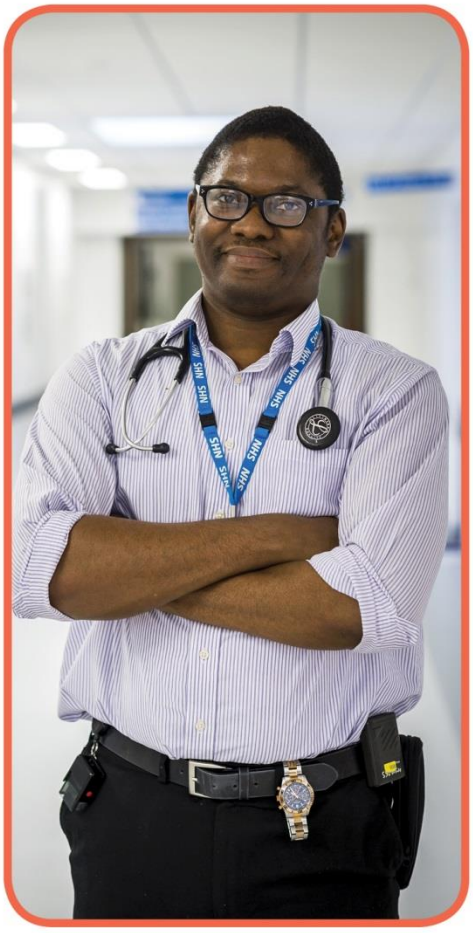
Burton Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 2016 - 2017



SAFE | EFFECTIVE | POSITIVE

Take PRIDE

- Passion
- Respect
- Innovation
- Determination
- Excellence

Burton Hospitals NHS Foundation Trust

Annual Report and Accounts 2016 to 2017

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

Contents

Annual Report 2016 - 2017

Contents

Foreword from the Chairman and Chief Executive

On behalf of the Board of Burton Hospitals NHS Foundation Trust, we present the Annual Report and Accounts for the financial year 2016/17.

The Trust has made great strides over the past 12 months. Our patients continue to be at the centre of everything we do and our hard working staff are driving improvements and providing high quality care to our local populations on a daily basis. In the year since we joined the organisation, we have been overwhelmed by the dedication, professionalism and commitment our staff show to delivering the very best possible outcomes and experience to the people of Burton, Lichfield, Tamworth and the surrounding areas.

It's also an incredibly exciting time to be part of the Trust. We know that with increased demand for our services, more and more people will need us to be there for them in their hour of need. That brings expectations and we need to work together to meet them while maintaining our high standards.

We have set an ambitious goal of being rated as "Outstanding" by the Care Quality Commission (CQC). It is ambitious because we know we have a huge amount of work to do to get there, after being rated as 'Requires Improvement' following the CQC inspection in July 2015. But we are taking steps to achieve this. We are focused on recruiting and retaining the best clinical and non-clinical staff to work at our hospitals and we are in constant dialogue with our patients and their loved ones about the services they want and how we can improve their care.

A key strand of this ambition is the Quality Improvement Strategy for 2016-19, which we launched in September 2016. This sets out the achievements we have made from the original strategy, published in 2013, as well as setting out how we want to improve care and patient experience.

Our mantra remains to have 'Safe, Effective, Positive' services and care for our patients. That is not going to change and we know this is what our staff strive for on a daily basis. More than ever though, we are working in a changing healthcare landscape and this presents us with new challenges and opportunities for the future.

We will not be facing those challenges by ourselves though. There is no doubt that our partners will play a significant part in our journey towards excellence. Over the last year, we have moved forward with our plans to collaborate with our neighbours at Derby Teaching Hospitals NHS Foundation Trust.

Moving forward with Derby will bring huge benefits to both Trusts, allowing us to identify and pursue new opportunities as well as share expertise and resources locally. We need to ensure that the services we are providing are in line to the needs of our populations.

Alongside this, we are continuing to work with our partners across Staffordshire and Stoke-on-Trent as part of the Sustainability and Transformation Partnership (STP). Staffordshire is one of the most challenged areas of the country and as one of the main acute providers in the county, we are playing a huge part in helping to

shape its future. Our patients tell us that they want to receive their care where they live, preferably in their own home and not in a hospital setting when it's not required.

The STP will provide us with a blueprint for delivering place-based care in the local communities offering support at home, or close to home, for those with long-term conditions and our most vulnerable elderly patients. We will continue to be part of these discussions throughout 2017/18 to ensure we can provide the best care for our patients.

The Trust will also be continuing the transformation of our Community Hospitals in Lichfield and Tamworth. A great deal of work has been done to ensure these excellent and much-valued facilities meet the care requirements and demands of their populations, and this will continue throughout 2017/18.

We were delighted to welcome new additions to the Trust's Executive Board over the past year. Paula Gardner, who had been working as the Trust's Deputy Chief Nurse, was appointed as Chief Nurse in June 2016. Paula has a wealth of nursing experience and, in conjunction with Medical Director Dr Magnus Harrison, is leading the Trust's quality strategy to continually improve the care to patients.

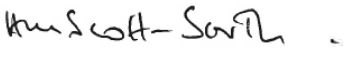
We also welcomed Jonathan Tringham to the position of Director of Finance, Information, Performance and Estates in December 2016. Jonathan also has a wealth of NHS experience, most recently at one of our community providers in Staffordshire, and we were delighted to welcome him to our Board.

The Non-Executive Directors and Governors play a crucial role in the smooth running of our Trust and we would like to thank them for their time, their valuable input and their hard work over the past year. They ensure that staff and public members have a voice on hospital issues. We'd also like to extend our gratitude to those governors who have stepped down over the last year, namely Maqsood Hussain, Emma Salt and Rebecca Carlton.

We would also like to thank Andrew Hughes, who finished his role as Non-Executive Director last year and Dennis Heywood, who will finish in July 2017. Their significant contributions are much appreciated by the Board. Andrew has been replaced on the Board by Joy Street and Dennis will be replaced by Steve Hollingsworth. We warmly welcome them both to the Trust.

Finally, we would like to thank the tireless work of our staff and volunteers over the last year. Coming to hospital can be an incredibly distressing time for patients and their loved ones but our staff show dedication, respect, and a great deal of care to ensure that they receive the best experience possible.

We are incredibly proud of our staff and volunteers and they play an integral role in helping the Trust achieve their ultimate purpose of providing timely, compassionate care to our local populations.



John Rivers
Chairman

Helen Scott-South
Chief Executive

Part 1 - Performance report

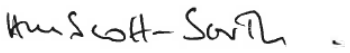
1.1 Overview of performance

1.1.1 Statement from the Chief Executive

The overview of performance provides a short summary of the Trust's aims, objectives and performance, together with the key risks to the achievements of those objectives during the year.

These are challenging times, but it is the commitment of our dedicated team of 3,500 staff and volunteers who are working hard to deliver and demonstrate these important values to our patients and their families and friends that is making the difference. However, we all acknowledge that this is a continuing journey towards our goal of ever-higher standards of quality and care and achieving an Outstanding rating by the Care Quality Commission. Like most other hospitals, we have experienced growing demand for emergency care which has placed pressure on not only our 'Front Door' services but also on our diagnostic and planned care services. However, throughout 2016/17 our staff, across the Trust, have been able to rise to this challenge which has ensured that performance against a number of key operational standards, has not only continued to improve but in the latter part of the year reached compliance against the Four Hour Urgent Care routine elective and diagnostic national standards, whilst ensuring that we continue to deliver safe and effective care throughout.

From a financial perspective, the Trust had agreed to deliver a planned deficit of £9.9m in line with the Control Total set by NHS Improvement. The actual result was a deficit of £8.2m and generation of £7.4m 'in year' Cost Improvement savings.



Helen Scott-South
Chief Executive

1.1.2 Statement of the purpose and activities of the Foundation Trust

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

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

The Sir Robert Peel Community Hospital in Tamworth provides the local population with services including a Minor Injuries Unit, outpatient clinics,

rehabilitation beds, day case surgery, endoscopy and X-ray and pharmacy services.

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

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

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

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

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

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

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

Our Hospital facilities

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

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

Services at a glance:

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

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

1.1.3 History of the Foundation Trust and its statutory background

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

1.1.4 Vision, objectives and values

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

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

The Staffordshire and Stoke-on-Trent STP was published on 15 December 2016. This followed a series of ten "Conversation Staffordshire" and "Conversation

Stoke-on-Trent" events hosted by both local Healthwatch organisations during November and December 2016. The STP priorities are:

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

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

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

A strategic collaboration programme of work was established during 2015/16 to answer two key questions**:**

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

The Trusts have agreed that the following guiding principles will form the basis of the collaboration work:

- Queen's Hospital will remain a vibrant District General Hospital
- Derby Teaching Hospitals NHS Foundation Trust will have access to a larger population across which to plan its services.

Both Trusts have considered the options for securing future sustainability and have decided that some form of strategic collaboration is likely to be the best way to address the specific sustainability challenges, as outlined in a Strategic Outline Case which was agreed by both Boards in October 2016.

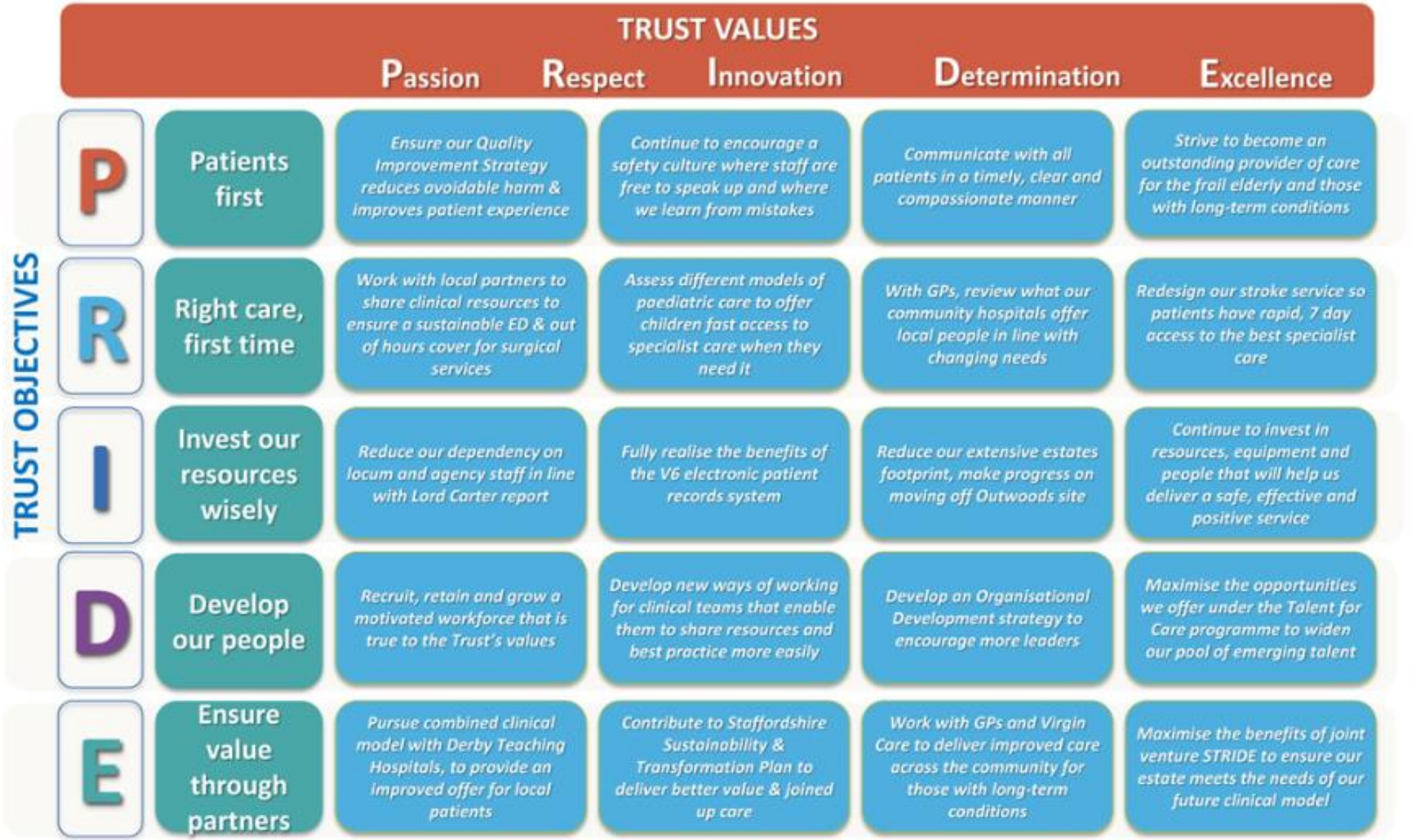
Since then, the Trusts have been working together to examine how they might reduce duplication and costs and support the future delivery of sustainable services for the benefit of patients and taxpayers. This could result in both clinical

services and shared services working in an integrated way across Trusts, with input into Staffordshire and Derbyshire STPs.

A Strategic Collaboration Board and Project Team have been established, as well as Patient and Staff Reference Groups (with the support of HealthWatch Staffordshire, Derbyshire and Derby), which acts in an advisory capacity to the programme. The Outline Business Case is due for consideration during 2017/18.

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

The STP and collaboration with Derby Teaching Hospitals NHS Foundation Trust form the bedrock of the Trust's plans for the years ahead. A "Plan on a Page" for 2016/17, (see diagram below) outlines the key priorities for the Trust, linked to the wider strategy. The ambition ***"To Be The Best, Every Patient, Every Time"*** is at the heart of the Trust's vision, mission and values.


TRUST VALUES
Passion
Respect
Innovation
Determination
Excellence
TRUST OBJECTIVES
P
Patients first
Ensure our Quality Improvement Strategy reduces avoidable harm & improves patient experience
Continue to encourage a safety culture where staff are free to speak up and where we learn from mistakes
Communicate with all patients in a timely, clear and compassionate manner
Strive to become an outstanding provider of care for the frail elderly and those with long-term conditions
R
Right care, first time
Work with local partners to share clinical resources to ensure a sustainable ED & out of hours cover for surgical services
Assess different models of paediatric care to offer children fast access to specialist care when they need it
With GPs, review what our community hospitals offer local people in line with changing needs
Redesign our stroke service so patients have rapid, 7 day access to the best specialist care
I
Invest our resources wisely
Reduce our dependency on locum and agency staff in line with Lord Carter report
Fully realise the benefits of the V6 electronic patient records system
Reduce our extensive estates footprint, make progress on moving off Outwoods site
Continue to invest in resources, equipment and people that will help us deliver a safe, effective and positive service
D
Develop our people
Recruit, retain and grow a motivated workforce that is true to the Trust's values
Develop new ways of working for clinical teams that enable them to share resources and best practice more easily
Develop an Organisational Development strategy to encourage more leaders
Maximise the opportunities we offer under the Talent for Care programme to widen our pool of emerging talent
E
Ensure value through partners
Pursue combined clinical model with Derby Teaching Hospitals, to provide an improved offer for local patients
Contribute to Staffordshire Sustainability & Transformation Plan to deliver better value & joined up care
Work with GPs and Virgin Care to deliver improved care across the community for those with long-term conditions
Maximise the benefits of joint venture STRIDE to ensure our estate meets the needs of our future clinical model

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

Patients First
Right care, first time
Invest our resources wisely
Develop our people
Ensuring value through partners

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

Passion
Respect
Innovation
Determination
Excellence

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

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

1.1.6 Going concern disclosure

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

1.2 Performance analysis

1.2.1 Performance framework

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

- Key performance measures are adequately reflected in the risk register and related action plans.
- The Trust has adopted a forward looking approach to the review of targets to support the self-certification process and provide appropriate assurance of delivery.
- The Trust provides appropriate reports and briefings to the Board on significant performance monitoring issues, confirming the action taken/proposed to address these.

- The Trust ensures that data quality is complete, accurate and robust and provides adequate assurance to the Board on all targets.

1.2.2 Operating review - key performance measures

National Targets and Regulatory Requirements	2015/16 Target	2015/16 Actual	2016/17 Target	2016/17 Actual	2016/17 Performance Against National Target
Compliance with Core Standards as declared to the Care Quality Commission		✓			✓
Clostridium difficile – Number of cases (including Samuel Johnson Community Hospital and Sir Robert Peel Hospital)	20	27	15	13	✓
MRSA - maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level (including Samuel Johnson Community Hospital and Sir Robert Peel Hospital)	0	2	0	3	X
Referral to Treatment Waiting Times - Incomplete Pathways (including Samuel Johnson Community Hospital and Sir Robert Peel Hospital)	92%	92.60%	92%	94.27%	✓
Maximum waiting time of 4-hours from arrival in A&E to admission, transfer or discharge (including attendances at Samuel Johnson Community Hospital and Sir Robert Peel Hospital)	95%	93.01%	95%	90.61%	X
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93%	95.40%	93%	95.90%	✓
Maximum waiting time of 2 weeks to first outpatient appointment for all suspected Breast Cancer referrals	93%	81.40%	93%	91.00%	X
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96%	98.70%	96%	99.10%	✓
Maximum waiting time of 31 days from diagnosis to subsequent treatment: Surgery	94%	97.10%	94%	94.50%	✓
Maximum waiting time of 31 days from diagnosis to subsequent treatment: Drug Treatments	98%	99.50%	98%	100%	✓
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	85%	86.20%	85%	78.90%	X
Maximum waiting time of 62 days from urgent referral to treatment for consultant screening service referrals	90%	100%	90%	96.70%	✓
Please note Cancer Figures are for April 16 to February 17 only (Latest Available)					

1.2.3 Analysis of key areas of performance

With the introduction of Meditech Version 6 on 1 March 2016, which is the Trust's fully integrated Electronic Patient Record solution, this supported the Trust to return to national reporting of the Referral to Treatment (RTT) waiting times target for incomplete pathways in November 2016 and the Trust has been compliant in each month since. The Trust paused the reporting of RTT data momentarily in April 2016 in order to ensure all processes that ensure accurate reporting were in place and that the data was fully validated.

As with RTT, the Trust has seen a significant improvement in the A&E target (95% under 4 hours) performance through the course of 2016/17. Whilst being a challenging year, like the majority of NHS hospitals, the establishment of the A&E Delivery Board and the focus on the transformation of our acute pathways, the Trust has worked with its partners; those responsible for commissioning services, community organisations and Local Authorities to improve the levels and quality of care provided so patients can be seen, treated and safely discharges in a timely manner. The result has been an improving trend in performance within the Trust, culminating with compliance against the standard in March 2017 at 97.26%, placing the trust as one of the strongest performers in the country.

The 62 day Cancer Standard remains a key standard where compliance has not consistently been delivered. Whilst this is a picture reflected nationally, as is the significant growth in demand, a continued focus on ensuring appropriate capacity is in place at key steps of the tumour site pathways. A systematic review of the patient pathways themselves is also underway to ensure a more timely treatment after initial referral. The Trust has actively been working with Derby Teaching Hospitals NHS Foundation Trust, our main tertiary cancer centre, to ensure a seamless transition for patients requiring specialist treatment in Derby.

Patients treated	2015/16	2016/17	Variation
Non-elective patients	34,376	35,744	1,368
Elective inpatients	3,857	4,008	151
Day case procedures	27,658	29,240	1,582
Renal Unit	5,931	5,745	-186
New outpatients	79,120	82,868	3,748
Follow up outpatients	136,970	138,609	1,639
A&E attendances (including Minor Injury Units)	130,044	125,023	-5,021
All patients	**417,956**	**421,237**	**3,281**

Notes

- Inpatient figures are based on the number of spells
- Non-electives excluding well babies
- Outpatient figures are based on the number of Consultant attendances
- A&E attendances include both planned and unplanned attendances

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

1.2.4 Transformation

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

- **Planned Care**, including Outpatient redesign, improving theatres and elective pathways and developing our diagnostic services;
- **Unplanned Care**, focussed on the acute pathway, processes in the Emergency Department, reducing attendances and avoiding admission and supporting early, effective discharge;
- **Community Hospitals,** shaping the vision for the two hospitals to become hubs for their community's offering enhanced range of services to the population served.

Alongside these key strands of work, a key element of developing a culture of transformation within the organisation is to ensure all staff have the opportunity to be included. The first cohort of Trust and wider health community staff undertook training on the newly introduced QSIR (Quality, Service Improvement and Redesign) Programme. This provided an opportunity to learn how to implement, measure and analyse service improvements in their areas with the programmes to be rolled out further in the coming year.

1.2.5 Financial review

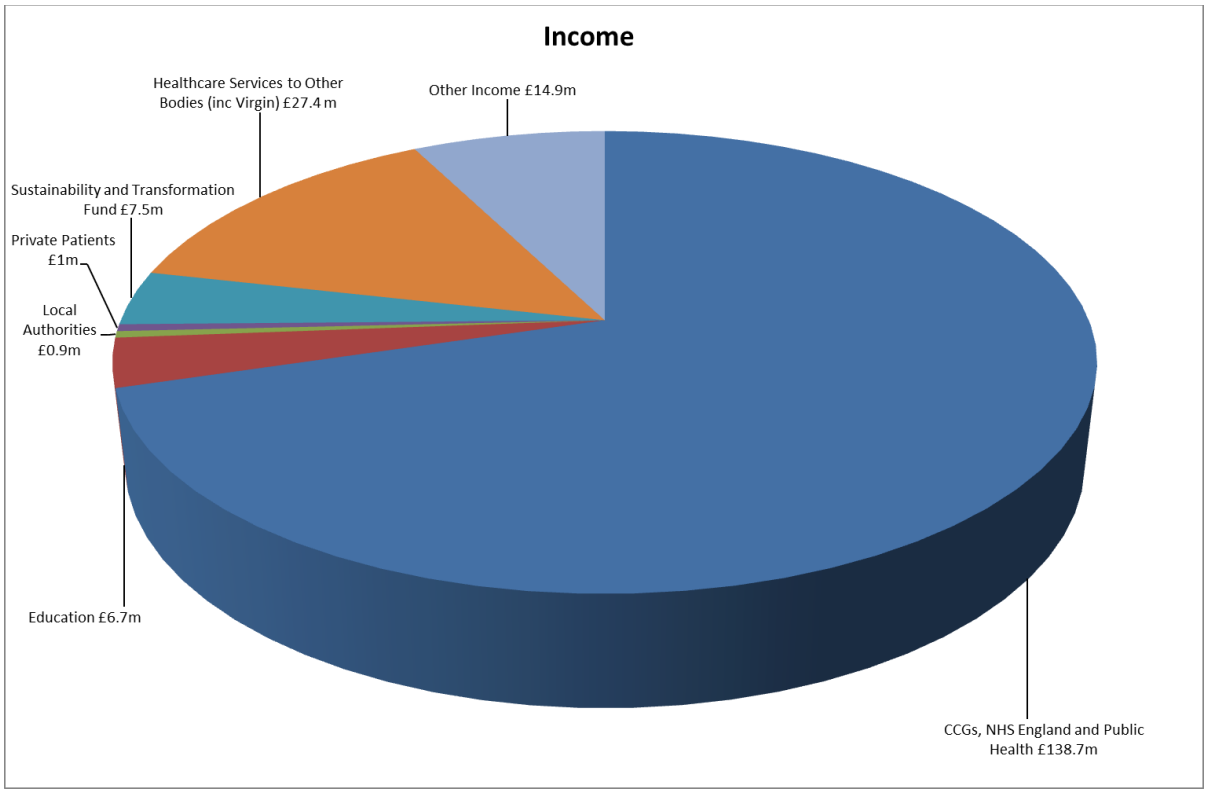
The Trust recorded a deficit of £8.2 million for the year after having received £7.549 million funding from the Sustainability and Transformation Fund for meeting financial targets. Throughout the year the Trust continued to receive financial support in the form of an Interim Working Capital Loan from the Department of Health. As at 31 March 2017 the Trust had received £38.3 million in loans of which £12.9 million related to loans received in 2016/17.

Financial performance for year ending 31 March 2017

	£'000
Earnings before Interest, Taxation, Depreciation and Dividends	1,007
Depreciation	(6,102)
Finance Costs and Dividends	(3,031)
Income from Charitable Donations	71
Impairment of Non Current Assets	(254)
Gains on Disposal of Assets	93
Investment Return	19
Retained Deficit for Year	(8,197)

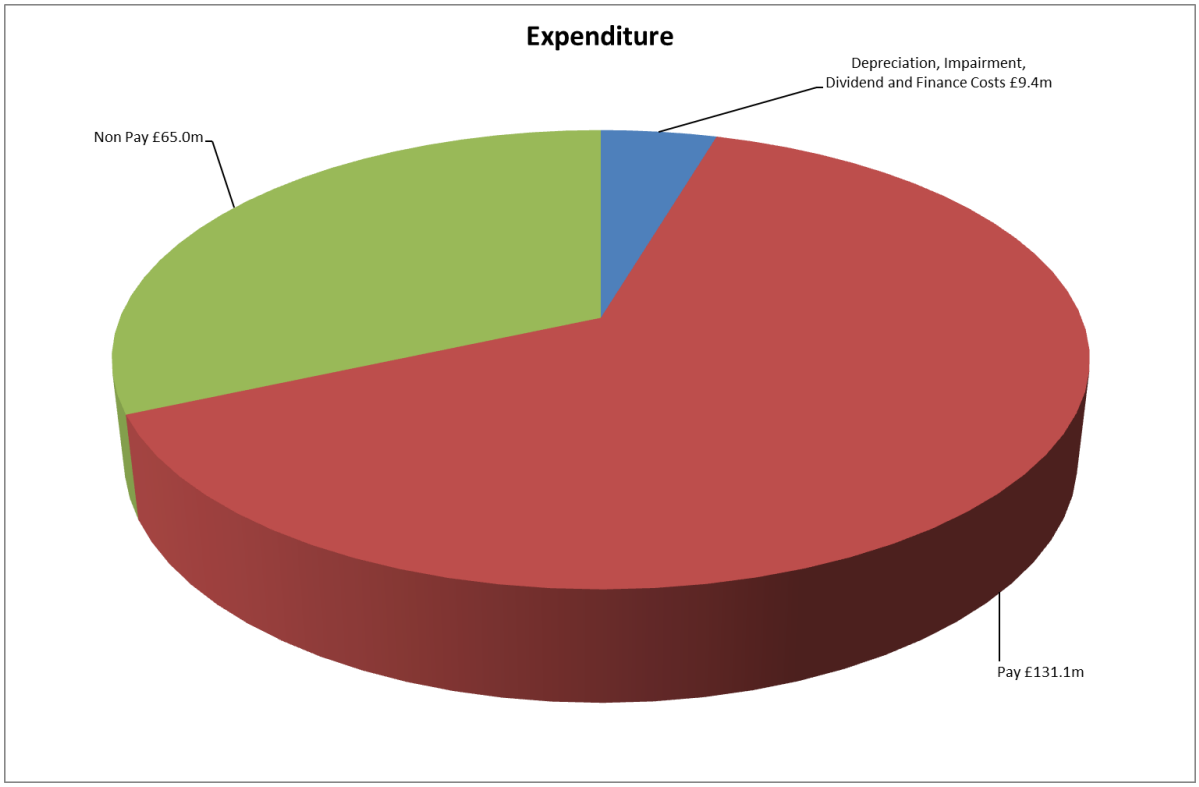
Income

Income for the year amounted to £197.2 million of which £169 million was for clinical services and a further £7.5 million from the Sustainability and Transformation Fund. The balance includes income for staff training and other supplies and services provided.



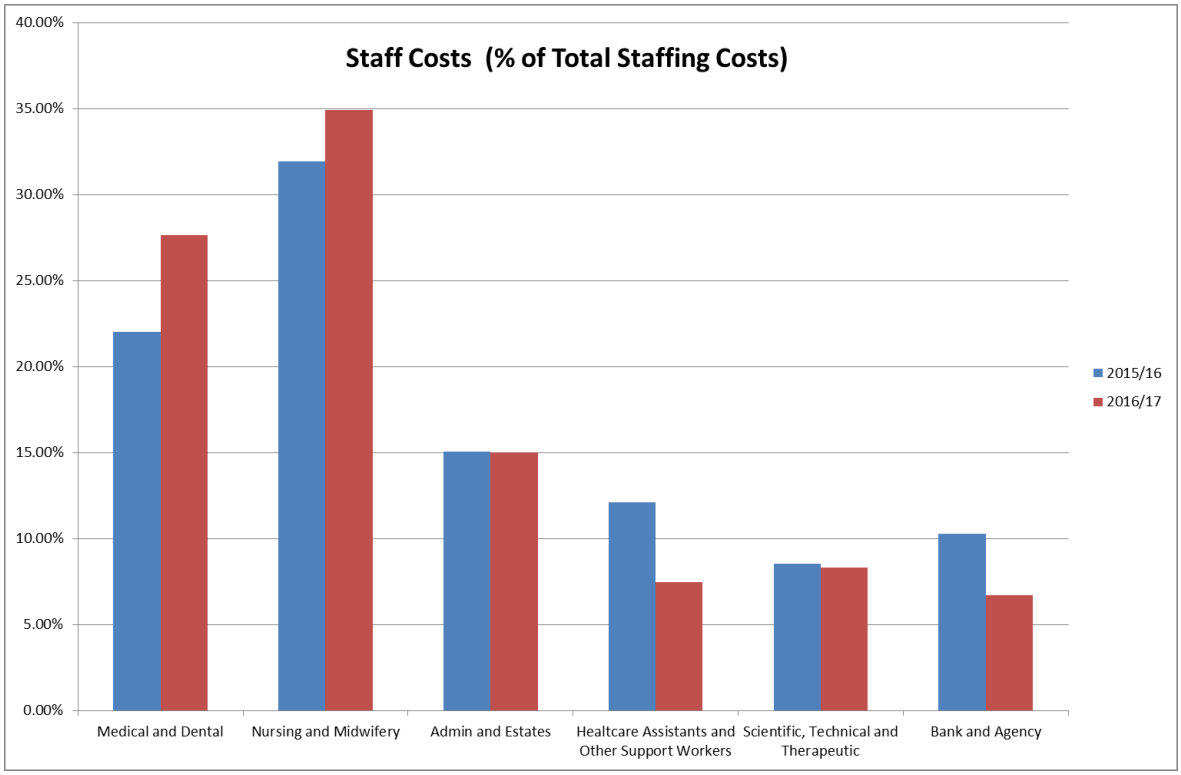
Expenditure

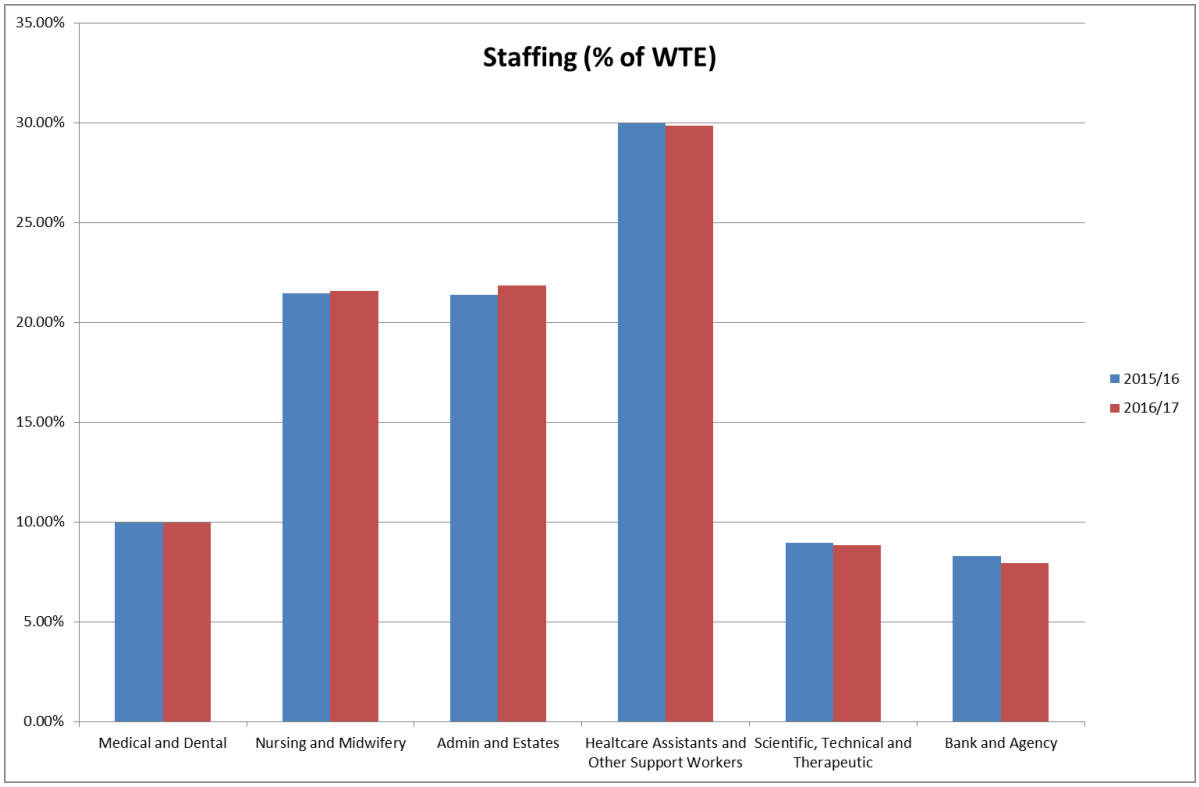
Total costs incurred during the year amounted to £205.5 million.



Pay costs

The Trust spent £131.1 million on pay costs. The breakdown over staff groups is shown below.





1.2.6 Financial disclosures

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

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

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

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

Value for money

The Trust's Auditors, on the basis of their work, having regard to the guidance issued by the Comptroller and Auditor General in November 2016, are satisfied that, in all significant respects, the Trust had proper arrangements in place to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

1.2.7 Social, community and human rights issues

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

1.2.8 Important events since the end of the financial year

Appointment of Non-Executive Directors

Due to Andrew Hughes stepping down and with Dennis Heywood leaving the Trust on 31 July 2017 the Appointments Committee of the Council of Governors, supported by an external recruitment consultant, led the process to recruit two Non-Executive Directors. The Appointments Committee agreed that, due to the collaboration work with Derby Teaching Hospitals NHS Foundation Trust, the Term of Office would be for one year. In addition, the Board of Directors required two specific skill sets; a financially qualified Non-Executive Director and a Non-Executive Director with previous Board / Senior NHS experience.

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

- Joy Street, who has previous Board and senior NHS experience, was appointed from 1 April 2017 to 31 March 2018;

- Steve Hollingsworth, who has a financial background, was appointed from 5 April 2017 to 31 March 2018.

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

Council of Governors Elections

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

Elections will be held in East Staffordshire, Lichfield & Tamworth and the Staff – Non Clinical constituencies.

1.2.9 Overseas operations

The Trust has no overseas operations.

1.3 Sustainability and Carbon Reduction

Climate change brings new challenges to the healthcare sector both in its direct effects to the healthcare estate and the impact it has on patient health. The NHS in England has an approximate carbon footprint of 23 million tonnes of CO_2e per year and, despite an increase in efficiency, an increase of around 40% has been observed since 1990. Within its Carbon Reduction Strategy (2009) the NHS upheld the view that carbon reduction is an integral corporate responsibility of every NHS organisation. The Trust acknowledges the responsibility that it has to our patients, employees, local communities and the environment, by working hard to minimise our carbon footprint.

As a healthcare provider it is our duty to contribute towards targets set within the NHS Carbon Reduction Strategy including a 34% reduction in the NHS carbon footprint by 2020, and 80% by 2050, compared to a 1990 baseline. It is accepted that work must be undertaken at the Trust to significantly reduce our current emissions in order to meet these targets. Consequently, we endeavour to work in partnership with staff, contractors and our local communities to promote sustainability and climate change mitigation, and to embed sustainability within the organisation.

1.3.1 Policies

In order to embed sustainability within our business it is important to explain where sustainability features in our processes and procedures. During 2017/18 we will be developing an updated Sustainable Development Management Plan (SDMP) and we have also identified the need for an Adaptation Plan to outline the ways in which we will respond to the challenges that climate change imparts upon our organisation and community.

Policy Area	Is sustainability considered?	Planned actions
Travel	No	A Sustainable Travel Plan has been developed and will be submitted for Board approval/ratification in 2017/18.
Business Cases	No	No planned actions.
Procurement – environmental, social and suppliers' impact	No	An updated Procurement Policy, including sustainability considerations, is under development and will be submitted for Board approval/ratification in 2017/18.

1.3.2 Management structure

The Chief Executive has overall responsibility for ensuring compliance with statutory regulations related to environmental management, energy consumption and sustainability; ensuring that appropriate accountability is devolved to Directors, Managers and Heads of Departments.

The Executive and Non-Executive Directors with responsibility for sustainability will oversee the Trust's forthcoming Sustainable Development Management Plan and its implementation in practice. They will also guide, lead and nurture the Sustainable Development Group, to ensure that the Trust's sustainability and carbon reduction vision, goals and objectives are delivered and targets achieved.

Both the Chief Executive and Directors with a responsibility for sustainability will ensure that suggestions progressed to the Board conform to current carbon reduction legislation and the Trust's own sustainability goals.

1.3.3 Partnerships

The NHS policy framework sets the scene for commissioners and providers to operate in a sustainable manner. Crucially, for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms. We have not currently established any strategic partnerships for carbon reduction but seek to develop these in the near future.

It is important to highlight the link between sustainability reporting of commissioners and providers. The NHS Sustainable Development Unit state that sustainability reporting, on the part of Clinical Commissioning Groups (CCGs), can actively support and encourage providers to reduce the environmental impacts of their services and improve public health. For commissioned services, sustainability indicators for our CCGs are as follows:

Organisation Name	SDMP	Sustainable Development Reporting score
NHS East Staffordshire CCG	Yes	Minimum
NHS South East Staffordshire and Seisdon Peninsula CCG	No	Poor
NHS Southern Derbyshire CCG	Yes	Good

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

1.3.4 Carbon Reduction Targets

The Trust has taken a number of steps to reduce its overall carbon footprint, in order to improve the environment in which our staff and patients live and to ensure progress towards achieving the following targets:

- 34% reduction in CO_2e emissions by 2020, compared to 1990 baseline
- 80% reduction in CO_2e emissions by 2050, compared to 1990 baseline
- Achieve a rating of 35-55 GJ/100m^3 for all "new builds"
- Achieve an overall rating of less than 65 GJ/100m^3 for the combined Trust estate.

The Climate Change Act presents a requirement for reductions in emissions compared to a 1990 baseline. The Trust has changed markedly during the 27 years following the baseline year including:

- Between 1990 and 1993 a £34 million capital development was undertaken to re-develop the Belvedere Road site. Re-development enabled the transfer of clinical services from the Victorian/1940s Burton General Hospital to the Burton District site (now Queen's Hospital).
- Demolition of Victorian Wings on the Burton District Hospital site enabled provision of a Cook/Chill Food Central Processing Unit.

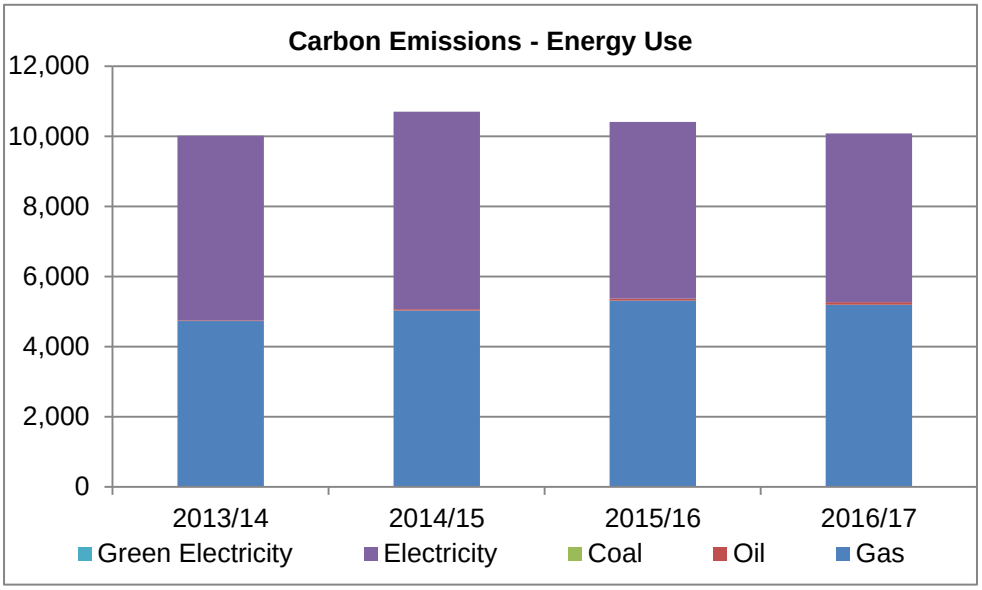
- Construction and purchase of Private Finance Initiative Independent Sector Treatment Centre (ISTC) at Burton District Hospital site.
- Acquisition of Community Hospital sites at Tamworth and Lichfield.

1.3.5 Performance

Energy

The Estates Department plays a lead role in promoting energy efficiency within the Trust; including managing consumption and ensuring that all new developments incorporate efficient designs where practical. The Estates Department also seeks to provide safe, comfortable and high quality working environments that are provided with reliable sources of energy to assist the Trust in maintaining its activities in the most cost-effective and sustainable manner. The Trust consumed 134,939 GJ of energy, a spend of £1,537,566 in 2016/17, which is a 2.6% decrease on energy use and a 0.2% increase on energy spend compared to 2015/16.

Energy consumption and attributable tonnes of CO_2e					
Resource		**2013/14**	**2014/15**	**2015/16**	**2016/17**
Gas	Use (kWh)	25,783,217	27,397,150	28,931,890	28,327,036
	tCO_2e	4,734	5,030	5,312	5,201
Oil	Use (kWh)	64,387	161,067	238,268	254,748
	tCO_2e	17	42	61	66
Coal	Use (kWh)	0	0	0	n/a
	tCO_2e	0	0	0	0
Electricity	Use (kWh)	9,735,614	10,408,095	9,309,585	8,901,325
	tCO_2e	5,267	5,631	5,036	4,816
Green Electricity	Use (kWh)	0	0	0	0
	tCO_2e	0	0	0	0
Total Energy CO_2e		**10,018**	**10,703**	**10,409**	**10,083**
Total Energy Spend		**£2,085,322**	**£2,092,266**	**£1,534,665**	**1,537,566**

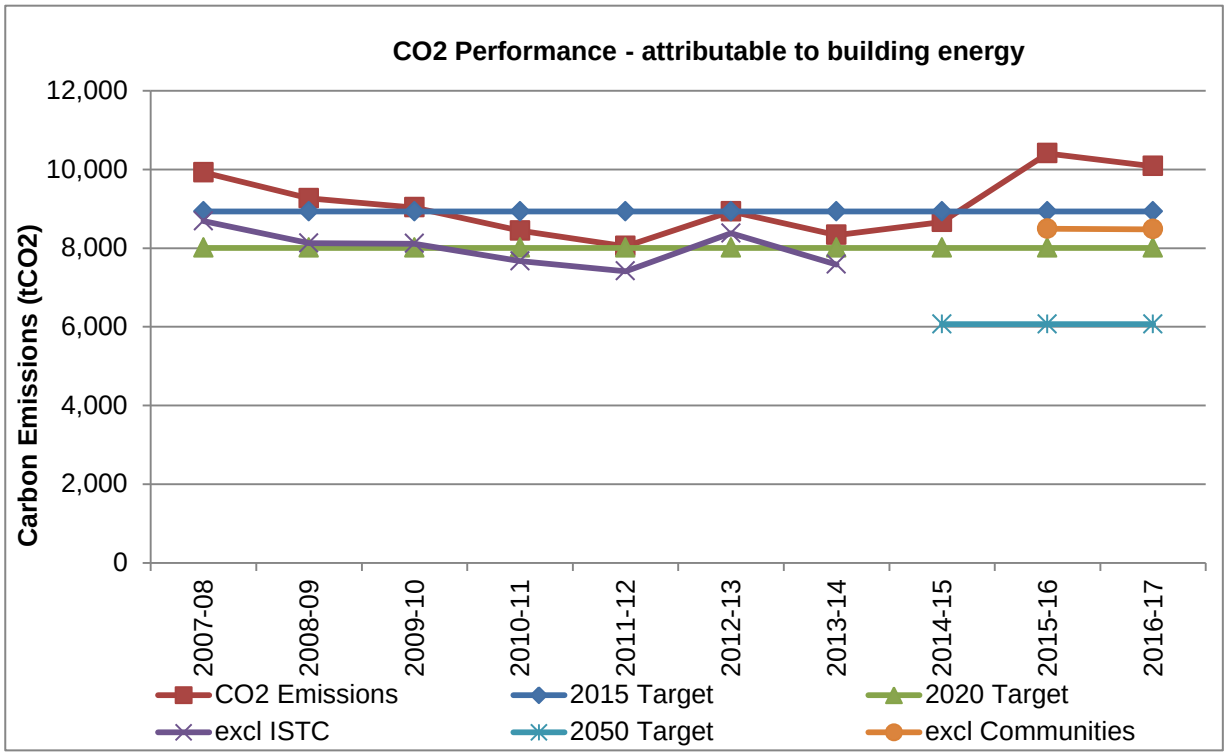


In account of the changes undertaken at the Trust since the baseline year of 1990, emissions attributable to building energy have been normalised to floor area to ensure accurate comparisons can be made. In 2016/17 building energy emissions of 124kg CO_2 per metre squared were observed, in comparison to 209kg per

metre squared in 1990. This represents a 41% reduction in building energy emissions in 2016/17 compared to 1990. However, with a building energy rating of 66GJ/100m^3 the target detailed within our Trust Energy Policy, for a rating of less than 65GJ/100m^3 for the combined estate, is not currently being met.

Year	CO_2 emissions per metre squared	Building energy rating for the combined Trust estate
1990 baseline	209Kg CO_2/m^2	78GJ/100m^3
2016/2017	124Kg CO_2/m^2	66GJ/100m^3

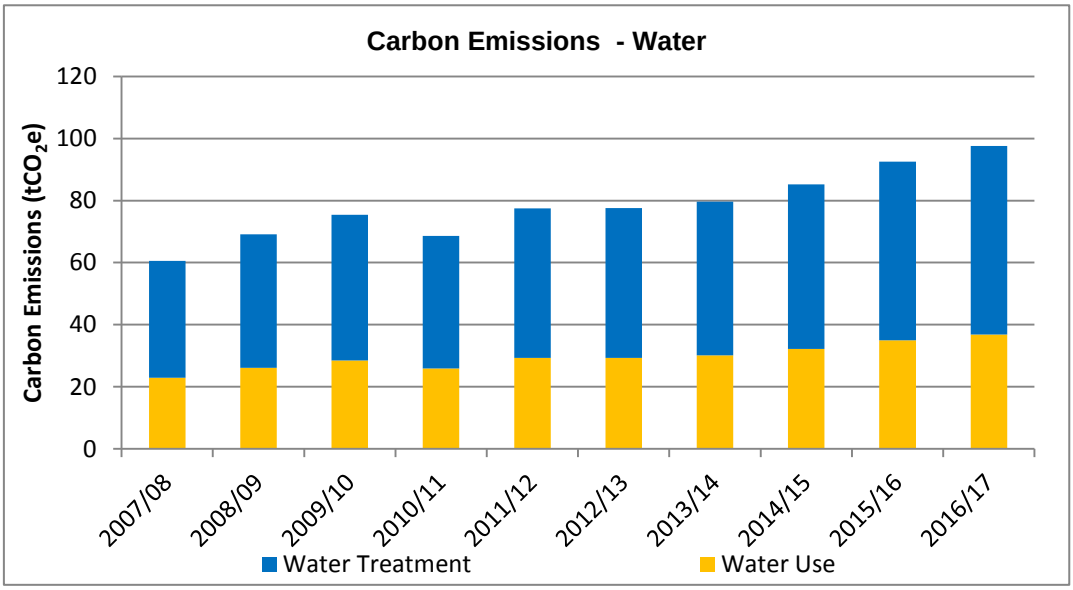
The Trust's overall carbon performance for emissions attributed to building energy is highlighted in the following graph. The target for a 10% reduction in emissions by 2015 was met in 2014/15, however, building energy emissions rose to above these levels in 2015/16 and 2016/17. The recent impact of acquiring the Community Hospital sites is clearly shown on the following graph.



Water

The Trust consumed 107,166 m^3 of water, a spend of £151,104 in 2016/17, which is a 5% increase on water consumption and a 3% decrease on water spend compared to 2015/16.

Water consumption and attributable tonnes of CO_2e					
Water		2013/14	2014/15	2015/16	2016/17
Mains	m^3	87,434	93,578	101,558	107,166
	tCO_2e	80	85	92	97
Water & Sewage Spend		**£156,800**	**£93,578**	**£202,559**	**£195,875**



Waste

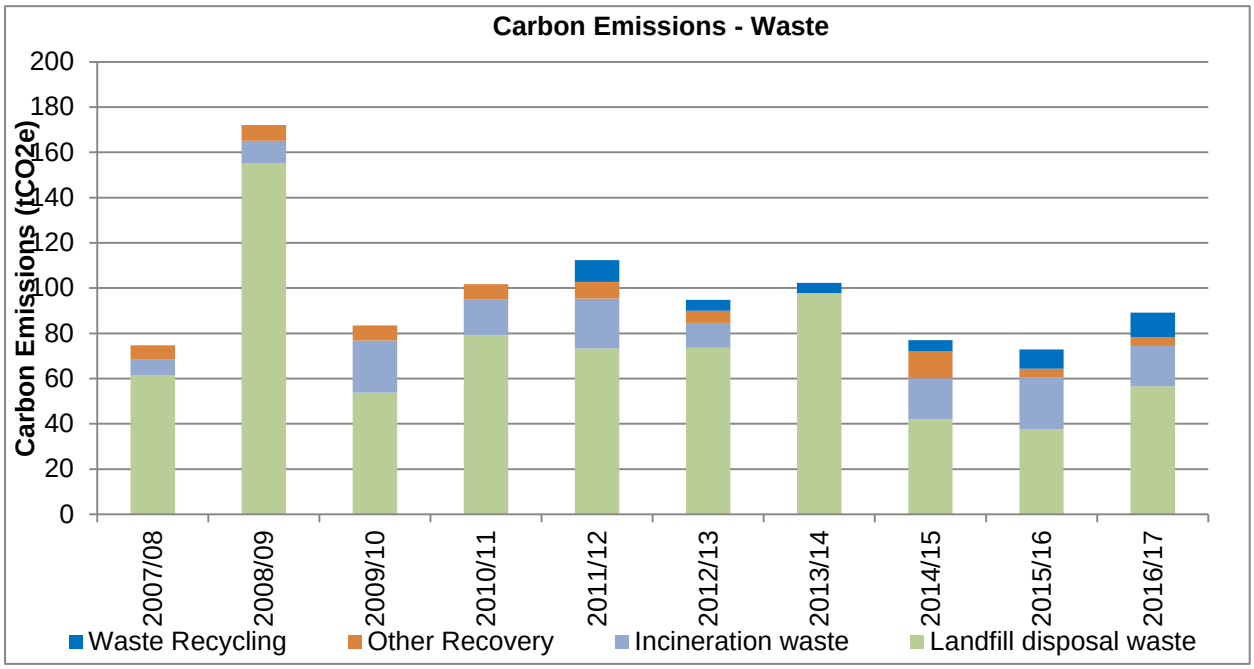
As a waste producer, the Trust is required to comply with waste management legislation, including the 'waste hierarchy', which ranks waste management options according to the impact that each has on the environment; valuing prevention, re-use, recycling and recovery above disposal. The Trust is committed to working with its waste contractors to ensure that our waste is treated both safely and in keeping with the waste hierarchy.

In line with our sustainable waste management values, the Trust continues to use reusable sharps boxes rather than plastic single-use containers. Utilising reusable sharps boxes reduces the amount of plastic waste sent for disposal amongst sharps by approximately 25% each year.

An average recycling rate of 94% for general waste was achieved in 2016/17; compared to 88% in 2015/16. In addition, 60% of the Trust's healthcare waste was suitable for Alternative Treatment or Incineration with Energy Recovery during 2016/17; these methods of treatment are classed as "Other Recovery" in the waste hierarchy.

Unfortunately, the transport and treatment of waste does contribute to the Trust's carbon footprint and the Estates Department endeavours to monitor and report upon these carbon emissions. The Estates Department is currently working with all of our waste management contractors to assess the carbon emissions produced during transport and treatment of our waste to guarantee that we are well informed regarding the environmental impact of our waste management activities.

Waste disposal and attributable tonnes of CO_2e					
Waste		2013/14	2014/15	2015/16	2016/17
Recycling	(tonnes)	213.43	229.33	428.00	510.00
	tCO_2e	4.48	4.82	8.56	10.71
Other recovery	(tonnes)	0.00	571.79	193.85	191.01
	tCO_2e	0.00	12.01	3.88	4.01
High Temp disposal	(tonnes)	0.00	82.14	104.15	80.96
	tCO_2e	0.00	18.07	22.81	17.81
Landfill	(tonnes)	400.08	172.00	154.25	182.63

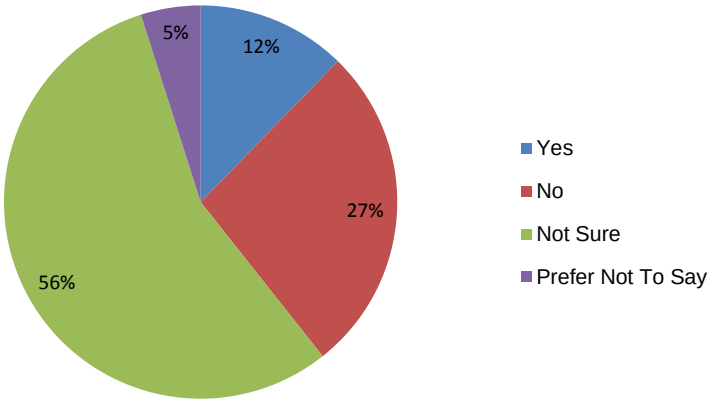


Travel

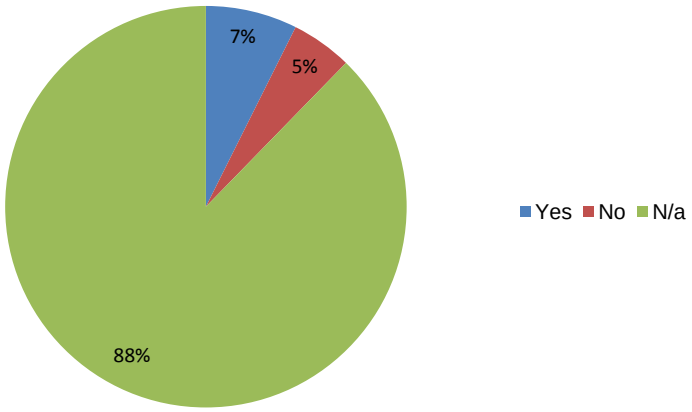
The Trust can improve local air quality and the health of our community by promoting active travel, which is any form of travel that incorporates exercise such as walking or cycling, to our staff and the patients and public that use our services. A Trust-wide travel survey was conducted in July 2016 to provide a baseline of staff travel behaviours. Uptake of the survey was low, with only 122 staff responding to the survey. The results of the survey have been used during the development of a Sustainable Travel Plan, for which Board approval will be sought in 2017/18. The travel survey will be repeated annually, to highlight any changes in staff travel behaviours and increased participation in the survey will be encouraged.

The results of the survey suggest an over-reliance on single occupant car travel (utilised as a primary means of transport by 65% of participants) within the Trust. The data also highlights reluctance in adopting sustainable transport measures, evidenced in 88% of participants responding 'not applicable' when asked whether they would like to use their car less for their journey to work. However, a significant number of respondents (68%) stated that they could be encouraged to use cycling, public transport or car sharing during their commute, providing that the Trust implement measures to promote such travel options. Unfortunately, only 12% of respondents stated that the Trust encourages and facilitates sustainable travel.

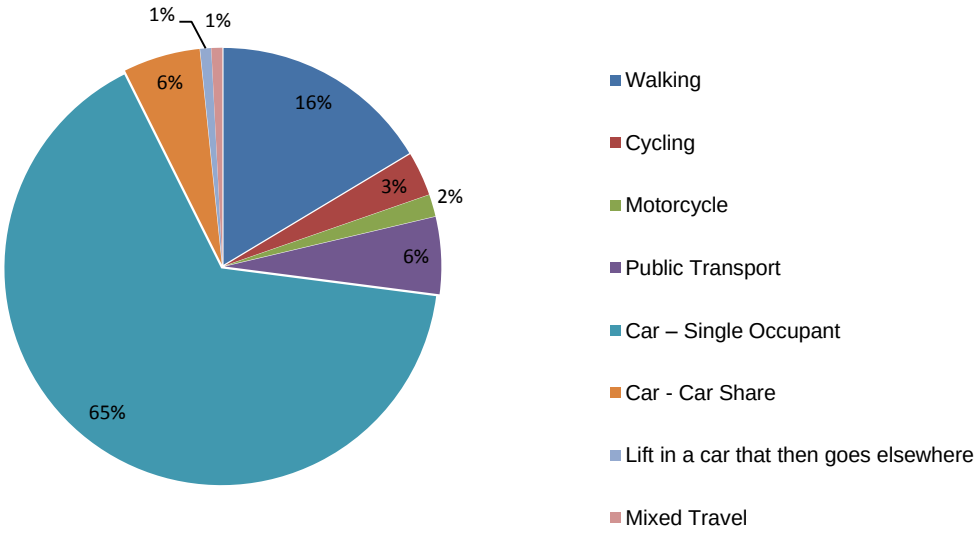
In your opinion, does the Trust encourage and facilitate responsible car use and sustainable travel?



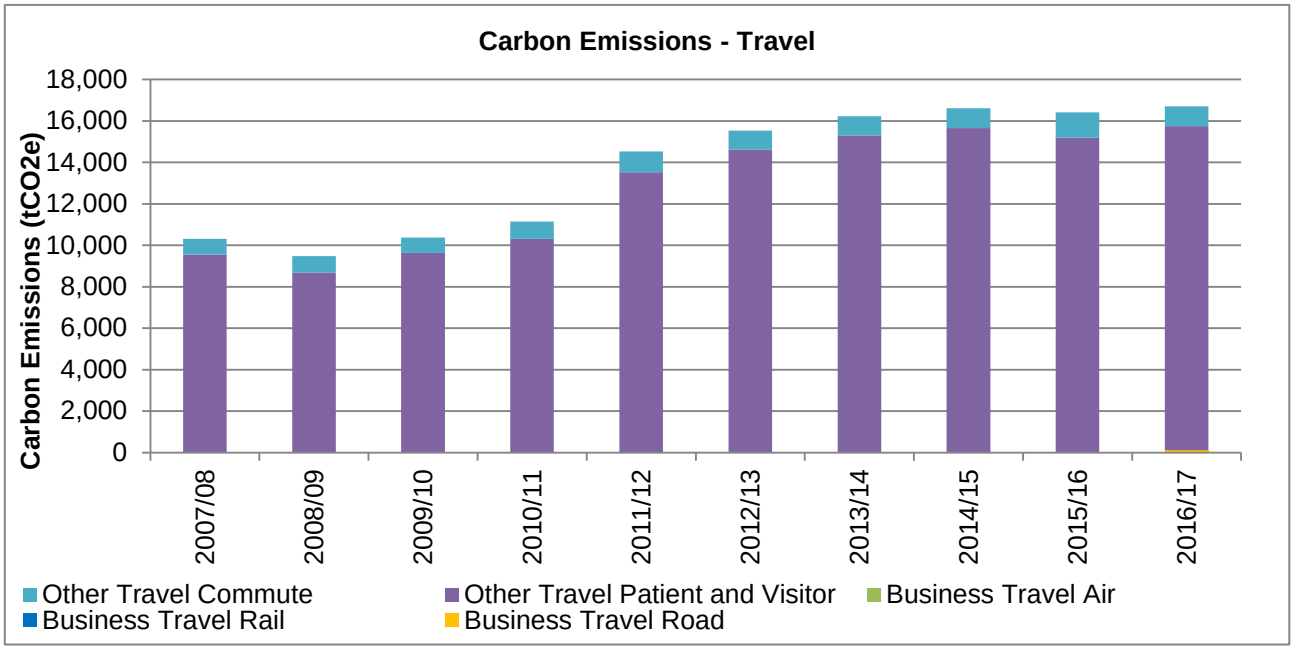
Would you like to use your car less frequently for your journey to work?



What is your primary mode of transport into work?



Tonnes of CO_2e attributable to staff and patient travel				
Category	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Business Travel, Road	Information unavailable	Information unavailable	Information unavailable	118
Business Travel, Rail	Information unavailable	Information unavailable	Information unavailable	Information unavailable
Business Travel, Air	Information unavailable	Information unavailable	Information unavailable	Information unavailable
Patient and Visitor	15,168	15,522	15,195	15,627
Staff Commute	932	969	1,216	960



Procurement

The Procurement Department is responsible for procurement activity across a range of goods and services. Approximately 60% of the total NHS carbon footprint is attributable to procurement and, as such, we are committed to upholding sustainable processes within this area. An updated procurement policy is being developed for Board approval which encompasses the principles of sustainability; including objectives to ensure that goods and services procured:

- Are manufactured, delivered, used and disposed of in an sustainable and socially responsible manner
- Deliver long-term value for money for the Trust and Public Sector as a whole.

Signed

Helen Scott-South
Chief Executive and Accountable Officer
On behalf of the Board of Directors - 24 May 2017

Part 2 Accountability Report

2.1 Directors' Report

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

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

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

The composition of the Board of Directors as at 31 March 2017 is made up of the following:

2.1.1 Non-Executive Directors

Mr John Rivers CBE – Chairman
Dr Stephen Goode CBE – Deputy Chairman
Mr John Bale
Dr John Davies – Senior Independent Director
Mr Paul Doona
Mr Dennis Heywood

The Trust considers each of the listed Non-Executive Directors to be independent. Due to Andrew Hughes stepping down and the departure of Dennis Heywood on 31 July 2017 the Trust has recruited two Non-Executive Directors, Joy Street and Steve Hollingsworth, who are due to commence in April 2017.

2.1.2 Executive Directors

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

2.1.3 Management of the Trust

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

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

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

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

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

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

In February 2017 the Trust engaged Deloitte LLP to undertake an independent review of Board capability. This work was jointly commissioned with Derby Teaching Hospitals NHS Foundation trust as part of the collaboration work to review:

- Board capability and capacity;
- Effectiveness of the Board and associated governance arrangements;
- Risk management processes.

This review involved interviews with Board Members, observations of meetings and discussions with the Council of Governors and stakeholders. The draft report has noted no material concerns in relation to capability and effectiveness of the Board of Burton Hospitals NHS Foundation Trust and the ability to handle the transaction with Derby Teaching Hospitals NHS Foundation Trust. The Trust is noted as having strong governance arrangements in place for risk management. The final report is expected early in the new financial year.

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

The Board meets bimonthly, in public, with regular supporting information sessions and ad hoc meetings as necessary. In addition, the Board holds a 'Meet the Board' event where Governors, Members of the Trust and the public are invited to discuss pertinent matters affecting the Trust. There were 17 public and private and one private extra-ordinary Board of Director meetings held in 2016/17.

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

The Council of Governors and Board have a constructive partnership, working together to achieve the aims of the Trust. However, there may be circumstances when disagreements could occur between the Council of Governors and the Board. Details of this Dispute Procedure can be found in the Trust's Constitution.

During 2016/17 changes to the Board / Senior Management are summarised as:

- Chief Nurse / Chief Operating Officer role:

  Following a review of management and operational structures by the Chief Executive, Helen Scott-South, a number of key changes were made to the Executive Director portfolios which included separating the Chief Nurse / Chief Operating Officer role. Mr Duncan Bedford was appointed as the Chief Operating Officer in April 2016.

- Chief Nurse role:

  Mr Brendan Brown resigned as Chief Nurse in June 2016 to pursue a career at another Trust. Following a competitive recruitment process, Mrs Paula Gardner was appointed to the role of Chief Nurse on 15 June 2016.

- Director of Finance, Information, Performance & Estates:

  Jon Sargeant resigned as Director of Finance, Information, Performance & Estates in October 2016 to pursue a career at another Trust. Jonathan Tringham joined the Trust on a full-time secondment on 1 December 2016. In the interim period, Stephen Fowkes, Deputy Director of Finance, was Acting Director of Finance.

2.1.4 Key Responsibilities

The Board has a number of key responsibilities:

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

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

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

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

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

2.1.5 Board of Directors as at 31 March 2017 – profiles

For a clear statement regarding the balance, completeness and appropriateness of the Board of Directors please refer to page 26.

Non-Executive Directors

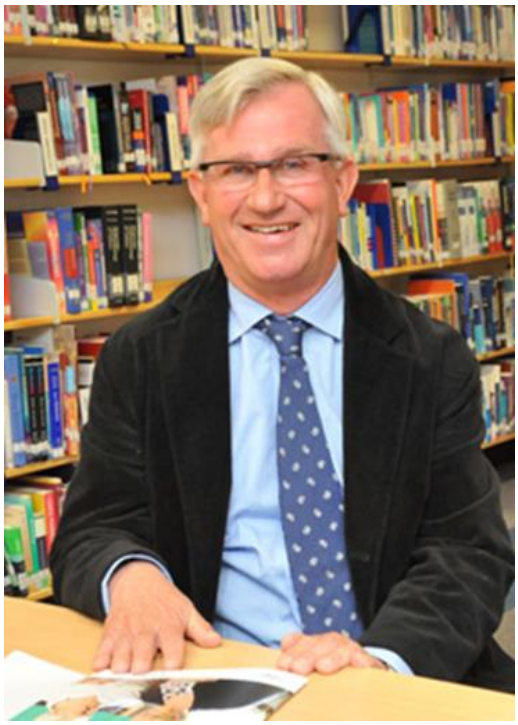
John Rivers CBE – Chairman

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

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

John serves as Chair of the Nominations and Remuneration Committee.

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



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

Stephen is Deputy Chairman, Chair of the Finance and Performance Committee and Chair of the Risk Committee.

John Bale - Non-Executive Director

John is Managing Director of Bale Crocker, a well-established management consulting practice with a blue chip client base. He advises large organisations, such as law firms, accountancy firms and banks on effective leadership, business development and performance improvement. He spent 12 years with IBM, latterly as Sales Development Director for IBM Global Services Northern Europe. He was then Business Development Director and later Global Lead for Relationship Management with Accenture, the worldwide consulting firm. John has been a Founding Fellow of the Institute of Professional Sales; an Associate Member of the Chartered Institute of Marketing; a senior associate of Judge Business School, University of Cambridge; an adjudicator each year at the UK National Sales Awards and National Business Awards; and Chair of the Board of Trustees of Faith in Families, a nationally influential charity.

John is Chair of the People Committee and the Charitable Funds Committee.

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

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

John is Chair of the Quality Committee.

Paul Doona - Non-Executive Director

Paul, a chartered accountant, was Finance Director and Company Secretary of St Modwen Properties Plc from 1985 to 1999, managing the flotation and restructure of the company. Following several years as Finance Director, and subsequently Chief Executive of Claims Direct Plc, Paul undertook a number of executive roles in the internet gaming sector. Paul's non-executive roles have encompassed various sectors including leisure, property, financial services, recruitment asset management and natural resources businesses. In addition to the Trust, Paul is currently a Non-Executive Director of the Dudley Building Society, a member of the Audit Committee at Midland Heart Housing Association, and a Director of a number of commercial property businesses.

Paul is Chair of the Audit Committee and Chair of the Client Informed Group for STRIDE LLP.

Dennis Heywood - Non-Executive Director

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

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

Executive Directors

Helen Scott-South
Chief Executive

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

(photo credit: ACJ Media)

Dr Magnus Harrison
Medical Director and Deputy Chief Executive

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

Prior to working at the Trust, Magnus was the Clinical Director for Emergency Medicine at University Hospital North Midlands NHS Trust. Magnus has additional roles with the Royal College of Emergency Medicine (RCEM) and represents the RCEM on the Academy of Medical Royal Colleges patient feedback committee.

Duncan Bedford
Chief Operating Officer

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

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

Tosca Fairchild
Director of Governance (non voting)

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

Tosca's role ensures that the Trust meets all its governance, corporate, legal and statutory obligations (NHS Improvement and CQC) and enhances the safety and quality of the services that it provides. Tosca is extremely passionate about governance, public accountability and transparency.

Paula Gardner
Chief Nurse

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

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

Louise Thompson
Director of Communications (non voting)

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

Her portfolio includes external and internal communications, stakeholder management, staff engagement, brand management and reputation management, as well as advising on the Trust's broader community relations and partnerships.

Jonathan Tringham
Director of Finance, Information, Performance & Estates

Jonathan was appointed as Director of Finance, Information, Performance and Estates in December 2016. He has worked in the NHS for 24 years starting as a Regional Finance Trainee in Sussex in 1992.

Since then he has had roles in a variety of commissioning and provider organisations with 15 years' experience as a Director of Finance across Birmingham and Staffordshire.

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

Roger Smith
Director of Human Resources (non voting)

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

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

Alison Wynne
Director of Strategy and Partnerships

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

Alison's focus is on development of a comprehensive strategy for the Trust to ensure sustainable acute and community hospital services for Burton, Tamworth and Lichfield, linking with the wider health and social care system.

2.1.6 Previous Director Profiles

Brendan Brown
Chief Nurse – until 13 June 2016

Brendan joined the Trust as Director of Nursing in February 2013 from Derby Hospitals NHS Foundation Trust where he had previously held a number of Senior Nursing and management positions.

He has a background in acute medicine, oncology and specialist palliative care, and attained a Masters with distinction at the University of Nottingham.

Brendan is passionate about the nursing profession, and has made many positive changes to patient care and the nursing workforce since his appointment. He was jointly responsible, together with the Medical Director, for patient safety and clinical quality.

In March 2015, he took over the portfolio for operational management and became the Chief Nurse and Chief Operating Officer.

Jon Sargeant
Director of Finance, Information, Performance & Estates – until 31 October 2016

Jon has previously worked for East Midlands Ambulance Service as Director of Finance and Performance and prior to that he has worked at various hospitals in London.

Over the past 15 years Jon worked at Director level, as well as leading a reconfiguration project for NHS London based around Epsom and St Helier Hospitals in South London.

Andrew Hughes
Non-Executive Director

Andrew has an extensive background in leading healthcare and consultancy organisations, managing strategy, delivery and recovery at all levels.

He held Executive Director roles at both specialist acute and mental health trusts in the West Midlands and is a Managing Consultant and owner of Meant, advising healthcare organisations in this country and abroad.

Formerly an Associate Clinical Tutor at Warwick Medical School, Andrew is a Visiting Lecturer at the Faculty of Technology, Design and Environment at Oxford Brookes University.

Andrew is a Trustee of Teenage Cancer Trust and, from April 2016, Chair of Partners in Paediatrics.

2.1.7 Attendance at Board meetings 2016/17

Name and Title	Number of Meetings **	Total No of Attendances
John Rivers Chairman	18	18
John Davies Non Executive Director	18	15
Andrew Hughes [1] Non Executive Director	12	11
Stephen Goode Non Executive Director	18	17
Dennis Heywood Non Executive Director	18	17
Paul Doona Non Executive Director	18	15
John Bale Non Executive Director	18	15
Helen Scott-South Chief Executive	18	16
Brendan Brown [2] Chief Nurse	4	4
Magnus Harrison Medical Director	18	17
Jon Sargeant [3] Director of Finance, Information, Performance & Estates	9	8
Steve Fowkes [4] Acting Director of Finance	2	2
Jonathan Tringham [5] Director of Finance, Information, Performance & Estates	7	7
Duncan Bedford [6] Chief Operating Officer	17	15
Paula Gardner [7] Chief Nurse	14	12
Alison Wynne Director of Strategy & Partnerships	18	17
Tosca Fairchild * Director of Governance	18	15
Roger Smith * Director of HR	17	14
Louise Thompson * Director of Communications	17	15

1 Andrew Hughes left the Trust on 17 December 2016
2 Brendan Brown left the Trust on 13 June 2016
3 Jon Sargeant left the Trust on 31 October 2016
4 Steve Fowkes was Acting Director of Finance from 1 November – 30 November 2016
5 Jonathan Tringham joined the Trust on 1 December 2016
6 Duncan Bedford joined the Trust on 18 April 2016
7 Paula Gardner was appointed as Chief Nurse on 15 June 2016

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

2.1.8 Meetings of the Non-Executive Directors

In accordance with guidance set out in the Independent Regulator's Foundation Trust Code of Governance, arrangements have continued during the year for the Chairman and Non-Executive Directors to meet outside the normal Board meetings, including undertaking the appraisal of the Chief Executive's

performance. These meetings are attended by the Chief Executive at the Chairman and Non-Executive Directors request. The Chairman carries out the Chief Executive's appraisal during the year and delivers a report on this to the Nominations and Remuneration Committee for consideration. The Non-Executive Directors also meet to discuss and appraise the Chairman's performance. The Senior Independent Director conducts the Chairman's appraisal and delivers a report on this to the Council of Governors for consideration. In addition, the objectives that have been set for the Non-Executive Directors are shared with the Council of Governors, via its Appointments Committee.

2.1.9 Appointment and removal of Non-Executive Directors

Under the Trust's Constitution, the Council of Governors has the power to appoint and remove the Chairman and Non-Executive Directors of the Trust. The termination of an appointment requires the support of three quarters of the Council of Governors, in addition to other requirements of the Constitution being met. Non-Executive Directors are generally appointed on a three year term, which can be renewed. In line with the Code of Governance, any terms beyond six years, e.g. two three year terms would be subject to rigorous review and be on the basis of an annual appointment. At the end of the 2016/17 year there were 22 Governors on the Council with all the seats filled. A resolution for removal would therefore require the approval of 17 Governors.

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

Non-Executive Director	Appointed	Re-appointed	Expiry of Current Term of Office
John Rivers	14 March 2016	15 December 2016	31 March 2018
John Davies	12 February 2013	12 February 2016	11 February 2019
Paul Doona	1 January 2015	-	31 December 2017
Stephen Goode	12 February 2013	12 February 2016	11 February 2019
Dennis Heywood	1 December 2014	-	31 July 2017
John Bale	1 March 2015	-	28 February 2018

2.1.10 Significant commitments of the Trust Chairman

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

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

2.1.11 Risk management

The Trust adopts a robust approach to risk management with the structures and processes in place to successfully deliver the Trust's objectives. The Director of Governance is the Trust's Chief Risk Officer and provides Board leadership on risk management. Leadership arrangements for clinical, non-clinical, operational, financial and quality risk management are clearly defined and embedded throughout the Trust, supported by a number of appropriate policies and procedures. Further details on the Trust's risk management process can be found in the Annual Governance Statement in Part 2.8 of this report.

2.1.12 Board of Directors committee structure

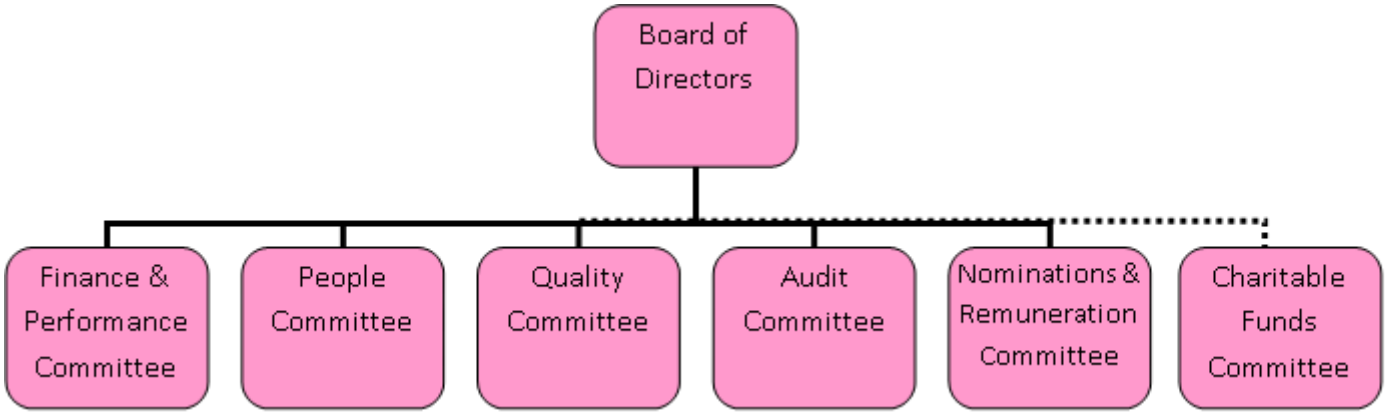
The Board of Directors is supported by a number of Committees.

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

2.1.13 Audit Committee

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

Further information on the Trust's approach to risk management can be found in the Annual Governance Statement later in Part 2.8 of this report.



The Risk Committee reports into the Audit Committee, providing additional oversight on the Trust's Risk Management arrangements.

Attendance at Audit Committee Meetings

Name and Title	No of Meetings *	Total No of Attendances
Paul Doona Non Executive Director and Committee Chair	6	6
Andrew Hughes Non Executive Director	3	1
Stephen Goode Non Executive Director	6	6
John Davies Non Executive Director	6	4
Dennis Heywood Non Executive Director	4	1
John Bale Non Executive Director	3	2

* Including one Extra-Ordinary Audit Committee Meeting

During 2016/17 the following issues were considered by the Committee as significant in relation to the financial statements, operations and compliance:

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

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

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

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

Value for money - The Trust's Auditors, on the basis of their work, having regard to the guidance issued by the Comptroller and Auditor General in November 2016, are satisfied that, in all significant respects, the Trust had proper arrangements in place to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

The Trust's Auditors

The Trust's External Auditors for the 12 months ending 31 March 2017 were Grant Thornton. The external audit fee for 2016/17 was £40,000, which included an audit of the charitable fund and the Quality Accounts. There were no additional non audit fees.

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

Appointment process for the External Auditor

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

Provision of non-audit services by the External Auditor

Grant Thornton did not provide any non-audit services to the Trust in 2016/17.

2.1.14 Nominations and Remuneration Committee

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

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

Terms of Reference – Board Committees

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

2.1.15 Declarations of interests / related party transactions

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

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

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

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

http://www.burtonhospitals.nhs.uk/Publication-scheme.htm

2.1.16 Contact with Directors

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

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

2.1.17 Disclosures relating to quality governance

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

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

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

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

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

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

Further to an independent review of Well Led Governance by Deloitte LLP in July 2014, the Trust engaged Deloitte LLP to undertake Board Capability Review in February 2017. This work was jointly commissioned with Derby Teaching Hospitals NHS Foundation Trust as part of the collaboration work to review:

- Board capability and capacity;
- Effectiveness of the Board and associated governance arrangements;
- Risk management processes.

This review involved interviews with Board members, observations of meetings and discussions with the Council of Governors and stakeholders. The Board expect to receive the final report early in the new financial year.

Further information regarding governance can be found in the Annual Governance Statement in Part 2.8 of this report and within the Trust's Quality Report 2016/17 on page 102.

2.1.18 Patient care

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

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

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

2.1.19 Stakeholder relations and partner working

The Trust has undertaken a number of activities during 2016/17 aimed at developing and enhancing its relationships with key partners and stakeholders. These include:

Derby Teaching Hospitals NHS Foundation Trust

The Trust has developed plans for a proposed formal collaboration with Derby Teaching Hospitals, based on improving patient care locally and supporting clinical sustainability. A Strategic Outline Case was developed in autumn 2016, followed by work on an Outline Business Case, which is for consideration in 2017/18. The Trust has been proactive in securing stakeholder support for the planned collaboration and in engaging with patients and the public on the plans.

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

The Trust forms part of the Staffordshire and Stoke-on-Trent local health system and is a key part of the Sustainability and Transformation Plan. It is also an associate member of the Derbyshire plan, given its proximity to the neighbouring county and to Derby Teaching Hospitals.

The Staffordshire and Stoke-on-Trent STP was published in December 2016, and is focused on the shift away from reliance on acute hospital care, and to delivering more care in the place where people live. This will include looking at the provision of urgent care and planned care, and examining the potential for community-based healthcare hubs. It also includes a large focus on prevention and wellbeing.

Virgin Care

The Trust started work with Virgin Care, which were appointed by East Staffordshire Clinical Commissioning Group as prime provider and commissioner for community health services in East Staffordshire on 1 May 2016. The work includes looking at improving pathways for certain long-term conditions such as diabetes and chronic obstructive pulmonary disease, as well as streamlining work to support projects aimed at reducing unnecessary attendances to the Emergency Department.

Community Groups

The Trust has continued to work to connect with the public during the year and has undertaken a number of projects with different community groups, including local secondary schools, charities and community organisations.

The Trust's partnership with Burton Albion Community Trust goes from strength to strength, with the community prostate screening programme being expanded, among other initiatives.

The Trust has also supported Burton YMCA with food bank donations and is exploring the potential for working together on local healthcare initiatives for the YMCA clients.

STRIDE Joint Venture

The Trust is part of a joint venture company formed with private sector partner Health Innovations Partners Ltd in July 2015.

The purpose of this partnership, known as Strategic Transformation Real Innovation and Delivering Excellence (or STRIDE as it is more commonly known), is to enable the Trust to draw on private sector expertise as it continues to grow and transform.

The vision for STRIDE is that the Trust's present and future estate, and the non-clinical service provision, should act as an enabler to deliver the clinical vision, providing a high quality, efficient environment, to support the delivery of changing models of care.

2.1.20 Income / financial disclosures

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

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

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

2.1.21 Disclosures to auditors

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

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

2.1.22 Political donations

The Trust has not made any political donations.

2.2 Remuneration report

2.2.1 Annual statement on remuneration

During the course of 2016/17 there were three new appointments made to the Executive Management Team, Duncan Bedford as Chief Operating Officer, Paula Gardner as Chief Nurse and Jonathan Tringham as Director of Finance, Information, Performance & Estates.

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

2.2.2 Senior manager remuneration policy

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

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

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

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

Future Policy Table

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

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

2.2.3 Senior manager disclosure A - remuneration

		1st April 2016 to 31st March 2017							1st April 2015 to 31st March 2016						
Name and Title	Note	Salary (Bands of £5,000) £000	Other Remuneration (Bands of £5000) £000	Taxable Benefits (to nearest £100) £00	Annual Performance Bonuses (Bands of £5,000) £000	Long Term Performance Bonuses (Bands of £5,000) £000	Pension Related Benefits (Bands of £2,500) £000	Total Remuneration (Bands of £5,000) £000	Salary (Bands of £5,000) £000	Other Remuneration (Bands of £5000) £000	Taxable Benefits (to nearest £100) £00	Annual Performance Bonuses (Bands of £5,000) £000	Long Term Performance Bonuses (Bands of £5,000) £000	Pension Related Benefits (Bands of £2,500) £000	Total Remuneration (Bands of £5,000) £000
Chris Wood Chairman/Non-Executive Director	1	0	0	0	0	0	0	0	35 to 40	0	0	0	0	0	35 to 40
John Rivers Chairman/Non-Executive Director	2	40 to 45	0	0	0	0	0	40 to 45	0 to 5	0	0	0	0	0	0 to 5
John Davies Non-Executive Director		10 to 15	0	0	0	0	0	10 to 15	10 to 15	0	0	0	0	0	10 to 15
Stephen Goode Non-Executive Director		10 to 15	0	0	0	0	0	10 to 15	10 to 15	0	0	0	0	0	10 to 15
Andrew Hughes Non-Executive Director	3	5 to 10	0	0	0	0	0	5 to 10	10 to 15	0	0	0	0	0	10 to 15
Dennis Heywood Non-Executive Director		10 to 15	0	0	0	0	0	10 to 15	10 to 15	0	0	0	0	0	10 to 15
Paul Doona Non-Executive Director		10 to 15	0	0	0	0	0	10 to 15	10 to 15	0	0	0	0	0	10 to 15
John Bale Non-Executive Director		10 to 15	0	0	0	0	0	10 to 15	10 to 15	0	0	0	0	0	10 to 15
Helen Ashley Chief Executive	4	0	0	0	0	0	0	0	155 to 160	0	0	0	0	47.5 to 50	205 to 210
Helen Scott-South Chief Executive	5	185 to 190	0	0	0	0	Not Available	185 to 190	10 to 15	0	0	0	0	0	10 to 15

		1st April 2016 to 31st March 2017							1st April 2015 to 31st March 2016						
Name and Title	Note	Salary (Bands of £5,000) £000	Other Remuneration (Bands of £5000) £000	Taxable Benefits (to nearest £100) £00	Annual Performance Bonuses (Bands of £5,000) £000	Long Term Performance Bonuses (Bands of £5,000) £000	Pension Related Benefits (Bands of £2,500) £000	Total Remuneration (Bands of £5,000) £000	Salary (Bands of £5,000) £000	Other Remuneration (Bands of £5000) £000	Taxable Benefits (to nearest £100) £00	Annual Performance Bonuses (Bands of £5,000) £000	Long Term Performance Bonuses (Bands of £5,000) £000	Pension Related Benefits (Bands of £2,500) £000	Total Remuneration (Bands of £5,000) £000
Jon Sargeant Director of Finance, Information, Performance & Estates	6	75 to 80	0	0	0	0	Not Available	75 to 80	125 to 130	0	0	0	0	10 to 12.5	140 to 145
Magnus Harrison Medical Director		45 to 50	150 to 155	0	0	0	47.5 to 50	250 to 255	40 to 45	140 to 145	0	0	0	240 to 242.5	420 to 425
Brendan Brown Chief Nurse	7	25 to 30	0	0	0	0	Not Available	25 to 30	120 to 125	0	0	0	0	0	120 to 125
Tosca Fairchild Director of Governance		90 to 95	0	0	0	0	Not Applicable	90 to 95	90 to 95	0	0	0	0	0	90 to 95
Roger Smith Director of Human Resources		90 to 95	0	0	0	0	12.5 to 15	100 to 105	85 to 90	0	0	0	0	30 to 32.5	120 to 125
Alison Wynne Director of Strategy & Partnerships		110 to 115	0	0	0	0	0	110 to 115	90 to 95	0	0	0	0	0	90 to 95
Louise Thompson Director of Communications		75 to 80	0	0	0	0	22.5 to 25	95 to 100	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Maggie McManus Director of Operations	8	5 to 10	75 to 80	0	0	0	Not Available	75 to 80	70 to 75	0	0	0	0	Not Available	75 to 80
Jonathan Tringham Director of Finance, Information, Performance & Estates	9	50 to 55	0	0	0	0	65 to 67.5	120 to 125	-	-	-	-	-	-	-

		1st April 2016 to 31st March 2017							1st April 2015 to 31st March 2016						
Name and Title	Note	Salary (Bands of £5,000) £000	Other Remuneration (Bands of £5000) £000	Taxable Benefits (to nearest £100) £00	Annual Performance Bonuses (Bands of £5,000) £000	Long Term Performance Bonuses (Bands of £5,000) £000	Pension Related Benefits (Bands of £2,500) £000	Total Remuneration (Bands of £5,000) £000	Salary (Bands of £5,000) £000	Other Remuneration (Bands of £5000) £000	Taxable Benefits (to nearest £100) £00	Annual Performance Bonuses (Bands of £5,000) £000	Long Term Performance Bonuses (Bands of £5,000) £000	Pension Related Benefits (Bands of £2,500) £000	Total Remuneration (Bands of £5,000) £000
Duncan Bedford Chief Operating Officer	10	120 to 125	0	0	0	0	Not Available	120 to 125	-	-	-	-	-	-	-
Paula Gardner Chief Nurse	11	80 to 85	10 to 15	0	0	0	35 to 37.5	135 to 137.5	-	-	-	-	-	-	-
Steve Fowkes Acting Director of Finance	12	5 to 10	75 to 80	0	0	0	Not Available	80 to 85	-	-	-	-	-	-	-

2.2.4 Senior manager disclosure B - pension benefits

Name	Note	Real increase in pension at age 60 (Bands of £2500) £000	Real increase in lump Sum at age 60 (Bands of £2500) £000	Total accrued pension at age 60 at 31 March 2017 (Bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2017 (Bands of £5000) £000	Cash Equivalent Transfer value at 31 March 2017 £000	Cash Equivalent Transfer value at 31 March 2015 £000	Real Increase in Cash Equivalent Transfer Value £000	Personal Contribution (Bands of £2500) £000
Helen Scott-South Chief Executive		Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Magnus Harrison Medical Director		2.5 to 5	2.5 to 5	45 to 50	130 to 135	761	667	94	12.5 to 15
Brendan Brown Chief Nurse		0	0	0 to 5	0 to 5	14	29	0	Not Available
Roger Smith Director of Human Resources		0 to 2.5	2.5 to 5	15 to 20	50 to 55	0	361	0	10 to 12.5
Tosca Fairchild Director of Governance		Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Louise Thompson Director of Communications		0 to 2.5	0	0 to 5	0 to 5	21	11	10	7.5 to 10
Jon Sargeant Director of Finance, Information, Performance& Estates		0 to 2.5	0	40 to 45	115 to 120	761	736	25	12.5 to 15
Alison Wynne Director of Strategy & Partnerships		0	0	15 to 20	45 to 50	277	370	0	12.5 to 15
Maggie McManus Director of Operations		Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Jonathan Tringham Director of Finance, Information, Performance & Estates		0 to 2.5	0 to 2.5	35 to 40	95 to 100	594	538	37	Not Available
Duncan Bedford Chief Operating Officer		Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Paula Gardner Chief Nurse		0 to 2.5	5 to 7.5	20 to 25	56 to 70	422	373	49	2.5 to 5
Steve Fowkes Acting Director of Finance		Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available

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

Notes to previous tables

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

1 Chris Wood was Chairman until 11/03/16
2 John Rivers was appointed Chairman with effect from 14/3/16
3 Andrew Hughes left the Trust on 17/12/16
4 Helen Ashley was Chief Executive until 29/2/16
5 Helen Scott-South joined the Trust on 15/3/16
6 Jon Sargeant left the Trust on 31/10/16
7 Brendan Brown left the Trust on 13/06/16
8 Maggie McManus ceased to be a Director on 31/5/16
9 Jonathan Tringham joined the Trust on 1/12/16
10 Duncan Bedford joined the Trust on 18/4/16
11 Paula Gardner was appointed Chief Nurse on 15/06/16
12 Steve Fowkes was Acting Director of Finance from 1/11/16 to 30/11/16

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

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

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

“Not Applicable” – Pensions information listed above as “Not Applicable” is because the employee was not a member of the NHS Pension scheme.

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

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

	2015/16 £'000	2016/17 £'000
Total pay costs (per Note to Accounts 9.1)	99,554	101,119
Average number employed* (per Note to Accounts 9.2)	2,998	3,011
Median salary within the Trust	22,236	22,458
Highest Paid Director	**Magnus Harrison ****	**Magnus Harrison ****
Mid Point of Salary Banding	182,500	202,500
Ratio to Median	8.13	9.02

* Including Bank and Agency

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

The banded remuneration of the highest paid director in the Trust during the financial year 2016/17 was £202,500 (2015/16, £182,500). This was 9.02 times (2015/16, 8.13) the median remuneration of the workforce, which was £22,458 (2015/16, £22,236). In 2016/17 one employee received remuneration in excess of the highest paid Director who was a Medical and Dental Consultant. The remuneration ranged from £13,591 to £182,500 per Whole Time Equivalent (2015/16, £13,456 to £202,500). The ratio has increased year on year as a result of the part year effect (11 months) of the Highest Paid Director's salary in 2015/16.

2.2.6 Annual report on remuneration

- **Service contracts**

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

- **Non-Executive Directors**

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

- **Remuneration Committee**

The Trust has two Committees that deal with remuneration:

The Nominations and Remuneration Committee

The Nomination and Remuneration Committee is a Board Committee that comprises of all the Non-Executive Directors. One of this Committee's key

responsibilities is to decide the remuneration, allowances and other terms and conditions of the Chief Executive and all other Executive Directors.

The Committee receives advice from the Director of Human Resources.

The Appointments Committee

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

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

Attendance at Nominations and Remuneration Committee meetings

Name and Title	No of Meetings	Total No of Attendances
John Rivers Chairman and Committee Chair	7	7
Andrew Hughes Non Executive Director	6	6
Steve Goode Non Executive Director	7	6
John Davies Non Executive Director	7	6
Dennis Heywood Non Executive Director	7	7
Paul Doona Non Executive Director	7	6
John Bale Non Executive Director	7	5
Helen Scott-South Chief Executive	7	6

Attendance at Appointments Committee meetings

Name and Title	No of Meetings	Total No of Attendances
John Carr [1] Lead Governor and Committee Chair	2	2
Bernard Peters [2] Lead Governor and Committee Chair	3	1*
David Rogers Governor	5	5
Phil Hodson-Walker Governor	5	5

Name and Title	No of Meetings	Total No of Attendances
Elly Briggs Governor	5	5
Amy Plenderleith Governor	5	5
Sheila Jackson Governor	2	2

1 John Carr ceased to be Lead Governor and a Committee member on 18 October 2016
2 Bernard Peters became Lead Governor and a Committee member on 19 October 2016

* Bernard Peters declared an interest in one particular process and therefore he did not attend two meetings. Sheila Jackson attended these meetings.

2.2.7 Expenses paid to Governors and Directors

Directors	2015 / 16	2016 / 17
Total Number of Directors in office during the year	18	19
Number to whom expenses were paid	13	10
Total value of expenses paid	£17,930	£17,797

Governors	2015 / 16	2016 / 17
Total Number of Governors in office during the year	25	25
Number to whom expenses were paid	5	9
Total value of expenses paid	£1,440	£2,792

The following elements are included in the expenses:

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

Helen Scott-South
Chief Executive
24 May 2017

2.3 Staff report

2.3.1 Analysis of staff costs

	2015/16			2016/17		
	Permanently employed total £000	Other £000	Total £000	Permanently employed total £000	Other £000	Total £000
Salaries and wages	99,554	0	99,554	101,119	0	101,119
Social security costs	7,143	0	7,143	9,139	0	9,139
Pension costs – defined contribution plans employer's contribution to NHS pensions	11,678	0	11,678	11,953	0	11,953
Pension costs – other	0	0	0	0	0	0
Other post employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0
Temporary staff – external bank	0	0	0	0	0	0
Temporary staff – agency /contract staff	0	10,172	10,172	0	8,785	8,785
NHS charitable funds staff	0	0	0	0	0	0
Total	**118,375**	**10,172**	**128,547**	**122,211**	**8,785**	**130,997**

2.3.2 Analysis of average staff numbers

	2015 /16			2016/17		
	Permanent	Other	Total	Permanent	Other	Total
Medical and Dental	299	26	325	300	26	326
Ambulance staff	0	0	0	0	0	0
Administration and estates	643	40	683	649	42	691
Healthcare assistants and other support staff	641	51	692	658	48	706
Nursing, midwifery and health visiting staff	898	121	1,019	899	107	1,006
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	269	10	279	266	16	282
Healthcare science staff	0	0	0	0	0	0
Social care staff	0	0	0	0	0	0
Agency and contract staff	0	0	0	0	0	0
Bank staff	0	0	0	0	0	0

	2015 /16			2016/17		
	Permanent	Other	Total	Permanent	Other	Total
Other	0	0	0	0	0	0
Total average numbers	**2,750**	**248**	**2,998**	**2,772**	**239**	**3,012**

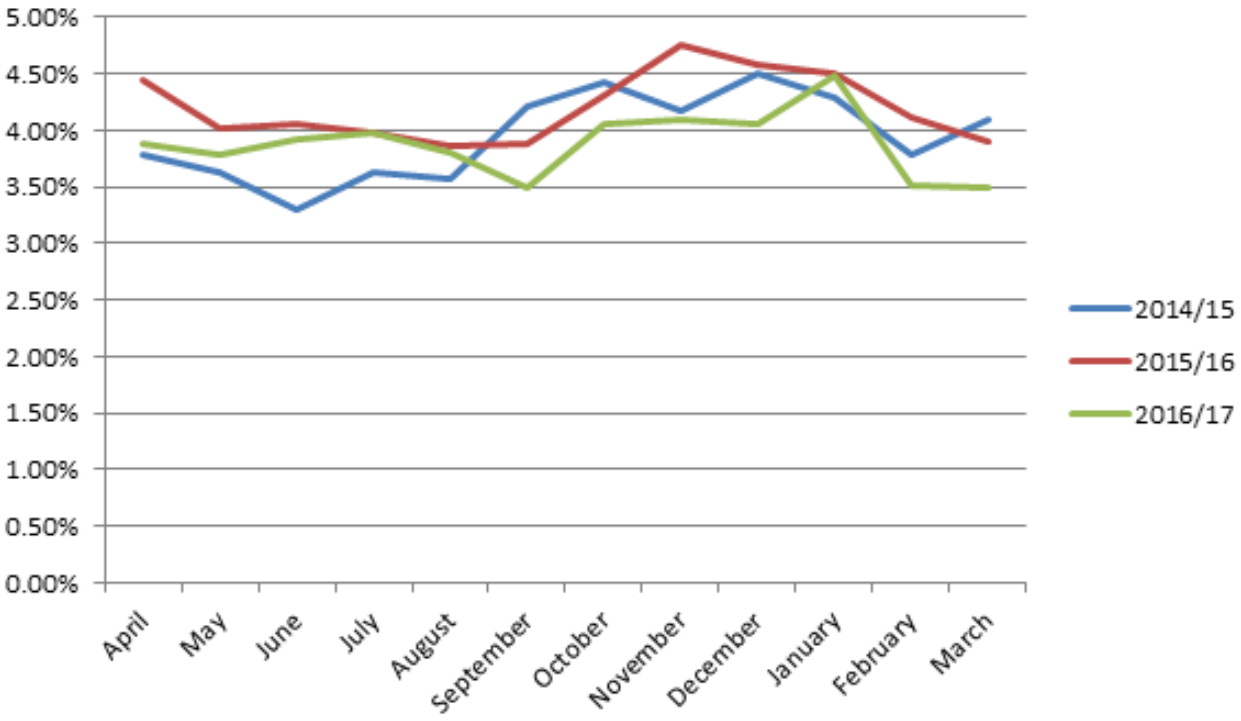
As at 31 March 2017, a breakdown of the average number of Trust employees can be seen in the following table:

	Male	Female	Total
Total Number of Trust Employees	598	2,647	3,245
Of which:			
Senior Managers (Band 8C and above)	12	16	27
Board Directors	10	5	15

2.3.3 Managing sickness absence

Sickness absence is monitored by the Board of Directors on a monthly basis and is also submitted to the Trust's Commissioners as part of monthly monitoring. The following graph demonstrates that in 2016/17, average sickness absence has decreased to 3.88% in comparison to the 4.18% reported in 2015/16.

Trust Sickness in 2016 / 17



2.3.4 Staff policies

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

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

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

2.3.5 Slavery Act

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

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

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

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

Spend categories

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

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

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

- For all collaborative / national arrangements (circa 50% of all our spend):

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

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

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

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

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

Future actions

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

- Include additional statements on modern slavery in the latest draft of the Procurement Policy;
- Develop a list of the potentially highest risk suppliers;
- Develop a due diligence approach for where modern slavery is identified.

Considerations

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

2.3.6 Health and Safety

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

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

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

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

2.3.7 Occupational Health

The Trust provides Occupational Health Services for all staff with an on-site Occupational Health Department.

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

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

The Trust's Occupational Health service is key to the success of the health and wellbeing programme for staff. The Trust is currently considering ways to develop links with a number of organisations that can help the Trust to achieve its goals.

2.3.8 Counter Fraud and Corruption

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

During 2016/17 the Trust received ten counter fraud referrals. None of these referrals resulted in confirmed instances of fraud or corruption. However, two cases are on-going.
The key principles of The Bribery Act 2010 are now embedded in the Trust and our Director of Finance is the Executive Lead on behalf of the Board. Training on this important subject is provided to all appropriate staff.
For the avoidance of doubt this means that the expectation of each employee, contractor and agent of the Trust at all times and in all business dealings is as follows:

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

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

2.3.9 Staff attitude and opinion survey results

The Trust's overall response rate declined by 3.3% from the previous year, although the Trust remained above the national average for Acute Trusts.

	2015 (previous year)	2016 (current year)		
	Trust	Trust	Acute Benchmarking Group Average	Trust Improvement / Deterioration
Response rate	**46.8%**	**43.5%**	**39.9%**	**-3.3%**

The Staff Engagement score from the 2016 Annual Staff Survey Results has slightly decreased in the year.

	2015 (previous year)	2016 (current year)		
	Trust	Trust	Acute Benchmarking Group Average	Trust Improvement / Deterioration
Staff Engagement Score	**3.87**	**3.80**	**3.81**	**-0.07**

Staff Engagement has continued to be a key priority throughout the year as part of the Trust's continuing improvement journey and in order to more fully involve staff in discussions on various strategic partnerships, including the planned collaboration with Derby Teaching Hospitals and the Staffordshire and Stoke-on-Trent STP. The Human Resources and Communications teams have worked together to develop programmes of engagement that seek honest feedback from staff about how they are feeling, and that encourage two-way conversations about ideas for improvement.

For each of the 32 key findings from the 2016 National Staff Survey, the acute trusts in England were placed in order from 1 (top ranking score) to 99 (bottom ranking score). The Trust's five highest and five lowest ranking scores are presented in the following tables:

Top 5 Ranking Scores	2015 (previous year)	2016 (current year)		Trust Improvement / Deterioration
	Trust	Trust	Acute Benchmarking Group Average	
Key Finding 11 Percentage of staff appraised in last 12 months	94%	96%	87%	+1%
Key Finding 28 Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	24%	26%	31%	+2%

Top 5 Ranking Scores	2015 (previous year) Trust	2016 (current year) Trust	2016 (current year) Acute Benchmarking Group Average	Trust Improvement / Deterioration
Key Finding 25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	27%	24%	27%	-3%
Key finding 22 Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	15%	13%	15%	-2%
Key Finding 24 Percentage of staff / colleagues reporting most recent experience of violence	62%	72%	67%	+10%

(lower scores better except for key findings 11 and 24)

Bottom 5 Ranking Scores	2015 (previous year) Trust	2016 (current year) Trust	2016 (current year) Acute Benchmarking Group Average	Trust Improvement / Deterioration
Key Finding 29 Percentage of staff reporting errors, near misses or incidents witnessed in the last month	89%	88%	90%	-1%
Key Finding 27 Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	27%	41%	45%	+14%
Key Finding 3 Percentage of staff agreeing that their role makes a difference to patients / service users	91%	89%	90%	-2%
Key Finding 15 Percentage of staff satisfied with the opportunities for flexible working patterns	49%	48%	51%	-1%

Bottom 5 Ranking Scores	2015 (previous year) Trust	2016 (current year) Trust	2016 (current year) Acute Benchmarking Group Average	Trust Improvement / Deterioration
Key Finding 19 Organisation and management interest in and action on health and wellbeing (1-5 scale)	3.66	3.53	3.61	-0.05

(lower scores better)

It is clear from these results that staff awareness regarding whistleblowing and reporting of incidents of bullying and harassment or incidents of violence have significantly increased. The results for bullying and harassment incidents will be explored further with detailed analysis being undertaken prior to consideration and challenge by the People Committee, a sub-committee of the Board of Directors. In response to the quality of appraisals, an audit of appraisals will be completed in June 2017 following completion of the annual appraisal process. The appraisal training will be developed and based on best practice.

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

2.3.10 Expenditure on consultancy

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

2.3.11 Off-pay-roll arrangements

Table 1: For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2017	0
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

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

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months.

No. of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	0
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	0
No. for whom assurance has been requested	0
Of which...	
No. for whom assurance has been received	0
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received.	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017.

Number of off-payroll engagements of Board members and / or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed Board members, and / or senior officials with significant financial responsibility during the financial year. This figure **must** include both off- payroll and on-payroll engagements	15

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

2.3.12 Staff exit packages

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

2.3.13 Exit packages; non-compulsory departure payments

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

2.4 Disclosures - NHS Foundation Trust Code of Governance

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

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

Areas of Non-Compliance

There were no areas of Non-Compliance.

2.5 Council of Governors

The Council of Governors is made up of 13 publicly elected Governors, five staff elected Governors, and four appointed Governors. The Governors meet on a regular basis and are actively involved in various Trust activities. The elected Governors, as at 31 March 2017, and the appointed Governors during 2016/17 can be seen in the following tables:

2.5.1 Elected Governors as at 31 March 2017

Type and Area	Name	Term of Office
Public Governor, East Staffordshire	John Anderson	3 years ending Sept 2018
Public Governor, East Staffordshire	John Carr	3 years ending Sept 2017
Public Governor, East Staffordshire	Graham Lamb	3 years ending Sept 2019
Public Governor, East Staffordshire	Roger Lewis	3 years ending Sept 2017
Public Governor, East Staffordshire [1]	Bernard Peters	3 years ending Sept 2018
Public Governor, East Staffordshire	David Rogers	3 years ending Sept 2018
Public Governor, South Derbyshire	Sheila Jackson	3 years ending Sept 2018
Public Governor, South Derbyshire	Gemma Price	3 years ending Sept 2019
Public Governor, Lichfield & Tamworth	Navinder Dhillon	3 years ending Sept 2018
Public Governor, Lichfield & Tamworth	Pam Dhanda	3 years ending Sept 2018
Public Governor, Lichfield & Tamworth	Malcolm Pearson	3 years ending Sept 2017
Public Governor, Lichfield & Tamworth	Phil Hodson-Walker	3 years ending Sept 2017
Public Governor, North West Leicestershire and the Rest of England	Merryl Patrick	3 years ending Sept 2019
Staff Governor, Other - Non-clinical	Elly Briggs	3 years ending Sept 2017
Staff Governor, Nursing & Midwifery	Cathy Brown	3 years ending Sept 2018
Staff Governor, Volunteers	Elaine Day	3 years ending Sept 2018
Staff Governor, Other Clinical	Allison Dean	3 years ending Sept 2019
Staff Governor, Medical & Dental	Susan Williams-Jones	3 years ending Sept 2018

[1] Lead Governor appointed on 19 October 2016

2.5.2 Appointed Governors during 2016/17

Name	Appointed Governor	Term of Office
Susan McGarry	Local Authority – East Staffordshire Borough Council	Term of Office ends May 2018
Amy Plenderleith	Local Authority – South Derbyshire District Council	Term of Office ends May 2018
Garry Jones	Voluntary Sector	Term of Office ends June 2019
David Hanson	Higher Education Representative	Term of Office ends June 2019

2.5.3 Terms of office of Governors

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

2.5.4 Elections held in 2016/17

The annual Governor elections took place in September 2016 with a total of four seats being contested (one seat in East Staffordshire, one seat in South Derbyshire, one seat in North West Leicestershire and the Rest of England and one Staff Governor seat for Other Clinical Staff). All seats were filled during the election, resulting in a full complement of Governors.

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

The results of these elections can be seen in the following table:

Governor elections held during 2016/17

Date of election results	Constituency	No. of Eligible Voters	No of seats	No. of Candidates	Election Turnout	Elected Governor(s)
22.07.2016	Staff – Other Clinical	752	1	1	Unopposed	Allison Dean
22.07.2016	North West Leicestershire and the Rest of England	640	1	1	Unopposed	Merryl Patrick
05.09.2016	East Staffordshire	3321	1	2	13%	Graham Lamb
05.09.2016	South Derbyshire	1353	1	2	12.3%	Gemma Price

2.5.5 Governor roles and responsibilities

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

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

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

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

2.5.6 Contact procedure for the Council of Governors

Members may contact Governors via the following:

Email: membership@burtonft.nhs.uk

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

2.5.7 Register of Governors' interests

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

2.5.8 Governor developments

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

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

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

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

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

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

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

2.5.9 Council of Governors reporting committees

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

- **Membership and Communications Committee**

The Membership and Communications Committee supports the recruitment of

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

- **External Auditors Appointments and Liaison Committee**

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

- **Appointments Committee**

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

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

2.5.10 Informal Governors meetings

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

2.5.11 Public meetings

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

Attendance at Council of Governor meetings 2016/17

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

Name and Title	Number of Meetings *	Total Number of Attendances
John Rivers Chairman	8	8
Graham Lamb [1] Public Governor – East Staffordshire	5	5
John Carr Public Governor – East Staffordshire and Lead Governor until 18 October 2016	8	8
Maqsood Hussain [2] Public Governor – East Staffordshire	4	2
John Anderson Public Governor – East Staffordshire	8	6
David Rogers Public Governor – East Staffordshire	8	8
Roger Lewis Public Governor – East Staffordshire	8	6
Bernard Peters Public Governor – East Staffordshire and Lead Governor from 19 October 2016	8	7
Navinder Dhillon Public Governor – Lichfield & Tamworth	8	4
Pam Dhanda Public Governor – Lichfield & Tamworth	8	5
Phil Hodson-Walker Public Governor – Lichfield & Tamworth	8	6
Malcolm Pearson Public Governor – Lichfield & Tamworth	8	5
Merryl Patrick [3] Public Governor – NW Leicestershire and the Rest of England	5	4
Sheila Jackson Public Governor – South Derbyshire	8	5
Gemma Price [4] Public Governor – South Derbyshire	5	3
David Hanson [5] Partner Governor – Higher Education	6	5
Garry Jones [6] Partner Governor – Support Staffordshire	7	4
Susan McGarry [7] Partner Governor – East Staffordshire Borough Council	6	4
Amy Plenderleith Partner Governor – South Derbyshire District Council	8	4
Susan Williams-Jones Staff Governor – Medical & Dental Staff	8	8
Cathy Brown Staff Governor – Nursing & Midwifery Staff	8	7
Emma Salt [8] Staff Governor – Other Clinical Staff	3	2

Name and Title	Number of Meetings *	Total Number of Attendances
Allison Dean Staff Governor – Other Clinical Staff	5	5
Elaine Day Staff Governor – Volunteers	8	8
Elly Briggs Staff Governor – Other Staff	8	5
Rebecca Carlton [9] Partner Governor – East Staffs Borough Council	2	0

Notes

1 Graham Lamb term of office began 28 September 2016
2 Maqsood Hussain term of office ended 28 September 2016
3 Merryl Patrick term of office began 28 September 2016
4 Gemma Price term of office began 28 September 2016
5 David Hanson term of office began 21 September 2016
6 Garry Jones term of office began 23 June 2016
7 Sue McGarry term of office began 21 September 2016
8 Emma Salt term of office ended 28 September 2016
9 Rebecca Carlton term of office ended 20 September 2016

* Including one Extra Ordinary Council of Governors meeting.

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

Director attendance at Council of Governor meetings 2016/17

Name and Title	Dates Attended *
John Davies Non-Executive Director and Senior Independent Director	20 April 2016; 23 June 2016; 21 September 2016; 19 October 2016; 15 December 2016; 18 January 2017; and 16 March 2017
Andrew Hughes[1] Non-Executive Director	20 April 2016; 23 June 2016; 21 September 2016; 19 October 2016; and 15 December 2016
Stephen Goode Non-Executive Director and Deputy Chair	23 June 2016; 21 September 2016; 15 December 2016; and 18 January 2017
Paul Doona Non-Executive Director	20 April 2016; 23 June 2016; 21 September 2016; 19 October 2016; 15 December 2016; 18 January 2017; and 16 March 2017
John Bale Non-Executive Director	20 April 2016; 21 September 2016; 19 October 2016; 15 December 2016; 18 January 2017; and 16 March 2017
Helen Scott-South Chief Executive	23 June 2016; 21 September 2016; 19 October 2016; 18 January 2017; 16 March 2017; and 28 March 2017
Magnus Harrison Medical Director	20 April 2016; 23 June 2016; 19 October 2016; 15 December 2016; 18 January 2017; and 16 March 2017
Jon Sargeant [2] Director of Finance, Information, Performance and Estates	21 September 2016
Jonathan Tringham Director of Finance, Information, Performance and Estates	15 December 2016; 18 January 2017; and 16 March 2017
Paula Gardner Chief Nurse	23 June 2016; 21 September 2016; 19 October 2016; 15 December 2016; 18 January 2017; and 16 March 2017

Name and Title	Dates Attended *
Duncan Bedford Chief Operating Officer	20 April 2016; 23 June 2016; 21 September 2016; 19 October 2016; 15 December 2016; and 16 March 2017
Tosca Fairchild Director of Governance	20 April 2016; 23 June 2016; 21 September 2016; 19 October 2016; 15 December 2016; 18 January 2017; 16 March 2017; and 28 March 2017
Alison Wynne Director of Strategy and Partnerships	23 June 2016; 21 September 2016; 15 December 2016; 18 January 2017; and 16 March 2017
Louise Thompson Director of Communications	18 January 2017; and 16 March 2017
Roger Smith Director of Human Resources	15 December 2016; 18 January 2017; and 16 March 2017

1 Andrew Hughes left the Trust on 17 December 2016
2 Jon Sargeant left the Trust on 31 October 2016

* Includes one Extra Ordinary Council of Governors meeting.

2.5.12 Trust membership

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

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

Public Constituencies

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

Staff Constituencies

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

There are five representatives from the Staff Constituency representing:

- Medical and Dental staff
- Nursing and Midwifery staff

- Other clinical staff
- Other staff - non-clinical
- Volunteers

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

Membership numbers for the Trust

Public Constituency Members Constituency	Figures as at 31 March 2016	Figures as at 31 March 2017
East Staffordshire	3,053	2,983
South Derbyshire	1,404	1,335
Lichfield & Tamworth	1,555	1,484
North West Leicestershire & the Rest of England	640	627
Total Membership	**6,652**	**6,429**

Staff Constituency Members Constituency	Figures as at 31 March 2016	Figures as at 31 March 2017
Medical & Dental	195	206
Nursing & Midwifery	918	910
Other Clinical	733	731
Other	920	925
Volunteers	207	171
Total Membership	**2,973**	**2,943**

The total number of Members for the Trust, detailed in the above tables, as at 31 March 2017 equals 9,372.

2.5.13 Membership Strategy

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

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

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

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

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

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

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

2.5.14 Membership development and engagement

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

Member Information Events

Following on from the Members events on osteoarthritis in 2014 and dementia in 2015, the Governors held a Diabetes Information Event in May 2016 at Sir Robert Peel Hospital in Tamworth. This event gave the Trust an opportunity to present an overview of diabetes, including its symptoms and care pathways within the hospitals and in the community. The Diabetes Centre team led this event and held workshops on topics such as:

- Foot care
- Healthy diet choices
- Fats and Food
- Hidden sugar in drinks and food
- Hypoglycaemia and treatment choices.

This event was attended by in excess of 20 Members together with a number of Governors. Due to the positive feedback received following this event, the Governors and the Diabetes Centre team will be holding a further event on 24 May

2017 on healthy lifestyle choices and diabetes at the Medical Education Centre on the Queen's Hospital site.

Listening Events

The Governors have taken the opportunity to engage with Members and the public at the Listening Events which were held in July 2016 to explain the Trust's strategy and the importance of partnership working. These Listening Events provided the Governors with an opportunity to engage with both public and staff Members.

Sustainability & Transformation Plan for Staffordshire

Healthwatch Staffordshire facilitated a number of "Conversations Staffordshire & Stoke on Trent" as part of the Sustainability & Transformation Plan for Staffordshire and Stoke-on-Trent. A number of Governors attended these sessions to engage with local constituents.

In addition, Governors were invited to attend Ambassador Training for the Sustainability & Transformation Plan with a view to determining whether they would consider an Ambassador role as part of this process.

Derby Teaching Hospitals NHS Foundation Trust Collaboration Work

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

It is also important to ensure that staff, patients, their families and carers are involved in the development of the potential partnership. If the Outline Business Case is approved the trusts will want local people to help develop the care pathways for a number of specialties that involve closer working between Burton and Derby Hospitals. This would mean considering the vision for future services and how clinical outcomes and patient experience could be improved. In order to support this work a Patient Reference Group has been established, with Governor involvement from both trusts, together with a recruitment event for Members and members of the public to be involved. In order to ensure that staff from both organisations are engaged, a Staff Reference Group has been developed to support the process with the involvement of Staff Governors from both trusts.

In addition to the above, a number of Governors have engaged with constituents at events at local schools, GP surgeries, Patient Participation Groups and events organised by local councils.

The Trust rebranded its Members magazine in 2015, with the first publication of 'Your Hospitals' produced in June 2015 to replace Foundation Focus. Your Hospitals continues to be produced biannually and is emailed to those Members who have chosen to receive their communications electronically.

The Council of Governors monitors the effectiveness of the Strategy through the delivery of its objectives which is reported back through the Membership and Communications Committee. This Committee will ensure that the Strategy

remains a meaningful and relevant document. The Membership Strategy is reviewed annually and the Committee will continue to develop Membership through a recruitment, communications and engagement action plan.

A number of mechanisms have been developed to allow the Board, and in particular the Non-Executive Directors, to develop an understanding of the views of Governors and Members, including a 'Meet the Board' session bi monthly allowing Governors, Members and members of the public to informally ask the Board of Directors questions about pertinent issues.

Board of Directors and Council of Governors meetings are held in public, with the date, time and venue publicised on the Trust website and in the local media allowing stakeholders to meet Board members and Governors.

2.6 Regulatory Ratings

2.6.1 Single Oversight Framework

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

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

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

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

Burton Hospitals NHS Foundation Trust is in Segment 3.

This segmentation information is the Trust's position as at 31 March 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website. The Trust has current Enforcement Undertakings to rectify the breach of the Provider Licence in relation to financial planning and governance. The following table describes the four segments:

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

Finance and use of resources

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

Area	Metric	2016/17 Q3 Score	2016/17 Q4 Score
Financial Sustainability	Capital Service Capacity	4	4
	Liquidity	4	3
Financial Efficiency	I&E Margin	4	4
Financial Controls	Distance from Financial Plan	2	1
	Agency Spend	3	3
Overall Scoring		**3**	**3**

2.6.2 Care Quality Commission Inspection

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

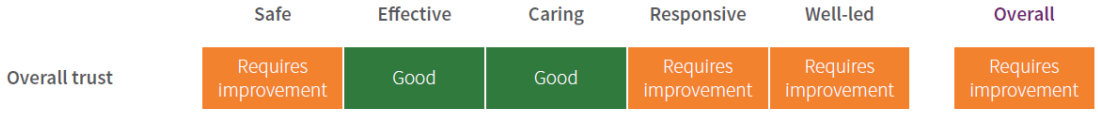
CQC inspectors use professional judgement, supported by objective measures and evidence, to assess services against five key questions:

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

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

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

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



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

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

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

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

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

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

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

The CQC reviewed:

- The role of healthcare providers and commissioners;
- The role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews;

- The contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

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

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

Although the Trust is no longer in special measures, Enforcement Undertakings still remain in relation to the breach of Provider Licence relating to financial planning and governance.

2.7 Statement of Accounting Officers Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Burton Hospitals NHS Foundation Trust

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

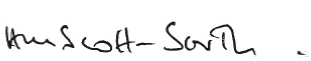
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Direction which requires Burton Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- Prepare the financial statements on a going concern basis.

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

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



Helen Scott-South
Chief Executive
24 May 2017

2.8 Annual Governance Statement for the Period 1 April 2016 to 31 March 2017

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Burton Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Burton Hospitals NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

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

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

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

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

training which incorporates best practice techniques from the National Patient Safety Agency (NPSA).

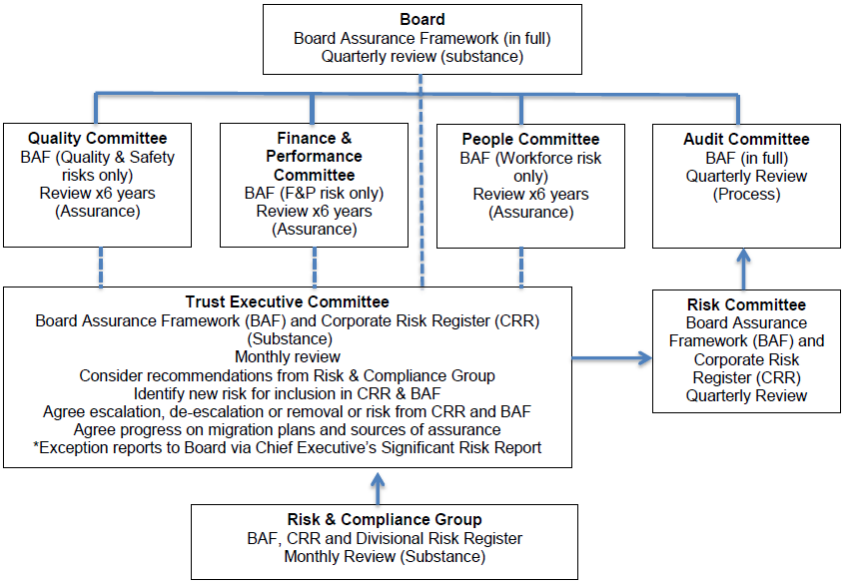
Responsibility and accountability arrangements for risk management are seen in the table below:

Chief Executive	The Chief Executive is accountable for ensuring an effective risk management system is in place in order to meet the statutory requirements relevant to the Trust. As Accountable Officer, the Chief Executive is accountable to the Chairman and the Board of Directors for ensuring there is an effective system of risk management and internal control in place, and for meeting all statutory and corporate governance requirements. The Chief Executive delegates responsibility for the maintenance of the system of internal control to the Executive and Divisional Management Teams (Divisional Directors / Divisional Medical Directors and Divisional Nurse Director).
Director of Governance	The Director of Governance is the Trust's Chief Risk Officer and is responsible for developing and implementing systems of internal control. The Director of Governance is responsible for the development and implementation of the Trust Risk Management Strategy and Risk Management Policy. The Director of Governance is responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet its requirements in relation to risk management and is also responsible for ensuring risk registers are reviewed on a monthly basis. The Director of Governance has responsibility to ensure that Trust has a robust Board Assurance Framework
Director of Finance, Information, Performance & Estates	The Director of Finance, Information, Performance & Estates has delegated responsibility for managing the strategic development and implementation of financial risk management and is responsible for implementing financial systems of internal control including the reporting of fraud to NHS Protect. The Director of Finance, Information, Performance & Estates is responsible for informing the Board of Directors of the key financial risks within the Trust, the actions being taken to control them, and provides written advice to the Accountable Officer on the content of the Annual Governance Statement regarding financial risk. The Director of Finance, Information, Performance & Estates is also the Trust Senior Information Risk Owner (SIRO) with ownership of the Trust's Information Risk Policy. The Director of Finance, Information, Performance & Estates provides written advice on information risks to the Accountable Officer for the Annual Governance Statement.
Executive Directors	Executive Directors have delegated responsibility for governance and risk management arrangements within their areas of control. All Executive Directors are accountable to the Chief Executive and the Board of Directors for the maintenance of effective systems of internal control within their areas of responsibility. Executive Directors are responsible for reporting on controls and assurances of the highest risks to the Trust objectives through the Board Assurance Framework (BAF). Each Director is responsible for risk management leadership including the implementation of, and compliance with, current Trust policies and for ensuring sufficient resources have been allocated to

	undertake effective risk management. Leading by example, Executive Directors are fundamental in establishing and sustaining an environment of openness on risk management within their Divisions.
Board of Directors	The Board of Directors is responsible for endorsing the organisation's system of internal control, including risk management as identified in the Risk Management Strategy and has collective responsibility for: ➢ Providing leadership on the management of risk; ➢ Agreeing the Trust Objectives and developing the Board Assurance Framework; ➢ Reducing, eliminating and exploiting risk in order to increase resilience; ➢ Determining and communicating the risk appetite for the Trust; ➢ Ensuring the approach to risk management is consistently applied; ➢ Making sure assurances are available to demonstrate that risks have been identified; assessed and all reasonable steps have been taken to manage them effectively and appropriately; ➢ Ensuring appropriate resources are available to support the risk management system and to manage risk within the agreed risk appetite; ➢ Protecting the reputation of the Trust; ➢ Correctly identifying risk, the scoring of risk and compliance with Trust controls.

4. The risk and control framework

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



Key – CRR – Corporate Risk Register

The Board of Directors approved the revised Risk Management Strategy in October 2016 taking account of structural changes. All risks are managed and mitigated in accordance with the approach outlined above. Future risks that may impact the Trust's ability to deliver the Operational Plan have been identified Action plans to manage and mitigate these are being prepared in accordance with the process identified above and the impact of mitigating actions will be closely monitored by the appropriate Board Committee. The Board of Directors receives a regular summary report from each of its Committees providing both assurance and, by exception, escalation of those items the Board should be made aware of.

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

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

The Trust is dedicated to promoting and nurturing a just or 'no blame' culture to promote open and honest processes for reporting incidents and raising concerns. The Trust has the 'Being Open when Patients are Harmed Policy' incorporating Requirements of Duty of Candour Policy which was reviewed and approved in March 2015.

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

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

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

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

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

In addition, the Trust has appointed a Freedom to Speak Up Guardian which is a newly created role for every Trust in England. It follows the publication of the Freedom to Speak Up Review which was commissioned by the Secretary of State in February 2015, chaired

by Sir Robert Francis QC. This role supports the profile of raising concerns in the organisation and provides challenge to staff and the Board if the culture does not provide the appropriate atmosphere to allow concerns to be raised. The Freedom To Speak Up Guardian also provides confidential advice and support to all staff in relation to concerns regarding patient safety and / or the way their concern has been handled.

The Board Assurance Framework

During the past year, the Board of Directors continued to monitor and review the risks within its Board Assurance Framework (BAF). The risks within the BAF were collectively agreed as the areas that would have a direct impact on the Trust's ability to deliver its priorities and objectives. Strategic risks were reviewed and reassessed with Board Committees considering the strategic risks relevant to them as well as the high scoring operational risks that may pose a threat to strategic objectives, challenging and monitoring the risk mitigation actions in place. The highest scoring BAF risks at 31 March 2017 were:

- **Ineffective implementation of services changes and reconfigurations could lead to loss of market share and impact on the Trust's reputation due to negative media coverage, staff and community reactions – Risk Score 20.**

- **Failure to invest in the current estate and improve the quality of environment could lead to non-compliance with CQC Standards – Risk Score 20.**

- **Failure to undertake work with Virgin Care and GPs, at pace, to deliver improved care pathways for 2016/17 will result in no activity reduction in frailty, COPD, Diabetes and Heart Failure, as well as lost opportunity for improving service delivery – Risk Score 20.**

The Trust has continued to strengthen the Risk Management and BAF processes. Internal Audit undertook a follow-up review of the BAF in 2016/17 and made an assessment of **significant assurance with minor improvement opportunities** reflecting that the Trust had undertaken work to action the recommendations made within the 2015/16 Internal Audit review of the BAF and Risk Management.

Corporate Governance Statement

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

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

In addition, the Trust has been exploring collaborative working with Derby Teaching Hospitals NHS Foundation Trust. The two trusts have an overlapping population base, operating 11 miles apart with respect to the Queen's Site. Along with the rest of the NHS, both Trusts are experiencing clinical, operational and financial challenges which are increasing over time. These pressures impact on the annual performance against national quality and operational performance standards.

Both Boards approved a Strategic Outline Case in October 2016 and agreed that some form of strategic collaboration was likely to be the best way to address the specific sustainability challenges. The Outline Business Case is due to be considered during 2017/18.

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

Information Risks

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

The Trust Executive Committee approved an Information Governance Policy, setting out the overall framework for information governance arrangements at the Trust, supported by additional documents such as the Information Risk Management Programme. A systematic review of risks relating to information systems and data flows has been carried out and corrective actions identified when required. A new incident reporting system Datix was implemented during 2016/17 to capture record and analyse reported issues relating to information systems and confidential data.

The Trust is required to undertake a self-assessment against the Information Governance Toolkit (IGT) on an annual basis. There are 45 Requirements based on 6 initiatives which include Confidentiality and Data Protection Assurance, Information Security Assurance and Clinical Information Assurance. Each Requirement is made up of Attainment Levels 0-3 (0 being the lowest and 3 the highest). For each Requirement the Trust must provide evidence to ensure they meet the criteria set out for each Attainment Level.

The IGT is monitored throughout the year and the Trust has to submit an interim position mid-year and a final position as at 31 March 2017. The IGT is scored against the following three Grades:

Not Satisfactory	Not evidenced Attainment Level 2 or above on all requirements
Satisfactory with Improvement Plan	Not evidenced Attainment Level 2 or above on all requirements but improvement plan provided
Satisfactory	Evidenced Attainment Level 2 or above on all requirements

The table below provides the Requirements by Level against the previous year's results.

Assessment	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Self-assessed Grade
Version 14 (2016-2017)	0	0	22	23	45	83%	**Satisfactory**
Version 13 (2015-2016)	0	0	24	21	45	82%	**Satisfactory**

The Trust achieved an overall score of 83% and is satisfied that the Information Governance assessment is adequate. The score is a 1% improvement on last year's performance.

There are no Requirements Level 1 or below. The number reaching the maximum attainment of Level 3 has increased by 2 to 23 in total. NHS Digital continue to rate the Trust as "Satisfactory" for the period 2016/17.

Policies

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

Care Quality Commission (CQC)

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

Care Quality Commission Inspection – July 2015

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

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

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

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

The Trust received notification that the CQC would undertake a full re-inspection during July 2015 across all three sites following the same methodology as used during the Inspection in 2014. The purpose of the visit was to evaluate the Trust against the CQC standards across five key domains: Safe, Caring, Effective, Responsive to Patient's

Needs and Well Led. This Inspection was an opportunity to highlight the progress that the Trust had made since the last visit, and to showcase the work that the Trust was proud of, as well as to gain constructive feedback that would support improvements in the quality of the services that the Trust offers to its patients.

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

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

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

The report listed 33 recommendations, 17 actions which the Trust 'must take' and 16 actions that the Trust 'should take'. Clearly, the Trust's services can always improve and, in response to the recommendations, a detailed action plan was developed by the Director of Governance pulling together all recommendations from all high external reviews, including those remaining from the Keogh Review in 2013, CQC and Well Led Review into a Consolidated Action Plan (CAP). The actions continue to be monitored and updated monthly to reflect the progress made by the Trust in delivering and then embedding the recommendations. Actions from a further two external reviews were incorporated during the year; Review of Health Services for Children Looked After and Safeguarding in Staffordshire which was undertaken by the CQC and a Clinical Commissioning Group review into Serious Incidents. The Board of Directors monitors the delivery of the Consolidated Action Plan, supported by the Quality, Finance and Performance and the People Committees who review the evidence to support the delivery of actions.

The Chief Nurse arranged a Trust-wide Mock CQC Inspection in November 2016 in order to benchmark the Trust against the previous Key Lines of Enquiry. A number of areas were identified that had demonstrated significant improvements and there were some areas where further actions were required. The CAP was reviewed against the findings and two actions that were previously archived were re-introduced to allow further work to be undertaken. These were ensuring learning following Never Events and the Surgical World Health Organisation Checklist.

Previously, the Finance & Performance Committee received quarterly self-assessment compliance reports against the Care Quality Commission (CQC) regulations for each of the Trust's registered locations following review by the responsible Executive Director. This supported the quarterly monitoring submission as previously required by the Independent Regulator, Monitor. Since the implementation of the Single Oversight Framework by NHS Improvement the requirement to provide this quarterly monitoring has ceased. Therefore, the Quality Committee receives the quarterly self-assessments against the CQC regulations. Where any shortfall in compliance is identified, an action plan is developed, received and monitored by the relevant Board committee.

Other

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

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

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

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

4.1. Capacity

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

4.2. Finance

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

4.3. Cost Improvement Schemes

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

4.4. Performance

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

4.5. Internal Controls

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

4.6. Regulators

The Trust has current Enforcement Undertakings to rectify the breach of the Provider Licence in relation to financial planning and governance. As a result the Trust strengthened governance arrangements with the appointment of the Director of

Governance in 2014 who has, and continues to provide strong leadership for governance and risk. In addition to the external reviews commissioned previously, Deloitte has undertaken a Board Capacity Review in March 2017 The draft report has noted no material concerns in relating to capability and effectiveness of the Board of Directors and the Trust is noted to have strong governance arrangements in place for risk management. The independent regulator undertook a sustainability review in 2015 which covered clinical sustainability and drivers of the deficit. The Trust continues to address issues within its control and work with Derby Teaching Hospitals NHS Foundation Trust and the Staffordshire and Stoke-on-Trent Sustainability and Transformation Programme to support this work.

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

The framework assesses providers' performance against five themes:

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

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

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

Extract from NHS Improvement Single Oversight Framework – September 2016

The Trust has current Enforcement Undertakings to rectify the breach of the Provider Licence in relation to financial planning and governance, therefore the Trust was placed in segment 3.

5. Information Governance

The Information Governance Steering Group reports to the Finance and Performance Committee which reports to the Board of Directors. The Information Governance Steering Group is chaired by the Chief Information Officer, who reports to the Director of Finance as Senior Information Risk Owner, and monitors the overall arrangements for data quality

including the implementation and review of the Data Quality Policy. The Information department undertakes routine validation checks and report on completeness of key data items. There were no serious incidents relating to confidentiality breaches, cyber-security or data loss during the reporting period.

6. Annual Quality Report

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

The Trust has adopted a comprehensive approach to the development of the Quality Report that provides information and assurance on the quality of services for local people, patients and their families, stakeholders and staff and demonstrates that, from the ward to the Board, the Trust is committed to improving services further.

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

- Internal Quality Compliance Inspections have been streamlined and pertinent questions have been included in the Board To Ward process to ensure that further assurance is received from Ward and Departmental level.
- A Trust wide Mock CQC Inspection was undertaken in November 2016 to provide a benchmark in preparation for future CQC inspections.
- The Trust's Quality Improvement Strategy has been revised and launched during the year and identifies quality improvement priorities for 2016-19. It has been developed in consultation with patients and staff and aims to further progress the Trust's ambitions identified within the 2013-15 Quality Strategy; continuing to ensure that our patients receive services that are consistently safe and effective with a focus on improving the experiences of our patients.
- A Quality Stocktake has been developed to encompass all quality improvements under one umbrella.
- Regular Trust wide Quality Summits have been held during 2016/17 with a view to hold quarterly Quality Summits in 2017/18.

6.1 Governance and Leadership

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

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

6.2 Policies

The Trust has a number of clinical and non-clinical policies which incorporate the quality requirements at an operational and strategic level. Robust development and approval processes ensure that quality assurance is considered throughout the drafting and approval stages. Key policies support the Information Governance arrangements for data collection, security, reporting and quality. The Data Quality Policy provides clarity on staff responsibilities, procedures and training requirements and references to the Information Governance and Health Record keeping data requirements. Policies are subject to regular review (defined on each document) and are available to all staff via the Trust intranet.

6.3 Systems and Processes

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

6.4 People and Skills

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

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

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

6.5 Data use and Reporting

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

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

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

7. Review of effectiveness

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

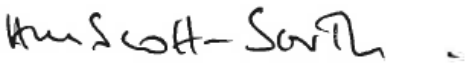
Board of Directors	The Board receives regular reports on all risk areas and reports from the relevant reporting committees and working groups.
Audit Committee	The Audit Committee has adopted a holistic approach to risk management and considers clinical, financial, quality and organisational matters.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

The Head of Internal Audit Opinion has confirmed that "Our overall opinion for the period 1 April 2016 to 31 March 2017 is that Significant Assurance with minor improvement opportunities can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control."

8. Conclusion

As Accountable Officer I am confident that no significant internal control issues have been identified. However, the Trust has current Enforcement Undertakings under Section 106 and Section 111 issued by the Regulator in relation to the breach of the Provider Licence in 2013 and is under Segment 3 of the Single Oversight Framework.

Signed



Helen Scott-South
Chief Executive
24 May 2017

Quality Account 2016 - 2017

Contents:

Part 1:

Statement on Quality from the Chief Executive

Our aim is to provide outstanding healthcare to all of our patients and I am delighted to introduce our Quality Account for 2016/17, which outlines the steps we have made to achieve that goal as well as our priorities for the coming year.

We want to put our patients at the very heart of everything we do at Burton Hospitals, so this Quality Account demonstrates how we are doing that and I hope it gives our local population the confidence that their hospitals are providing high quality, effective services.

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

The Trust has made significant strides in improving the quality of our services but we know that we must continue to look forward and we want to set ourselves more bold and ambitious targets for providing safe, effective and positive services.

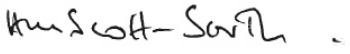
Our ambition is to be rated as an outstanding healthcare provider by the Care Quality Commission (CQC). The Trust currently has an overall rating of 'Requires Improvement' and we want to make sure that when the CQC next visit us, that we can demonstrate all the improvements we have made to patient care.

To assist us in reaching those targets, our priorities for 2016/17, agreed by the Board of Directors following consultation with patients, staff, stakeholders and members of the public, are:

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

Staff across our three hospitals are striving for the very best possible care and outcomes for our patients on a daily basis. I'm confident that this Quality Account not only recognises their many achievements, but also provides them with the support and guidance to continue putting the people of Burton, Lichfield, Tamworth and the surrounding areas first.

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



Helen Scott-South
Chief Executive

Part 2:

2.1 Priorities for improvement

Developing the Quality Account

The Quality Account reports annually on the quality of services delivered by NHS healthcare providers to the public. The primary purpose of this document is to allow the Trust to demonstrate commitment to the delivery of continuous, evidence-based quality care, and to explain the Trust's progress over the past year against the priorities identified within the Trust's 2016/17 Quality Account.

A variety of engagement events took place during 2016/17 with both external stakeholders and internal staff groups to provide feedback on the Trust's services.

Summary of Quality Accounts Engagement 2016/17

An engagement programme and analysis of patient feedback took place in 2016/2017 to gauge what is important to our patients and local community and identify the areas that they think we should improve upon.

Your Hospital Survey

The survey asked respondents to rate the Trust in the domains of Safety, Communication, Kindness and Compassion and Clinical Care.

It is difficult to make statistical comparisons between this year's and previous surveys as respondents are self-selecting and in previous years the survey was conducted at a wider range of engagement activities. There were a similar number of respondents to the previous year. The scores for each domain have continued to improve. The highest priority for improvement, for those patients and members of the public who took part in the survey, continues to be Communication, although this score reflects sustained improvement when compared to previous years.

Overall survey scores 2013/14, 2014/15, 2015/16 and 2016/17

	2013/14	2014/15	2015/16	2016/17
Safety	70	80	81	84
Kindness and Compassion	69	81	85	88
Communication	58	65	68	76
Clinical Care	70	80	86	84

Negative comments relating to communication related to; information around appointments in terms of cancellations and correspondence; issues regarding telephone access; and information given in response to patients' questions.
The Trust does however receive positive comments regarding communication:

Engagement Events linked to the SSTP and Burton & Derby Collaboration

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

Engagement took place at 4 events held during July including Queen's Hospital and the Town Hall, Burton; Samuel Johnson Community Hospital, Lichfield; and Sir Robert Peel Community Hospital in Tamworth. These '*Delivering care where it counts'* sessions gave patients, carers, members of the public and representatives of patient and community groups the opportunity to discuss issues and to ask questions.

Further engagement, linked to the SSTP, took place in the autumn with 10 'Conversation Staffordshire' public events being held across the county. Over 90 people attended events held at Burton, Lichfield and Tamworth. Feedback and comments from participants at these events has been published in the Conversation Staffordshire Events Report produced by Healthwatch Staffordshire.

Discussions focussed on a number of themes including a Digital NHS, Mental Health, Primary and Community Care, Focused Prevention, Planned Care and Urgent and Emergency Care.

The Trust actively participated in the recruitment campaign of 200 SSTP ambassadors across Staffordshire and Stoke-on-Trent. Communications and engagement plans linked to both the SSTP and Derby/Burton collaboration continue to be the priority going forward into 2017/18.

The first edition of a new newsletter, the Burton & Derby Collaboration Update, was launched in February 2017 which aims to keep our local communities and stakeholders informed about how Burton Hospitals and Derby Teaching Hospitals are planning to work more closely together.

The Trust is also committed to engaging with staff and seven listening events took place in March to give staff an update on the progress of major projects and to give them the opportunity to ask questions and give their feedback.

The Trust's commitment to engaging with local communities and listening to patients' views is an important part of the collaboration. Local people have been invited to contribute their views on the development of care pathways for a number of specialities that involve closer working between Burton and Derby Hospitals. Over 50 people attended two workshops held at Burton and Derby Hospitals in March 2017. Participants had the opportunity to give their feedback and ideas on ways of ensuring the patient voice helps shape future services.

Review of the priorities for 2015/16

The following section reviews the priorities for quality improvement that were identified last year and provides a summary of the progress towards their achievement.

Priority 1:

To reduce avoidable, hospital acquired pressure ulcers.

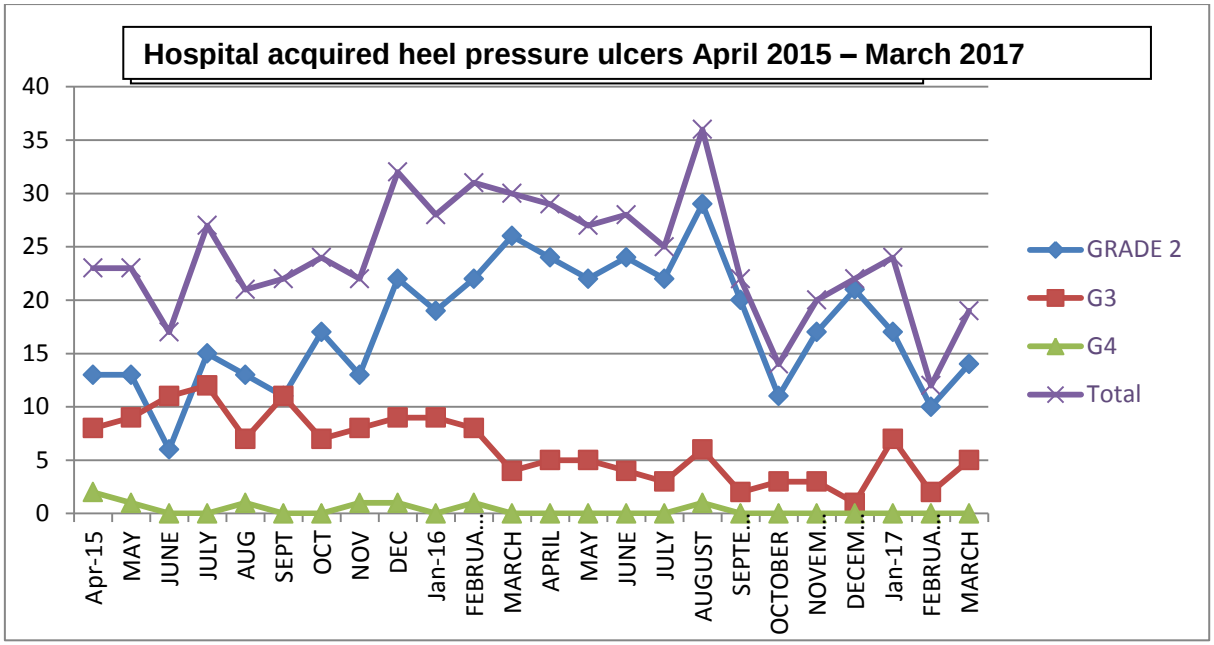
How does this link to our Quality Improvement Strategy?

Strategic Aim 2: Eliminate Avoidable Harm

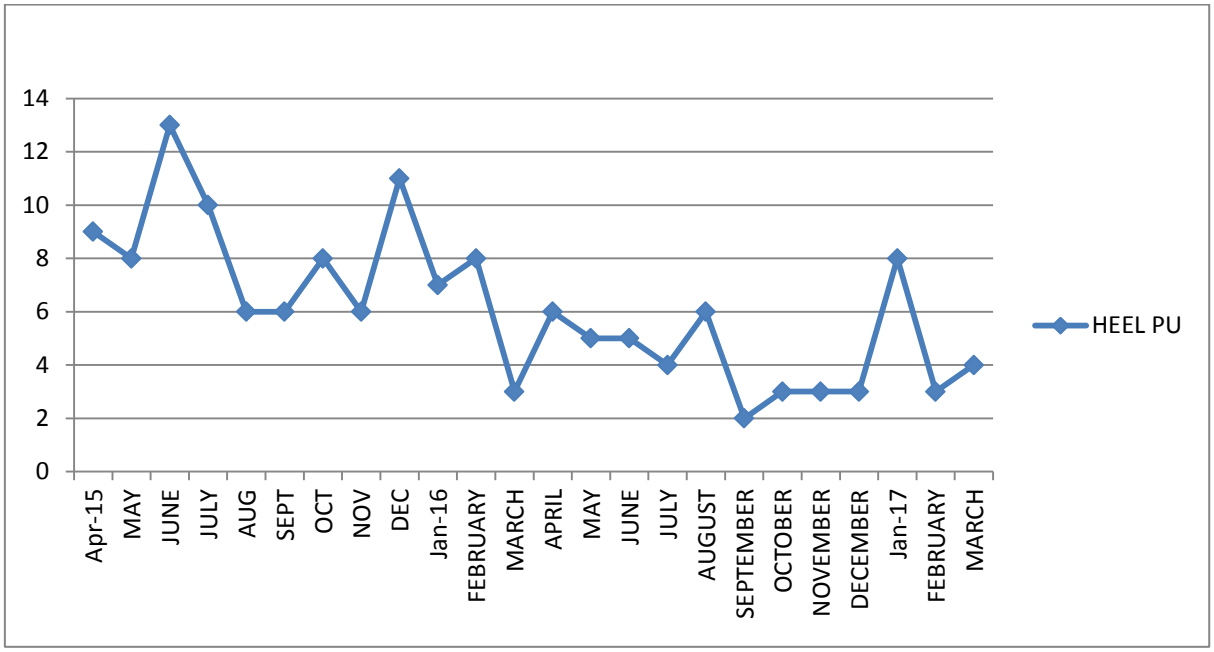
Why is this a priority area?

The NHS Safety Thermometer indicates that Burton Hospitals Trust is above national average, although the rate has, on average, been gradually decreasing over the last year. Pressure ulcer incidence has decreased, particularly in the case of grade 3 hospital acquired pressure ulcers. However, the incidence of grade 2 pressure ulcers and sacral/buttock pressure ulcer rate is still high. The rate of pressure ulcers to the heel has reduced considerably.

The following graph illustrates hospital acquired pressure ulcer incidence between April 2015 and March 2017:



What has been achieved so far?



- There has been a reduction in heel pressure ulcers. This is attributable to the "Float the Heels" campaign where staff are encouraged to use pillows to offload heels, or in some cases, pressure relieving boots.
- The SKINS Bundle bedside document is now routinely used by staff throughout the Trust. This provides "at a glance" information of patient skin checks and interventions made, particularly in response to problems such as developing redness of the skin.
- The Root Cause Analysis process involving investigation of grade 3 pressure ulcers has enabled staff to establish reasons why certain events have occurred and how they may be prevented in the future. This is discussed at fortnightly Incident Safety Alert meetings. Common trends and

themes are identified; lessons learnt are established, and good practice is shared.

- Examples of shared good practice which has been taken on board by other wards is the introduction of padded silicone masks to prevent pressure injury to the bridge of the nose, and nasogastric tubes with soft protective tubing to prevent ear pressure injury.
- Common trends and themes in the case of avoidable pressure ulcers have been poor or absent documentation and inadequate repositioning and/or heel offloading in some cases. Findings are brought back to clinical areas so that staff can be informed and prompted to address these problems.
- Grade 2 pressure ulcer investigation has now been incorporated into Datix, (risk management system), prompting staff to identify actions or omissions which may have contributed towards pressure injury. Lessons learnt from this are shared amongst ward staff and brought to the ISA meeting.
- A variety of educational methods have been used to reiterate pressure ulcer prevention messages. These have included the Pressure Ulcer Prevention E-Learning Package (with graded test); face-to-face teaching in lecture theatres, or with smaller groups on wards. Accompanying educational materials have included: “Pressure Ulcer Prevention in a Nutshell” (incorporating all the important messages on one piece of paper, presented in a pictorial fashion) and the SKINS Bundle Made Easy leaflet.
- Staff are now prompted on Meditech to give and explain the React to Red patient information leaflet to patients and/or their family/carers. React to Red is part of a national pressure ulcer prevention campaign.
- A mattress audit has been undertaken to identify mattresses or covers which do not meet requirements and replacements have been organised.
- Eighteen Talley Quattro Acute high specification pressure relieving mattresses have been purchased to replace ageing Nimbus 3 mattresses.

What does the Trust plan to do?

The main aims are to reduce avoidable grade 3 hospital acquired pressure ulcers further, by preventing the development of grade 2 pressure ulcers. Steps have been taken to ensure this. However, staff engagement has been difficult at times, and this is apparent in poor attendance at Tissue Viability Champion meetings and educational sessions. Therefore, messages are not always cascaded back to the clinical areas. Feedback of attendance is provided to Matrons and Senior Sisters to encourage more staff to attend next time.

The following have been planned:

- Visit by Tissue Viability Team to Derby Hospital to strengthen links, identify good practice and share it.
- In view of the incidence of sacral/buttock pressure ulcers, there was a seating audit on the 16th March 2017 to establish the types and condition of seating equipment in the Trust. Currently, three different types of seating cushion are being trialled on a number of wards.
- Moisture lesion versus pressure ulcer campaign is to be launched. A “Trolley Dash”, with the assistance of a wound product company, is planned to educate staff on grading pressure ulcers and identification of moisture lesions.

- Further educational sessions on Wound Assessment and Dressing Choice, and Pressure Ulcer Prevention (including Root Cause Analysis Process).
- A dressing choice chart with colour pictures is currently being developed to enable staff to choose appropriate treatments for wounds.
- A wall poster incorporating pressure ulcer prevention methods; assessment and reporting process.
- Greater involvement of the patient and relative/carer in taking responsibility in preventing pressure ulcers, and ensuring they take the message home with them. It is hoped that this will provide them with knowledge to prevent pressure injuries occurring at home.

Priority 2:

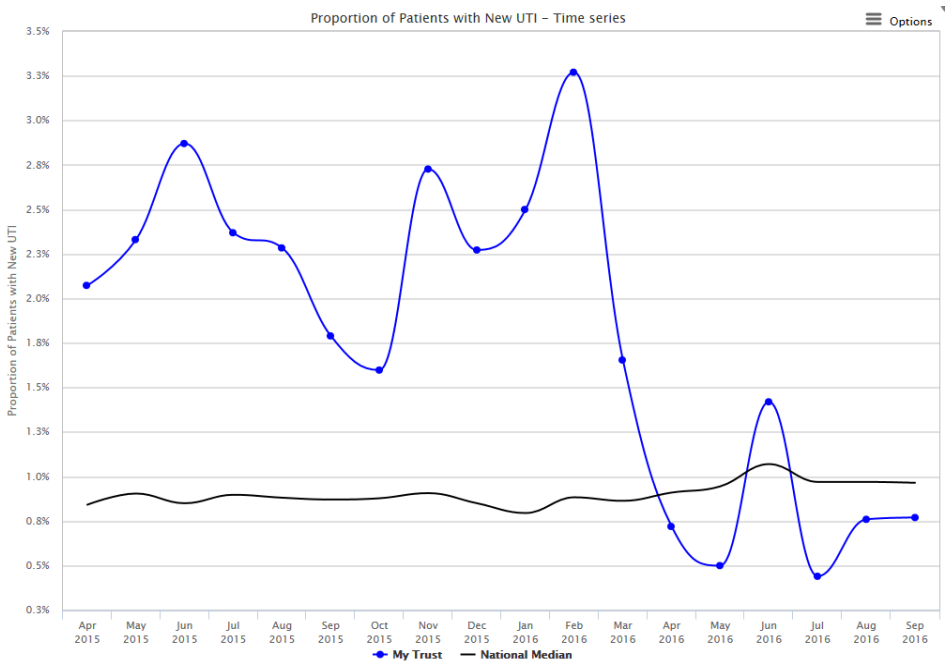
To reduce avoidable healthcare catheter associated urinary tract infections.

How does this link to our Quality Improvement Strategy?

Strategic Aim 2: Eliminate Avoidable Harm

Why is this a priority area?

The NHS Safety Thermometer indicates that Burton Hospitals Trust is above national average, although the rate has, on average, been gradually decreasing over the last year. Please see graph below for trends on diagnosis of a new Urinary Tract Infection (UTI).

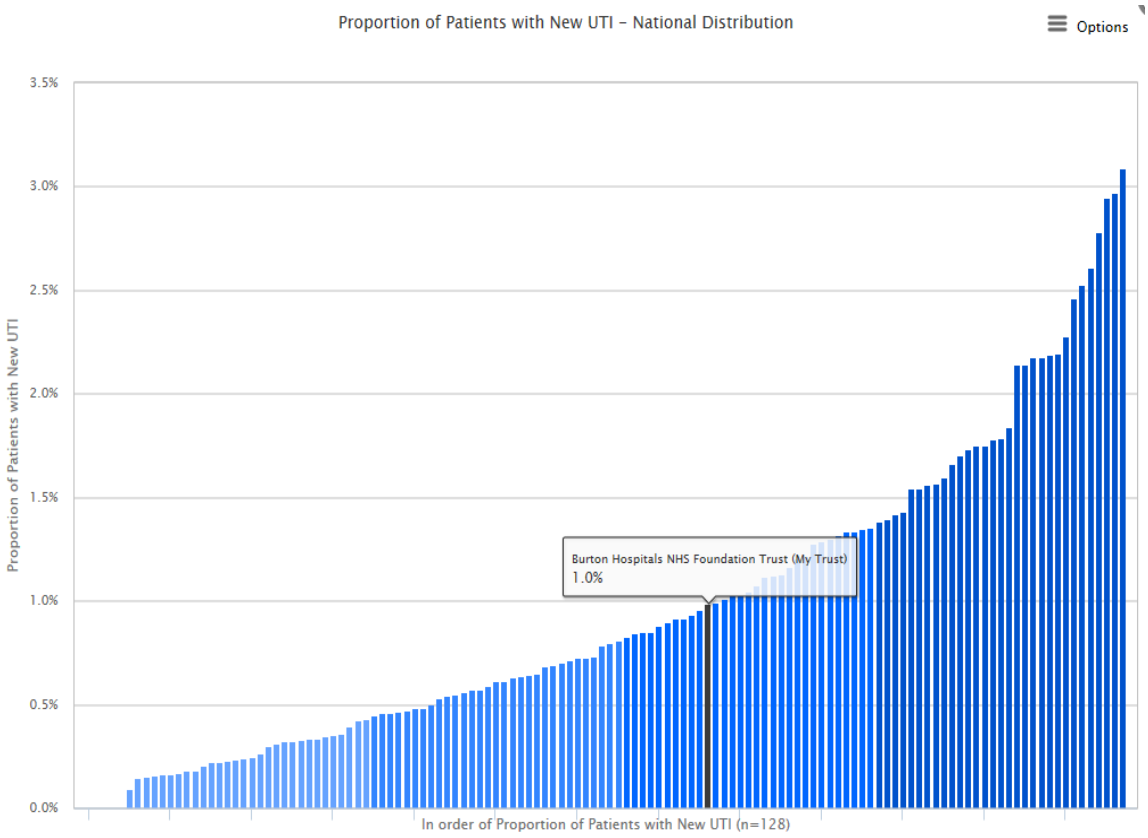


What has been achieved so far?

- The Trust launched the Quality Improvement Strategy with a main aim to reduce avoidable harm
- Blast training has been completed by the infection prevention and control team for a 3 month period to embed HOUDINI in practice. HOUDINI is a protocol to support, primarily, nursing staff in assessing if a urinary catheter should remain insitu. Each letter of the HOUDINI acronym indicates a reason not to remove the urinary catheter.
- Implemented HOUDINI paperwork- this is a nurse led protocol for removing catheters as soon as is clinically justified.
- Catheter management policy has been updated.
- Audit- this has been completed by 2 junior doctors and showed a marked improvement from the baseline audit, these include:

  - reason for catheter insertion following HOUDINI criteria rose to 86% from 83% from the baseline audit
  - duration of catheters went from 75% of catheters being left in for more than 10 days to us now removing 77% of catheters within 10 days
  - quality of documentation- this went from 62% of patients having partial documentation to now 93% of documentation being fully complete.

- Work remains on-going with the agreement to take part in research with the University of Nottingham who are developing an antimicrobial catheter to prevent bacterial colonisation on the surface of long-term catheters.



What does the Trust plan to do?

- Maintain audits to assess on-going performance and monitor improvements in practice
- Repeat 'blast' training to ensure HOUDINI is embedded in practice- this will be completed with a joint effort from nursing and medical staff.
- Introduce a new catheter record proforma, which will supersede the original HOUDINI form, this will prompt better quality documentation and holistic assessment of patients
- Work with teams in our information department to improve our electronic system to have 'pop up' boxes built in as a visual prompt/reminder to nursing staff when they are documenting on a patient's elimination needs.
- Update our Aseptic Non Touch Technique (ANTT) policy to include catheter sampling and on-going management of catheters
- Commence an advertising campaign in conjunction with our communication department to launch the new education roll out and the catheter record form, this will include stands in high staff areas, screen savers etc.
- Introduce CAUTI (Catheter Acquired Urinary Tract Infection) champions in ward areas to ensure best practice is maintained.

Priority 3

Improve communication between our staff and patients

How does this link with our Quality Improvement Strategy?

Strategic Quality Priority: provide a consistently positive experience for patients.

Why is this a priority area?

The NHS belongs to the people and the NHS constitution (Oct 2015) sets out the principles and values of the NHS in England. Of the seven key principles, principle 3 '*the NHS aspires to the highest standards of excellence and professionalism'*, stating that care is '*safe, effective and focused on patient experience'* and principle 4 '*the patient will be at the heart of everything the NHS does',* which states the NHS will *actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services',* supports priority 3 to improve how we communicate between staff and patients.

In December 2016, the CQC released a report on their review of the way NHS Trust review and investigate the deaths of patients in England.

> '*Two behaviours that underpin the vision and purpose of the NHS in England are openness and learning in order to improve'. The NHS 'system' must enable transparency and learning'* Learning, Candour and accountability - CQC Dec 2016

At Burton Hospitals NHS Foundation Trust (BHFT), we are committed to openness and transparency and using patient feedback constructively to improve patient experience and the services we provide. We are committed to delivering excellent

services at this vibrant DGH and ensuring our services are inclusive and meet the needs of our local community.

Effective communication and feedback is key to achieving our goal of openness. As well as providing monthly reports to the Board on complaints, patient experience and clinical incidents, the Trust also uses feedback from local partner agencies, such as Healthwatch to measure the effectiveness in how we communicate with patients and families.

To support improvements in communication between staff and patients we are dedicated to ensuring our patients and visitors are able to easily raise concerns and raise complaints, the Trust has endeavoured to ensure this process is easy and user-friendly.

We have:

- Rolled out communication clinics to other areas within the Trust
- Ensured there are posters and information about how to raise concerns in all areas of the Trust to promote our commitment to respond to issues
- PALS leaflets are available across the organisation, in English, Urdu, Polish and leaflets are also available on yellow paper with black print for visually impaired patients
- A 'Share your Experience' Feedback form has been developed to ensure making a complaint is easy
- Strong links have been developed with local complaint advocacy services, including Healthwatch Staffordshire, Mind (Derby/Derbyshire) and POhWER (Leicestershire)
- The Complaint service responds to all patient complaints and PALS concerns, along with soft intelligence issues raised by local GP's, CCG's, other NHS Trusts as well as local Members of Parliament
- The PALS team logs and responds to feedback from a number of social media outlets, including, Facebook, Twitter, NHS Choices and Patient Opinion
- PALS awareness training has been undertaken with front of house volunteers to ensure that our teams are further supported by volunteers who provide front of house support.
- Patient Experience comes under the remit of the Complaint Manager and therefore, feedback from local Healthwatch's is also triangulated to ensure that themes of feedback are logged, along with intelligence from Friends and Family Test results
- Dedicated and targeted complaint training has been delivered in the Trust to senior staff who undertake complaint investigation training to ensure that individuals understand their role and what is required to ensure a complaint is investigated effectively
- Our Complaints and PALS team are dedicated to delivering an excellent experience of the service and their performance in monitored by Complaint Satisfaction Questionnaire feedback
- All complaints received are logged and a management plan developed on receipt. In line with our KPI requirements in 2016/17 100% of complaints received were acknowledged with 3 working days

- Accountability for complaints is led by the Divisional Nurse Director and General Manager's for the Business Unit and overseen by the Divisional Associate Director and Divisional Medical Director
- The number of formal complaints and compliments is shared with the organisation weekly via the Trust's e-newsletter
- There are robust links between the Complaint's Team and the Clinical Risk Governance Teams to ensure that any complaints which may need investigating as serious incidents (SI) or internal safety alerts (ISA) are coordinated effectively to provide the patient with a seamless service
- The Trust introduced a new reporting database, Datix, in 2016 and the Complaints Team now log all contacts on the system, which is a trust wide system which supports the triangulation of complaints, incidents and legal claims. Datix also supports the effective management of complaints Future plans include, further alignment of the Complaints and Serious Incident process, when these investigations are shared and development of structure mechanisms to respond to SI/ISA and complaints via combined meetings.

Question Text	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Did staff welcome you and show you things you needed to know when you arrived on the ward?	96	98	98	96	97	96	97	96	94	97	98	99
Have you been treated with kindness and compassion by staff?	99	99	98	98	98	97	99	98	97	99	99	99
Do nurses explain things to you in ways you understand?	98	97	98	98	97	97	98	98	95	97	97	98
Do therapists (Physios/ Occupation Therapists/ Speech Therapists/ Dieticians,) explain things to you in ways you understand?	-	-	-	-	99	99	98	99	95	98	99	98
Do doctors explain things to you in ways you understand?	95	93	94	93	93	94	93	95	92	94	97	95
Have you been able to get the attention of staff when you needed it?	98	98	96	96	96	96	97	96	95	97	96	97
Do you get enough help from staff to eat and drink?	99	100	99	99	97	99	100	99	98	98	99	96
If you have had any pain, do you think that staff have done all they can to help control it?	95	97	97	96	95	97	97	96	94	97	96	99

Have staff done all they can to help you stay clean?	99	99	99	99	98	100	99	98	98	99	99	99
If you need help getting to the toilet or bathroom, do you get it in time?	97	97	95	96	95	96	96	96	95	93	96	95
Total	97	97	97	97	96	97	97	97	95	97	98	98

Inpatient Experience Scores

In patient experience scores are monitored within the divisions and monthly at patient experience group. They are also reported monthly to the commissioners at the clinical quality review meeting and quarterly at the quality committee meeting.

Patient Leaders

A consistent theme for improvement is around doctors explaining things to patients in a way that they understand. The Trust is keen to explore different ways to improve communication between patients and doctors including introducing a Patient Leaders scheme. The Patient Leaders scheme will empower patients to become more involved in decisions made about their treatment and care. Patients will be given a card with examples of questions which they may like to ask Doctors during ward rounds. The aim is to encourage patients to ask questions and to give them the confidence to discuss any issues they may have. Suggested questions will include: *Do I need this catheter or can it be removed? Can my cannula be taken out? Have I been screened for blood clots? Why am I on antibiotics? What are my blood test results and what do they mean?* Patients can ask any questions they like and if they do not wish to ask the questions themselves they can talk to a nurse who will ask the questions on their behalf. The scheme is being piloted on Wards 3 and 4 at Queen's Hospital.

Accessible Information Standard

From 1st August 2016 all organisations that provide NHS care or adult social care were legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services. To ensure compliance the Trust has implemented the following improvements:

- a communication alert has been set up on the Trust's electronic patient and health records, Meditech v6
- working with partners such as GP's, Dentists and other health providers to ensure patient referrals include details patients communication needs
- produced *"How do you communicate?"* posters which are displayed around the Trust

The Trust will be further utilising The Kinda Magic Toolkit to ensure that patient experience feedback is effectively gathered from patients with cognitive impairments.

A new electronic Patient Information System has been introduced to improve the patient information leaflets which will make it easier for leaflets to be reviewed and kept up to date.

Communication Initiatives

Individual wards and clinics have organised their own activities and initiatives to improve communication and engagement with patients and their families, including:

- a Wellbeing Day held on Darwin Ward at Samuel Johnson Hospital which gave patients, families and members of the community the opportunity to talk to staff and give their feedback on what was important to them regarding services provided by the hospital
- regular events held at a Sir Robert Peel Hospital including a Christmas Carol Concert featuring Tamworth Voices, a local voluntary choir, which over 130 people attended
- a support group for patients diagnosed with glaucoma is run by the Ophthalmology Department at the Treatment Centre. Friends, relatives and carers are also invited to attend meetings which are run by glaucoma nurse specialists who offer support and advice on how to manage the condition. Doctors are available to provide information and to answer any questions that people may have. Patients and relatives also have the opportunity to chat to each other and share their experiences
- communication clinics, held twice a week on Ward 8, are now well established with families and carers having the opportunity to talk to the multi-disciplinary team about any issues or concerns they may have regarding a relative who is going into care
- a comments board on Ward 3 which gives patients the opportunity to comment on what they feel the Ward could do better
- the Rheumatology Department continues to run support groups for patients and they will be launching a newsletter for patients in the Spring
- the Oncology Department ran a series of four Health and Wellbeing Days in September, November, January and March for patients and carers. Participants were able to try holistic therapies; given ideas for exercises; as well as being offered psychological support; signposting to other support groups; and information about MacMillan support. It was also an opportunity for patients and carers to ask any questions. The days proved very successful and more events are being planned for 2017
- Due to the success of the Maternity Open Days, and following consultation with patients on the ward, the department have introduced bespoke evening and weekend tours of the ward for smaller groups
- The Youth Forum continues to go from strength to strength with members contributing to the development of a new patient experience feedback survey for the Paediatric Assessment Unit; and have given their feedback on the SSTP and Burton/Derby collaboration
- Frontline Dance returned to the Trust in June with a series of dance, music and storytelling performances in Outpatients, paediatrics, Physiotherapy and Oncology. The company is an integrated company with disabled and non-disabled dancers performing together to promote a positive image of disability. This worked particularly well in the Physiotherapy Amputee Clinic

- The Trust worked in partnership with East Staffordshire Community Arts based at the Brewhouse in Burton, and Age UK, to produce another celebration of Older People's Creativity in October

Plans are already underway to build on these initiatives in 2017/18 to further strengthen the patient voice as we improve services and to give members of our communities opportunities to give their feedback and views.

Regulation 20: Duty of candour

Since October 2014 NHS providers are required to comply with the duty of candour. This means that providers must be open and transparent with service users about their care and treatment, including when it goes wrong.

What we have done:

- With the implementation of Datix on 1st August 2016 the Duty of Candour section has been developed to meet the requirements, which also enables the evidence of documents to be uploaded to Datix
- A designated section has been developed more explicitly within the Internal Safety Alert and Serious Incident investigation reports to meet the necessary aspects of Duty of Candour
- The different aspects of Duty of Candour has been populated as a mandatory fields to the Internal Safety Alert and Serious Incident investigation Action Plans to ensure that this process is followed and implemented
- Template letters to patients and/or relatives have been re-designed, in consultation with staff working in clinical departments, to include terms of reference, this has been shared across the Trust as well as available on the Trust's Governance intranet site
    - 'link' letters for patients/relatives to bridge between the complaints and the ISA/SI process have been developed to ensure patients/relatives are informed of the escalation of the complaint to ISA/SI investigation
    - Translation contractual services have been utilised to ensure that initial duty of candour letters are provided through different languages, to ensure duty of candour is met
- Meetings to share the investigation reports are organised and take place either off-site at patients/relatives preferred address or within the Trust
- Duty of candour is monitored through the Governance reports within the Business Units, highlighted at the Incident Review Group Executive Meeting

Freedom to Speak Up

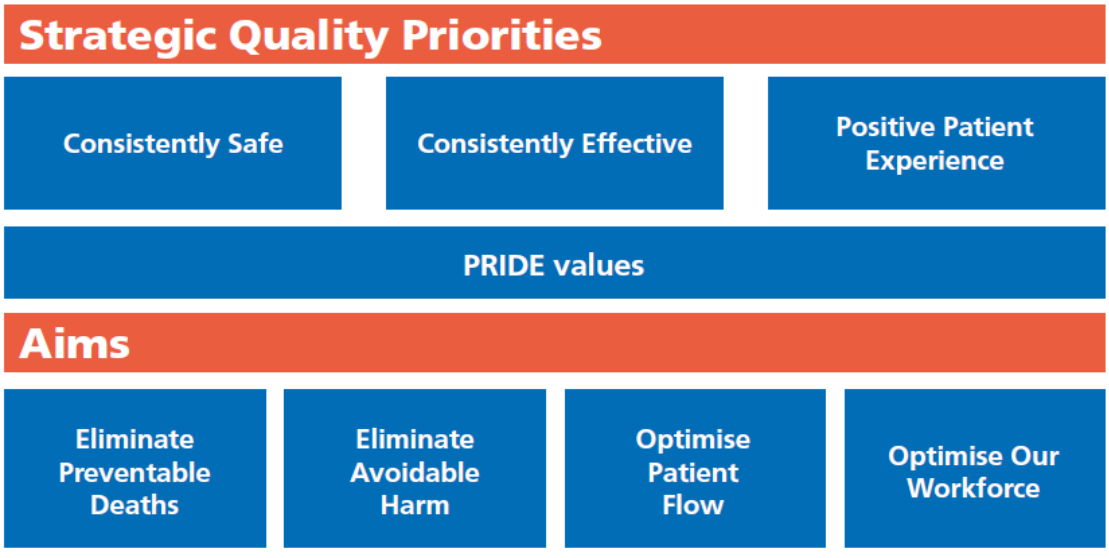
The new national Freedom to Speak Up: Raising Concerns (Whistleblowing) policy is being implemented within the Trust. This 'standard integrated policy' was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS. It is expected that this policy (produced by NHS Improvement and NHS England) will be adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients.

Freedom to Speak Up Guardian at the Trust is Alison Bell who will be working with Trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers.

Priorities for the coming year

It is recommended by the Department of Health that organisations choose at least three priorities for quality improvement.

Our ambition is to become a leading Trust in terms of offering the safest, most effective and positively experienced patient care by eliminating avoidable harm; eliminating avoidable deaths; optimising patient flow and optimising our workforce. Our overarching purpose is to ensure the quality of care is right first time and to reduce variation in practice. Our strategic aims and quality priorities will be delivered through our staff promises to take PRIDE; to have Passion, Respect, be Innovative have Determination and strive for Excellence in all that we do.



Our Quality Improvement Strategy (QIS) also describes our unity of purpose as a healthcare provider; namely the Positive Patient Experience. This will act as a 'North Star' and is explained as our unwavering commitment to uphold the Positive Patient Experience no matter what changes and challenges the Trust faces as an organisation. This focus on delivering the best patient experience will guide our organisation and keep it on track when faced with competing priorities.

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

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

The five Sign up to Safety pledges:

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

- *Early Warning Score and Response*

Further improve all aspects of patient escalation from accurate recording of observations through to timely senior medical review.
Implement a single chart system for recognition of the deteriorating patient, namely NEWS.

- *Acute Kidney Injury*

Optimise our detection and management of AKI. Follow 'Safe Kidney' *Safe Surgery.*

Sustain our active use of the WHO checklist & briefings. Embed this and de briefings.

- *Falls*

Further reduce falls and improve our initial falls assessment and post falls process

- *Pressure Ulcers*

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

- *Catheter associated urinary tract infections*

The most common hospital acquired infection is urinary tract infection and many of these are linked to the patient having a catheter. We aim to reduce the number of

inappropriate catheters in the hospital by making sure they are removed when they have served their purpose or are only put in for the right clinical reasons. If we can reduce the number of inappropriately used catheters we can have a real impact on the number of infections as a result.

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

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

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

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

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

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

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

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

Our three Quality Improvement Priorities are:

Priority 1:

Frailty

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

Why is this a priority area?

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

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

What will the Trust do?

From the CQUIN surrounding frailty which was to promote a system of timely identification and proactive management of frailty in the acute setting work will continue

- Implement frailty stratification across the organisation to inform appropriate care planning
- Improve education surrounding frailty to enable improved quality of care, care planning and admission prevention
- Work cohesively with our community partners to support the pathway for frailty inclusive of admission prevention and to expedite discharge
- Progress the work with nursing homes to support frail elderly remaining at home
- Continue the work with the frailty team to ensure rapid assessment of the frail elderly and completion of the comprehensive geriatric tool
- Work to promote advanced care planning and good end of life care
- Promote the personalisation of the frail elder person and the maintenance of their independence

Target for 2017/18	To achieve KPIs regarding frailty, reduce LOS and admissions for the frail elderly
Director Leads	Paula Gardner
Monitored by	Older Persons Operational Group Quality rounds Patient experience metrics Monthly complaints data
Reported to Board of Directors via	Quality Committee

Priority 2:

The implementation of an adapted Ward Assurance tool.

How does this link to our Quality Improvement Strategy?

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

Why is this a priority area?

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

The nursing care indicators cover essential elements of care, which are both important to patients/carers and are identified as risks to the Trust if there is a failure to meet the Trust minimum standard.

- Patient observations
- Pain Management
- Continence
- Infection prevention and control
- Privacy and Dignity
- VTE assessments and prophylaxis
- Medicine prescribing and administration
- Moving and Handling
- Tissue Viability
- Falls
- Nutrition
- Discharge

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

As a Trust we have consistently achieved the Trust target of 95%, for 32 consecutive months. This tool is no longer providing us with the necessary assurance, and is no longer meaningful in identifying areas for quality and safety improvements. We have adapted the tool to focus on areas we have identified we need to further improve, such as pressure prevention. In addition we wanted the tool to encourage the auditors to involve our patients and provide real time patient feedback to questions, rather than reliance on documentation. The monthly results of the audits will provide our patients, staff and the Trust Board with assurance that our core care delivery meets the Trust standards, and improve patient experience.

What will the Trust do:

The tool is being used in conjunction with the current tool and the audit is being carried out by senior nurses within the organisation over a four month period (January 2017-April 2017). During which time, regular meetings with the senior team are being held to discuss any identified flaws within the tool, and what the scores would have been if utilising the adapted tool. It is expected that all ward areas will see an initial dip in the ward assurance scores giving drive and focus for quality improve men and improved patient experience. As a result we would expect to see a gradual reduction in harm free care and an improvement in patient experience results.

The Divisional Nurse Directors and Head of Midwifery will provide assurance to the Divisional Boards and the Quality Review Group that standards are being met by each area and where there is failure to meet the standard, there is an agreed framework for improvement which will be monitored within the Divisions and reported to the Chief Nurse.

Target for 2017/18	To achieve above 95% in all in-patient areas. To see a reduction in harm free care and an improvement in patient experience metrics.
Executive Leads	Paula Gardner
Monitored by	Monthly Unannounced Audit. Divisional Nurse Directors and the Deputy Chief nurse. Patient experience data. Patient Safety Thermometer data.
Reported to Board of Directors via	Quality Committee

Priority 3:

Improving Discharge

How does this link to our Quality Improvement Strategy?

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

Why is this a priority area?

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

What will the Trust do?

The Trust has identified the following areas for focus in 2017/18

- Implement with Health Economy Partners full Discharge to Assess model for Home and Bed based Services
- Improve the education programme regarding Complex Discharge and Patient Choice
- Reduction in the numbers of Stranded Patients through focus on reduction on internal and external delays
- Full implementation and embedding of the SAFER and RED and Green Day principles in all areas

Target for 2017/18	• Reduction in the numbers of patients waiting 6 days or more in Hospital (Stranded Patient Metric) • Reduce the numbers of Health and Social Care Assessments undertaken in Hospital (Discharge to Assess model)
Director Leads	Duncan Bedford
Monitored by	Performance Reviews A&E Delivery Board
Reported to Board of Directors via	Trust Executive Committee

2.2 Statements of Assurance from the Board

Income and contracts

During 2016/17 Burton Hospitals NHS Foundation Trust provided the Commissioner Requested Services identified within the NHS standard contract

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

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2016/17.

Participation in Clinical Audit and Clinical Outcome Review

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

During 2016/17, 34 national clinical audits and 9 national confidential enquiries covered relevant health services that Burton Hospitals NHS Foundation Trust provides.

During that period, Burton Hospitals NHS Foundation Trust participated in 94% of national clinical audits and 100% of national confidential enquiries of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Burton Hospitals NHS Foundation Trust was eligible to participate in during 2016/17 are as follows:

National Clinical Audit and Clinical Outcome Review	Host Organisation
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)
Adult Asthma	British Thoracic Society
Asthma (paediatric and adult) care in Emergency Departments	Royal College of Emergency Medicine
Bowel Cancer (NBOCAP)	Royal College of Surgeons
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)

National Clinical Audit and Clinical Outcome Review	Host Organisation
Child Health Clinical Outcome Review Programme - Chronic Neurodisability	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Child Health Clinical Outcome Review Programme - Young People's Mental Health	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health
Elective Surgery (National PROMs Programme)	NHS Digital
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons
Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database	The Royal College of Physicians
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database	Royal College of Physicians
Falls and Fragility Fractures Audit Programme (FFFAP) – National Joint Registry	Royal College of Physicians
Head and Neck Cancer	Saving Faces – The Facial Surgery Research Foundation
Maternal, Newborn and Infant Clinical Audit Programme – maternal morbidity and mortality confidential enquiries	MBRRACE - UK – National Perinatal Epidemiology Unit
Maternal, Newborn and Infant Clinical Audit Programme – maternal mortality surveillance	MBRRACE - UK – National Perinatal Epidemiology Unit
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal Mortality Surveillance	MBRRACE - UK – National Perinatal Epidemiology Unit
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal mortality and morbidity confidential enquiries	MBRRACE - UK – National Perinatal Epidemiology Unit
Medical & Surgical Clinical Outcome Review Programme - Acute Non Invasive Ventilation	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Medical & Surgical Clinical Outcome Review Programme - Acute Pancreatitis	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Medical & Surgical Clinical Outcome Review Programme - Provision of Mental Health Care in Acute Trusts	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
National Audit of Dementia	Royal College of Psychiatrists

National Clinical Audit and Clinical Outcome Review	Host Organisation
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Royal College of Physicians
National Comparative Audit of Blood Transfusion – Blood management in Scheduled Surgery	NHS Blood and Transplant
National Diabetes Audit – Adult Inpatients	NHS Digital
National Diabetes Audit – Adults (Core)	NHS Digital
National Diabetes Audit – Pregnancy in Diabetes	NHS Digital
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)
National Lung Cancer Audit (NLCA)	Royal College of Physicians
National Ophthalmology Database – Adult Cataract Surgery	
National Prostate Cancer Audit	Royal College of Surgeons
Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health
Paediatric Pneumonia	British Thoracic Society
Renal Replacement Therapy (Renal Registry)	UK Renal Registry
Sentinel Stroke National Audit Programme (SSNAP)	Royal College of Physicians
Severe Sepsis and Septic Shock	Royal College of Emergency Medicine
Smoking Cessation	British Thoracic Society
Stress Urinary Incontinence Audit	British Association of Urological Surgeons

The national clinical audits and national confidential enquiries that Burton Hospitals NHS Foundation Trust participated in during 2016/17 are as follows:

National Clinical Audit and Clinical Outcome Review
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
Adult Asthma
Asthma (paediatric and adult) care in Emergency Departments
Bowel Cancer (NBOCAP)
Cardiac Rhythm Management (CRM)
Case Mix Programme (CMP)
Child Health Clinical Outcome Review Programme - Chronic Neurodisability

National Clinical Audit and Clinical Outcome Review
Child Health Clinical Outcome Review Programme - Young People's Mental Health
Diabetes (Paediatric) (NPDA)
Elective Surgery (National PROMs Programme)
Endocrine and Thyroid National Audit
Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database
Falls and Fragility Fractures Audit Programme (FFFAP) – National Joint Registry
Head and Neck Cancer
Maternal, Newborn and Infant Clinical Audit Programme – maternal morbidity and mortality confidential enquiries
Maternal, Newborn and Infant Clinical Audit Programme – maternal mortality surveillance
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal Mortality Surveillance
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal mortality and morbidity confidential enquiries
Medical & Surgical Clinical Outcome Review Programme - Acute Non Invasive Ventilation
Medical & Surgical Clinical Outcome Review Programme - Acute Pancreatitis
Medical & Surgical Clinical Outcome Review Programme - Provision of Mental Health Care in Acute Trusts
National Audit of Dementia
National Cardiac Arrest Audit (NCAA)
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
National Comparative Audit of Blood Transfusion – Blood management in Scheduled Surgery
National Diabetes Audit – Adult Inpatients
National Diabetes Audit – Adults (Core)
National Diabetes Audit – Pregnancy in Diabetes
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Prostate Cancer Audit
Neonatal Intensive and Special Care (NNAP)
Paediatric Pneumonia
Renal Replacement Therapy (Renal Registry)
Sentinel Stroke National Audit Programme (SSNAP)
Severe Sepsis and Septic Shock
Smoking Cessation
Stress Urinary Incontinence Audit

The national clinical audits and national confidential enquiries that Burton Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases

submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit and Clinical Outcome Review	% of cases
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	100
Adult Asthma	100
Asthma (paediatric and adult) care in Emergency Departments	96
Bowel Cancer (NBOCAP)	97 of HES
Cardiac Rhythm Management (CRM)	100
Case Mix Programme (CMP)	100
Diabetes (Paediatric) (NPDA)	100
Elective Surgery (National PROMs Programme)	100
Endocrine and Thyroid National Audit	100
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database	100
Falls and Fragility Fractures Audit Programme (FFFAP) – National Joint Registry	100
Head and Neck Cancer	100
Maternal, Newborn and Infant Clinical Audit Programme – maternal morbidity and mortality confidential enquiries	100
Maternal, Newborn and Infant Clinical Audit Programme – maternal mortality surveillance	100
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal Mortality Surveillance	100
Maternal, Newborn and Infant Clinical Audit Programme – Perinatal mortality and morbidity confidential enquiries	100
Medical & Surgical Clinical Outcome Review Programme - Acute Non Invasive Ventilation	100
Medical & Surgical Clinical Outcome Review Programme - Acute Pancreatitis	100
Medical & Surgical Clinical Outcome Review Programme - Provision of Mental Health Care in Acute Trusts	100
National Audit of Dementia	56
National Cardiac Arrest Audit (NCAA)	100
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	100
National Comparative Audit of Blood Transfusion – Blood management in Scheduled Surgery	100
National Diabetes Audit – Adult Inpatients	100
National Diabetes Audit – Adults (Core)	100
National Diabetes Audit – Pregnancy in Diabetes	100
National Emergency Laparotomy Audit (NELA)	100
National Heart Failure Audit	100
National Joint Registry (NJR)	100
National Lung Cancer Audit (NLCA)	100
National Prostate Cancer Audit	100
Neonatal Intensive and Special Care (NNAP)	100
Paediatric Pneumonia	100

National Clinical Audit and Clinical Outcome Review	% of cases
Renal Replacement Therapy (Renal Registry)	100
Sentinel Stroke National Audit Programme (SSNAP)	100
Severe Sepsis and Septic Shock	92
Smoking Cessation	100
Stress Urinary Incontinence Audit	100

The reports of 26 national clinical audits and clinical outcome review programmes were reviewed by the provider in 2016-17 and Burton Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Clinical Audit	Actions being taken to improve quality
National Ophthalmology Database	No data was submitted for this benchmarking audit.
Perinatal Mortality Surveillance	Stillbirth and neonatal mortality rates were more than 10% below the national average in 2013. The rates increased slightly in 2014, but were still below the national average. Reviews of all stillbirths and neonatal deaths are presented and discussed at a multidisciplinary forum. Guidelines have been reviewed to focus more on the care of the mother.
RCEM Procedural Sedation	A new form has been introduced for completion for all patients undergoing procedural sedation in the Emergency Department. The completed forms are scanned in to the patient notes. Education on the correct method of monitoring during the procedure and assessment prior to discharge is on-going.
RCEM Vital Signs in Children	Reminders have been sent to all Emergency Department staff of the need for appropriate monitoring of vital signs. The documentation has been changed to indicate when a repeat set of observations is required, and that senior review has taken place when indicated.
RCEM VTE Risk in Lower Limb	A new policy has been introduced to ensure that assessment of risk of Venous Thromboembolism (VTE) is carried out for all patients with reduced mobility due to lower limb fracture. Reminders have been posted in the plaster room to ensure that assessment takes place and the result recorded.
Paediatric Diabetes	100% of patients received a structured education programme. The need for improved eye screening levels has been publicised throughout the department, although this was mainly a data quality issue. More resources have sought to improve data capture and data quality.

National Clinical Audit	Actions being taken to improve quality
Diabetes Inpatients	Patient feedback was good, 85% reported that they were 'satisfied' or 'very satisfied' with their diabetes care. Lack of foot assessment was highlighted. Feet checks on admission are to be incorporated in to the admission assessment, and the SKINS assessment chart has been amended for diabetic patients. Insulin prescribing errors have been addressed in regular teaching sessions.
Emergency Laparotomy	The Trust had generally good outcomes with short intervals between decision to operate and surgery, and high levels of consultant involvement in imaging, anaesthesia and surgery. Our mortality rate (12%) and length of postoperative stay (median 13 days) were comparable to the national average. Case ascertainment was low at 56%, but improvements have been made to the system for identifying suitable patients and submission levels have since improved. This work in still on-going.
NCEPOD Acute Pancreatitis	A detailed pathway for patients with acute pancreatitis is being developed. The use of 'NEWS' scoring charts are being piloted and will be used throughout the Trust. Members of the coding team will be invited to attend surgical audit meetings to discuss any coding issues
Heart Failure	Currently under review.
Cardiac Rhythm Management	All patients with sinus node dysfunction should have a permanent pacemaker fitted unless contraindicated. The indication for pacemaker implantation is now being more accurately recorded, and the Trust is now implanting more dual chamber devices compared with single chamber devices.
UK Parkinson's	The Trust no longer has a consultant neurologist therefore unable to assess the results of the audit. The Trust does not routinely treat Parkinson's anymore and therefore will not be participating in future UK Parkinson's audit until further notice.
FFFAP Hip Fracture Database	The report indicated higher than expected crude and adjusted mortality rates. All deaths are currently being reviewed and an action plan is being formulated. Discussions with physiotherapy staff are on-going regarding the need to mobilise patients as soon as possible after surgery.
Oesophago-Gastric Cancer	Currently under review.

National Clinical Audit	Actions being taken to improve quality
National Joint Registry	Data quality issues involving records entered on to the registry not matching HES data are being investigated, and are mainly due to data being entered at the wrong site. Results for the Trust are good, with very low revision rates. Mortality rates fall within expected levels.
NNAP	Results were good for all care processes except use of steroids in pre-term labour, and proportion of babies being fed mothers milk at discharge. A joint audit of preterm labour between the obstetric and paediatric departments was undertaken, and the use of steroids now forms part of a CQUIN. Resources have increased to ensure that all appropriate patient data is input to the BADGER system. Training on the BADGER system is undertaken by all clinical staff including Junior Doctors.
Pregnancy in Diabetes	The Trust has taken steps to promote the importance of pre pregnancy care for women with diabetes. Clear pathways have been agreed for rapid referral to antenatal diabetes clinics, and these are now working well
Sentinel Stroke National Audit Programme	A formal stroke strategy group is being set up to include patients and carers, as well as clinicians and service commissioners. IPC compression devices are being introduced on to wards for prevention of venous thromboembolism (VTE) in stroke patients. Discussions with another trust are on-going regarding provision of seven day hyper acute stroke and TIA services.
Paediatric asthma	The Trust's care of children with acute wheezing/asthma continues to be highly efficient and effective. The results were particularly good for providing discharge information, written asthma action plans and advice to arrange follow up with GP within 2days. The Trust is working towards national improvement objectives for Paediatric Asthma Care for 2017-18.
MBBRACE Maternal Mortality	This report has not yet been formally reviewed by the Trust. No maternal deaths occurred at the Trust during the report period.
Prostate Cancer	Data quality was good overall and better than the national average for key parameters. No patient satisfaction information was collected as this was specific to specialist centres. No changes to practice were recommended as a result of the report.

National Clinical Audit	Actions being taken to improve quality
Bowel Cancer	The report showed very high rates of data completeness and accuracy. Effective processes of care are in place with high rates of radical treatments offered using laparoscopic surgery and enhanced recovery techniques. Outcomes are very good with lower mortality rates and shorter lengths of in-hospital stay than the national average.
Lung Cancer	This report has not yet been formally reviewed and will be included in next year's quality account
Myocardial Infarction	This report has not yet been formally reviewed and will be included in next year's quality account
National Diabetes (Adults)	Results have shown an improvement in all core processes. Changes to practice should ensure that the correct samples are taken for chemical analysis. Structured education for type 2 diabetic patients is given by primary care, and this information needs to be sourced from the patient and recorded. The diabetes team are actively targeting patients with the highest blood glucose levels and those who regularly miss outpatient appointments.
Rheumatoid and Early Inflammatory Arthritis (Second Report)	The second report showed improvement in key areas for the Trust, and we performed significantly better than the national average for waiting times, treatment times and support for self-management. Delays in seeing a consultant are due to staffing levels being significantly below the levels recommended by the Royal College of Physicians of 1 consultant per 85,000 population.

The reports of 144 local clinical audits were reviewed by the provider in 2016/17 and Burton Hospitals NHS Foundation Trust intends to take the actions to improve the quality of healthcare provided.

Local Clinical Audit Topic	Actions to improve quality
Hypothermia in the Treatment of Neonatal Encephalopathy	Developmental follow-up are to detect impairment or normality and promote early intervention where required. All babies undergoing cooling will now have neurodevelopmental follow up until at the least 2 years of age Audit, has shown promising results highlighting the importance of commencing passive cooling early and appropriately in District General Hospitals prior to transfer to reduce long term disability

Local Clinical Audit Topic	Actions to improve quality
Small cell oncology patient pathways	Revised timely pathways have now been introduced locally. Protocol is now in place and agreed by oncology staff that patients are alerted as being diagnosed with small cell and they are provided with urgent oncologist referral and urgent pre-assessment. These are followed up by urgent chemotherapy according to the fitness of the patient
Preoperative Anaemia in elective C Section	Pre-operative anaemia is common in elective caesarean sections. Most patients who are anaemic prior to caesarean section are not treated and blood transfusions are rare in elective caesarean sections Decision for elective caesarean section is often made very late, sometimes the day before the surgery, meaning there is little that can be done at that stage to optimise Hb without delaying delivery Patients may be being treated in the community for anaemia with no mention in the hospital notes, making these results inaccurate Following the audit results staff have been educated regarding the need to be aware and follow the British Committee for Standards in Haematology Guidelines. The Audit report was shared with O & G Department
Colonoscopy Completion Rates Re-Audit	The original audit highlighted an average time of 30 minutes per procedure against an average of 20 minutes per procedure at re-audit, with new scopes introduced. The new generation of equipment is more reliable and the clearer images results in more sound diagnosis. Since this re-audit the community Hospital theatres have purchased a total of 22 new scopes. This will result in shorter waiting times for patients and the opportunity to identify conditions sooner, which will enable patients to start treatment quicker leading to better outcomes.
Group and Save for Elective Gynaecology Surgery	The guidelines for group and save were revised to avoid unnecessary costs and wastage regarding blood products. Following the previous guidelines the Trust would have had a costing of £2,622.56 and following the new guidelines had a costing of £1,302.42, thus giving a saving of £1,320.14 over a 6 month period
Pain relief following C-Section	Audit confirmed that the Trust are meeting targets for prescribing NSAIDs and antiemetics, and also meeting target for patients being comfortable post-op (100%) Post-Operative Nausea and Vomiting (PONV) and Itching is a significant side effect, therefore agreed that single prophylactic dose of I/V Ondansetron to be administered to reduce the incidence of PONV and Pruritus.

Local Clinical Audit Topic	Actions to improve quality
UTI Diagnosis and Management in older people	The results are conclusive that antibiotics are regularly prescribed to older patients without a full clinical assessment and diagnosis taking place. 100% of the cases investigated received antibiotics either before the urine sample was reported on or no sample was taken at all. This was based on a urine dip test. In 50% of the cases the patient was prescribed the wrong anti biotic or there was no evidence of infection following microbiology results and therefore was prescribed inappropriately. 30% of cases did not have a urine sample sent off at all. Following these results a new clinical guideline was written and circulated. This guideline was ratified in December 2016
Insulin Prescribing Errors	Insulin has been identified as one of the top 10 high risk medicines worldwide. Research in England and Wales found insulin errors are twice as likely to cause harm to patients. Audit highlighted that within the Trust Insulin was not being prescribed on admission due to lack of knowledge or difficulty understanding the current insulin charts/administration regime. It was identified that further training for junior doctors was required. The Trust has now made the safer use of Insulin e-prescribing module mandatory for all junior doctors.
Children and Adolescent Mental Health Services (CAMHS) Referral Pathways	The children's ward was having to deal with an increasing numbers of young people requiring admission for mental health assessment. Accessing this service proved to be problematic when occurring out of normal working hours therefore 4 pathways, depending on age and whether the referral was during the week/weekend was available. The rationale for this audit was to ensure that the pathways were embedded in practice. Following a CQC report it was identified that there was a need for the pathways to be audited. The audit identified that staff were unaware of all the various pathways. Therefore it was agreed to merge the 4 pathways into one document and educate staff appropriately. The pathway is now displayed prominently and easily accessible in all areas

Participation in clinical research

The Trust is committed to clinical research as a driver for improving the quality of care and patient experience. Research also provides an opportunity for staff to develop their own skills and knowledge. Engagement with clinical research, predominantly via our membership of the West Midlands Clinical Research Network, also demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques. We are endeavouring to link in with primary care colleagues in order to offer research participation to as wide a population as possible. The Trust is developing an excellent reputation for the conduct of commercially sponsored studies, having been named a flagship site by one such company. This is a result of the work of one of our consultants who has acted as Chief Investigator leading a number of studies not only locally, but nationally.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered to our patients, contributing to wider health improvement. Furthermore, it allows clinical staff to stay abreast of the latest treatment options, providing an evidence base which leads to successful patient outcomes.

The Health Research Authority (HRA) is a new body tasked with streamlining procedures and removing duplication throughout the research governance and approval process, in order to speed up the opening of research studies.

To date, with one month left of the financial year, 420 patients have been consented and recruited into research studies approved by the HRA. We anticipate that this figure should reach around 500 by the end of the current financial year.

The number of patients receiving relevant health services provided or sub-contracted by Burton Hospitals NHS Foundation Trust in reporting period 2016/2017 that were recruited during that period to participate in research approved by a research and ethics committee was 638.

During the year the Trust were involved in conducting 139 clinical research studies in areas including:

- Anaesthetics
- Cancer
- Paediatrics
- Dermatology
- Respiratory medicine
- Gastroenterology
- Musculoskeletal disorders
- Ophthalmology
- Diabetes
- Cardiology
- Reproductive health
- Haematology
- Metabolic and endocrine disorders
- Cardiovascular/Lipids

In 2016/17 the National Institute for Health Research (NIHR) supported all of these studies through its research networks.

The Trust aims to complete 100% of these studies within the agreed time and to the agreed recruitment target. However, recruitment targets and completion dates are commonly adjusted as research studies progress to take into account, for

instance, slower than expected recruitment which may result in extension of the end date of the trial. Conversely, some studies complete early in the light of conclusive findings at an earlier than expected stage. Most of the studies undertaken at the Trust are hosted as part of national research and often, recruitment targets and completion dates are influenced at a national level.

A wide range of clinical and non-clinical staff, within the various specialities, were involved in participating in and supporting research approved by the HRA at the Trust during 2016/17.

Of the 11 studies for which capability and capacity were confirmed so far during 2016/2017, 80% were given permission by an authorised person within 40 days of receipt of a valid completed application, as required by HRA metrics. Some delays were caused by changes in the national process for confirming capacity and capability to support research studies. 90% of the studies were established and managed under national model agreements. Out of the 11 studies permitted to start, one was eligible to use a 'research passport'. The research passport scheme is a nationally adopted process coordinating and streamlining pre-engagement checks for external staff entering NHS premises to conduct research activities.

Use of the CQUIN payment framework

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

A proportion of the Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The monetary total for income in 2016/17 conditional upon achieving quality improvement and innovation goals was £3.5m.The monetary total for the associated payments in 2015/16 was £3.3m.

A summary of developments and achievements and specific performance achieved against each CQUIN scheme in 2016/17 is detailed in the tables below.

Summary of developments and achievements against the 2016/17 CQUIN schemes

Topic	Development
Sepsis – emergency care	Timely identification and treatment for patients with Sepsis in the emergency department.
Sepsis – in acute patient care settings	Timely identification and treatment for patients with Sepsis in acute in patient settings
Frailty	Promotion of a system of timely identification and proactive management of frailty in the organisation

Topic	Development
Cancer care	Improving outcomes of urgent referrals for suspected cancers, and root cause analysis of all long waiters and a clinical harm review for a positive diagnosis.
Planned care	Assurance of compliance with NICE Guidelines.
Improving quality and efficiency on the patient journey.	Elimination of unnecessary hospital attendances for patients by improving the new to follow up appointment ratio's.
Planned care	Best Practice in day surgery outpatient appointments.

Performance achieved against 2016/17 CQUIN schemes – with milestones set throughout the year

Topic	Target timescale	Target	Achievement
Sepsis – emergency care Audit of compliance of sepsis screening of appropriate patients. Audit of compliance of patients with sepsis that requires intravenous antibiotics within 1 hour of presentation to ED, and have a review of the antibiotics within 3 days of prescribing.	Quarterly Quarterly	90% compliance Variable targets each quarter	Achieved Partial achievement
Sepsis – in patient acute settings Establishment of a baseline data collection. Audit of compliance of sepsis screening of appropriate patients Audit of compliance of patients with sepsis that requires intravenous antibiotics within 90 minutes of the identification of red flag sepsis, and have a review of the antibiotics within 3 days of prescribing.	Q1 Quarterly – Q2 – Q4 Quarterly	 Variable targets each quarter Variable targets each quarter	Achieved Achieved Q2/Q3/Q4 Achieved Q2/Q3/Q4
Frailty Establishment of baseline data collection. Audit of compliance of patients over the age of 75 years, who are screened for frailty and their frailty is graded and recorded, a comprehensive geriatric assessment is initiated and shared with the GP and a care plan is provided according to the patient needs.	Q1 Quarterly	 Variable targets each quarter.	Achieved Achieved Q2/Q3/Q4

Topic	Target timescale	Target	Achievement
Cancer Improving outcomes for urgent GP referrals for suspected cancer to first treatment within 62 days.	Quarterly	Variable targets each quarter.	Partial achievement
Cancer Root cause analysis on all long waiters and a clinical harm review for a positive diagnosis.	Quarterly	100% compliance	Partial achievement
Planned Care - drugs Utilisation of a system to ensure the Trust is prescribing /making available specific drugs approved by NICE.	Quarterly	100% compliance	Partial achievement
Improving quality and efficiency on the patient journey Reduction in the first follow up appointment ratio.	Q2 – Q4	Variable targets each quarter.	Partial achievement
Planned care Best Practice in day surgery outpatient appointments. Migrating from day case to outpatient procedures. Audit of practice and implementation of plan.	Quarterly	Variable targets each quarter.	Fully Achieved
Specialist CQUIN Preventing term admissions to neonatal unit.	Quarterly	100% compliance	Achieved
Specialist CQUIN Timely discharge from the adult critical care unit.	Quarterly	100% compliance	Partial Achievement

The CQUIN schemes for 2017/18 have been determined following discussions with Commissioners and through areas identified nationally as topics for further quality improvements.

Areas for CQUIN payment framework in 2017/18

Topic	Rationale
NHS e- Referrals	As technology is becoming embedded in everyday life, an e referral system can provide patients with an instant referral into secondary care.
NHS Advice and Guidance	The CQUIN sets out to improve the GP access to consultant advice on potential referrals into secondary care.
Transformation CQUIN – reduction in follow up out patient activity.	To align the work with the Sustainability and Transformation Plan(STP) for Staffordshire

Topic	Rationale
NHS Improving services for people with mental health needs who present to A&E	Patients with a known mental ill health are 5 times more likely to present to an acute hospital. The Trust and the mental health trust are incentivised to work together to improve the patient outcomes and patient experience.
Specialist CQUIN – hospital medicine optimisation	This CQUIN aims to support the procedural and cultural changes required to fully optimise use of medicines commissioned by specialised services.

Statements from the Care Quality Commission (CQC)

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

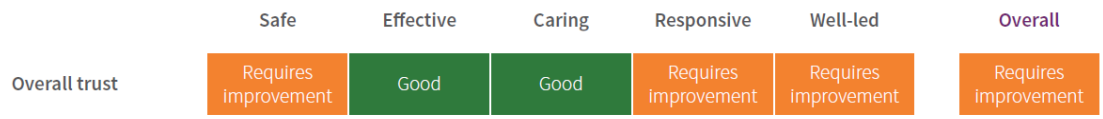
CQC inspectors use professional judgement, supported by objective measures and evidence, to assess services against five key questions:

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

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

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

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



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

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

a great reflection on the quality of care that is offered to the Trust's wider community.

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

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

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

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

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

The CQC reviewed:

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

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

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

The Trust is required to register with the CQC and its current registration status is 'registered'. The Trust has no conditions on its registration. The CQC has not taken enforcement action against the Trust during 2016/17.

The Trust has not participated in any special reviews or investigations by the CQC during 2016/17. The CQC will return to the Trust in due course to check that improvements have been made.

Data Quality

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

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

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

The Data Quality Group provides a regular report to the Information Governance Steering Group which in turn reports to the Finance and Performance Committee.

During 2016/17 the following actions to improve Data Quality were carried out:

- A work plan to improve Data Quality was implemented and monitored by the Data Quality Group.
- Overall data quality was monitored via high level Key Performance Indicators based on data extracted by the Information Department and the Human Resources team.
- An audit of key data items in Trust systems was carried out as well as a completeness and validity check as part of the annual IG Toolkit process
- Standard Operating Procedures for report production have been reviewed and updated.
- A new Data Quality Training Package has been devised and uploaded in to the Electronic Staff Record (ESR) system for use by staff.

The quality of data in the ESR system has improved so that the Trust is now ranked joint first out of 445 organisations submitting data.

NHS Digital has introduced a new metric to measure the quality of patient activity data. This is known as the Data Quality Maturity Index (DQMI) and was first published in November 2016. The indicator measures the Data Quality of seven nationally collected data sets. The Trust's value for July to September 2016 is 99.2%. The Trust is one of 51 providers (out of 388) who scored over 99%.

It is essential that Data Quality is not only maintained but improved upon; therefore the Trust will be taking the following actions to improve data quality in 2017/18:

- Implementation of a Data Quality improvement work programme
- Review of Trust performance for key Data Quality indicators including reference to national comparators and external reports.
- Continue to target key areas such as outpatients, wards, secretarial support to ensure demographic data is accurate and kept up to date.
- Monitor compliance with Data Quality standards

NHS number and General Medical Practice Code

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

Accurate recording of the patient's general medical practice code is essential to enable the transfer of clinical information about the patient between healthcare providers thus helping to deliver seamless care for patients. This is particularly important when coming to discharge patients from hospital.

The Trust submitted records during 2016/17 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records in the data for the period April to December 2016, the latest data available, that included the patient's valid NHS number was:

	Trust %	National %
For admitted patient care;	99.6	99.2
For outpatient care; and	99.9	99.5
For accident and emergency care	98.4	96.6

The percentage that included the patient's valid General Medical Practice Code was:

	Trust %	National %
For admitted patient care;	100	99.9
For outpatient care; and	100	99.8
For accident and emergency care	100	98.9

Information Governance Assessment Report

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

The Trust's Information Governance Assessment Report overall score for 2016/17 is 83% which is an increase of 1% on the previous year. A full breakdown of the position is as follows:

Trust Score for Attaining Information Governance Standards

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

Trust performance is rated as Satisfactory by NHS Digital.

Burton Hospitals NHS Foundation Trust was not subject to the payment by results Clinical Coding Audit during 2016/17 by the Audit Commission.

2.3 Reporting against core indicators

The 4 hour performance target continued to be challenging throughout 2016/17. Performance significantly improved in February and March and the target was achieved in March 2017. Overall attendances decreased compared to 2015/16 by 5351, this was due to the closure of the Minor Injuries Unit overnight. Attendances at A&E were marginally down on the previous year and this occurred in the latter part of the year and is attributable to the transformation work around streaming and assessment areas.

Referral to Treatment Waiting Times – Admitted Pathways Trust's performance was better than the national average and the Trust achieved the 90% target. The Trust also continues to place a greater emphasis on achieving the non-admitted target (reducing the number of patients waiting over 18-weeks) to ensure our patients are treated in a timely manner in order of clinical priority and time on the waiting list.

As a result of the upgrade of the Trust's Patient Administration System from Meditech Version 5 to Version 6 in March 2016 a decision was taken to suspend the national reporting of 18 week Referral to Treatment (RTT) waiting time performance, to enable a thorough overview of the pathways and data in the new system. This step is a commonplace amongst Trusts, during the introduction of new Patient Administration systems, and ensures that reported RTT performance information is accurate.

To this end, the Trust worked with alongside the NHS Intensive Support Team (IST), to undertake a review of the process associated with inputting and reporting RTT pathway performance in the new system of Meditech to ensure robust data quality and ultimately reporting processes were in place. Recommendations were provided following the review which provided the cornerstone of an action plan which would see the trust return to national reporting of RTT performance by November 2016 at the earliest.

The Action plan focussed on ensuring that users, throughout the organisation, were suitable trained; all pathways that were migrated from the old version of Meditech to the new, were validated; Pathways were mapped in Meditech to ensure that they functioned as per national rules; Data quality reports were developed to ensure that checks on the data could be run and that ongoing validation could be undertaken to provide sufficient assurance as to the validity of the waiting list information. The completion of these actions required considerable work across Operational, Information and IT teams which ensured that after a follow up review by the IST in early November 2016, full sign off to return to reporting was given. Since this date the Trust has reported on a monthly basis a compliant waiting list position.

CDiff performance has achieved the annual target of 20 with a year to date position of 12 cases. The Trust has had confirmation from our Commissioners that the annual target of 20 cases will remain the same for 2017/18.

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

2016/17 performance against key national indicators, including comparison against target and previous year's performance

Performance against local indicators:

April 2016 – March 2017

Performance Indicator	Target 2016/17	2016/17 Actual	2015/16 Actual	2016/17 Performance Against Target	2016/17 National*** Actual
Waiting Times in A&E (% under 4 hours) Burton, Samuel Johnson Community Hospital and Sir Robert Peel Hospital	95%	90.6%	93.0%	Red	89.0%
Referral to Treatment Waiting Times - Incomplete Pathways *** Burton, Samuel Johnson Community Hospital and Sir Robert Peel Hospital	92%	94.3%	92.6%	Green	90.0%
Cancer target - Urgent referral to treatment of all cancers in 62 days^	85%	78.9%	86.2%	Red	81.6%
Cancer target - 62 day wait for first treatment from consultant screening service referral^	90%	96.7%	100.0%	Green	91.6%

Performance Indicator	Target 2016/17	2016/17 Actual	2015/16 Actual	2016/17 Performance Against Target	2016/17 National*** Actual
Cancer target - 31 day wait for second or subsequent treatment: Surgery^	94%	94.5%	97.1%	Green	95.2%
Cancer target - 31 day wait for second or subsequent treatment: Drug Treatments^	98%	100.0%	99.5%	Green	99.3%
Cancer target - Urgent referral for suspected cancers in two weeks^	93%	95.9%	95.4%	Green	94.3%
Cancer target - Two week wait for patients referred with breast symptoms^	93%	91.0%	81.4%	Red	93.6%
Cancer target - Diagnosis to treatment of cancer in 31 days^	96%	99.1%	98.7%	Green	97.4%
Clostridium Difficile - No. of Cases	<= 20	13	27	Green	

****National 2016/17 Actual Data**
>Figures cover England only not UK
^Cancer figures are Apr-Feb (latest available)
*****RTT Incomplete Pathways are snapshot of patients waiting as at end of Mar 2017**

Performance Indicator	2016/17 Actual	2015/16 Actual
Patient Safety Measures		
Mortality (CHKS RAMI) includes Community Hospitals	100	95
Mortality (SHMI) - Oct 2015 - Sep 2016	1.01	0.95
Mortality (SHMI) Banding - Jul 2014 - Jun 2015	NA	NA
Mortality (SHMI) % of pts admitted to a hospital within the trust whose treatment included palliative care. - Oct 2015 - Sep 2016	1.42	1.27
Mortality (SHMI) % of pts admitted to a hospital within the trust whose deaths were included in the SHMI and whose treatment included palliative care. - Oct 2015 - Sep 2016	29.82	25.2
Patients with MRSA infection (rate per 1000 bed days) 2016/17	0.018	0.012
Patients with C.Difficile infection (rate per 100,000 bed days) 2016/17 includes Community Hosptials	7.99	16.69
Medication errors (per 1000 inpatient admissions exc. neonates) inc. Community Hospitals	7.8	7.1

Clinical Effectiveness Measures				
Re-admission rate by Age: 2016/17 within 28 days of discharge	0-15	12.1%	0-15	11.1%
	16+	11.1%	16+	10.6%
Re-admission rate overall: 2016/17 within 28 days of discharge	11.4%		10.7%	
Cancelled Operations - including Community Hospitals from 2016/17	271		302	
% of patients waiting less than 4 hours in A&E	90.6%		93.0%	
% of patients risk assessed for VTE	94.8%		96.5%	
Patient Experience Measures				
Treated with Kindness & Compassion	98%	98%		
Overall Patient Experience Score	97%	96%		
Handover times between ambulance crews and A&E staff (% within 15 minutes)	76.1%	84.5%		

Note: All the figures include Community Hospitals data except where stated otherwise

NB: The annual data is not available from the HSCIC for NHS Trusts with the highest and lowest result for each of the indicators from the HSCIC.

The Board ensures that quality improvement is central to all Trust activities. This is achieved by routine monitoring, ensuring the Trust participate in national improvement campaigns, celebrating success with our staff awards and proactively seeking patient views on our services.

For the past three years the Trust has used a number of indicators to measure performance in relation to quality. These indicators were chosen as they are areas that matter to patients, and cover the wide range of services that are provided. Performance against these indicators is shown in the table below with further explanation given in the succeeding sections.

Part 3: Overview of Quality

Patient Safety Indicators:

Mortality

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

- SHMI measures inpatient and day case deaths, within 30 days of discharge whether in the hospital or the community. HSMR measures a selected group of inpatient and day case deaths within 56 diagnostic groups. This accounts for approximately 80% of deaths in hospital

- HSMR makes adjustments, based on factors such as deprivation and palliative care, where SHMI does not
- SHMI attributes death to the hospital at which the patient was last seen, whilst HSMR divides the number between the Trusts that the patient has attended.

Current situation

The Trust's current SHMI rate is 0.93; normal is 1.00. The lower the score the better, so the Trust was rated better than expected. This was for August – October 2016; the latest available score.

The current HSMR rate for patients is 101, normal is 100, the lower the score the better, therefore the Trust was performing slightly worse than expected. This was for October 2016; the latest available score. This score is presently within the given parameters and is being discussed and challenged at the Mortality Assurance Group. The Group has no current concerns. A system called Healthcare Evaluation Data (HED) will automatically forward an alert to the Trust if the rate falls outside said parameters.

HSMR also allows the Trust to scrutinise mortality ratios at specialty level, for specific diagnostic groups. If a hospital has an unexpected high score, then an alert is sent to the hospital. Currently there is one alert for the Trust from the Care Quality Commission for Acute and unspecified Renal Failure and one alert from the National Hip Fracture Database.

Each month, the HSMR ratio for the Trust is scrutinised, to look for best practice and any anomalies. This information is reported to a number of groups including the Trust Executive Committee, Board of Directors and Quality Committee. Prior to reporting to these groups all Trust Mortality data is scrutinised and acted upon by the Trust Mortality Assurance Group that meets on a monthly basis.

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

The Trust has recently experienced 2 mortality outlier alerts;

1. The Trust has participated in an investigation by the Care Quality Commission relating to a mortality outlier alert for acute and unspecified renal failure. The Trust have taken the following actions to address conclusions or requirements reported by the CQC and have made the following progress by 13th March 2017:
    a. Carried out an investigation into the highlighted patients from the alert and reported the findings back to the Mortality Assurance Group by the senior consultant for Acute Kidney Injury within the Trust

b. Once all the details from the internal investigation had been accepted by the Mortality Assurance Group, a formal response was returned to the CQC
c. Following the formal response from the Trust, CQC requested an action plan to address further areas identified for improvement.
d. The Trust has currently drafted a response outlining action plans and this response is to be placed on the next Mortality Assurance Group agenda to discuss and agree.

2. An alert resulted from identified outliers from a national hip fracture database audit programme for 2015. The Trust has made the following progress by 13th March 2017:

    a. The Trust identified 26 potential outliers from the HED Database.
        i. Medical Records were requested and disseminated amongst 3 senior clinicians to complete the mortality review pro forma
        ii. A confirm and challenge session took place whereby cases were discussed to determine if there were any themes or trends amongst the deaths.
        iii. No practice was highlighted that warranted further concerns.

    b. A multi-disciplinary practice review of the hip fracture service was conducted.

        i. General improvements were discussed
        ii. A generic action plan will be developed and discussed and agreed at the Mortality Assurance Group.

The Trust has actively been using the HED database since 2015. The HED database was designed and managed by Queen Elizabeth Hospital, Birmingham. This system supports a range of reports, which enable individual doctors to receive feedback on their mortality ratio and overall clinical performance. The HED team have been on-site at Burton and given training overviews to a number of staff in order that they can obtain individual feedback. HED are willing to continue supporting and training staff where ever needs are identified.

Healthcare Associated Infection

The indicators show that the Trust in the main is performing well in relation to healthcare associated infection. Preliminary results from Public Health England show that the Trust rate is below the national rate following point prevalence surveillance activity. Rates of *C.difficile* infection are the lowest ever achieved by the Trust and well within the centrally set target number of cases. For the first time in almost two years there was a case of Meticillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infection. Norovirus arrived in the Trust early this year with quarter three providing a significant challenge. An investigation of MRSA colonisation in a cluster of patients took place and learning applied to reduce the risk of recurrence. Staff are now further protected by introduction of a more applicable policy to manage inoculation injury. A major revision of the indwelling urinary catheter policy was completed which should over time reduce the incidence of catheter associated urinary tract infection. The embedding of this

policy into practice is one of the foci for the coming year. There were personnel changes in the Infection Prevention and Control Team (IPCT) during the year. Another team development day has informed and driven the programme to be effected in the next financial year.

Meticillin-resistant Staphylococcus Aureus (MRSA) blood stream infections

Robust post infection review is undertaken for all cases where MRSA is identified in the blood stream of patients. The technical definition applying to initial attribution of cases is a case which emerges after the day of or the day following the day of admission. This occurred in two cases this year. Given the findings of the reviews both cases were deemed locally as not being attributable to the Trust. Both were referred to an arbitration process conducted by NHS England. In both cases the arbitration process also decided that the cases were not attributable to the Trust. It is now almost two years since the last Trust attributable case.

***Clostridium difficile* (*C. difficile*) infection**

The Trust is subject to an externally set target in relation to the maximum permissible number of this infection. The target for the year 2016/17 remained unchanged from the previous year of no more than twenty cases. The circumstances surrounding each case are subject to rigorous examination both internally by the Trust and by Commissioners. This scrutiny provides assurance concerning those cases that are regarded as being unavoidable. Where lapses in care have been identified cases are defined as being avoidable. Plans are then formulated to ensure that those lapses in care have been addressed thus reducing the risks to other patients. There have been thirteen cases in the Trust this year and of these eight are agreed as being unavoidable and five due to lapses in care. This represents the fewest ever number of cases attributable to the Trust since records began.

Carbapenemase Resistant Enterobacteriaceae

There have been no significant issues with these highly resistant bacteria. Surveillance has been maintained and appropriate screening undertaken for all potential cases. Screening has shown no evidence of transmission of infection or colonisation between patients.

Meticillin-sensitive Staphylococcus Aureus (MSSA) bacteraemia

The presence of this bacterium in the blood stream of patients is reported to Public Health England (PHE) by all Trusts as part of national surveillance and data collection. No national targets have been set for the number of these cases. Using the same technical definition as that defined for MRSA the number of cases that could be described as attributable to the Trust amount to seven for the year 2016/17 which is a small increase compared to last year.

Escherichia coli (E.coli) bacteraemia

Overall rates of this very common infection have remained at the same level as the number reported last year. Eighty four per cent of the affected patients

acquired this infection in the community prior to admission to the Trust. One hundred and twenty cases were reported to PHE.

Hand hygiene

Audit of hand hygiene practice continues to rely on observation as the means of determining compliance. This has remained at levels well over 90% for the whole year. Observation brings with it distorted results resulting in inflated compliance as human behaviour will change if being observed.

A pilot study involving electronic methods of quantitative data collection has been completed and confirms previous national and international research findings that compliance will be less than that reported by observational methods. Further work is underway to overcome some technical issues with the system. Once these have been resolved the pilot will be repeated. Work to refine the data on which the system depends will also continue alongside the pilot to ensure that data quality is robust. The main benefit of investing in such a system is that measures of hand hygiene compliance are produced in real time with data collected continuously rather than for a short time on one day in the month. Thus the data produced will more accurately reflect actual practice.

Point Prevalence Survey of Healthcare-Associated Infections and antimicrobial use

The Trust participated in this national survey which took place for the UK between September and November 2016. There were five main aims and objectives of the survey which are listed below:

- Raising awareness of Healthcare Associated Infections (HAI) and antimicrobial usage within hospitals
- Identify priority areas locally and nationally for interventions and surveillance
- Measure the use of devices at hospital & national level these include, Urinary Catheters, Peripheral Vascular Cannula, Central Vascular Cannula, Intubation
- Measure the prevalence of HAI determining the bacteria involved, the patterns of resistance and whether these infection were associated with devices
- Determine how antibiotics are prescribed and used

The national survey took place in this Trust during November 2016 with all relevant patients (464) included. Preliminary results show that the rate of HAI in this Trust (5%) is below the national average. Previous historical surveys in England have shown national rates of 8.2% in 2007, 6.4% in 2011 and 7% in 2016 (provisional). It is anticipated that surveys of this type will be conducted on a regular although not annual basis in the coming years.

Infection prevention and control audit, surveillance and monitoring projects

Formal continual surveillance of certain orthopaedic operations has been maintained during the year. Additional surveillance was undertaken for large

bowel surgery during the final quarter of the year. It is not sustainable to maintain both activities on a permanent basis and the emphasis for the immediate future will be on orthopaedics. This decision is validated by the fact that infection rates have risen in this class of surgery resulting in a local investigation and implementation of a number of actions. The general range of audit is unchanged from last year and is listed below.

- Ward and departmental environment – IPCT and by Matrons
- MRSA screening
- MRSA decolonisation treatment
- *Clostridium difficile*
- Commode cleaning
- Additional audits in "hotspot" areas, particularly those areas where sporadic cases of *Clostridium difficile* infection have occurred
- Audit of endoscopy decontamination using nationally approved audit tools and in conjunction with Trust decontamination lead.
- Contract monitoring of mattress decontamination supplier

Screening patients on admission to determine whether they are colonised with MRSA continues in line with national guidance as issued in August 2014. Contractual standards have been and are being fully met.

Infection Prevention Metrics

The infection prevention and control team (IPCT) consolidate and analyse data from a number sources to identify areas and practices in the Trust which may benefit from more direct support. A number of practices are audited at ward level, that in most cases are related to the insertion and care of various devices such as indwelling urinary catheters and intravenous cannula. The environment is also audited to provide assurance of cleanliness and the acceptable state of equipment. Further assurance auditing is conducted by the IPCT and both the local data and assurance data is analysed and assessed against the number of key infections that occurred in an area. Where action is required outcomes and learning is shared. These data are formally reported to the Infection Prevention Board (IPB) and to the Quality Review Group.

Outcome Monitoring

In addition to reports to the IPB and QC other reports are produced for the individual Divisions with attendance at meetings by the IPCT. Weekly and monthly reports are also generated for Commissioners in accordance with contractual obligations. By these means information is widely disseminated, improvement plans shared and progress against internal and external measures monitored.

Challenges for 2017/18

The Trust will continue to strive to reduce healthcare associated infection to irreducible minimum levels. Performance against the target for *C.difficile* infection was exceptional last year but further work is required in the coming year to improve the quality of post infection review and shared learning. Support will be given in key policy areas where educational input will be required. These are the

reduction of catheter associated urinary tract infections and the embedding of the new inoculation injury actions following injury to staff. A major review of hand hygiene observational audit will be required irrespective of outcome of the electronic monitoring pilot. The link person system will be reviewed and re-invigorated. Further work will be undertaken to ensure an appropriate proactive and responsive service for the Community Hospitals located in Lichfield and Tamworth.

Medication Errors

Medicines are the most common therapeutic intervention in healthcare and they can save lives. However, ensuring medicines are delivered safely is complex. Medication errors can cause potential harm and hence medication safety is a key focus to ensure that our patients get the right medicine, at the right dose at the right times.

Errors can occur at any stage of the medication process including errors in supply from pharmacy, prescribing and also administration. To minimise errors, it is vital to have, clear evidence based clinical guidelines and protocols with a robust governance structure to ensure these are reviewed and up to date and also adequate staff training on medicines management issues.

The average number of medication incidents reported each month at Burton Hospitals in the last 12 months is 47 per month. Medication incidents account for 7% of the total incidents reported at the Trust. From those medication incidents graded, 98% resulted in no harm/near miss, 1.8% resulted in moderate harm and 0.2% resulted in severe harm.

The Burton Hospitals Medication Safety Officer (MSO) has been working across the Trust, with the governance team, to encourage incident reporting and ensure learning and sharing is happening.

The process for the review and cascade of shared learning continues to evolve; messages to staff are shared in a number of ways, including:

- The importance of error reporting is emphasised as part of clinical staff induction process.
- In August 2016 the Trust implemented the Datix System for recording of incidents. Datix icons are available on all staff desktops and do not require sign in access for staff to enter new reports. Datix training is available to staff.
- The Safe Medicines Practice group (chaired by the Trust MSO) reviews medication incidents and identifies any trends and themes. This is in addition to Divisional Governance review of incidents.
- Safe medication newsletters are issued on a regular basis to share learning from recent incidents. These also provide feedback to those staff who have reported incidents to know improvements are being made.
- The Trust appointed MSO is a member of the regional MSO group, which aims promote a minimum standard for safe working practices

across the West Midlands Region and shares local incidents and learning from them with staff at Burton Hospitals.

- Lead Divisional Pharmacists are now in post who can support Divisions with specific medication related issues, attending their governance meetings and raising the profile of safe medicines management.
- A review of our medication-related policy ratification process now ensures that all medication related policies are critiqued by the divisional pharmacist and reviewed/ratified by Trust Drugs and Therapeutics Group.
- Development of Antibiotic Stewardship Group to improve antibiotic prescribing across the Trust
- Sharing of Controlled Drug related medication incidents at the Local Intelligence Network meetings.

Within pharmacy, dispensing errors are recorded and monitored and, along with incidents reported via the Trust's incident reporting system, used by the Error Reduction Group (ERG) to ensure safe dispensing practice is used at every opportunity.

We are working within pharmacy to increase clinical pharmacy team presence on the wards to support the timely completion of medicines reconciliation and medication supply for new patients. This helps minimise any omitted doses of medicines and also identifies any prescribing errors at an early stage.

The Trust has an electronic prescribing and medicines administration system which allows the implementation of a variety of error-reduction strategies. These include warnings associated with high-risk drugs, dose calculators, drug monographs, interaction warnings, and the restriction of prescribing by individual password.

Further work in progress to assist medicines safety at Burton Hospitals includes:

- Review of medicines management training for clinical staff
- The development of a peri-operative medication management policy to ensure appropriate advice is given to patients regarding their medicines prior to elective surgery
- Development of a Trust midazolam policy to ensure Trust compliance with NPSA's (National Patient Safety Agency) Midazolam recommendations.

Falls

Patient safety is a key focus, especially when providing care and services to older and vulnerable persons. With people over the age of 65 making up 16% of the population it is not surprising that they occupy 65% of acute hospital beds. Patient falls account for approximately 40% of patient safety incidents reported to the National Patient Safety Agency (NPSA, 2007) and may result in injury that can lead to an increased length of stay, additional medical costs and ultimately a loss of confidence and independence for the patient. 10% of all patients aged over 65 who fracture their hips will die within 30 days. 50% of fragility fractures go onto fracture their hips and 50% never regain their previous level of mobility. The aging population means that incidence will increase by 50% by 2030.

In keeping with the above, the NHS Litigation Authority requires evidence of organisational use of risk assessments, monitoring, implementation and evaluation of appropriate actions in relation to slips, trips and falls.

The Trust, in accordance with the NICE quality standard Falls in Older People (2017), has been working to ensure that all patients at risk of falling are identified with the use of multifactorial falls assessment. A particular focus has been taken regarding the recording of lying and standing blood pressure and medication reviews.

Recognition of the importance of strength and balance training has seen continued use of the Tinetti assessment and the introduction of prescriptive exercise into older person's wards. The activity coordinator has also been actively engaging with patients to encourage maintenance of independence.

All falls resulting in harm are investigated and discussed at a multidisciplinary meeting to ensure shared learning and appropriate actions are embedded in practice.

The Trust will be taking part in The National Falls audit in May 2017 which will enable benchmarking of our current practice and enable positive changes that may be required to be actioned.

Incidents

NHS Trusts are required to submit the details of patient safety incidents to the National Reporting and Learning Service [NRLS]. The NRLS, thereafter, provides comparative feedback to Trusts twice a year. Trusts are able to use this information to identify and tackle areas of low reporting, as high reporting Trusts are considered to have a stronger safety culture; although the NRLS recognise that the use of incident reports should never be used as indicators of actual safety.

It is recognised that, even in organisations with a strong reporting and learning culture, not all patient safety incidents are recognised and reported by staff. In contrast, lower levels of incident reporting than peers should not be seen as positive sign, unless there is sufficient evidence supporting that these lowered rates are as a result of patient safety improvements.

Higher levels of reporting may reflect genuine safety concerns, or may reflect a safer reporting culture. As organisations vary in the services they provide; the location in which they are situated and the size of the organisation, comparative figures should be viewed in context.

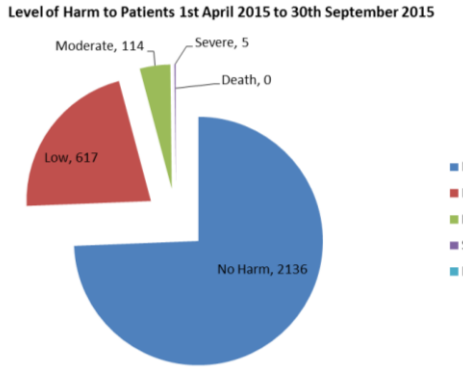
Burton Hospitals Foundation Trust has a responsibility to comply with legislation, regulations and standards as well as a common duty of care. The Trust Board promotes and encourages the development of a positive and fair blame incident reporting culture with an emphasis on reporting incidents allowing the Trust to continuously learn from incidents and improve the quality of services to patients, staff and the public.

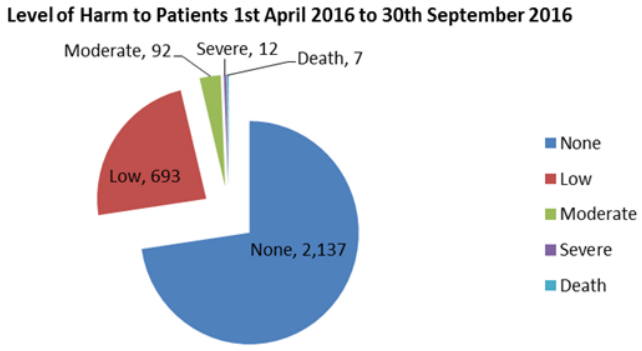
The table below identifies the number of patient safety incidents reported to the NRLS between 1st April 2014 to 31st October 2016 includes:-

Indicators	1 April 14 to 30 Sept 14	1 Oct 14 to 31 March 15	1 April 15 to 30 Sept 15	1 Oct 15 to 31 March 16	1 April 16 to 31 Oct 2016
Number of patient safety incidents reported	1574	2280	2872	2916	2941
Incident rate per 1000 bed days	20.95	28.84	38.04	35.84	36.7

The below table identifies the harm caused to patients from 1st April 2014 to 31st October 2016 as published by the NRLS

	1 April 14 to 30 Sept 14		1 Oct 14 to 31 March 15		1 April 15 to 30 Sept 15		1 Oct 15 to 31 March 16		1 April 16 to 31 Oct 16	
Degree of harm	Number of Incidents Occurring	%	Number of Incidents Occurring	%	Number of Incidents Occurring	%	Number of Incidents Occurring	%	Number of Incidents Occurring	%
No Harm	765	48.6	970	42.5	2136	74.1	2139	73.4	2137	72.7
Low	697	44.2	1137	49.9	617	21.5	654	22.4	693	23.6
Moderate	99	6.2	152	6.7	114	4.0	113	3.9	92	3.1
Severe	11	0.7	20	0.9	5	0.2	5	0.2	12	0.4
Death	2	0.1	1	0	0	0.1	5	0.2	7	0.2





The latest data that has been published by the NRLS identifies that Burton Hospitals NHS Foundation Trust continues to stay in the 'Acute (non-specialist) organisation' which now compares 136 organisations compared to the peer group of 'Small Acute Organisation' which had 28 organisations (published data including October 2013 to March 2014), however since the NRLS have removed this category meaning that BHFT is now benchmarked against much larger Trusts.

The latest NRLS data published identifies that the Trust continues to be placed in the middle 50% of reporter organisations per 1000 bed days, sitting at 86th place

out of the 136 organisations, we have fallen by 1 place since the previous NRLS publication in September 2016.

Moving from Safeguard to Datix

The Trust has been using Ulysses (Safeguard) at the organisation since approximately 2004 as the software system of choice but following a review of the products available in 2015, Datix was the successor.

Datix is used in the UK (and abroad) within more than 75% of the NHS and has been a global pioneer in the field of patient safety and continues to develop software to improve patient safety within organisations.

The Trust has the following modules available within Datix: -

- Incidents
- Risk Register
- PALS
- Complaints
- Claims
- Safety Alerts

During July and August 2016 an extensive training programme was instigated to ensure that staff knew how to report incidents as well as departmental managers knowing how to manage their incidents on the new Datix system. On 1st August 2016 Datix incident reporting module went live across the Trust and still continues to be developed to meet the need for the users of the system and to allow easy extraction of the information that the system holds.

Claims commenced on 3rd August 2016 followed by Complaints/PALS on the 1st October and the manual transfer from Safeguard and availability of all Risks on the Datix Risk Register module was completed at the end of October 2016.

From February 2017 the successful integration of Datix and Meditech V6 and ESR took place which allows greater quality of information populated into Datix due to the reporter of the incident being able to 'select' the appropriate person involved from a drop down list using the 'search' function.

The Safety Alerts module is currently being developed and will be live from 1st April 2017 after training and education for the end users. This module will enable more streamlined process and effective audit trails of the alerts received and implemented.

Training programmes have been developed by the Governance Department to raise awareness and improve incident reporting, Root Cause Analysis training which continues on a three monthly programme for investigation officers.

The Trust investigates serious incidents [SI's] in a thorough way, with added scrutiny and rigour provided by the Serious Incident Executive Review Group chaired by the Chief Nurse.

Analysis of the data from the different modules on Datix is presented via reports to a wide range of groups and committees within the Trust including Business Unit and Divisional Committees; Patient Experience Group, Medical Devices; and the Risk and Compliance Group (just an example). The Governance framework allows the escalation of information from the subcommittees to Trust Committees which then feed into the Trust Board.

Patient Information Leaflets – The Implementation of SharePoint

*Microsoft **SharePoint is** a browser-based collaboration and document management platform from Microsoft. Microsoft's content management system. It allows groups to set up a centralized, password protected space for document sharing'*

Document management controls the life cycle of documents in our organisation — how they are created, reviewed, and published, and how they are ultimately disposed/archived retained. Although the term "management" implies that information is controlled from the top of the organisation, an effective document management system should reflect the culture of the organisation that uses it. The tools that you use for document management have been developed to be flexible enough to enable the Business Units to control a document's life cycle that fits the Trust's culture and goals

The Governance Department have been developing SharePoint over the past 6 months and was able to go live on 7th February 2017. There have been three phases to the implementation of SharePoint at the Trust.

1) This meant that the first phase of moving all patient information leaflets (approximately 3000) were transferred over to SharePoint with the new link via the 'Patient Information' signage on the Trusts intranet page. This was successfully completed on the 7th February 2017
2) The second phase included the email system aspect which will go live on the 16th March 2017. This enables that at 3, 2, and 1 month intervals before the Patient Information leaflet expires, designated staff within the Business Units and the author/reviewer of the leaflet will receive an email to advise that this is 'notice' that the patient information leaflet will be expiring in 3, 2 or 1 months' time.
3) The final stage will be on 27th April 2017 where the Trust will commence the 'automatic' archiving of patient information when it is passed its expiry date, so that there will not be any patient information held on SharePoint which has passed their expiry date.

Clinical Effectiveness Indicators:

Readmission rates

The NHS Outcomes Framework indicators require Trusts to monitor the number of readmissions within 30 days. There are many reasons why a patient is readmitted into hospital within 30 days of being discharged. Sometimes this can be a planned re-admittance for clinical reasons. However, it can sometimes indicate that there were problems with discharge arrangements; the patient may have been discharged too early or there were insufficient services in place to support the

patient when they returned home. The Trust periodically audits notes of patients who have been readmitted within 30 days.

For the purposes of the Quality Account however, Trusts are required to report on the previous indicator of readmissions within 28 days. The percentage of the Trust's readmissions, based on 28 days, is 11.1%. This demonstrates a marginal increase on the outturn position for 2015/16, which stood at 10.7%. Through the Unplanned Care Transformation Programme, the Trust has worked on safe discharge from hospital which requires support services to be available from the day of discharge. These services are generally provided by a number of other organisations with whom the Trust has continued to work closely with during the year.

This year the Trust has continued the focus on improving discharge planning, engaging the multi-disciplinary team to ensure that patients are discharged safely when they are medically fit, linking this with their expected date of discharge (EDD). Through the implementation of Medworxx the Trust has greater insight into the status of each patient and whether they are experiencing any unnecessary delays, both internally within the Trust or awaiting external support. The Trust has continued it's work with Virgin Care who have been focussing on those patients with long term conditions such as diabetes and chronic obstructive pulmonary disease who tend to be the more frequently readmitted patients due to the nature of their disease.

Cancelled Operations

Operations are sometimes cancelled for clinical reasons; the patient may be unwell or their condition may have changed. However, on occasion operations are cancelled for non-clinical reasons; a bed may not be available or there may be theatre scheduling problems or equipment failure. Such cancellations can cause great anxiety, distress and inconvenience for patients and their families.

Any non-clinical cancellations are recorded, with key themes presented to the Trust Board. Through the Planned Care Transformation programme focus and attention is given to resolving underlying issues. A key theme nationally is insufficient elective beds as a result of high emergency demand, particularly in winter months.

This year the Trust enacted its Winter Plan with a focus on ensuring sufficient bed capacity for emergency patients as well as ensuring that appropriate levels of elective surgery could proceed without unnecessary cancellations to surgery. As such, a programme of additional elective operating took place in Autumn 2016 followed, in January, a period during which, a higher proportion of elective daycases, not requiring a bed post operatively, were scheduled alongside urgent inpatients. This ensured that elective activity was able to continue, with fewer cancellations seen within the Trust than experienced by many other organisations.

Emergency and Urgent Care

The focus of the healthcare system remains on the length of time people wait to receive treatment within an Emergency Department. It has been shown that

patients who are diagnosed and treated within 4 hours have better clinical outcomes and vastly improved patient experience.

The 4 hour ED waiting time standard remains a clear indicator of an effective and joined up emergency and urgent care system care. The Trust and its partners have continued to develop systems to improve waiting times and reduce delays both within the Emergency Department and the wider hospital setting. 2016/17 whilst being a challenging year, like the majority of NHS hospitals, has also seen an improving trend in performance within the Trust, culminating with compliance against the standard in March 2017 at 97.26%, placing the trust as one of the strongest performers in the country. Through the establishment of the A&E Delivery Board, the Trust is working with its partners at the Clinical Commissioning Group, Community Trust and Local Authorities to improve the levels and quality of care provided so patients can be safely discharges in a timely manner.

In 2016/17 the Trust has continued to develop, with its partners, the service Transformation Programme to improve the flow of emergency and urgent patients through the hospital and back in to the community. Notable new developments such as the introduction of Paediatric and Surgical Assessment Units, Streaming at the Front door, the introduction of Medworxx with focus of reducing delays to discharge and significant strides in medical recruitment to the Emergency department, have been integral to the improved performance. The current performance of the Trust against the 4 hour ED waiting time is a testament to the dedication of staff across the Queen's hospital site and community hospitals.

Patient Experience Indicators:

Inpatient Experience

The Trust aims to provide the best possible patient experience.

Being treated with kindness and compassion is a big part of the patient experience, along with ensuring that the Trust is responsive to the needs of inpatients, as it is recognised that often patients can be at their most vulnerable when they have cause to use hospital services.

A variety of methods are used to gain feedback on what patients and their families think about the Trust's services. This includes a number of local surveys that are carried out each month on all wards with a minimum of 20 patients and relatives responding to surveys. The Trust's monthly inpatient surveys undertaken anonymously by impartial volunteers show that the hospital continues to score well in kindness and compassion and responsiveness to patient needs. All questions relating to this have scored an average of 93% or above over for the year and in all areas have shown an improvement. This year a new question, *"Do therapists (Physiotherapists, Occupation Therapists, Speech Therapists, Dietitians) explain things to you in ways you understand?"* was added to the inpatient survey.

Question	Score 2013/14	Score 2014/15	Score 2015/16	Score 2016/17
Did staff welcome you and show you things you needed to know when you arrived on the ward?	93	94	96	97
Have you been treated with kindness and compassion by staff?	95	96	98	98
Do staff explain things to you in ways you understand?	94	95		
Do Nurses explain things to you in ways you understand?			97	97
Do therapists (Physiotherapists, Occupation Therapists, Speech Therapists, Dietitians) explain things to you in ways you understand?				98
Do Doctors explain things to you in ways you understand?			93	94
Have you been able to get the attention of staff when you needed it?	92	92	96	97
If you have had any pain, do you think that staff have done all they can to help control it?	95	95	97	97
Do you get enough help from staff to eat and drink?	94	97	98	99
Have staff done all they can to help you stay clean?	96	98	99	99
If you need help getting to the toilet or bathroom, do you get it in time?	92	93	96	96

Results for National Inpatient Experience Survey 2015

At the time of writing the 2015 results are the most up to date National Inpatient Experience Survey results available to the Trust.

The Trust performed as well as most other Trusts in the National Inpatient Survey 2015 in all key patient experience domains and is performing better than most other Trusts on four questions. There are no questions where the Trust scored worse than most other Trusts which is an improvement on 2014.

Domain	2015	
	Worse/ Same or Better	Trust Score
Emergency/A&E	Same	8.6
Waiting list and planned admissions	Same	9.0
Wait to get a bed on a ward	Same	7.8
The hospital and ward	Same	8.3
Doctors	Same	8.5

Domain	2015	
	Worse / Same or Better	Trust Score
Nurses	Same	8.6
Care and treatment	Same	7.9
Operations and procedures	Same	8.7
Leaving hospital	Same	7.2
Overall views of care and services	Same	5.6
Overall experience	Same	8.1

Indicator	2015 Survey	
	Better / Same or Worse	Trust score
Were you ever bothered by noise at night from hospital staff?	Better	8.5
Did a member of staff answer your questions about the operation or procedure?	Better	9.1
Did the anaesthetist or another member of staff explain how he or she would put you to sleep?	Better	9.6
Delay at discharge (due to waiting for medicines/to see a doctor/ambulance?)	Better	8.4

Patient's overall experience of their care as reported in the National Inpatient Survey is as good as most other Trusts.

Overall Impression	2015	
	Worse / Same or Better	Trust Score
Overall, experience on a scale of 0 - very poor to 10 - very good.	Same	8

The Maternity Services National Patient Survey is not available for 2016 as this is published every 2 years. There was a publication in 2015 which was reported in the last Quality Account. The next survey will occur in 2017.

Friends and Family Test 2016/17

All NHS Trusts in England and Wales are expected to ask all patients the Friends and Family Question. The Friends and Family Test is not intended to provide comparisons between Trusts or against national scores but as a local indicator of

satisfaction. This is presented as the percentage of patients asked who would recommend their care in this hospital to family and friends

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Inpatient & Daycase	98	97	97	96	97	96	98	97	96	97	97	97
A&E/MIU	69	82	89	91	83	84	87	93	86	95	93	87
Maternity	99	98	97	99	94	99	99	99	97	96	98	99
Outpatients	90	86	91	92	93	91	92	92	94	94	91	89

Delivering Same Sex Accommodation

The Trust has continued to work hard through the year with the Estates, Facilities and operational teams with the aim of complying with same sex accommodation standards and improving the environment. The Trust continues to declare compliance with the Government's requirement to eliminate mixed sex accommodation.

Queen's Hospital Burton
Patient Reported Outcome Measures (PROMs)

The Trust has a requirement to provide details on PROMs for 4 different surgical procedures. These 4 procedures are unilateral hip replacements, unilateral knee replacements, groin hernia surgery and varicose vein surgery.

All patients undergoing surgery at the Trust that fall under one of the identified procedures are asked at pre-operative assessment to complete a questionnaire. All forms that are completed by patients are returned to Quality Health who are the Department of Health approved contractor. All consent forms that are completed with regard to a patient's procedure are held within their notes.

Staff who are involved with the PROMs programme encourage participation in the questionnaires at every available opportunity and reiterate the importance to patients of capturing their feedback. Staff report good rates of participation and willingness by patients to take part in the survey.

All figures are derived from the Health Episode Statistics (HES) website. The data relating to the Trust, and nationally, for all procedures in terms of participation at pre-operative and the response rates of post-operative stages are shown in the tables on the following page. The EQ-5D scores and condition specific scores for each procedure are also shown in the following tables. The EQ-5D score identifies the percentage of respondents who recorded an increase in their general health following their operation, based on a combination of five key criteria concerning their general health for each procedure.

The data below is taken from the from the Health Episode Statistics (HES) website for the reporting period April 2015 – March 2016.

Table 1: Pre-operative participation and linkage

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	1,024	858	83.8%	574	66.9%
Groin Hernia	421	203	48.2%	169	83.3%
Hip Replacement	254	270	106.3%	181	67.0%
Knee Replacement	310	385	124.2%	224	58.2%
Varicose Vein	39	*	*	*	*

Table 2: Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate
All Procedures	858	852	99.3%	632	74.2%
Groin Hernia	203	203	100.0%	136	67.0%
Hip Replacement	270	268	99.3%	200	74.6%
Knee Replacement	385	381	99.0%	296	77.7%
Varicose Vein	*	*	*	*	*

Complaints

> *'a health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment'* Robert Francis QC Mid Staffordshire NHS

Burton Hospitals NHS Foundation Trust (BHFT) is committed to receiving patient feedback and using this constructively to improve patient experience and the services it provides. We are committed to delivering excellent services at this vibrant DGH and ensuring our services are inclusive and meet the needs of our local community.

At BHFT we view complaints as a '*gift'* and welcome feedback, either positive or negative, as feedback on Trust services is welcomed to improve service delivery. Additionally, we monitor the effectiveness of how we respond to issues. As a measure of quality, key performance indicators (KPI) are set for the Complaints service to ensuring that we strive to provide timely response which are of a good standard and sufficiently answer the concerns raised.

Complaint KPI's

2016/17
To maintain numbers in line with 2015/16 (baseline Apr '15- Mar '16)
90% of written complaints responded to within initial timescale agreed with complainant (monthly trajectory to be established 15/16)
100% of complaints acknowledged within 3 days
Reduce % of complaints that are either ongoing/reopened

Comparison of Formal Complaints and PALS contacts
*excluding compliments

	2014/15	2015/16	2016/17
Number of formal complaints *excluding soft intelligence	245	239	239*
PALS contacts *excluding compliments	3080	3064	1676*Safeguard 1714* Datix Total =3390* This equates to an 11% increase in activity through the complaints department.

Although, the NHS Complaints process is embedded in statute, since the public enquiry into Mid Staffordshire Hospitals NHS Foundation Trust, how Trust's undertake complaint investigations and respond to complaints has been very much in the public eye. After undertaking a review of the complaint process in 2014/15, the Trust has seen a reduction in the numbers of formal complaints received and this is felt to be due to the responsive of the organisation and its staff on how they respond when concerns are first raised.

However, as we are dedicated to ensuring our patients and visitors are able to easily raise concerns and raise complaints, the Trust has endeavoured to ensure this process is easy and user-friendly.

We have:

- Ensured there are posters and information about how to raise concerns in all areas of the Trust to promote our commitment to respond to issues
- PALS leaflets are available across the organisation, in English, Urdu, Polish and leaflets are also available on yellow paper with black print for visually impaired patients
- A 'Share your Experience' Feedback form has been developed to ensure making a complaint is easy
- Strong links have been developed with local complaint advocacy services, including Healthwatch Staffordshire, Mind (Derby/Derbyshire) and POhWER (Leicestershire)
- The Complaint service responds to all patient complaints and PALS concerns, along with soft intelligence issues raised by local GP's, CCG's, other NHS Trusts as well as local Members of Parliament
- The PALS team logs and responds to feedback from a number of social media outlets, including, Facebook, Twitter, NHS Choices and Patient Opinion
- PALS awareness training has been undertaken with front of house volunteers to ensure that our teams are further supported by volunteers who provide front of house support.
- Patient Experience comes under the remit of the Complaint Manager and therefore, feedback from the local Healthwatch is also triangulated to ensure that themes of feedback are logged, along with intelligence from Friends and Family Test results
- Dedicated and targeted complaint training has been delivered in the Trust to senior staff who undertake complaint investigation training to ensure that

individuals understand their role and what is required to ensure a complaint is investigated effectively

- Our Complaints and PALS team are dedicated to delivering an excellent experience of the service and their performance in monitored by Complaint Satisfaction Questionnaire feedback
- All complaints received are logged and a management plan developed on receipt. In line with our KPI requirements in 2016/17 100% of complaints received were acknowledged with 3 working days
- Accountability for complaints is led by the Divisional Nurse Director and General Manager's for the Business Unit and overseen by the Divisional Associate Director and Divisional Medical Director
- The number of formal complaints and compliments is shared with the organisation weekly via the Trust's e-newsletter
- The Trust introduced a new reporting database, Datix, in 2016 and the Complaints Team now log all contacts on the system, which is a trust wide system which supports the triangulation of complaints, incidents and legal claims. Datix also supports the effective management of complaints
- Future plans include, further alignment of the Complaints and Serious Incident process, when these investigations are shared and development of structure mechanisms to respond to SI/ISA and complaints via combined meetings.
- Formalised quality round feedback is coordinated and disseminated via the Complaint Manager. Matrons and Senior Ward Sister's undertake formals quality rounds and have specific themes and questions set each month, which are determined as a result of complaints received, themes of SI/ISA's or Friends & Family Tests. This provides a measure of these issues across the whole organisation, including the two community hospital sites

Changes or learning that have occurred as a result of patient feedback via the Complaint process

- Following a complaint about the management of an eye injury by an ENP in ED, a review of protocols and pathway of managing eye injuries has been undertaken to provide assurance that this was sufficiently robust
- Following a further concern raised in ED, additional triage nurses to be made available to support with patient assessments and waiting times
- As a result of a formal complaint, communication workshops were delivered to staff to raise awareness of the need for effective communication
- Communication books and logs introduced in AAC and Diabetes Unit

Complaints received by the Parliamentary and Health Service Ombudsman (PHSO)

Cases referred to the PHSO reflect the further stage to complaint investigating when local resolution has been exhausted. The Trust Complaint's Team work closely with the PHSO to support ongoing effective complaint investigations. The Trust has also offered to refer cases to the PHSO if a complainant remains dissatisfied with the information we have provided as we endeavour to be open, honest and transparent in our complaint investigating.

- In 2015/16 there were 9 new referrals to the PHSO
- In 2016/17 there were 11 new referrals to the PHSO

Compliments

Just as concerns and compliments are welcomed, the Trust also receives compliments and is committed to ensure this good news is shared widely in the organisation and with the staff involved. Compliments are received via a number of routes, including patient feedback, PALS leaflets, social media (including) Facebook, Twitter, NHS Choices and Patient Opinions.

Compliments for all 3 sites	2014/15	2015/16	2016/17
Total received	619	667	335*Safeguard 390*Datix total 725

Additional Quality Overview

Implementing guidance from the National Institute for Health and Care Excellence (NICE)

NICE was established as a Special Health Authority to make recommendations to the NHS on new and existing medicines, treatments and procedures. NICE guidance is published monthly and the Trust is notified on the day of publication that it is on the NICE website.

The Trust maintains a Policy which is accessible to all employees, outlining the core principles for a collective approach to planning and enabling the consistent dissemination, implementation and evaluation of NICE guidance. It is recognised that adequate implementation of NICE guidelines requires a robust process that involves all Trust staff. Therefore, the Trust has a NICE Working Group that meets monthly to consider each individual guideline and agree on a dissemination pathway and develop a system in which to receive a coherent response to the guideline from the named responsible individual informing of current Trust compliance. The NICE Working Group maintain up to date records of NICE compliance and identify and enable resolution of any issues that the Trust may have with implementation; this includes re-visiting any guideline that is being updated or developed.

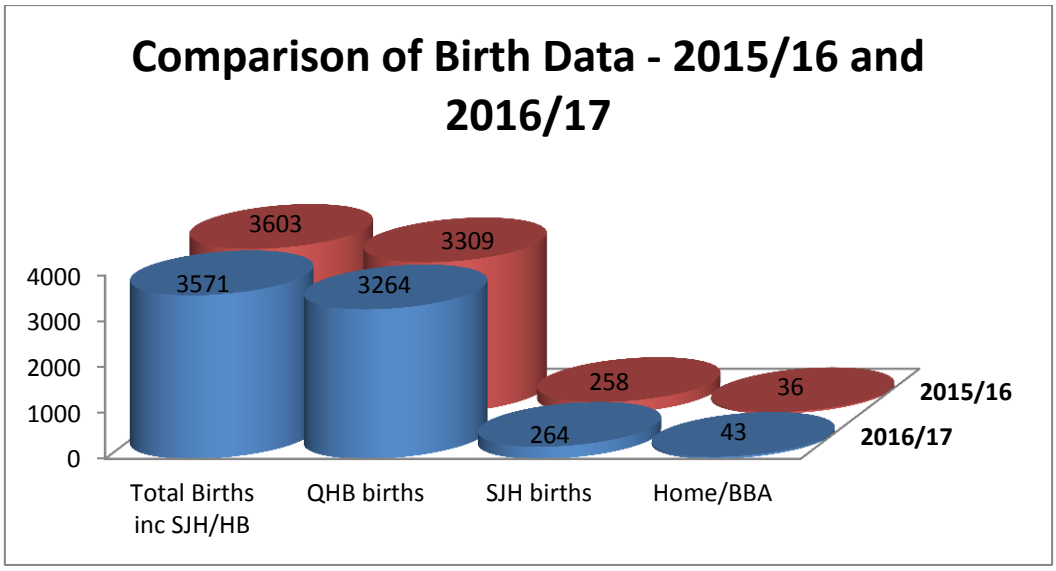
The NICE Working Group membership consists of:

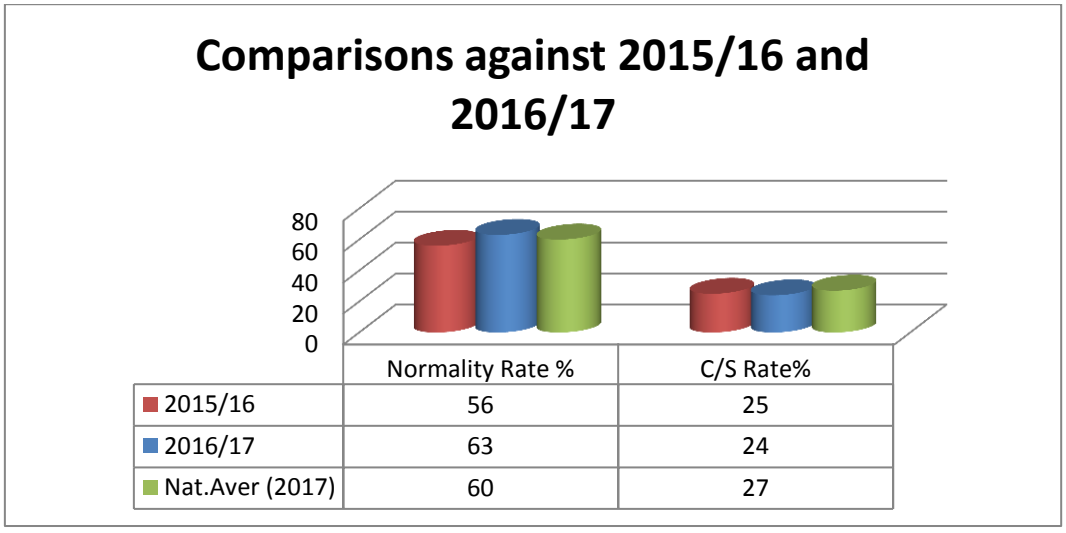
- Deputy Medical Director
- Associate Director (Medical Directors Office) – Chair
- Divisional Medical Director – Medicine
- Divisional Medical Director – Surgery
- Head of Pharmacy
- Clinical Audit manager

The NICE Working Group reports into the Trust Quality Review Group, which in turn reports to the Quality Committee which is a sub-Committee of the Board of Directors.

Overview of maternity services

Maternity provision within Burton Hospitals Foundation Trust is an integrated service, with care being provided at Queens Hospital, the Midwifery Led Unit (MLU) at Samuel Johnson Hospital in Lichfield and in the Community. A multidisciplinary team provided care for 3571 births in 2016-17; the graphs below compare 2015-16 to 2016-17 and performance against the national average for 2017:





The multidisciplinary team work in close cooperation to provide a seamless journey throughout pregnancy. Antenatal and postnatal care is delivered across a wide geographical area by the community midwifery services, who also undertake a small number of home births per year. Approximately 22% of women who birth with the Trust will have a midwife as their lead professional; initiatives are in place to increase these numbers.

The Consultant led unit is based at Queens Hospital and compromises of an ante natal clinic, maternity assessment unit, which includes a 24 hour triage facility, a combined ante natal/ post natal ward and a central delivery suite. The majority of Midwifery staff rotate on a daily basis to all areas; this includes Ante-Natal Clinic, Maternity assessment, Delivery Suite, the provision of caesarean section cover, and the Ante-Natal / Post Natal Wards. The Service is covered by all Obstetric Consultants, with a designated Service Consultant covering the unit during the week, with an on call service for the evening and weekends. There is also a dedicated team of Obstetric Anaesthetic consultants, ensuring senior cover and leading the evolution within this discipline. Senior Midwifery cover is also provided by both an on call manager and Supervisor of Midwives. This close working relationship of the multidisciplinary team ensures the service has a continuum for evolving and ensuring the best journey for all women choosing to birth at the Trust.

The Trust's Central Delivery Suite comprises 7 delivery rooms, each with en-suite facilities. These rooms are adaptable to deliver both high risk and low risk midwifery-led care. Two of these are set up specifically to deliver midwifery led care, one with a couch instead of the bed and birthing stool (bed available). This includes a birthing pool suite, which is inclusive of women who are classed as higher risk, as telemetry is available to monitor fetal well-being (wireless, waterproof Cardiotocography CTG which has been well received by our women and families.

There is a dedicated Obstetric theatre and recovery area within the footprint of delivery suite, enabling provision for timely emergencies and elective caesarean sections. Women having an elective caesarean section are on the enhanced recovery programme, which is a bundle of 'best evidence based practices' with the intention of helping patients recover faster after surgery with better clinical outcomes and fewer complications. This includes key steps in the patient's journey from decision to care in the community following discharge. The key components to its success are reinforcing the women's expectations around an early return to '*normal'* in all aspect of recovery and the collaboration between the woman and the multidisciplinary team. Those parents who suffer a pregnancy loss are cared for in a dedicated bereavement suite and supported by a bereavement team. Attached to the footprint of the central delivery suite is also a level 1 neonatal facility, which is part of the central new born network.

The Midwifery led unit at the Samuel Johnson Community Hospital in Lichfield provides an alternative model of maternity care to the community of South Staffordshire and beyond. This year the unit celebrated the recognition of 75 years of midwifery lead service provision in Lichfield. The unit has 2 pool rooms, 3 delivery rooms, triage facility and a 3 bedded ward. Alternative therapies are also delivered including aromatherapy and reflexology. Risk assessment clinics are run, to ensure all women booked are appropriate and fully aware of the service, this robust assessment has led to a lower than national average transfer rate.

Community midwifery is provided across the Burton area to all women living in that geographical area irrespective of where they choose to deliver their baby. Community midwives employed by the Trust provide care to women in South

Staffordshire, South Derbyshire and North West Leicestershire, and women may choose to birth at any of the cross border hospitals.

High quality, safe, effective care that is responsive to our women and families is reflected in the high performance of the Quality key performance indicators across the service.

Maternity services are clearly in the spotlight, it is a time of ambition and change, with a clear dictate coming from Government to improve maternity outcomes. There is now real impetus to make the vision reality, one which the maternity service at Burton Hospitals Foundation Trust has embedded. We are working closely with both our commissioners, users and SSTP to ensure real change comes to fruition, ensuring outcomes and service provision continues to excel.

2016/17 has seen changes that have benefits for both maternity service users and the wider Trust.

Reconfiguration of service

The maternity service has relocated to wards now directly opposite delivery suite, this has provided an improved journey for our women. This also released beds for our frail elderly population as part of the Trusts winter plans. This has proved to be a great success for the entire Trust.

Business Unit

The women's and Children's business unit brings together maternity, paediatrics, neonatal and gynaecology under one leadership team. This has provided continuity and ownership of a total service ensuring a seamless transitions for this demographic. As such a vision has been produced setting out our gold standard objectives for the next two years of how we envisage the service to evolve in order to provide excellent family centred healthcare for the women and children in our local population.

Community HUB

A community hub has been established this year at Samuel Johnson Hospital (SJH) and provides the continuation of exciting improvements for service delivery to our local population. Our acclaimed stand-alone unit provides the ideal location for enhanced services of the hub. This includes, extended alternative therapies, antenatal and postnatal provision, from community midwifery, falling in line with the vision of Better Births and importantly user feedback. This has been accomplished by the closure of the second base (office) for the west team at Sir Robert Peel (SRP) Hospital, providing a cohesive team at SJH, services however will not be affected, but office space at SRP will be released to the Trust. The ultimate vision is to introduce health visitor, paediatrics, community children's nurses, and social service input through the hub. This falls in line with the Trust vision for GP's at the community hospitals. The East team have identified an opportunity to establish a hub in Stapenhill and are working closely with the children's centre to bring this to fruition.

The Bereavement service

One of our bereavement midwives has undertaken stage 1 EMDR training; this is the first midwife in the country to undertake this, led by Steve Forsyth Interim Deputy Chief Nurse. EMDR, Eye Movement Desensitisation Reprocessing, looks at eye movement therapy, to assist with associated memories of a traumatic event as a result, these unprocessed memories and the accompanying sights, sounds, thoughts and feelings are stored in the brain in 'raw' form, where they can be accessed each time we experience something that triggers a recollection of the original event. While it isn't possible to erase these memories, the process of EMDR can alter the way these traumatic memories are stored within the brain - making them easier to manage and causing less distress.

EMDR is a form of psychotherapy developed in the 1980s by American psychologist Francine Shapiro.

Today, the therapy is used to treat a wide range of psychological difficulties that typically originate in trauma, such as direct or indirect experiences of violence, accidents or natural disaster. EMDR therapy is also used to treat more prolonged, low-grade distress that originates in shock or loss in adult life and/or issues experienced during childhood. The experiences outlined above often lead to a post-traumatic stress disorder diagnosis, for which EMDR has been recommended by the National Institute of Health and Care Excellence (NICE).

Increasingly, EMDR therapy is also being used for the treatment of other issues including:

- depression
- performance anxiety
- phobias and fears
- anxiety
- low self-esteem.

Reported benefits of EMDR include:

- A reduction in re-experiencing trauma memories.
- Feeling more able to cope with and manage trauma memories without needing to avoid potential triggers.
- Feeling more able to engage in and enjoy pleasurable activities and relationships.
- Reduced feelings of stress, anxiety, irritation and hypervigilance - allowing you to rest well, address pressure and/or conflict and go about your daily business without feeling fearful and prone to panic.
- Reduced feelings of isolation, hopelessness and depression.
- A boost in self-confidence and self-esteem.

RCM award

Policy into Practice Award

Reducing the stillbirth rate via a proactive approach to managing cases of reduced fetal movements

This project examined possible factors behind a rising historical stillbirth rate by focusing on aspects of care to identify practice changes which could both reduce this rate and improve maternal and fetal outcome. A correlation between incidences of reduced fetal movements and antepartum stillbirth was observed. Using this as a driver for change an antenatal care bundle for management of reduced fetal movements has been implemented over time. Subsequently the rate has fallen to levels well below the UK average; approximately 3 SB's per 1,000 births in 2013 compared to a national average of approximately 5 per 1,000 births, with further reductions in 2014/2015 to less than 1 per 1,000 births.

Burton Hospital is a District General Hospital (DGH) with currently around 3500 deliveries/year. Our stillbirth rate almost doubled between 2007 and 2010, reaching a peak of 6.3 per 1000 births in a unit with just under 4000 deliveries. A proactive approach to investigating potential causes for this included a review of all cases by both a local multidisciplinary panel review and external review by the Perinatal Institute.

This enabled us to identify key themes, including reduced fetal movements, all of which were subsequently described in the **2015 term antepartum stillbirth report.** A local multidisciplinary Stillbirth Review Group examines in detail the episode to identify improvements in care, resulting in:

- Multilingual stickers
- Reduced fetal movement proforma
- Reduced fetal movements audit
- Low threshold for induction of labour

These projects have been developed in the 16 months in collaboration with obstetric colleagues however the stickers, proforma and audit have been led and implemented by midwives.

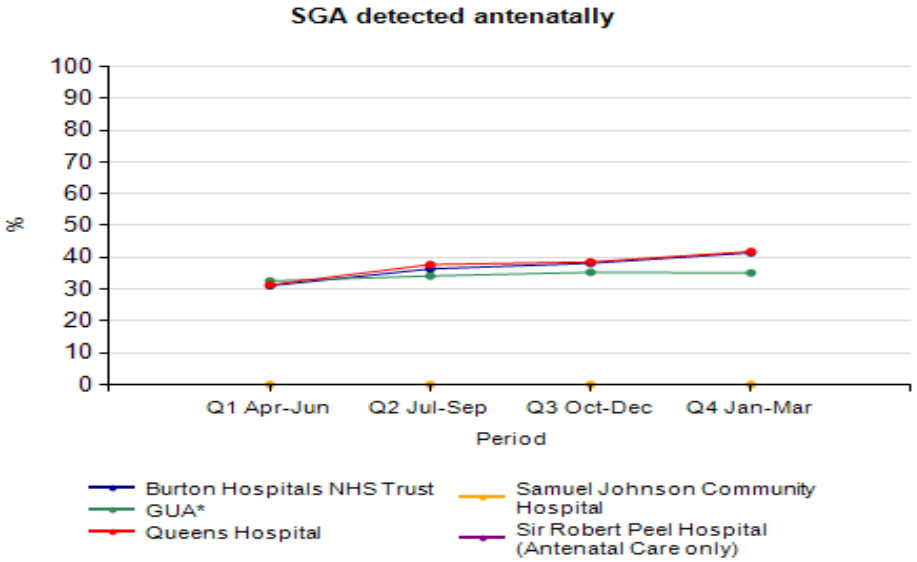
High rates of surveillance

Fetal growth restriction (FGR) is associated with stillbirth, neonatal death and perinatal morbidity. A recent epidemiological analysis based on the comprehensive West Midlands database has underlined the impact that fetal growth restriction has on stillbirth rates, and the significant reduction which can be

achieved through antenatal detection of pregnancies at risk. Customised assessment of birthweight and fetal growth has also been recommended by the RCOG since 2002 and is re-emphasised in the 2013 revision of the Green Top Guidelines.

The Perinatal Institute (PI) provides tools for assessment of fetal growth and birth weight by defining each pregnancy's growth potential through the Gestation Related Optimal Weight (GROW) software, including:

- GROW-chart: customised antenatal charts for plotting fundal height and estimated fetal weight.
- GROW-centile: for calculation of customised birthweight centiles - as an individual centile calculator, or as a bulk centile calculator for databases of pregnancies



The above graphs identify the Trusts performance against the national average; the GUA (green line) is the GAP user average. The graph BHFT (QHB) demonstrates the significant increase in detection rate, and highlights a positive aperture. This is also reflected in the percentages of birthweight centiles produced, with the Trust again a top performer. These centiles help to predict on the immediate potential health of the new born, and identifies undiagnosed growth restriction. The Trust is now using the tool provided by the PI to quantify the undiagnosed group. However it must be stressed that the tool may not detect all growth restricted foetuses.

Commitment to improving safety

A multidisciplinary team attended the inaugural RCM/RCOG labour ward leader's workshop-working together for safety. This one-day interactive workshop is designed to address some of the current challenges in maternity services around leadership on delivery suite. The workshop will support labour ward leaders to work collaboratively together to develop safe and cohesive teams delivering effective and safe care.

Mr. Hunt, Secretary of State for Health, announced on 17th October 2016, new measures to make giving birth safer, including maternity safety funding and publishing maternity ratings. The announcement follows a commitment made by the Government in November 2015 to reduce the number of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and by 50% by 2030.An £8million Maternity Safety Training Fund, distributed through HEE, will support every NHS trust in England to use multi-disciplinary training to improve their maternity safety, with at least £40,000 available for each trust. In return, trusts are asked to commit to key actions to improve safety; as such the service has conducted a GAP analysis against current training, which has formulated the bid. The Trust were successful in this bid, enabling the provision for the training of:

- K2 Fetal Monitoring Training System

  The Perinatal Training Programme is an interactive computer based training system covering a comprehensive spectrum of learning that can be accessed over the internet, anywhere, anytime, from within your own hospital or from home. It is a cost effective option compared to the high cost and inconvenience associated with traditional 'lecture based' training courses. Covering extensive subject areas in fetal monitoring training and maternity crisis management the Perinatal Training Programme teaching material is broad and deep. As well as CTG interpretation and labour management, it also covers physiology, underlying intrapartum fetal monitoring and perinatal asphyxia. Topics also include, amongst others, shoulder dystocia, pre-eclampsia and maternal haemorrhage and so, with real cases presented to teach by example, the Perinatal Training Programme provides users with the complete learning experience.

- PRactical Obstetric Multi-Professional Training

  PROMPT (PRactical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working

- Human factors training

  Human Factors training in healthcare enhances clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour in clinical settings. The training equips participants with a set of non-technical skills that complement technical competency and include teamwork, situation awareness, decision making, communication and workload management.

  Healthcare staff need to recognise that human error is inevitable and that cooperative and collaborative teams are the greatest asset to achieving safety and high reliability in complex and hazardous work environments. The training provides participants with an in depth understanding of the

human causes of error and thereby develops the ability to take a proactive approach to the avoidance, trapping and mitigating of errors.

- 3rd trimester ultra sound scanning training surveillance

  To provide provision for women with reduce fetal movements to have increased surveillance in line with RCOG guidance, further improving outcomes and reducing still births.

Overview of cancer services

The National Cancer Peer Review Process has been undertaken annually for many years. This year the process has changed slightly to align with other reviews of specialist services which are commissioned directly from NHS England. Quality Surveillance Team (QST) formerly *the National Peer Review Programme***.** This new team and programme have been developed to meet the requirements of the new health care environment and national specialised commissioning directorate. The mission of the QST is to improve the quality and outcomes of clinical services by delivering a sustainable and embedded quality assurance programme for all cancer services and specialised commissioned services within NHS England.

Each cancer site has completed a self-declaration on the new portal and these are available for commissioners to review and seek further assurance where necessary.

Due to the change in process no teams were subject to an internal validation, however the Lead Nurse, Manager supported each team to undertake the self-assessment.

The Team has had a joint external review with Derby Teaching Hospitals NHS Foundation Trust for Cancer of Unknown Primary (CUP) and a separate report is expected.

Self-Declaration Process Results

Site	Cycle	Progress to date	Assessment Result	Issues Identified as Part of Self Declaration
AOS/ Chemotherapy (these 2 sites are in one section now)	SD	Completed	92%	There is a lack of consultant cover for acute oncology ward reviews, to mitigate this risk an oncology specialty doctor is available to complete ward rounds to review acute oncology admitted patients.
Breast	SD	Completed	100%	No issues identified
Head & Neck Locality	SD	Completed	67%	This is a local support team. There is no specialist ward but team provide an outreach service that attend the wards to train staff as and manage tracheostomies at all times, speech and language therapists and dieticians are available.

Site	Cycle	Progress to date	Assessment Result	Issues Identified as Part of Self Declaration
Gynae	SD	Completed	100%	No issues identified
Lung	SD	Completed	50%	The Trust has identified there is no cover for the consultant radiologist who does interventional radiology and no cover for the clinical oncologist. Long-term oncology input is still to be confirmed. They are delays in EGFR results. QST to request information if any progress has been made with these issues
Colorectal	SD	Completed	88%	No comments or risks identified. This lower than 100% score is related to the core team members attendance at MDT
Skin	SD	Completed	83%	This below 100% score is related to MDT attendance by the core members.
Brain/CNS	SD	Completed	0%	Please see Trust response to the additional information request from the QST
Urology	SD	Completed	60%	This less than 100% score is related to attendance at MDT for core members and the lack of cross cover for the Consultant Oncologist. Although we do not meet the required Oncology attendance we have a very good working relationship with the Oncologist which is a significant improvement from the previous year.

Proposed level of assessment for 2017

Trust	Site Name	Service Name	Level of surveillance following annual assessment 2016
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Brain and Central Nervous System (Adult)	Level 2
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Local Lung Cancer Team	Level 2
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Local Urology	Level 1

Trust	Site Name	Service Name	Level of surveillance following annual assessment 2016
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Head and Neck (Adult)	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Gynaecological	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Oesophageal and Gastric (Adult)	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Skin (Adult)	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Chemotherapy (Adult)	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Local Breast Cancer Team	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Specialised Colorectal Services	Level 1
Burton Hospitals NHS Foundation Trust	Queen's Hospital, Burton Upon Trent	Cancer: Head and Neck (Adult)	Level 1

Response to the Questions Raised by the QST following Self Declaration

Risk identified by provider organisation	SSQD alert Yes/No	Issue identified by QST/Commissioners	Trust response required Proposed action to address issue	Trust response required Date for resolution
No lead clinician identified, we are currently working with Derby and Stoke to address this. \nWe do not currently have a documented pathway for clinicians to follow. This will be developed and agreed over the next few months.\nWe do not automatically received information back from the regional Centre and are unaware whether they comply with this element of the measures.\nWe are reliant on Derby and Stoke to provide our neuro service at Burton. We do have a service level agreement with Stoke, but nothing firmly in place at present with Derby.	NO	The Trust has raised multiple risks regarding resources, agreed pathways and feedback from the regional centre. QST to enquire if the trust has made any progress with an action plan to resolve or mitigate the risks raised.	We have closed to 2ww referrals since May 2016. The follow up care for patients is therefore not undettaken currently at Burton. Any incidental findings are escalated to our Acute oncology Nurses who liaise directly with Nottingham (our Supra-Regional Centre) and the MDT outcomes are communicated back to the patient and the relevant team. This therefore mitigates any risk. We have had no Serious Untoward Incidents with regards to this elment of the pathway.	
1. Only one consultant radiologist who does interventional radiology. There is no cover when he is on leave. Escalated through cancer steering group and hospital executives.\n2. Long-term oncology input still to be confirmed. There is no cover at present when clinical oncologist unable to attend MDT. Derby/Burton cancer teams are addressing this issue.\n3.We are unable to get EGFR results in a timely manner. The sample has to be sent to a third laboratory for the ALK testing.	NO	The trust have identified there is no cover for the consultant radiologist who does interventional radiology and no cover for the clinical oncologist. Long-term oncology input is still to be confirmed. They are delays in EGFR results. QST to request information if any progress has been made with these issues	There is now an agreement in place with Derby Teaching Hospitals with regards to providing additional interventional radiology on site from March 2017 seven interventional radiologists will be rotating to the Burton site to cover lists. This is in addition to the interventional radiologist employed by Burton Hospitals.	

Overall Recommendations

Action Plan Update from 2016:

Action	Plan
Continue to roll out eHNA	All sites using eHNA (electronic tool for Holistic Needs Assessment) strengthening processes with each site
Continue to review the provision of chemotherapy and adapt the service to utilize the day unit appropriately	To use the Chemotherapy MDT meeting to ensure progress
Develop the role of the Cancer Steering Group. Improve escalation processes where necessary.	Terms of reference amended to review functionality in November 2016. Cancer escalation meeting now in place chaired by Deputy Chief Operating Officer
Review MDT Function as per audit cycle	Completed
Meet with MDT Leads to establish any concerns/ items for escalation	Completed
Work with radiology to have a long term solution for interventional radiology	Work with radiology to support their development of services. No solution was identified in 2016. It is anticipated a solution will be achieved in 2017 as part of the collaboration with Derby Teaching Hospitals NHS Foundation Trust.

Action Plan 2017

Action	Plan
To Review MDT Co-ordinator function and standardise across sites	Data Manager and Lead Nurse to meet with Operations Managers and Lead Clinicians
Develop further the cancer escalation meetings to improve compliance against targets	Work with Operations Managers to support compliance with cancer targets.

Workforce

Staff Engagement

The results of the Staff Survey have been summarised and presented in the form of 32 Key Findings. These Key Findings are grouped into nine themes as set out in the table below. The overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged. The last 12 months

have been challenging for the Trust and whilst the Trust's staff engagement score fell slightly from 3.87 in 2015 to 3.80, this was average when compared with trusts of a similar type.

Results from annual Staff Survey showing change in performance at the Trust by Key Finding (KF) between 2015 and 2016, and ranking in 2016 compared with all Acute Trusts

Appraisals & support for development	Change since 2015 survey	Ranking compared with all acute trusts in 2016
KF11. % appraised in last 12 months	**No change**	**Highest (best) 20%**
KF12. Quality of appraisals	**No change**	**Below (worse than) average**
KF13. Quality of non-mandatory training, learning or development	**No change**	**Above (better than) average**
Equality & diversity	**Change since 2015 survey**	**Ranking compared with all acute trusts in 2016**
KF20. % experiencing discrimination at work in last 12 months	**No change**	**Lowest (best) 20%**
KF21. **%** believing the organisation provides equal opportunities for career progression/ promotion	**Decrease (worse than)**	**Average**
Errors & incidents	**Change since 2015 survey**	**Ranking compared with all acute trusts in 2016**
KF28. % witnessing potentially harmful errors, near misses or incidents in last month	**No change**	**Lowest (best) 20%**
KF29. % reporting errors, near misses or incidents witnessed in last month	**No change**	**Lowest (worst) 20%**
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	**No change**	**Average**
KF31. Staff confidence and security in reporting unsafe clinical practice	**No change**	**Above (better than) average**
Health and wellbeing	**Change since 2015 survey**	**Ranking compared with all acute trusts in 2016**
KF17. % feeling unwell due to work related stress in last 12 months	**No change**	**Above (worse than) average**
KF18. % attending work in last 3 months despite feeling unwell because they felt pressure	**No change**	**Below (better than) average**
KF19. Organisation and management interest in and action on health and wellbeing	**Decrease (worse than)**	**Below (worse than) average**

Working patterns	Change since 2015 survey	Ranking compared with all acute trusts in 2016
KF15. % satisfied with the opportunities for flexible working patterns	No change	Lowest (worst) 20%
KF16. % working extra hours	No change	Average
Job satisfaction	**Change since 2015 survey**	**Ranking compared with all acute trusts in 2016**
KF1. Staff recommendation of the organisation as a place to work or receive treatment	No change	Below (worse than) average
KF4. Staff motivation at work	No change	Above (better than) average
KF7. % able to contribute towards improvements at work	Decrease (worse than)	Below (worse than) average
KF8. Staff satisfaction with level of responsibility and involvement	Decrease (worse than)	Below (worse than) average
KF9. Effective team working	No change	Average
KF14. Staff satisfaction with resourcing and support	No change	Above (better than) average
Managers	**Change since 2015 survey**	**Ranking compared with all acute trusts in 2016**
KF5. Recognition and value of staff by managers and the organisation	No change	Average
KF6. % reporting good communication between senior management and staff	No change	Below (worse than) average
KF10. Support from immediate managers	No change	Average
Patient care & experience	**Change since 2015 survey**	**Ranking compared with all acute trusts in 2016**
KF2. Staff satisfaction with the quality of work and care they are able to deliver	Decrease (worse than)	Average
KF3. % agreeing that their role makes a difference to patients / service users	No change	Lowest (worst) 20%
KF32. Effective use of patient / service user feedback	No change	Above (better than) average
Violence, harassment & bullying	**Change since 2015 survey**	**Ranking compared with all acute trusts in 2016**
KF22. % experiencing physical violence from patients, relatives or the public in last 12 months	No change	Lowest (best) 20%

Violence, harassment & bullying	Change since 2015 survey	Ranking compared with all acute trusts in 2016
KF23. % experiencing physical violence from staff in last 12 months	**No change**	**Average**
KF24. % reporting most recent experience of violence	**No change**	**Highest (best) 20%**
KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**No change**	**Lowest (best) 20%**
KF26. % experiencing harassment, bullying or abuse from staff in last 12 months	**No change**	**Above (worse than) average**
KF27. % reporting most recent experience of harassment, bullying or abuse	**Increase (better than)**	**Lowest (worst) 20%**

Actions:

Objective	Deliverables	Responsible	Monitoring	Completion Date
Divisions to receive the Trust Wide and divisional report and create and agree proposed actions for improvement	➢ Actions plans presented to Divisional Boards.	Divisional Directors/Associate Director Estates & Facilities	Performance Reviews	31/05/2017
Improving the Quality of Appraisals	➢ Audit to be undertaken on the Quality of Appraisals undertaken (written) ➢ Local Survey of staff satisfaction for this are of work to be completed	Director of HR	People Committee report	31/07/2017

Objective	Deliverables	Responsible	Monitoring	Completion Date
Launch Health & Wellbeing Plan/Strategy	➢ Health & Wellbeing Plan to Trust Board for approval ➢ Communication & Launch of Plan Trust Wide	Director of HR Director of HR/Director of Communications	Trust Board	30/06/2017
To undertake a review of bullying and harassment including reporting	➢ To analyse results and undertake a detailed review of all aspects of bullying and harassment	Director of HR	People Committee report	31/07/2017
Review Equality issues/scores	➢ In line with the Equality Delivery System analyse reports and outcomes to demonstrate progress/actions on the equality agenda.	Public and Patient Engagement Team?	People Committee report	30/09/2017

The NHS Constitution and in particular the four Staff Pledges, is at the heart of the Workforce Strategy. It is recognised that having a highly motivated workforce will have a significant impact on achieving the high quality care that patients require.

The last 12 months has continued to be a very challenging environment for the Trust but despite this we have seen staff satisfaction levels improve in a number of areas related to the Staff Pledges. The Trust is confident that this will give us a platform to continue to make improvements in 2016.

Staff Pledge 1 The NHS commits to provide all staff with clear roles and responsibilities and rewarding jobs for the teams and individuals that make a difference to patients, their families and carers and communities.

Staff Pledge 2 The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.

Staff Pledge 3 The NHS commits to provide support and opportunities for staff to maintain their health, wellbeing and safety.

Staff Pledge 4 The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local

partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

Some of the highlights from the survey relating to these pledges are detailed in the tables on the following pages.

Development of the workforce

The Trust is committed to ensuring that our workforce undertakes the essential safety training required for their roles. Staff can access their essential training either via e-learning or classroom sessions. Almost 40% of our training is completed through e-learning modules all of which include competency based assessment tests.

Following some changes to staff requirements in April 2016, where statutory and mandatory training compliance dipped to 88%, we have seen Trust compliance recover to 90% in June 2016 and remain consistently at or above this level.

The Trust have been committed to the West Midlands Streamlining project for around the last two years. As more organisations have come on-board over this time we are now beginning to realise the benefits of the project as CSTF (Core Skills Training Framework) competencies are now being transferred electronically between Trusts, thus reducing the amount of statutory and mandatory training new starters need to undertake on joining the Trust.

A considerable amount of work has gone into developing our own internal talent pool over the last twelve months, including amending our appraisal paperwork to capture talent rating and staff readiness to progress. As we commence the appraisal season in 2017 we will also be capturing these ratings centrally in ESR for the first time to enable central reporting. Another key part of this project has been to compile a compendium of career profiles for all of our band 8 and above managers. This has enabled us to not only more fully understand the development needs and career aspirations of our top talent but it has also helped us to identify our business critical posts and will enable us to develop robust succession plans for these roles moving forward.

Work continues around the Talent for Care national strategic framework. There have been significant interactions with local schools to engage with students to promote the NHS as an employer. Events and engagement activities have been supported by our local NHS Ambassadors from across the Trust.

A workforce and organisation development plan has been produced; this plan outlines workforce priorities for the next 14 months. This plan draws together the key programmes that the Trust does to attract, retain, support, develop, engage and reward its people to meet its priorities in a financially sustainable manner.

Student placements

In 2016/17 the Trust achieved all the key performance indicators within the Learning and Development Agreement with Health Education England for quality

placement provision for students. During this time frame pre-registration healthcare students attended a total of 17,683 placement days.

The Trust continues to be successful in recruiting new registrants. A large proportion of these have graduated from Wolverhampton University, our onsite provider. Additionally, we have also recruited from other universities. Between April 2016-17, 34 newly appointed nurses commenced our innovative and robust new preceptorship programme.

We currently support 28 seconded students in a variety of disciplines including nursing, midwifery, pharmacy and occupational therapy. During 2016-17 6 of these have successfully completed their secondments.

Burton Hospitals, in collaboration with nine practice partners and the University of Wolverhampton have been chosen by Health Education England to run a trainee nursing associate “trailblazer” project. As a result, we have 5 trainee nursing associates who commenced a 2 year programme in January 2017.

Leadership

The Leadership and Management Framework launched in April 2014 is now fully embedded within the Trust and a twelve month plan of leadership programmes and short management courses is available to staff. We have seen many success stories resulting from our leadership programmes over the last couple of years as staff have developed in their careers and progressed onto new roles both within the Trust and to other NHS organisations.

A key current focus is building our internal coaching capability within the Trust and we will be running our second internal cohort in the second half of 2017.

The Environment

Orthopaedic ward block upgrade, of Wards 19, 20 and areas of Ward 30

As part of our ongoing improvement plan and in light of the Patient-Led Assessments of the Care Environment (PLACE) scores the ward block is undergoing a refurbishment scheme. This includes replacement flooring and new ceiling including heating, ventilation and lighting. The upgraded systems will help increase the efficiency of the services within the building and lower running costs. The new décor and lighting scheme provides a more modern feel to the clinical areas and coupled with the additional hand rails and dementia friendly considerations will enhance the overall patient experience.

Catering developments

Following the catering improvement suggestions stemming from the action plans of the PLACE audit, we are delighted to share that we have started a development plan to move the main ward areas over to a bulk service for food provided to the patient, this was trialled last year and those areas gave the highest PLACE scores for delivery to the bedside.

LED lighting replacement schemes

With the previous few years the Trust is still continuing to drive energy efficiency and reduce its carbon emissions, the Trust is still working through a scheme of replacing old fluorescent, sodium and mercury lighting and external with new efficient LED solutions. This is being done throughout the corridors and within departments and specific areas as they are refurbished, also a large scheme has seen all the external lighting replaced giving increased light output, improving safety for patients, visitors and staff, as well as providing energy savings.

Mental health assessment room

Following on from the CQC recommendations we have now created a Mental Health Assessment room within our emergency care pathway, this will allow a space for a patient to be assessed and as such receive the right level of care in a timely manner.

Ward 14 bay refurbishment

During the ward moves towards the later part of the last year, the capacity was increased in one of the ward 14 bays. This went from 4 beds to 6, and at the same time enabled the opportunity to refurbish the area to fall in line with modern needs, this in turn creates a better feel for both patients and staff using this area.

Creation of a new SAU

Part of the improvement to the patient journey through the hospital a new Surgical Admissions Unit has been created, providing a pleasant and modern environment for the patients as they enter the hospital.

Fire safety improvements

As usual we still strive towards compliance, and once again heavy investment has been apportioned towards fire safety, including new upgraded fire systems at the main Queens's site, and large improvements to fire stopping and compartmentation across the estates. The Trust 5 year emergency lighting scheme is well underway and the following financial year should see completion of the main site patients areas, this adds to patient safety bring the patient spaces up to statuary standards.

Nutrition

In last year's update we set out our aims to focus on five main work streams:

1. Procurement and Production
2. Changes to our patient feeding system
3. Automation of process
4. Increased commerciality
5. Catering presence at ward level

Nutrition is integrated in many aspects of the catering decision making process and with the employment, in July 2016, of a Catering Dietician.

Progress in the five work streams this year has been;

1 Procurement and Production. All new products purchased are vetted by the dietician to establish their nutritional value and in particular for special medical diets. All patient menus are being systematically checked so that any diet menu is fit for purpose.

2 Changes to our Patient Feeding system. In the autumn of 2016 we piloted a different feeding system. The service replaced the pre-plated one with a ward based service from a hostess trolley, giving advantages in providing a choice at service time, different portion sizes and a better presentation of the food with catering staff involved in this service. This, as expected, has proved very popular resulting in patients eating better resulting in better nutrition.

This coming spring and summer will see a further seven wards transfer onto this new style of service, after which we will switch attention on to the remaining patient feeding areas and develop their new service delivery.

3 Automation of process. With the appointment of the Catering Dietician we have worked on the link between the catering costing programme and the nutrition data base and have a better understanding how this works. This allows us to analysis dishes better and produce nutritional data for retail labels.

Work has begun on improving our patient meal ordering method. Currently we collect patient choices through scanning menus but with changes to the service delivery and the requirement of patients to make a choice up to 24 hours prior to the meal changes are required.

4 Increased commerciality. With the increasing pressure of external produce price rises and the need to keep within financial boundaries the retail catering operation has to take every opportunity. Catering does however have a part in the wellbeing of staff and visitors through these outlets by offering a healthier range of products.
In April 2016 we began by setting some differentials in product prices, change some promotions and the product mix in some vending machines. This coming year we are removing most of the high sugar drinks and continuing to widen price differentials of high fat dishes.

5 Catering presence at ward level. With the introduction of the new service to many of the wards we aim to build up relationships between staff that regularly service particular wards and their individual needs. This will develop over the next two years are working practices change and individual working times are adjusted to the service needs. By doing this we will be able to build teams that are more responsive to the wards and patients' needs and subsequently provide good nutrition.

Catering is going through a number of changes in its production work area, patient and retail services. Nutrition and the standards of nutrition provided by these areas of catering are most important in both patient recovery and the wellbeing of staff and visitors. Alongside other factors such as finance we continue to improve nutrition in all areas.

Operational Plan 2017/18 & 18/19

The Trust developed its two year Operational Plan. The development of the plan followed a formal planning methodology and describes an organisation which 'supports local communities with excellent healthcare when they need it most' with an ambition to 'be the best, every patient every time'.

The key objectives as laid out in the plan are to ensure that the Trust is financially and clinically sustainable, with plans to ensure that the Financial Control total is met and that plans for collaboration with Derby Teaching Hospitals Foundation Trust (DTHFT) are explored in detail, with a focus on delivering the best clinical pathways for our patients. The Operational Plan also explains how he trust will play an active role in the development of the Staffordshire Sustainability and Transformation Plan (SSTP) and ensure that the Trust is able to meet key operational standards such as the ED 4 hour, Cancer and the 18 week Referral to Treatment (RTT) standards.

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

BHFT Quality Account 2016/17
Statement from East Staffordshire CCG on behalf of all South Staffordshire CCGs and Southern Derbyshire CCG.

Priorities for 2016/17

Priority 1 – To reduce pressure ulcers
Priority 2 – Decrease healthcare catheter associated urinary tract infections
Priority 3 – Improved communications with staff/patients

The CCG is pleased to see the positive improvements already achieved across all priority areas for last year and welcomes plans for next steps. In particular, the initiatives in place in respect of patient leaders, accessible information and communication initiatives are to be commended.

Priorities for 2017/18

1. **Frailty**
   Work already underway at the Trust is reported to the CCG's Clinical Quality Review Meeting with the Trust. The CCG looks forward to receiving further reports on progress and notes actions planned will have a positive impact.
2. **Implementation of Adapted Ward Assurance Tool**
   The Trust provides good rationale for adapting the existing tool and the proposed actions are reasonable to ensure the new tool is effective.
3. **Improving Discharge**
   CCG is aware the Trust has been working in partnership with Virgin Care to reduce admissions and is pleased to see this as a priority area for 2017/18 and looks forward to seeing outcomes in due course. The CCG is also aware of the improvements made at the Trust to ensure discharge letters are received by GPs in a timely manner.

Quality Overview

- The CCG is encouraged by the collaboration between Burton Hospital Foundation Trust and Derby Teaching Hospital Foundation Trust and looks forward to continued progress.
- The trust is to be commended for its commitment to clinical audit and its participation in clinical research.
- The CCG notes the trust's current CQC rating is "Requires Improvement" at the Queen's site. Both Sir Robert Peel and Samuel Johnson Hospitals are rated as "Good". In November 2016 the Trust undertook a "mock" CQC inspection, supported by the CCG and other stakeholders. The outcome from this inspection was very positive.
- CCG acknowledges the challenges faced by the trust in respect of achieving the 4 hour target in A&E and the improvements made following the transformational work that has been undertaken in partnership with Virgin Care. The Trust has reconfigured the emergency pathway to rationalise admissions by introducing

initiatives such as the Surgical Assessment Unit and Paediatric Assessment Unit, which have streamlined admissions to the wards.

- The two week wait for patients with suspected breast cancer has not been achieved and work is ongoing between the Trust and Commissioners to improve performance.
- The Trust has been subjected to a number of Contract Performance Notices where they have failed both national and local quality measures. Remedial Action Plans have been submitted to the Commissioner and both organisations have worked together to achieve a satisfactory resolution.
- The CCG is aware of the SHMI and HSMR scores and the work of the Mortality Assurance Group. The CCG welcomes the openness of the trust and regular discussions about mortality are held at Clinical Quality Review meetings.
- The trust is continuing to perform well in respect of Healthcare Associated Infections and has low C.difficile rates against set targets. The improvements planned for the coming year are acknowledged.
- CCG welcomes the appointment of Medication Safety Officer and acknowledges the significant number of actions already taken to improve medication safety.
- The CCG appreciates that falls, as an important area of patient safety, has been the subject of close scrutiny and that the Trust is taking the opportunity to take part in the National Falls Audit in 2017. We look forward to seeing the results in due course.
- The CCG recognises that the trust is an open reporter of incidents and works to ensure that all areas of their business report incidents for investigation. However, the Quality Account for 2016/17 does not include a report on the number of Never Events reported by the Trust. The CCG also noted this information to be missing last year. The number of Never Events reported in 2017/18 is four. In addition, fourteen local avoidable events (which are managed in the same way as never events) were reported. All but one related to patients being sent home with a cannula in situ that was no longer needed. One was a fall from a trolley.
- During the year the Trust reported a number of serious incidents with the same theme. A focussed piece of work was commissioned by the CCG and has led to improvements at the Trust.
- As suggested in 2015/16, the Quality Account would benefit from including a summary of lessons learned and improvements made in respect of quality and safety. This could include learning from patient feedback, complaints, compliments, incidents and PALS contacts.
- The CCG notes the steps taken by the trust to gain feedback from patients and the efforts to improve scores month on month.
- The Trust continues to report all episodes where they have been unable to offer same sex accommodation, all of which occur in high dependency areas, and are recognised as an open and honest reporter. The Trust policy has been shared regionally and nationally as an example of best practice.
- The CCG welcomes the initiatives in place to further improve maternity services such as reconfiguration of services, the community hub and the enhancements to the bereavement service. The CCG receives regular reports on the quality of maternity service and is always pleased to see the high level of patient satisfaction. Commissioners also note the Trust has been shortlisted for an Annual Midwifery Award in relation to reducing the stillbirth rate via a proactive approach to managing reduced fetal movements.

- The Trust does not currently employ a nurse qualified in Learning Disability care which has been recognised as a gap. Work is ongoing to secure funding to make an appropriate appointment.
- CCG notes the work undertaken by the trust to develop their workforce. Although they have a number of vacancies across many areas of their business, steps are taken to recruit staff as quickly as possible.
- There have been ongoing issues at the Trust in respect of providing a Neurology Service. Working with Commissioners, the Trust has made significant efforts to provide a service, utilising neighbouring providers where possible. To date this matter has not been resolved.
- Ongoing work is underway in the trust to upgrade and improve the environment.

The CCG continues to enjoy a positive relationship with the trust and notes the Trust is an open and honest reporter. It is anticipated this relationship will continue in the coming year. The CCG has also been encouraged to observe the apparently seamless transition to a new executive team, specifically welcoming the contribution made by the new Chief Nurse in summer 2016. The CCG looks forward to this continuing. The CCG can state that to the best of our knowledge, the data provided by the Trust is accurate.

Healthwatch Staffordshire Response to Burton Hospitals NHS FT Quality Account 2016/17

Introduction

Healthwatch Staffordshire was pleased to have been invited to comment on the Quality Accounts of the Trust and welcomes the detailed and comprehensive report.

Healthwatch Staffordshire has been working closely with the Trust on ensuring strong patient engagement in its collaboration with Derby. We are committed to ensuring that patients are involved in the development of new clinical pathways, and have been pleased with the response of the Trust in taking this forward, although we also know there is more to do in ensuring patients are working with clinicians in developing their plans.

There is significant comment about improvements in communication and engagement within the report. The communication section gives equal standing to complaints and seeking feedback about patient experience and goes on to describe a number of ways in which local feedback is being sought and then acted upon. Indirect and direct reference to the red to green initiative is also clearly demonstrated in relation to feedback and effective outcomes. We welcomed the questions used to gain fuller information about patient experience and the outlined positive evidence.

The clinical and safety areas are really well supported with explanations of the underpinning reason for selection, expectations and the actions the Trust is taking. There are some good examples where the Trust has gone beyond collecting data and has adapted data collection tools to enable more rigorous collection of specific target data they consider to be locally important.

The Trust seems to be involved in a very high number of national clinical audits, outcomes review, confidential enquiries and local internal reviews and we acknowledge the level of resource this must involve. The evidence includes the results and also how changes in practice are being implemented.

We would like to point out that there is little comment about the increase in the number of patients dying as a result of harm and this information would have been helpful.

We praise the high level of mandatory training and the use of ESR to enable central reporting of talent ratings and staff readiness to progress.

Healthwatch Staffordshire is pleased that following a complaint handled through our Complaints Advocacy service, the Trust has put in place a Trust wide training programme on sepsis. This fitted with the Trust's priorities on infection and reducing avoidable harm.

Priorities 2017/18

Healthwatch Staffordshire notes the priorities for the forthcoming year on frailty, ward assurance and improving discharge and welcome these as fitting with the issues that the public raise with us. We urge the Trust to learn from experiences elsewhere, particularly on ward assurance where there is good practice in place within the County, and also to work with patients and carers to understand what works well from their point of view, what are the current barriers and how these can be overcome. Healthwatch Staffordshire stands ready to help the Trust with this patient involvement. We were however unsure about the outcomes the Trust plans to measure for the frailty priority.

Conclusion

Healthwatch Staffordshire looks forward to having the opportunity to review the 2017/18 Quality Account next year and particularly to be able to assess how the quality initiatives have impacted on the Trust's staff and the residents of Staffordshire.

Annex 2: Statement of Directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    - Board minutes for the period 1 April 2016 to 24 May 2017;
    - Papers relating to quality reported to the Board over the period 1 April 2016 to 24 May 2017;
    - Feedback from Commissioners dated 12/05/2017;
    - Feedback from the Governors dated 12/05/2017
    - Feedback from local Healthwatch organisations dated 15/05/2017
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2015;
    - The 2016 national patient survey 30/03/2017;
    - The 2016 national staff survey 07/03/2017;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 17th May 2017;
    - Care Quality Commission Quality Report dated 22/10/2015;

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

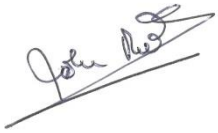
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

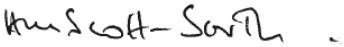
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts

regulations) as well as the standards to support data quality for the preparation of the Quality

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board





John Rivers
Chairman

Helen Scott-South
Chief Executive

Annex 3: Independent auditor's limited assurance report to the Council of Governors of Burton Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Burton Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of Burton Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and additional supporting guidance in the 'Detailed requirements for quality reports for foundation trusts 2016/17' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period, in section 2.3;
- waiting times in A&E (% under 4 hours), in section 2.3

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2016 to 24 May 2017;
- papers relating to quality reported to the Board over the period 1 April 2016 to 24 May 2017;
- feedback from Commissioners dated 12/05/17;
- feedback from Governors dated 12/05/17;
- feedback from local Healthwatch organisations dated 15/05/17
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2015;
- the 2016 national patient survey dated 30/03/2017;
- the 2016 national staff survey dated 07/03/17;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 17/05/2017; and
- any other information obtained during our limited assurance engagement.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Burton Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Burton Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Burton Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance to the categories reported in the Quality Report; 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 which can result in materially

different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Burton Hospitals NHS Foundation Trust.

Our audit work on the financial statements of Burton Hospitals NHS Foundation Trust is carried out in accordance with our statutory obligations 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 Burton Hospitals NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Burton Hospitals NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Burton Hospitals NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Burton Hospitals NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Burton Hospitals NHS Foundation Trust and Burton Hospitals NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the work described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
Birmingham
25 May 2017

Annual Accounts 2016 - 2017

Foreward to the Accounts

Financial statements for Burton Hospitals NHS Foundation Trust for the period ending 31st March 2017.

These accounts for the period ended 31st March 2017 have been prepared by Burton Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Independent auditor's report to the Council of Governors of Burton Hospitals NHS Foundation Trust

Our opinion on the financial statements is unmodified

In our opinion:

- the financial statements give a true and fair view of the financial position of the Burton Hospitals NHS Foundation Trust (the Trust) as at 31 March 2017 and of its expenditure and income for the year then ended; and
- the financial statements have been prepared properly in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2016/2017 and the requirements of the National Health Service Act 2006.

Emphasis of matter – Going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1.29 to the financial statements concerning the Trust's ability to continue as a going concern. The Trust incurred a deficit of £8,197,000 during the year ended 31 March 2017 and at that date had net current assets of £1,018,000. The Directors are seeking additional support from NHS Improvement for 2017/18 and 2018/19 of £9,700,000 and £33,800,000 respectively. As disclosed in note 1.29 to the financial statements, this support has not, at the date of the Trust's signing of these financial statements, been confirmed. These conditions, along with the other matters explained in note 1.29 to the financial statements indicate the existence of a material uncertainty, which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

What we have audited

We have audited the financial statements of Burton Hospitals NHS Foundation Trust for the year ended 31 March 2017 which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers' equity, the Statement of Cash Flows and the related notes.

The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2016/17.

Overview of our audit approach

- Overall materiality: £3,639,000, which represents 1.8% of the Trust's gross operating expenses;
- We performed a full-scope audit of Burton Hospitals NHS Foundation Trust
- Key audit risks were identified as:
    - Valuation of income from patient care activities and existence of associated receivables
    - Going concern material uncertainty disclosures

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that, in our judgement, had the greatest effect on our audit and how we tailored our procedures to address these risks in order to provide an opinion on the financial statements as a whole. This is not a complete list of all the risks we identified:

Audit risk	How we responded to the risk
Valuation of income from patient care activities and existence of associated receivables The Trust receives 86% of its income from patient care activities from commissioners of healthcare services, (being Clinical Commissioning Groups, NHS England, and Public Health). These contracts include the rates for and level of patient care activity to be undertaken by the Trust. The Trust recognises patient care activity income during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in the contracts with NHS commissioners, are subject to verification and agreement by the NHS commissioners. As such, there is the risk that income of a particular value is recognised for these additional services that is not subsequently agreed to by the NHS commissioners. We, therefore, identified the valuation of income from patient care activities and the existence of associated receivables as a significant risk requiring special audit consideration.	Our audit work included, but was not restricted to: • gaining an understanding of the Trust's system for accounting for income from patient care activities and evaluating the design of the associated controls; • evaluating the Trust's accounting policy for recognition of income from patient care activities for appropriateness; • agreeing, on a sample basis, income from patient activities to signed contracts and contract adjustments; • obtaining an exception report from the Department of Health (DoH) that details differences in reported income and expenditure; and receivables and payables between NHS bodies; agreeing the figures in the exception report to the Trust's financial records; and for differences calculated by the DoH as being in excess of £100,000, obtaining corroborating evidence to support the amount recorded in the financial statements by the Trust; • evaluating, on a sample basis, aged debtors to assess likelihood of debt recoverability including agreeing a sample of receivables to post year end cash receipts The Trust's accounting policy on recognition of income from patient care activities is shown in note 1.4 to the financial statements and related disclosures are included in notes 3 and 22.
Going Concern material uncertainty disclosures The Trust received financial revenue	Our audit work included, but was not restricted to: • determining whether the procedures performed by management for identifying material uncertainties that may

Audit risk	How we responded to the risk
support totalling £12,864,000 during the in 2016/17 financial year. The Trust incurred a £8,197,000 financial deficit in delivering its services in 2016/17 and management anticipates that it may take some time before the Trust income equals or exceeds its expenditure. The Trust will therefore require further working capital loans to pay its expenses in 2017/18 and 2018/19. The source and value of this support/loans has yet to be confirmed. In the prior year, the Foundation Trust Annual Reporting Manual 2015/2016 did not explicitly require disclosure in the financial statements of material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern. In the current year, the Department of Health Group Accounting Manual 2016/17 explicitly requires these disclosures. Given the sensitive nature and the updated requirements specifically requiring these disclosures in the financial statements, we have identified this as an area of focus in our audit. We therefore identified financial support and its impact on the going concern disclosures as a significant risk requiring special audit consideration.	cast significant doubt on the Trust's ability to continue as a going concern were appropriate; • assessing the appropriateness of the assumptions and judgements underpinning the cash-flow forecasts used by management to assess the existence of material uncertainties relating to going concern • verifying that the disclosures within the financial statements explaining the material uncertainty that casts significant doubt on the Trust's ability to continue as a going concern are appropriate and accurately explain the events and conditions that gave rise to the uncertainty and the assumptions and judgements made by management in its assessment; and • verifying that the disclosures within the financial statements comply with the reporting requirements detailed in Department of Health Group Accounting Manual 2016/17. The Trust's accounting policy in respect of the going concern basis of preparation is shown in note 1.29 to the financial statements.

Our application of materiality and an overview of the scope of our audit

Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

We determined materiality for the audit of the Trust's financial statements as a whole to be £3,639,000, which is 1.8% of the Trust's gross operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding.

Materiality for the current year is lower than the level we determined for the year ended 31 March 2016 to reflect our view that the deficit position in the year and borrowings level of the Trust at the year-end had a significant effect on the Trust and its environment.

We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 75% of financial statement materiality for the audit of the financial statements. We also determined a lower level of specific materiality for certain areas such as disclosures of senior manager salaries and allowances in the Remuneration Report and related parties.

We determined the threshold at which we will communicate misstatements to the Audit Committee to be £182,000. In addition we will communicate misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Chief Executive as Accounting Officer; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

We conducted our audit in accordance with International Standards on Auditing (ISAs) (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of financial statements of public sector bodies in the United Kingdom'. Our responsibilities under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code) and those standards are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

We are independent of the Trust in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based, and in particular included an interim visit to evaluate the Trust's internal control relevant to the audit including relevant IT systems and controls over key financial systems.

Overview of the scope of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2016, as to whether 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 these criteria as that necessary for us to consider under the Code 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 2017, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code. Based on our risk assessment, we undertook such work as we considered necessary.

Other reporting required by regulations

Our opinion on other matters required by the Code

Our opinion on the Remuneration Report is modified

In our opinion the part of the Remuneration Report subject to audit does not include required pension related benefits disclosures within the Senior Manager Disclosure – Remuneration table and it does not include required pension benefits disclosures in the Pensions Benefits table. Except for these disclosures, in our opinion, the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2016/17 and the requirements of the National Health Service Act 2006.

Our opinion on the other information published in the annual report is unmodified

In our opinion the other information published together with the audited financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the audited financial statements.

Matters on which we are required to report by exception

Under the ISAs (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to report to you if:

- we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the annual report is fair, balanced and understandable; or
- the annual report does not appropriately disclose those matters that we communicated to the Audit Committee which we consider should have been disclosed.

Under the Code we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2016/17 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; or
- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in respect of the above matters.

Responsibilities for the financial statements and the audit

What the Chief Executive, as Accounting Officer, is responsible for:
As explained more fully in the Statement of Accounting Officer's Responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2016/17 and for being satisfied that they give a true and fair view. The Accounting Officer is also responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

What we are responsible for:
Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

We are required under Section 1 of Schedule 10 of the National Health Service Act 2006 to satisfy ourselves 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.

Certificate

We certify that we have completed the audit of the financial statements of Burton Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code.

MARK STOCKS

Mark Stocks
Partner
for and on behalf of Grant Thornton UK LLP

The Colmore Building
20 Colmore Circus
Birmingham
West Midlands
B4 6AT
25 May 2017

Accounting Policies

1.1 Basis of Preparation of Accounts

These accounts have been produced on a going concern basis in accordance with International Financial Reporting Standards and the Department of Health Group Accounting Manual.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of Plant, Property and Equipment, Intangible assets, inventories and certain financial assets and financial liabilities at their value to the business by reference to their current costs.

1.3 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.4 Income Recognition

Income is accounted for by applying the accruals convention. The main source of income for the Trust is from commissioners (Clinical Commissioning Groups and NHS England) in respect of healthcare services provided under local agreements. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material considerations of sale have been met, and is measured as the sums due under the sale contract.

Interest revenue is accrued on a timely basis, by reference to the principal outstanding and interest rate applicable.

Revenue relating to patient spells that are part completed at the year end are apportioned across financial years.

1.5 Expenditure

Expenditure is accounted for by applying the accruals convention.

1.6 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Property, Plant and Equipment:

In accordance with International Financial Reporting Standards a valuation of Property, Plant and Equipment was carried out in March 2010 using the Modern Equivalent Asset valuation basis. The Trust appointed professional valuation experts GVA Grimley to carry out this exercise. A further valuation was carried out at 31st March 2017 in accordance with the Trust Policy of annual revaluations on a rolling basis.

Going Concern
In accordance with International Accounting Standard 1 the Directors of the Trust have assessed whether the Trust is a 'going concern'. In concluding that the Trust is a 'going concern' the Board of Directors have considered the Trust's overall financial position and expectation of future financial support. In the context of IAS 1(which assumes the anticipated continuation of non-trading entities in the public sector) and confirmation of continuing cash support from the Trust Development Authority the Board of Directors has concluded that the Trust is a going concern. See additional disclosure at Note 1.29.

1.7 Key sources of estimation uncertainty
The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property, Plant and Equipment:
In accordance with International Financial Reporting Standards a valuation of Property, Plant and Equipment was carried out in March 2010 using the Modern Equivalent Asset Valuation. Professional valuers GVA Grimley were appointed to carry out the valuation. Key assumptions used for the valuation included:

i. Where appropriate buildings were valued based on the alternative site basis
ii. Anticipated building and plant "lives" were based on the Trust's current strategic plans for its estate.
iii. Equipment was valued based on depreciated replacement cost using estimated lives appropriate to the nature of the equipment

A further revaluation was carried out at 31 March 2017 as part of the routine programme of establishing current valuations as set out in Trust Policy.

In addition the Trust has recognised a number of assets used by external service management contracts as being assets embedded under a Finance Lease. The value of these assets has been estimated and appropriate disclosures are contained in Notes 18.2 and 28.

Provisions
Provisions disclosed in Note 29 are based on reasonable accounting estimates of future costs.

Finance Leases
Where the Trust has recognised embedded Finance Leases in respect of assets supplied under a managed service contract these are valued based on estimates or actual costs as supplied by the service provider.

1.8 Employee Benefits
Pension Costs
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution

scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

1.9 Intangible non-current assets

Recognition

Intangible non-current assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Valuation and Depreciation

Intangible non current assets held for operational use are valued at historical cost and are amortised over the estimated life of the asset on a straight line basis. The only intangible assets currently recognised in the Trust's accounts are computer software systems.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives.

1.10 Property, Plant and Equipment

Recognition

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Subsequent additional expenditure on PPE is recognised if the value of that expenditure also exceeds the recognition threshold.

Valuation

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value as at 31st March 2017. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of Financial Position date. Fair values are determined as follows:

Land and buildings – these are valued based on the anticipated lives within the Trust's current Estates Strategy. Additionally the alternative site valuation method was used where appropriate.

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Increases arising on revaluation are taken to the revaluation reserve except when it reverses a revaluation decrease for the same asset previously recognised in the Statement of Comprehensive Income, in which case it is credited to the Statement of Comprehensive Income to the extent of the decrease previously charged there. A revaluation decrease is charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the Statement of Comprehensive Income.

Equipment was valued using depreciated historic cost based on the anticipated remaining useful life of the assets.

Depreciation, amortisation and impairments
Land and assets under construction are not depreciated.

Otherwise, depreciation and amortisation are charged on a straight line basis to write off the costs or valuation of tangible and intangible non-current assets, less any residual value, over their estimated useful lives. The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

Tangible current assets are depreciated based on the expected remaining useful life. When arriving at the appropriate lifespan for individual buildings the plans contained within the Trust's Estates Strategy is considered. The Trust's accounting policy on assigning asset lives is:

- Buildings including dwellings - in accordance with advice of professional valuer or 35 years where this is not yet known.
- Plant & machinery - between 5 and 15 years
- Transport equipment 7 years
- Information technology 5 years*
- Furniture & fittings 10 years
- Intangible assets (including Meditech V6 IT system) - up to 15 years

At each Statement of Financial Position date, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the Statement of Comprehensive Income. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to the Statement of Comprehensive Income to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Derecognition
Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met:

* the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
* the sale must be highly probable 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 dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

1.11 Donated assets

Under Department of Health instructions the receipt of donated assets is now shown as a credit to the Statement of Comprehensive Income rather than to a Donated Asset Reserve.

Donated property plant and equipment assets are recognised at their fair value on receipt and are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.12 Government grants

Government grants are grants from government bodies other than funds from NHS bodies or funds awarded by Parliamentary Vote. Revenue grants are treated as deferred income initially and credited to the Statement of Comprehensive Income to match the expenditure to which it relates. Capital grants are credited to the government grant reserve. Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the government grant reserve and, each year, an amount equal to the depreciation charge on the asset is released from the government grant reserve to the Statement of Comprehensive Income. Currently the Trust has no Government granted assets.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

<u>The Trust as lessee</u>

Amounts held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged directly to the Statement of Comprehensive Income.

As at the Statement of Financial Position date the Trust has equipment supplied under the terms of endoscopy, pathology and catheter laboratory classified as a finance leased assets. These have a net valuation as at 31 March 2017 of £1.94 million.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

The Trust as lessor

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

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.14 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable estimate.

1.15 Cash and cash equivalents

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

1.16 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the balance sheet date, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its estimated carrying amount is the present value of those cash flows.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts would be recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

1.17 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to the Statement of Comprehensive Income. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is

disclosed at Note 29 but is not recognised in the NHS Foundation Trusts Accounts.

1.18 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.19 Financial assets

Financial assets are recognised on the Statement of Financial Position when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value plus initial direct costs.

Financial assets are classified into the following categories: financial assets 'at fair value through profit and loss'; 'held to maturity investments'; 'available for sale financial assets', and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

The Trust's financial assets as at 31st March 2017 are disclosed in Note 31.1.

Financial assets at fair value through profit and loss and are assets held for trading
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Statement of Comprehensive Income. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the Statement of Comprehensive Income on de-recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method. The only loan currently recognised by the Trust has arisen as a result of a capitalisation of a finance lease.

Fair value is determined by reference to quoted market prices where possible.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Income to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

The Trust's financial liabilities as at 31st March 2017 are disclosed in Note 31.2.

1.20 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or "other financial liabilities".

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Statement of Comprehensive Income. The net gain or loss incorporates any interest earned on the financial asset.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Statement of Comprehensive Income. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the Statement of Financial Position date.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 33 to the accounts.

1.24 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.25 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

1.26 Corporation Tax

NHS Foundation Trusts are potentially liable to corporation tax in certain circumstances. The Trust has not identified any transactions that are subject to corporation tax in the period covered by these accounts.

1.27 Accounting for Annual Leave

With effect from the 1st April 2007, the Trust elected to recognise in the Statement of Financial Position a creditor in respect of untaken annual leave due to staff. A creditor of £174, 000 has been included in the Statement of Financial Position as at 31st March 2017.

Salaries, wages and employment-related payments 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.

1.28 Consolidation of Charitable Funds

The Burton Hospitals Charitable Fund is controlled by the Burton Hospitals NHS Foundation Trust acting as Corporate Trustee. The estimated net value of the Charity as at 31st March 2017 was £2.09 million. The Trust has taken the decision not to consolidate this within the accounts of the Trust on the grounds of materiality.

1.29 Going Concern

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

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

The Board of Directors has carefully considered the principle of “Going Concern” and the Directors have concluded that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern.

The Trust has recorded operating deficits of £1.8 million in 2013/14, £10.6 million in 2014/15, £17.2 million in 2015/16 and £8.2 million in 2016/17. Consequently the Trust has received financial support, in the form of Working Capital loans from the Department of Health of £38.264 million. The Trust expects to incur a sizeable financial deficit in 2017/18 and anticipates it may be some time before it can achieve financial balance on a sustainable basis. It requires additional revenue support loans of £9.7 million in 2017/18 and is expecting to repay £26.3 million in May 2018, for which it anticipates taking out a further loan. The Directors are seeking additional revenue support from NHS Improvement for 2017/18 of £9.7 million and £33.8 million (including £26.3 million replacement loan) in 2018/19. This working capital loan support has not, as at the date of these accounts, been confirmed.

Although these factors represent material uncertainties that may cast significant doubt about the Trust’s ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the 2016/17 Department of Health Group Accounting Manual the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

The Trust has agreed contracts with its local commissioners for 2017/18 and 2018/19 and services are being commissioned in the same manner as in previous years and there are no discontinued operations. Similarly no decision has been made to transfer services or significantly amend the structure of the organisation at this time*. The Board of Directors also has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health to continue to deliver the full range of mandatory services for the foreseeable future. During the year to 31 March 2017 the Trust received an Interim Working Capital Loan of £12.864 million. Further interim funding is available in 2017/18 and the Trust plans to draw an additional £9.7 million in revenue support and £2.8 million to support strategic capital developments.

The Directors consider that this provides sufficient evidence that the Trust will continue as a going concern for the foreseeable future. The Trust has received significant support in the recent past, has made no decision to request dissolution from the Secretary of State and has no reason to believe that support will not be provided.

* The Trust is currently undertaking a "collaboration" review in conjunction with Derby Teaching Hospitals NHS Foundation Trust. It is possible that this may lead to a merger of the 2 organisations or an acquisition of one by the other during the next financial year. However as at the 31st March 2017, no decision has been reached.

1.30 Contingent Liabilities

Contingent liabilities are not recognised, but are disclosed in note 30, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

1. possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

2. present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.31 Accounting standards that have been issued but have not yet been adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

IFRS 15 Revenue from Contracts with Customers -– Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2017

	Note	Year to 31 March 2017 £000	Year to 31 March 2016 £000
Revenue from patient care activities	3	168,958	165,165
Other operating revenue	5	28,203	19,752
Operating expenses	7	(202,439)	(198,989)
Operating surplus (deficit)		**(5,278)**	**(14,072)**
Investment revenue	14	19	24
Finance costs-Interest charges on finance leases	16	(578)	(376)
Surplus/(deficit) for the financial year		**(5,837)**	**(14,424)**
Dividends payable on Public Dividend Capital		(2,453)	(2,934)
Gains on Disposal of assets		93	119
Retained surplus/(deficit) for the year		**(8,197)**	**(17,239)**
Other Comprehensive Income			
Impairments	18	(642)	(327)
Revaluations	18	1,961	2,465
Total Comprehensive Income/(Expenditure) for the Period		**(6,878)**	**(15,101)**

Notes:

The total comprehensive expense as detailed above is the sum of both the retained deficit and movements on reserves.

STATEMENT OF FINANCIAL POSITION AS AT 31st MARCH 2017

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets			
Intangible assets	17	5,161	4,474
Property, plant and equipment	18	117,034	116,632
Total non-current assets		**122,195**	**121,106**
Current assets			
Inventories	21	4,417	4,113
Trade and other receivables	22	18,191	6,873
Non current assets held for sale		0	486
Cash and cash equivalents	23	4,516	4,954
		27,124	**16,426**
Non-current assets held for sale		**0**	**0**
Total current assets		**27,124**	**16,426**
Total assets			
Current liabilities			
Trade and other payables	25	(24,000)	(17,518)
Borrowings	26	(349)	(258)
Provisions	29	(541)	(1,345)
Other liabilities	27	(1,217)	(1,009)
Net current assets		**1,018**	**(3,704)**
Total assets less current liabilities		**123,213**	**117,402**
Non-current liabilities			
Borrowings	26	(39,781)	(26,963)
Provisions	29	(776)	(905)
Total assets employed		**82,656**	**89,534**
Financed by:			
Taxpayers' equity			
Public dividend capital	SOCiTE	54,591	54,591
Retained earnings	SOCiTE	(17,202)	(9,006)
Revaluation reserve	SOCiTE	45,267	43,949
Total taxpayers' equity		**82,656**	**89,534**

Helen Scott-South
Chief Executive
24th May 2017

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital (PDC)	Retained Earnings	Revaluation Reserve	Total
	£000	£000	£000	£000
Balance 1st April 2016	54,591	(9,006)	43,949	89,534
Changes in taxpayers' equity for period				
Deficit for the financial year	0	(8,197)	0	(8,197)
Transfers in respect of revaluation reserve	0	0	0	0
Net gain/(loss) on revaluation of property, plant and equipment	0	0	1,961	1,961
Impairments	0	0	(642)	(642)
Asset disposals	0	0	0	0
Other Reserve movements	0	0	0	0
Balance at 31 March 2017	**54,591**	**(17,202)**	**45,267**	**82,656**

	Public Dividend Capital (PDC)	Retained Earnings	Revaluation Reserve	Total
	£000	£000	£000	£000
Balance 1st April 2015	54,591	8,229	41,818	104,638
Changes in taxpayers' equity for period PDC received				
Deficit for the financial year	0	(17,239)	0	(17,239)
Transfers in respect of revaluation reserve	0	3	(3)	(0)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	2,465	2,465
Impairments	0	0	(327)	(327)
Asset disposals	0	0	0	0
Other Reserve movements	0	1	(3)	(2)
Balance at 31 March 2016	**54,591**	**(9,006)**	**43,949**	**89,534**

STATEMENT OF CASHFLOWS FOR THE PERIOD ENDING 31 MARCH 2017

	Year to 31 March 2017	Year to 31 March 2016
	£000	£000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	(5,278)	(13,953)
Depreciation and amortisation	6,102	5,763
Impairments	254	1,235
Gains/Loss on Disposal	0	(119)
Non Cash donations credited to income	(70)	(135)
(Increase)/Decrease in Trade and Other Receivables	(11,234)	1,962
(Increase)/Decrease in Inventories	(304)	(261)
Increase/(Decrease) in Trade and Other Payables	5,589	(333)
Increase/(Decrease) in Other Liabilities	208	(18)
Increase/(Decrease) in Provisions	(933)	703
Other Movements	0	0
Net cash generated (used) from operating activities	(5,666)	(5,156)
Cash flows from investing activities		
Interest received	19	24
Purchase of intangible assets	0	0
Purchase of Property, Plant and Equipment	(4,808)	(6,909)
Sales of Property, Plant and Equipment	634	0
Net cash generated from/(used in) investing activities	(4,155)	(6,885)
Cash flows from financing activities		
PDC received	0	0
PDC repaid	0	0
Loans from Department of Health	12,864	33,927
Loans repaid to the Department of Health	0	(14,845)
Other loans repaid	(3)	(5)
Capital element of finance lease rental payments	(528)	(249)
Other Capital receipts	0	10
interest paid	(413)	(241)
Interest element of finance lease	(18)	(29)
PDC Dividend paid	(2,488)	(2,934)
Cash flows from other financing activities	(31)	3
Net cash generated from/(used in) financing activities	9,383	15,637
Increase/(decrease) in cash and cash equivalents	(438)	3,596
Cash and Cash equivalents at 1 April	4,954	1,358
Cash and Cash equivalents at 31 March	4,516	4,954

2 Segmental Analysis

The Trust operates as only one key segment: the provision of healthcare. The principal financial report received by the Trust Board reports the position for the Trust as a single entity.

3 Revenue from Patient Care Activities

	Year to 31 March 17 £000	Year to 31 March 16 £000
CCGs/NHS England/Public Health	138,719	162,230
Non NHS:		
Local Authorities	895	937
Private Patients	958	1,012
Overseas patients (non reciprocal)	24	26
Injury cost recovery	942	816
Other*	27,420	144
	168,958	165,165

Road Traffic Act income under the Injury Cost Recovery Scheme is subject to an impairment provision of 22.94% to reflect the expected rates of collection. Additional impairments of RTA income were also recognised where the age of the debt was significant.

*Other income includes £27 million from Virgin Healthcare that was previously contracted by East Staffordshire Clinical Commissioning Group.

3.1 Mandatory and non-mandatory split of income

Of the total income from activities £168 million is mandatory and £1 million is non-mandatory income.

4 Private patient cap

The private patient cap as previously enforced under Section 44 of the 2006 NHS Act has been withdrawn and therefore the Trust will no longer report on this.

5 Other operating revenue

	Year to 31 March 17 £000	Year to 31 March 16 £000
Education and Training	6,740	6,755
Research and Development	67	83
Charitable and other contributions to expenditure	71	135
Non-patient care services to other bodies	6,609	5,686
Sustainability and Transformation Fund	7,549	0
Other income	7,167	7,093
	28,203	19,752

Other income includes

Car parking	1,413	1,385
Estates recharges	157	146
Pharmacy sales	2,908	3,201
Staff accommodation rentals	149	143
Staff Benefit Schemes	648	633
Clinical tests	114	114
Clinical excellence awards	76	91
Catering	572	591
Other	1,130	789
	7,167	7,093

6 Revenue

Revenue from Patient Care Activities	168,958	165,165
Other operating revenue	28,203	19,752
	197,161	184,917

7	Operating expenses	Year to 31 March 17 £000	Year to to 31 March 16 £000
	Services From NHS Trusts	5,902	6,695
	Services from other NHS bodies	776	663
	Services from Foundation Trusts	4,055	4,264
	Purchase of Healthcare Non NHS bodies	1,105	288
	Executive directors costs	1,139	1,077
	Non-executive directors costs	116	120
	Staff costs	129,857	127,470
	Drugs	18,231	17,971
	Supplies and services – clinical	11,894	10,968
	Supplies and services – general	2,450	2,419
	Establishment	1,077	1,401
	Transport	405	113
	Premises- Business Rates	910	977
	Premises Other	7,343	6,722
	Provision for impairment of receivables	131	166
	Increase in other provisions	(353)	0
	Changes in the Discount Rate	(64)	0
	Operating Leases	658	686
	Depreciation and amortisation	6,102	5,763
	Impairments and reversals of property, plant and equipment	254	1,235
	Audit fees-Statutory	39	40
	Clinical negligence insurance	3,842	3,284
	Legal Fees	7	1
	Patient's Travel	25	22
	Consultancy Costs	2,085	3,216
	Training and Conferences	478	504
	Car Parking & Security	69	86
	Redundancy	0	8
	Hospitality	9	9
	Insurance	0	9
	Losses and Ex Gratia Payments	50	0
	Loss on Disposal of assets	0	0
	Other*	3,847	2,812
		202,439	198,989

***Other Includes**

Internal Audit Fees	159	140
Subscriptions	359	332
FP10 Dispensing Fees	297	228
Other Contracted Services	957	569
Tests/Screening	179	222
Clinical Waste	245	258
Refuse Collection Non Clinical	110	108
Oxford Fertility Services	130	243
Insurance	172	171
Other	1,239	541
	3,847	2,812

8 Operating leases

8.1 As lessee

The Trust holds short term leases for a number of smaller assets including equipment and vehicles on 2 or 3 year leases.

It also leases equipment and vehicles supplied to staff under Salary Sacrifice arrangements.

	Year to 31 March 17 £000	Year to 31 March 16 £000
Payments recognised as an expense	658	686

Total future minimum lease payments	As at 31 March 17 £000	As at 31 March 16 £000
Within 1 year	534	583
Between one and five years	390	420
	924	1,003

9 Employee costs and numbers

9.1 Employee costs

	Year to 31 March 17 £000	Year to 31 March 16 £000
Salaries and wages	101,119	99,554
Social security costs	9,139	7,143
Agency staff	8,785	10,172
Termination Benefits	0	0
Employer contributions to NHS Pension Scheme	11,953	11,678
	130,996	128,547

9.2 Average number of persons employed

	Year to 31 March 17 Total Number	Year to 31 March 16 Total Number
Medical and dental	300	299
Administration and estates	649	643
Healthcare assistants and other support staff	658	641
Nursing, midwifery and health visiting staff	899	898
Scientific, therapeutic and technical staff	266	269
Bank and agency	239	248
	3,011	2,998

10 Pension Costs Future Contributions

The Trust's estimated employers contribution to the NHS Pensions Scheme for the year ended 31 March 2018 are £11.92 million.

11 Retirements due to ill-health

During the financial year 2016/17 there were 3 (1 in 2015/16) retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of this will be £70,159 (£71,107 2015/16). The cost will be borne by the NHS Pensions Agency.

12 Prior Year Adjustments

There are no prior year adjustments.

13 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust did not pay any interest under the terms of this Act.

14 Investment revenue

	Year to 31 March 17 £000	Year to 31 March 16 £000
Interest Revenue (Bank Accounts)	19	24
Total	19	24

15 Other gains and losses

There were no other gains or losses in 2016/17.

16 Finance Costs

	Year to 31 March 17 £000	Year to 31 March 16 £000
Interest on Loans from Department of Health	542	347
Interest on obligations under finance leases	36	29
Total	578	376

17.1 Intangible Fixed Assets	31 March 17 £000	31 March 16 £000
Gross cost at 1 April	5,400	1,019
	5,400	1,019
Additions - donated	8	10
Reclassifications	1,197	4,382
Disposals	(32)	(11)
Gross cost at 31 March	6,574	5,400
Amortisation at start of period	926	718
	926	718
Provided during the year	518	219
Disposals	(32)	(11)
Amortisation at 31 March	1,412	926
Net book value		
- Purchased at 31 March	5,142	4,456
- Donated at 31 March	19	18
Total at 31 March	5,161	4,474

Reclassifications include items moved from Assets Under Construction.

17.2 Revaluation reserve balance for intangible assets

As at 31 March 2017 the balance on the Revaluation Reserve held no value in respect of intangible assets.

18.1 Property, plant and equipment - for the year to 31 March 17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1.4.16	13,275	93,283	1,944	1,193	18,678	313	12,047	1,933	142,666
Prior Period Adjustments		0	0	0	0	0	0	0	0
Restated as at 1.4.16	13,275	93,283	1,944	1,193	18,678	313	12,047	1,933	142,666
Additions purchased	0	1,228	0	2,381	1,333	0	758	0	5,700
Additions leased	0	0	0	0	397	0	0	0	397
Additions donated	0	0	0	0	59	0	3	0	62
Impairments charged to operating expenses	0	(254)	0	0	0	0	0	0	(254)
Impairments charged to Revaluation Reserve	0	(642)	0	0	0	0	0	0	(642)
Reversal of impairments charged to operating expenses	0	16	(16)	0	0	0	0	0	0
Reversal of impairments charged to revaluation reserve	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	(1,024)	(164)	0	0	(9)	(1,197)
Revaluation	589	1,348	24	0	0	0	0	0	1,961
Transfer to Assets Held for Sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(108)	0	(2,726)	(47)	(2,881)
Cost or Valuation at 31.3.17	13,864	94,979	1,952	2,550	20,195	313	10,082	1,877	145,812
Depreciation at 1.4.16	0	2,753	133	0	12,049	210	9,514	1,375	26,035
Prior Period Adjustments									0
Restated as at 1.4.16	0	2,753	133	0	12,049	210	9,514	1,375	26,035
Charged during the year	0	2,860	72	0	1,579	20	885	168	5,584
Impairments charged to operating expenses	0	(0)	0	0	0	0	0	0	(0)
Impairments charged to Revaluation Reserve	0	0	0	0	0	0	0	0	0

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Reversal of impairments charged to operating expenses	0	0	0	0	0	0	0	0	0
Reversal of impairments charged to revaluation reserve	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(67)	0	(2,726)	(47)	(2,840)
Depreciation at 31.3.17	0	5,613	205	0	13,561	230	7,673	1,496	28,778
Net Book Value									
- Purchased at 1.4.16	13,275	86,805	1,811	1,193	5,208	104	2,523	435	111,352
- Finance Leased at 1.4.16	0	1,221	0	0	618	0	0	38	1,877
- Donated at 1.4.16	0	2,504	0	0	802	0	10	85	3,402
- Total at 1.4.16	13,275	90,530	1,811	1,193	6,629	104	2,533	558	116,632
- Purchased at 31.3.17	13,864	85,817	1,747	2,550	5,237	84	2,409	285	111,992
- Finance Leased at 31.3.17	0	1,149	0	0	756	0	0	30	1,935
- Donated at 31.3.17	0	2,400	0	0	641	0	0	66	3,107
- Total at 31.3.17	13,864	89,366	1,747	2,550	6,634	84	2,409	381	117,034
Asset Financing									
Owned	13,864	88,217	1,747	2,550	5,878	84	2,409	351	115,099
Finance Leased	0	1,149	0	0	756	0	0	30	1,935
	13,864	89,366	1,747	2,550	6,634	84	2,409	381	117,034

Valuation Land, Buildings and Dwellings

An independent professional valuation of the Land, Buildings and Dwellings was carried out by GVA Grimley at 31 March 2017. In accordance with International Financial Reporting Standards a Modern Equivalent Asset methodology was applied and, where appropriate the alternative site basis was used. The estimated useful lives of the relevant assets was calculated in accordance with the Trust's current strategic plans for its estate.

Disposals

During the Year the Trust disposed of, via sale, the Margaret Stanhope Centre building. This was shown in the 31.3.16 accounts as "asset held for sale".

18.1 Cntd **Property, plant and equipment - for the year to 31 March 16**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1.4.15	13,152	90,502	1,776	5,249	20,337	303	11,986	2,184	145,489
Prior Period Adjustments	0	0	0	0	0	0	0	0	0
Restated as at 1.4.15	13,152	90,502	1,776	5,249	20,337	303	11,986	2,184	145,489
Additions purchased	0	2,540	31	317	2,437	59	652	14	6,050
Additions leased	0	0	0	0	0	0	0	0	0
Additions donated	0	93	0	0	28	0	4	0	125
Impairments charged to operating expenses	0	(1,235)	0	0	0	0	0	0	(1,235)
Impairments charged to Revaluation Reserve	0	(327)	0	0	0	0	0	0	(327)
Reversal of impairments charged to operating expenses	0	0	0	0	0	0	0	0	0
Reversal of impairments charged to revaluation reserve	0	(10)	3	(4,373)	(339)	(3)	336	4	(4,382)
Reclassifications	609	1,721	135	0	0	0	0	0	2,465
Revaluation	(486)	0	0	0	0	0	0	0	(486)
Disposals	0	0	0	0	(3,785)	(45)	(931)	(269)	(5,030)
Cost or Valuation at 31.3.16	13,275	93,283	1,944	1,193	18,678	313	12,047	1,933	142,666
Depreciation at 1.4.15	0	(3)	67	0	13,925	232	9,554	1,460	25,235
Prior Period Adjustments	0	0	0	0	0	0	0	0	0
Restated as at 1.4.15	0	(3)	67	0	13,925	232	9,554	1,460	25,235
Transfers by Modified Absorbtion	0	0	0	0	0	0	0	0	0
Charged during the year	0	2,756	66	0	1,625	22	891	184	5,544

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Impairments charged to operating expenses	0	0	0	0	0	0	0	0	0
Impairments charged to Revaluation Reserve	0	0	0	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0	0	0	0
Reversal of impairments charged to revaluation reserve	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(3,501)	(44)	(931)	(269)	(4,744)
Depreciation at 31.3.16	0	2,753	133	0	12,049	210	9,514	1,375	26,035
Net Book Value									
- Purchased at 1.4.15	13,152	86,460	1,709	5,249	4,343	71	2,420	585	113,988
- Finance Leased at 1.4.15	0	1,292	0	0	1,071	0	0	38	2,401
- Donated at 1.4.15	0	2,753	0	0	998	0	12	101	3,864
- Total at 1.4.15	13,152	90,505	1,709	5,249	6,412	71	2,432	724	120,253
- Purchased at 31.3.16	13,275	86,805	1,811	1,193	5,208	104	2,523	435	111,353
- Finance Leased at 31.3.16	0	1,221	0	0	618	0	0	38	1,877
- Donated at 31.3.16	0	2,504	0	0	802	0	10	85	3,402
- Total at 31.3.16	13,275	90,530	1,811	1,193	6,628	104	2,533	558	116,632
Asset Financing									
Owned	13,275	89,309	1,811	1,193	6,010	104	2,533	520	114,755
Finance Leased	0	1,221	0	0	618	0	0	38	1,877
	13,275	90,530	1,811	1,193	6,628	104	2,533	558	116,632

18.2 Net book value of assets held under finance leases 2016/17

	£000
Valuation Gross cost 1.4.16	4,918
Additions during the year	397
Valuation Gross cost 31.3.17	5,315
Depreciation at 1.4.16	3,042
Charged during the year	338
Depreciation at 31.3.17	3,380
Net Book Value as at 31.3.17	1,935

Assets include equipment provided under Endoscopy and Pathology managed service contract and buildings, equipment and fittings provided under a Catheter Laboratory service contract.

18.3 Assets held for sale as at 31.3.17

	£000
Assets held for sale as at 1.4.16	486
Assets sold during the year	(486)
Assets held for sale as at 31.3.17	0

The Margaret Stanhope Centre was sold in March 2017.

19 The net book value of land, buildings and dwellings at 31 March 2017 comprises

	31 March 17 £000	31 March 16 £000
Freehold	103,828	104,395
Long Leasehold	0	0
Short Leasehold	1,149	1,221
	104,977	105,616
Protected assets	0	0
Non-Protected assets	104,977	105,616
	104,977	105,616

20 Capital Commitments

Commitments under capital expenditure contracts at the Statement of Financial Position were:

	31 March 17 £000	31 March 16 £000
Property, plant and equipment	447	267
Intangible assets	9	0
	456	267

21 Inventories

21.1 Inventories

	31 March 17 £000	31 March 16 £000
Drugs	1,380	1,458
Work in Progress	77	30
Consumables	2,909	2,595
Energy	51	30
	4,417	4,113

Work in Progress relates to pharmacy products that are in the process of being manufactured for resale.

21.2 Inventories recognised in expenses

	Year to 31 March 17 £000	Year to 31 March 16 £000
Inventories recognised as an expense in the period	24,003	22,524

22 Trade and other receivables

22.1 Trade and other receivables

	31 March 17 £000	31 March 16 £000
NHS receivables	11,459	3,722
Other receivables from related parties	155	0
Provision for the impairment of receivables	(853)	(843)
Prepayments	1,231	1,015
Accrued income	2,006	1,843
PDC	35	0
Other receivables	4,158	1,136
Total	18,191	6,873

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by government to buy NHS patient care services no credit scoring of them is considered necessary.

22.2 Outstanding receivables not impaired

	31 March 17 £000	31 March 16 £000
By up to three months	15,952	6,704
By three to six months	2,021	483
By more than six months	1,071	529
Total	19,044	7,716

22.3 Provision for impairment of receivables

	31 March 17 £000	31 March 16 £000
Balance at start of period	843	760
Increase in Provision	131	166
Amounts Utilised	(121)	(83)
Balance as at 31 March	853	843

23 Cash and cash equivalents

	31 March 17 £000	31 March 16 £000
Balance at start of period	4,954	1,358
Net change in year	(438)	3,596
Balance at 31 March	4,516	4,954
Made up of		
Cash with Government Banking Service	4,416	4,871
Commercial banks and cash in hand	100	83
Cash and cash equivalents as in Statement of Financial Position per Cashflow	4,516	4,954

As at 31.3.17 the Trust held £2,228 (£2,887 31.3.16) in respect of third party cash.

24 Non current assets held for sale

	31 March 17 £000	31 March 16 £000
Land for sale	0	486

The Land plot incorporating the Margaret Stanhope Centre was sold in March 2017

25 Trade and other payables

	31 March 17 £000	31 March 16 £000
NHS Payables	7,526	2,837
Amounts due to other related parties	5	26
Trade payables - capital	2,617	1,785
Social Security Costs	1,362	1,104
Taxes payable	1,531	1,383
Other payables	7,162	6,139
Accruals	3,796	4,244
	23,999	17,518

26 Borrowings

	Current		Non Current	
	31.3.17 £000	31.3.16 £000	31.3.17 £000	31.3.16 £000
Finance Leases	349	255	1,517	1,563
Working Capital Loans from Department of Health	0	0	38,264	25,400
Other Loans	0	3	0	0
	349	258	39,781	26,963

Notes

1. Working Capital Loan:

The Trust is in receipt of "distressed" Trust funding from the Department of Health.
The net loan is £38.264 million as at 31.3.17. £25.4 million is due for repayment in May 2018, £7.90 million is due in January 2020 and £4.97 million is due in March 2020.
Interest is payable at 1.50% per annum.

2. Other Loans

One item of equipment was purchased by the Trust with the offer of an interest free loan accepted.

27 Other Liabilities

	Current	
	31 March 17	31 March 16
	£000	£000
Deferred Income	1,217	1,009
	1,217	1,009

28 Finance lease obligations

The Trust currently has equipment supplied as part of managed service contracts for endoscopy, pathology and catheter laboratory contracts.

	31 March 17	31 March 16
	£000	£000
Gross Building Lease Liabilities	1,122	1,201
of which Liabilities are due:		
-not later than one year	92	102
-later than one and not later than five years	367	388
-later than 5 years	663	711
Finance charges allocated to future periods	(20)	(17)
Net buildings lease liabilities	1,102	1,184
-not later than one year	90	95
-later than one and not later than five years	361	378
-later than 5 years	651	711
	1,102	1,184

	31 March 17	31 March 16
	£000	£000
Gross Plant and Machinery Lease Liabilities	791	703
of which Liabilities are due:		
-not later than one year	276	185
-later than one and not later than five years	515	513
-later than 5 years	0	5
Finance charges allocated to future periods	(27)	(69)
Net Plant and Machinery lease liabilities	764	634
-not later than one year	259	160
-later than one and not later than five years	505	469
-later than 5 years	0	5
	764	634

29 Provisions

	Current		Non Current	
	31.3.17 £000	31.3.16 £000	31.3.17 £000	31.3.16 £000
Legal claims	59	86	0	0
Other	482	1,259	776	905
	541	1,345	776	905

	Redundancy	Legal Claims	Other	Total
	£000	£000	£000	£000
As at 1.4.16	0	86	2,164	2,250
Arising during the period	0	39	399	438
Change in the Discount Rate	0	0	(64)	(64)
Utilised during the period	0	(26)	(490)	(516)
Reversed unused	0	(40)	(751)	(791)
As at 1.4.2017	0	59	1,258	1,317
Expected timing of cash flows:				
Within one year	0	59	482	541
Between one and five years	0	0	248	248
After five years	0	0	528	528
	0	59	1,258	1,317

"Other" provisions include £0.905 million in respect of Injury Benefit Provisions.
Legal claims are handled by the NHSLA and therefore the net provision is calculated based on the net cost to the Trust arising from the policy excess.

£82 million is included in the provisions of the NHS Litigation Authority at 31st March 2017 in respect of clinical negligence claims against the Trust. (£67.2 million 31 March 2016).

30 Contingencies

30.1 Contingent liabilities

	31.3.17 £000	31.3.16 £000
Legal claims	29	33

The legal claim contingent liabilities recognises the potential cost to the Trust should the actual cost to the Trust exceed the estimate charged to the Statement of Comprehensive income based on guidance issued by the NHS Litigation Authority as the likely outcome.

30.2 Contingent assets

The Trust has no contingent assets.

31 Financial instruments

31.1 Financial assets

	Loans and receivables	Assets held at fair value through the I & E	Total
	£000	£000	£000
Receivables	14,954	0	14,954
Cash at bank and in hand	4,516	0	4,516
Total at 31.3.17	19,470	0	19,470

31.2 Financial liabilities

	Other	Liabilities held at fair value through the I & E	Total
	£000	£000	£000
Finance Leases	1,866	0	1,866
Loans	38,264	0	38,264
Provisions	1,317	0	1,317
Other Financial Liabilites	1,217	0	1,217
Payables	23,999	0	23,999
Total at 31.3.17	66,663	0	66,663

31.3 Maturity of financial liabilities

	31 March 17 £000
In one year or less	26,106
In more than one year but not more than two years	38,677
In more than two years but not more than five years	701
In more than five years	1,179
	66,663

31.4 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust's main borrowings are Interim Working Capital Loans with interest fixed at 1.5%. Other loans are notional bottowings attributable to Finance Leased assets. Therefore the Trust is not subject to interest rate risk.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups , which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its Prudential Borrowing Limit. The Trust is not, therefore, exposed to significant liquidity risks.

Market Risk

The Trust Board routinely monitors the market risks facing the Trust. Financial plans are produced and amended in accordance with changing market conditions.

Risk Management Strategy

The Trust has a detailed risk management strategy to ensure that all risks, financial or otherwise are carefully considered and reported to the Risk and Compliance Group.

32 Related Party Transactions

Burton Hospitals NHS Foundation Trust is a public benefit corporation authorised by NHS Improvement.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Burton Hospitals NHS Foundation Trust

Foundation Trusts are not controlled by the Secretary of State therefore the Trust needs to consider whether government bodies and other NHS organisations are related parties under the terms of IAS 24.

The Department of Health is regarded as a related party. During the year Burton Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent organisation. These include:

	Income £000	Expenditure £000	Receivables £000	Payables £000
Department of Health	39	0	47	163
Burton Hospitals Charitable Funds	0	0	0	5
Other DH Group Bodies	163,166	14,727	11,439	7,361
Other Government	0	0	0	0

Included within "Income" are receipts for services provided to the following organisations:

	£000
East Staffordshire Clinical Commissioning Group	40,073
South East Staffs and Seisden Peninsular Clinical Commissioning Group	44,241
Southern Derbyshire Clinical Commissioning Group	21,518
West Leicestershire Clinical Commissioning Group	13,224
NHS England (for Specialised Services)	20,872
Health Education England (Training & Education)	6,108
Cannock Chase Clinical Commissioning Group	5,768

The Trust takes part in the National Audit Office's annual National Fraud Initiative. This identifies where staff members may hold employment contracts with other organisations. Each case identified is investigated. No material related parties requiring disclosure were identified.

The Trust has also received revenue and capital payments from Burton Hospitals Charitable Fund. The Trust Board also acts as the Corporate Trustee of the Charity.

The Trustees Report and Audited Annual Accounts of the Charitable Fund are contained within a separate document.

33 Third party assets

As at 31 March 2017 the Trust was holding £124 behalf of patients (£242 as at 31 March 2016). Additionally various 3rd party deposits of £2,143 were held (£2,645 as at 31 March 2017).

34 Intra Government Balances

Balances with :	Receivables £000	Receivables due after more than one year £000	Payables due within one year £000	Payables due after more than one year £000
Department of Health	47	0	163	0
Public Health England	0	0	0	0
NHS England & Clinical Commissioning Groups	7,747	0	3,360	0
Health Education England	83		0	0
English NHS Trusts	1,452	0	648	0
Foundation Trusts	2,157	0	3,337	0
Special Health Authorities	0	0	0	0
Receivable from NHS NDBPs	0	0	0	0
Local Government Bodies	155	0	0	0
Other NHS Bodies	0	0	17	0
Other "Whole Government Account" Bodies	7	0	2,894	0
Total Government	11,648	0	10,418	0

35 Losses and Special Payments

	2016/17 Number	2016/17 £000	2015/16 Number	2015/16 £000
Losses				
Cash Losses	7	8	3	0
Bad Debts	822	21	372	20
Damage to Property	0	0	0	0
Total Losses	829	29	375	20
Special Payments				
Compensation Payments	0	0	0	0
Ex Gratia Payments	56	67	63	67
Total Special Payments	56	67	63	67
Total Losses and Special Payments	885	96	438	87

36 Termination Costs

The Trust incurred no termination costs during 2016/17.

37 Off Payroll Costs

As at 31st March the Trust had no persons earning more than £220 per day that are classed as "off payroll" transactions.

During the year the Trust did employ 2 persons who were within this category and took steps to ensure they were correctly paying Income Tax and National Insurance. These persons provided urgent cover as a Consultant Doctor and within Pharmacy respectively.

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