

Description	2018/19 Performance	2019/20 Target
Maintain agreed staffing levels for all wards in line with Safer Staffing	Planned vs Actual Mar 19 –overall 87.0%	Planned vs Actual >90%
Reduce the overall staff vacancy factor	9.72%	-
Reduce the number of complaints which include an element relating to staff attitude and behaviour	177	<10%
Improve patient's 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 2018 – Always / Nearly Always)	49%	>66%
If you needed attention, were you able to get a member of staff to help you within a reasonable time? (Q43 National Inpatient Survey 2018 – Yes always)	54%	>68%

How we will do it

- Continue with 6 monthly nursing staffing reviews to ensure workforce plans remain in alignment with the Trust's financial and activity plans.
- Continue to explore transformational workforce change, whilst being mindful that the rollout of new roles is dependent on a range of different variables; including a move towards a multi-professional approach.
- Build on the successes of previous nursing recruitment open days and schedule future dates for 2019/20.
- Explore innovative recruitment solutions; including International recruitment drives and a Memorandum of Understanding between all organisations in the STP to enable the fast and seamless movement of staff across the patch.
- Develop improved retention solutions such as piloting an 18 months (3x6) rotational programme for band 5 nursing preceptees and piloting the implementation of a 'transfer window' to enable band 5 nursing staff to move between departments.
- Continue to utilise 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.
- Continue with the New Deal programme relating to the apprenticeship career pathway for healthcare assistants and nursing degree course.
- Continue to collaborate with NHS Professionals in the provision of a quality flexible clinical workforce.

Measuring Progress

We will monitor and report on nurse staffing levels and incidents on a monthly basis to the Nursing & Midwifery Operational Committee. 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.

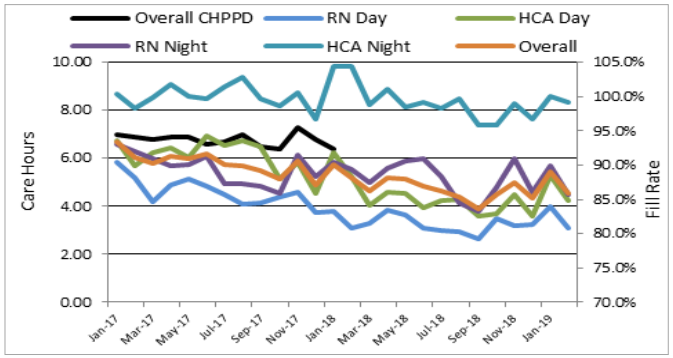


Table shows care hours and fill rate by registered and unregistered staff.
Jan 17 to Jan 19

Annex F 2019/20 priorities

Priority 2: Improve Responsiveness - Ensure all patients receive timely, high quality care by working with other providers to ensure care is provided by the right staff in the right place at the right time.

Rationale

We have experienced difficulties with capacity resulting in cancellations for patients and longer waits for treatment than we would like. It is equally important to increase our ability to treat patients quickly and safely in the Emergency Department, to do so we need to revolutionise and create an integrated emergency and urgent care hub.

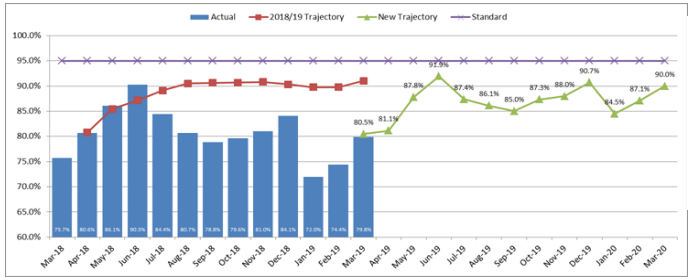
Patients with complex support needs after discharge from hospital , have the right to expect the right care package available to them in the right location, which is in line with best practice.

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.

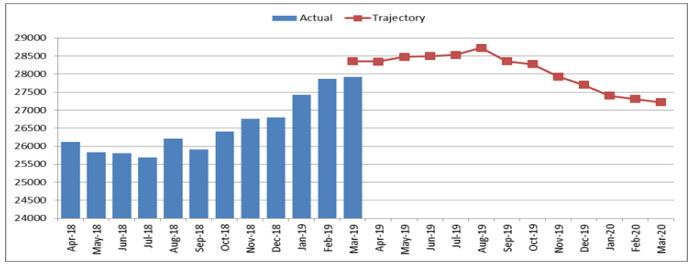
Current Position

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	2018/19 Performance	2019/20 Target
Number of patients who are cancelled	2.85%	0.80%
A&E four hour waiting time or equivalent new standard	81.14%	95%
Referral to Treatment Times – increase the number of patients treated within 18 weeks	78.4%	79%
Referral to Treatment incomplete pathways - Reduce number of patients waiting over 52 weeks	48 at Mar 19	20 by Mar 20
Reduce the 6 week diagnostic waiting times	5.90% Mar 19	2.7%
Reduce delayed transfers of care	3.41%	3.5%



A&E 4 Hour target
Performance to date and expected trajectory for the coming year.



Referral to Treatment Time
Performance to date and expected trajectory for the coming year.

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.

In line with our Operational Plan for 2019/20, we have developed detailed capacity plans and identified areas to delivery additional activity.

Further development of our Emergency and Urgent Care Hub will provide an opportunity to redesign our services to ensure they meet the needs of the community we serve.

Measuring Progress

We will monitor progress against the overall projects through the Quality Improvement Committee chaired by the Medical Director. The organisation is introducing weekly safety huddles at all levels from directors through to wards and departments to monitor and track improvements and issues at point of service delivery.

Annex F 2019/20 priorities

Priority 3: Patient communication and information – Improve the quality of communication and information provided before, during and after their care

Rationale

Patients frequently leave hospital uninformed about the details of their hospital stay, limited ability to accurately state their diagnosis and ongoing management after discharge. We will enable patients to understand key aspects of their care by providing accurate and understandable information enabling them to take greater control, potentially reducing readmission rates and unplanned visits to secondary care, whilst providing safer care and improving patient experience.

We are committed to ensuring carers are recognised as important partners in the care of patients and to promote a carer friendly culture. Carers have an important role in the effective and safe delivery of treatment and care of patients in hospital. It is important to identify, involve and support carers in the clinical setting in order to get the care of the patient right.

There can be adverse consequences resulting from delays to diagnosis and treatment.

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	2018/19 Performance	2019/20 Target
Radiology acknowledgement within 48 hrs for inpatients	MRI– 34.9% US – 92%	80%
Number of complaints relating to information, communication and consent	562	<20%
National Inpatient Survey Q55 – When you left hospital did you know what would happen next with your care?	65.1%	68.4%
National Inpatient Survey Q62 – Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	63.4%	67.0%
Carers Local Survey – Overall how satisfied are you with the support or services you and the person you care for have received in the last 12 months	83.65%	>10%

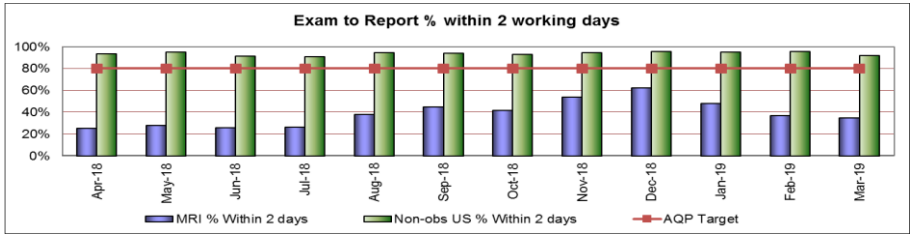


Table showing Exam to Report Times within 48 Hours – Performance to date against target, which will be continued in the coming year.

How we will do it

We will develop a the radiology acknowledgement improvement plan which identifies the various elements impacting on our ability to acknowledge and produce timely reporting for all radiology requests, thereby ensuring our clinicians take the necessary actions to address any findings. Our priority will be to ensure all inpatients results are acknowledged and actions taken by the team responsible for the patient within 48hrs of the report being available. For outpatients we will aim for reports to be acknowledged and actioned within 4 weeks.

The importance of clear and concise patient information cannot be under estimated and we will work towards publishing all our patient information leaflets on the Trust website, for patients, carers and families to download. In September 2018, the Trusts participated in a free six-month trial of patient information leaflets for informed consent. This was provided by EIDO Healthcare and sponsored by the Royal College of Surgeons. We are currently negotiating funding to extend the trial period to the end of 2019.

We will produce a Carers Welcome Pack which will contain useful and essential information on what help and support is available whilst they are caring for someone who is an inpatient at the hospital. The Carers Welcome Pack will include information for carers about where to access a statutory carers assessment and support available for carers in the local community.

Measuring Progress

We will monitor progress against the overall projects through the Quality Improvement Committee chaired by the Medical Director. The organisation is introducing weekly safety huddles at all levels from directors through to wards and departments to monitor and track improvements and issues at point of service delivery.

Annex G Safety Initiatives

Safety Initiatives

The national Sign up to Safety initiative to help NHS organisations achieve their patient safety aspirations and care for their patients in the safest way possible has now completed its five year plan. However, we will continue working on our safety initiatives to give patients reassurance and confidence that we are doing all we can to ensure the care they receive will be safe and effective at all times. Our work will continue to be around six key areas

University Hospitals Plymouth NHS Trusts has chosen to focus specific attention on six key safety initiatives which are monitored by executive team through their weekly executive huddle and through the Weekly Improvement Safety Huddle (WISH). The key safety initiatives have detailed programmes of work aligned to them and include:

- Radiology Acknowledgement
- Critical Medications
- Sepsis – focusing on emergency admissions
- Falls
- Pressure Ulcers
- Time Critical Backlogs

Radiology Acknowledgement

It is important to reduce the risk to our patients by ensuring all radiology patient results are reported within 48 hours and acknowledged and actioned by the team responsible for their care within a reasonable timeframe of the report being available for inpatients and within 4 weeks for outpatients.

Detailed improvement plans are being developed and will be tracked through our Quality Improvement Committee and weekly improvement huddles.

Critical Medications

On occasion patients are discharged from the hospital (inpatients) without their medications, these can include critical medicines. It is important to have a clear process trust wide, within wards, pharmacy and transport, to safeguard patients receiving their critical medicines when discharged. Further detail is included on page 8.

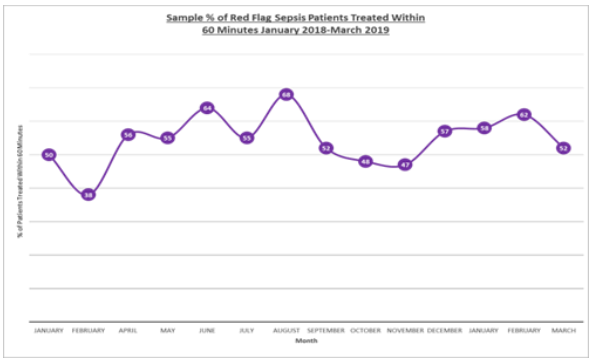
Sepsis

Sepsis is a time-critical medical emergency, if a patient presents with sepsis it is important they receive treatment within 60 minutes. If treatment is delayed it will affect their outcome.

One key step to improvement in the management of patients presenting with sepsis has been the introduction of NEWS2 observation charts, this has been introduced across the whole organisation with staff engaging in the national training programme.

We will continue to work towards ensuring all patients with sepsis received antibiotic treatment within the recommended 60 minutes, average treatment times to date are shown below.

Annex G Safety Initiatives

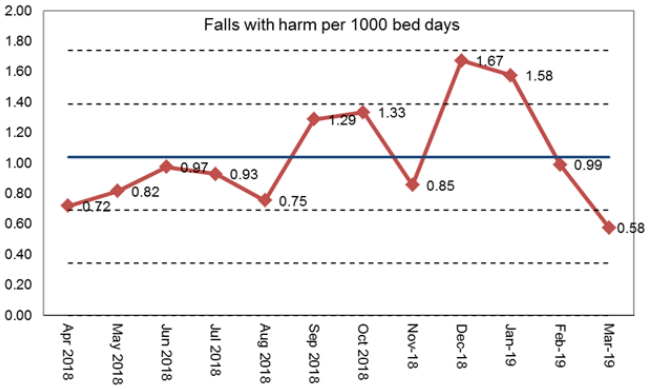


Reduce falls leading to harm

In the 12 months since April 2019 we have had 1.04 falls with harm (minor, moderate or severe) per 1000 bed days and therefore did not achieve our target reduction by 10% to 0.95 falls per 1000 bed days. In this time period there have been 16 falls resulting in severe harm to the patient, of which 3 were head injuries and the remainder fractured neck of femurs. This is an improvement on the previous 12 months when we reported 23 inpatient falls resulting in severe harm. We recognise that there has been an increase in falls with harm over the winter months and have undertaken thematic analysis to aid our understanding of this variation. We have identified that often patients fall and sustain severe harm when they are mobilising unsupervised and have unaddressed risk factors

Our actions to reduce harm from falls has focused on safe patient mobilisation, ensuring that there are interventions in place to address risk factors for patients. This includes an assessment of risk, performing a lying and standing blood pressure, safe footwear, access to walking aids, supervised mobilisation when required and a review of medications that increase falls risk. To supplement this we have piloted new non slip footwear, implemented a standard procedure for recording lying and standing blood pressure, highlighted cohort bay nursing as a strategy and have rolled out an enhanced care and observation team.

In the following 12 months we will aim to reduce both falls with harm and severe harm by 10%.



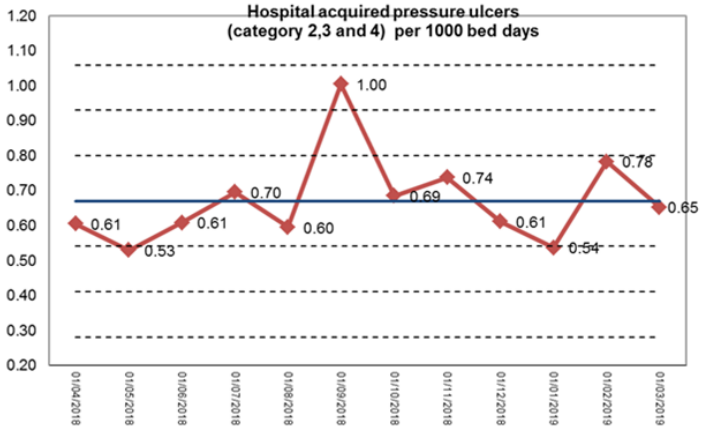
Pressure Ulcers

Since April 2018 we have reported 0.67 pressure ulcers of category 2,3, or 4 per 1000 bed days. Disappointingly we reported 12 category 3 or 4 pressure ulcers as being acquired in hospital. Going forward we are acting on lessons learnt from these incidents to put actions in place to prevent severe pressure damage. This includes a focus on assessment of risk followed by interventions being implemented to reduce that risk including repositioning, offloading devices, addressing nutritional and toileting needs. We are working hard with our inpatient areas to ensure all patients have an appropriate skin assessment matching their needs and that our staff are identifying pressure damage at an early stage, following the

Annex G Safety Initiatives

React to Red initiative. This initiative is a pressure ulcer prevention campaign that is committed to educating as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them.

Our aim in the next 12 months is to reduce total acquired pressure ulcers by 20% and also category 3 and 4 pressure ulcers by 50%.



Time Critical Backlog

We continue to experience difficulties with capacity which has resulted in patients being cancelled and being subjected to long waits for treatment. We recognise the importance of providing timely treatment for our patient and as such have implemented a robust approach to demand and capacity planning for the coming year. There is an expected 5.3% increase in outpatient appointments and 2.4% for our planned inpatient activity. In addition to fully meet our referral to treatment time for all specialties the Trust would also need to see an additional 7,575 non recurrent cases to clear the backlog.

Detailed plans have been agreed and are monitored at weekly improvement huddles for six key areas including:

- Neurology
- Thoracic Medicine
- Gastroenterology
- Ophthalmology
- Paediatrics
- Hepatology

People First

University Hospitals Plymouth NHS Trust and Livewell SW were jointly chosen as one of seven NHS organisations to take part in the National NHSi Improvement Programme, the aim of which is to create a culture of continuous improvement by empowering staff to develop their own improvement ideas and lead on their own projects which we are calling locally 'People First'.
The People First Programme has 3 core principles:

- Respect for Staff- aiming to make time at work rewarding
- Seeking VALUE in the eyes of those we care for- what is important to them
- Helping teams to lead their own improvement practice based on things that Matter most to them and align to our goals.

Annex G Safety Initiatives

It is a programme aimed at cultural change with people and will build capability through:

- Improving use of data and 'problem on a page' approach
- Training frontline staff in scientific learning practice known as 'Kata'
- Developing our management system to be in focus, supportive in coaching and more visual
- Developing frontline coaches with improvement practice skills (practice coaches). As part of this all executive directors are doing the same
- Developing specialist coaches (facilitators) who can lead practice events (rapid events for change)
- Support local improvement huddles to face into improving patient care

The People First programme will run through and join together all the work we do, uniting all the different aspects of our Quality Academy Improvement work with our operational strategy and staff development.

Our ambition is to create a sustainable and effective health system, working with our patients and partners in our community which delivers safe high quality services.

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 2019

Ann James
Chief Executive

Date: 30 June 2019

Annex I Statements from external stakeholders

Local Healthwatch (Plymouth, Cornwall, Devon and Torbay)
Local Healthwatch (Plymouth, Cornwall and Devon) continue to work with University Hospitals Plymouth 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 remains consistently high with the Emergency Department continuing to see a higher volume of patients compared to previous years. The ongoing infrastructure work at Derriford Hospital is welcomed as it demonstrates a commitment from the NHS to provide infrastructure that delivers seamless services. The recent improvements to the Emergency Department in resuscitation and paediatrics, plus further planned works too for emergency care improvements to patient flow in the Hospital should all help in managing the higher volume of patients seen at ED.

Patient feedback received around Derriford Hospital and its services continues to be generally positive, with most commenting on their experience of care received and the way that staff positively go about delivering that care. However, of concern are the continuing comments around waiting times for outpatient appointments and variable communication from service lines / departments.

We note the progress made against the 2018/19 Quality account priorities of:

- Priority 1: Staffing – Improve the patient experience by ensuring our wards and departments have the correct levels of staff with the appropriate skills.
- 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
- Priority 3: Reduce the overall number of patients who suffer harm whilst under the care of the hospital

The challenges faced by the Trust in delivering against these priorities is also recognised, in particular the challenges in recruiting nurses (in common with the wider NHS). Equally the work in developing people related programmes into a main workstream; the People First programme, is welcomed particularly at a time when operational pressures are bringing additional risks to patients.

We hope the People First programme will continue to drive change and that work with partners in the wider health and social care community in 2019/20 will deliver more integrated services and care; this is fully supported by local Healthwatch.

We note and support the Trust's priorities for 2018/19, particularly Priority 3, around:

- Priority 1: Staffing – Maintain safe staffing by ensuring that the right staff, are in the right place, at the right time.
- Priority 2: Improve Responsiveness - Ensure all patients receive timely, high quality care by working with other providers to ensure care is provided by the right staff in the right place at the right time.
- Priority 3: Patient communication and information – improve the quality of communication and information provided before, during and after their care

Healthwatch Plymouth continues to be engaged with the Trust and associated providers around Complex Discharge pathways, helping to ensure that the patient remains at the centre of discharge conversation. This work is now expanding to look at all discharges from hospital with the inaugural meeting held in April 2019. With Healthwatch partners we will continue to feedback patient concerns from the people in Cornwall and Devon who are treated as inpatients at Derriford Hospital.

Local Healthwatch continues to work with University Hospitals Plymouth 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 the 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.

Annex I Statements from external stakeholders

Both Healthwatch Cornwall and Plymouth continue to have a monthly presence at Derriford Hospital gathering the views of patients, relatives and carers.

NHS Devon Clinical Commissioning Group

NHS Northern Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) & South Devon and Torbay Clinical Commissioning Group, (SDT CCG) (as of 1st April 2019 known as 'NHS Devon CCG') is pleased to provide feedback on the Quality Account for University Hospitals Plymouth NHS Trust (UHPNT) 2018/19 and would like to offer the following commentary. UHPNT is commissioned by NHS Devon CCG as lead commissioner to provide a range of acute services. 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.

As commissioners we have taken reasonable steps to review the accuracy of data provided within this Quality Account and consider it contains accurate information in relation to the services provided and reflects the information shared with the commissioner over the 2018/19 period. This Quality Account summarises and reflects the evidence. The CCG is pleased to see the continued progress with aspects of the 2017/18 quality priorities.

We recognise the work undertaken by the Trust to address issues of long waiting times for treatment. The Trust continues to undertake clinical reviews of patients with extended waits and the backlog of long waits (over 52 weeks) has continued to fall, demonstrating the Trust's commitment to improving patient care.

In respect to Cancer Services we recognise and welcome the Trust's continued commitment to the ongoing re-design and review of both the cancer pathways and current workforce in order to support the needs of the local population.

Care Quality Commission (CQC) Involvement

We welcome and support the Trust's continued open and transparent communication of their involvement with the CQC during 2018/19 in this quality account and note the issues highlighted by the CQC and the level of action taken by the Trust to address those issues.

The CQC report of May 2018 highlighted areas where improvement was required, and the Trust is demonstrating a commitment to make sustainable improvements through action plans and work programmes. We can confirm that, as a commissioner, we have worked closely with the Trust during 2018/19 and will continue to do so in respect to all key objectives for 2018/19. These include:

Emergency Department Investment and Improvement

We recognise that the Trust has found the emergency department 4-hour standard challenging to achieve for a number of years. Earlier this year the Trust undertook a programme of building work to expand and reconfigure the paediatric and resuscitation areas within the ED department. This has already had a positive effect on the overall patient experience and has helped improve patient flow through the hospital.

National Staff Survey

Despite extreme operational pressures, we commend the Trust's success in significantly improving the participation rate of the staff survey and are able to demonstrate that they have a highly reliable data set relating to the 10 themes within the survey. The Trust's rate of improvement remains greater than the average of acute trusts.

Children's Services

NHS Devon CCG commends the development of the electronic advice and guidance to GP's designed by paediatric consultants to ensure referrals are timely and appropriate. GP's can now contact a paediatrician with a query or for guidance on how to manage a paediatric condition. Additionally, the Children's

Annex I Statements from external stakeholders

Community Nursing Team has been working closely with commissioners to promote Personal Health Budgets for eligible families who have children with complex health needs so they can have a more responsive care service at home.

People First Programme

The Trust is one of only 7 national sites chosen to partner with NHS Improvement in a programme of quality improvement work termed the People First Programme. The CCG is very supportive of the Trust in undertaking a comprehensive programme of activities to improve patient care and provide better outcomes and experiences for patients. Additionally, the Trust will use a single approach to build quality improvement right through the organisation with an ambition to join together all the different aspects of quality improvement alongside the operational strategy and staff development.

Looking Forward

Looking ahead, the CCG welcomes the specific priorities for 2019/20 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- Burke
Chief Nursing Officer / Caldicott Guardian
NHS Devon CCG

NHS Kernow Clinical Commissioning Group

NHS Kernow Clinical Commissioning Group is an associate commissioner of services at the Trust. The information contained within the report was reviewed and is considered an accurate summary reflection of the Trust's performance during 2018/19.

NHS Kernow welcomes the opportunity to provide this statement and the approach taken in developing and setting out its plans for quality improvement in 2019/20. It has proved to be a busy year with rising demand, comprehensive Care Quality Commission (CQC) inspections in April/May and then a follow-up in December 2018 alongside challenges across the system. Although improvements were noted, CQC have said that concerns remain and we look forward to supporting you in the People First Improvement Practices launching in 2019. The quality account clearly articulates where the Trust has achieved progress and identifies areas where further improvements are required.

Of particular concern are the improvements required in meeting NHS constitutional standards and the follow up backlog. We note that the Trust has devised detailed action plans and we are pleased to be working with you this year. It is clear that patients are recommending the Trust as the friends and family test reflect high levels of satisfaction across all areas.

NHS Kernow endorses the commitment within the quality account to addressing the challenges of 2018/19. We support the identified quality priorities for 2019/20, and where these will continue from the 2018/19 foundation work. They aim to deliver high quality, safe and accessible services; maximise the potential of the workforce to deliver high quality patient care and to diversify/ develop services that meet patient/ commissioner needs and expectations.

Nikki Thomas
Deputy Director of Nursing & Quality
NHS Kernow CCG

Annex I Statements from external stakeholders

NHS England - Specialised Commissioning, South East and South West

Thank you for sharing the University Hospitals Plymouth NHS Trust Quality Account with NHS England as the Specialised Commissioner for the Trust. This quality account provides a clear overview of the quality challenges the Trust is addressing and the improvements achieved during 2018/19.

NHS England Specialised Commissioning has significant concerns in relation to the performance and sustainability of some Specialties, workforce (capacity/capability) and of patient flow through the Trust as the main tertiary centre in the Peninsula.

Neurosurgery (complex); cardiac surgery and neurology are the specialties of particular concern. In all cases the service performance issues are well rehearsed, but there continues to be limited progress towards sustainable activity levels (agreed but not achieved in 2018/19) going forward. The Trust is advised to consider how it intends to deliver actions which deliver the required activity levels for 2019/20 whilst meeting patient waiting times, minimising risk and delivering good patient outcomes.

The quality implications of the ongoing poor performance cannot be underestimated and NHS England Specialised Commissioning expects the Trust to address these as part of its overall service delivery and quality improvement programme during 2019/20 and beyond.

Staffing remains a challenge within nursing and medicine and Specialised Commissioning endorses the work completed as a response to the CQC reports which highlighted concerns in the Diagnostic Imaging and Pharmacy services.

NHS England Specialised Commissioning is assured that significant work has been undertaken to achieve the improvements required to remove the two section 29A Warning Notices for Pharmacy and Diagnostic Imaging in 2019. It is also reassuring to see these workstreams will be further supported by the People First Programme.

NHS England Specialised Commissioning welcomes the specific priorities for 2019/20 which are highlighted within the report and considers these are appropriate areas to target for continued and sustained improvement.

Participation, follow-up and actions resulting from Peer Reviews are noted, while collaboration around understanding and responding to services on Specialised Services Quality Dashboards and in the Quality Surveillance Annual Declaration will be developed further in 2019/20 and may merit mention in a future Quality Account.

NHS England Specialised Commissioning endorses this Quality Account and looks forward to building upon the established collaborative working arrangements between the Trust and Devon CCG in order that improvements to the quality of care for patients accessing services from University Hospitals Plymouth NHS Trust will continue.

Wendy Cotterell
Regional Director of Nursing
Specialised Commissioning – South East and South West

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 Health and Adult Social Care Overview and Scrutiny Panel has been unable to consider these Quality Accounts as part of a standard committee meeting.

Annex I Statements from external stakeholders

Devon Health and Adult Care Scrutiny Committee

Devon County Council's Health and Adult Care Scrutiny Committee has been invited to comment on the University Hospitals Plymouth NHS Trust's Quality Account for the year 2018/19. All references in this commentary relate to the reporting period of the 1st of April 2018 to the 31st of March 2019 and refer specifically to the Trust's relationship with the Scrutiny Committee.

The Scrutiny Committee commends the Trust on a comprehensive Quality Account for 2018-19 and believes that it provides a fair reflection of the services offered by the Trust, based on the Scrutiny Committee's knowledge.

The Committee is pleased to see that improvements have been made since the 2018 Care Quality Commission (CQC) Warning surrounding Cancer Assessment and Pharmacy services. However, the Committee was disappointed to note that the Care Quality Commission felt that insufficient progress had been made in fully addressing the concerns in the 2018 Warning Notice. Of particular concern were the management issues within Radiography and the Diagnostic Imaging Service not meeting their targets.

In terms of the priorities for 2018-19 Members appreciate the work undertaken by the Trust in the improving of discharge care of patients. This has been an issue of importance to Members. The improvements to ward staffing are positive, but the Committee understands more time is needed to fully implement these changes. Nevertheless, the work done by the trust in this area with Lord Carter and the Department of Health has certainly been of great importance and it is pleasing that the results have been shared nationwide.

The Committee also notes the progress of the Trust in improving the treatment of conditions such as sepsis. The Committee is particularly impressed with the Trust's use of Scan4Safety to improve patient care.

The Committee fully supports the Trust's Quality priorities and goals for improvement in 2019/20. Staffing, improving responsiveness and improving patient communication and information are all crucial areas of work which will lead to an improved delivery of healthcare.

Members anticipate that regular information on the progress on the Trust's goals for 2019/20 and the continued work to meet the areas of weakness noted by the CQC.

The Committee welcomes a continued positive working relationship with the Trust in 2019/20 and beyond to ensure the best possible outcomes for Devon residents.

Lay Chair of the Patient Experience Committee

I believe this Quality Account gives a fair and accurate description of University Hospitals Plymouth NHS Trust during the last year.

The progress and successes it has made are rightly celebrated. Other improvements, not documented here, have also been made which contribute to better patient care and experience in many areas, both clinically and socially. The improvements described in the Quality Account and its annexes give an encouraging glimpse into the way the hospital seeks to live its values.

The Quality Account does not seek to diminish the Trust's problems and failings. These are not unique to University Hospitals Plymouth, or unusual among acute NHS Trusts. They are indications of the nationwide situation in provision of health and social care. The Trust has worked with external stakeholders to implement best practice, but not all improvements have given sustainable results. It is important the Trust works with national, regional and local partners to effect beneficial change; it is also important that the insight and expertise of frontline staff is used in forward planning.

Annex I Statements from external stakeholders

The Quality Account provides evidence that University Hospitals Plymouth NHS Trust learns from both its successes and its failings. The increasing programme of research, development and audit gives assurances that aspirations go beyond words.

The Care Quality Commission inspection in 2018 highlighted some serious problems, on which considerable progress has been made to remedy the issues. Staff commitment to patients maintains the CQC assessment of outstanding for patient care.

Implementation of the priorities choses for 2019/20 will further improve patient safety, outcomes, care and experience.

University Hospitals Plymouth NHS Trust remains my personal choice for hospital care.

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 University Hospitals Plymouth NHS Trust on the Quality Account

We have been engaged by the Board of Directors of University Hospitals Plymouth NHS Trust to perform an independent assurance engagement in respect of University Hospitals Plymouth NHS Trust's Quality Account for the year ended 31 March 2019 ("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 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

- Rate of clostridium difficile infections per 100,000 bed days (on page 41 of the Quality Account)
- Percentage of patient safety incidents resulting in severe harm or death (on page 41 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 2018 to June 2019;
- papers relating to quality reported to the Board over the period April 2018 to June 2019;
- feedback from commissioners dated 13 May 2019 and 17 May 2019;
- feedback from local Healthwatch organisations dated 17 May 2019;
- feedback from the Overview and Scrutiny Committees dated 17 May 2019 and 24 May 2019;
- feedback from other named stakeholders involved in the sign off of the Quality Account dated 17 May 2019;
- national inpatient survey 2018;
- 2018 national NHS staff survey;
- Head of Internal Audit's annual opinion over the Trust's control environment dated 23 May 2019;
- annual governance statement dated 24 May 2019; and
- Care Quality Commission's inspection report dated 16 August 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 University Hospitals Plymouth 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 University Hospitals Plymouth 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 University Hospitals Plymouth NHS Trust.

Our audit work on the financial statements of University Hospitals Plymouth NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as University Hospitals Plymouth NHS Trust's external auditors. Our audit reports on the financial statements are made solely to University Hospitals Plymouth 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 University Hospitals Plymouth 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 University Hospitals Plymouth 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 University Hospitals Plymouth NHS Trust and University Hospitals Plymouth 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 2019:

- 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

Annex J Independent auditor's report

- 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.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Bristol

14 June 2019