University Hospitals Bristol NHS
NHS Foundation Trust

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

ANNUAL REPORT 2009-10

University Hospitals Bristol Foundation Trust

Annual Report 2009/10

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

ANNUAL REPORT INDEX PAGE NO

1 CHAIRMAN'S STATEMENT

I am delighted to welcome you to the Annual Report for University Hospitals Bristol NHS Foundation Trust for the period 1 April 2009 to 31 March 2010.

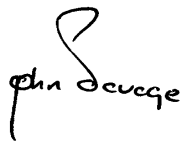
This last year has seen some changes to the Trust and some challenges; but the year ends in a good financial position. As a Board we are acutely aware of the challenges that lie ahead for the NHS, and we remain committed to delivering the very best healthcare possible to the people of Bristol and beyond.

In December, Dr Graham Rich stepped down from his position of Chief Executive. My Board colleagues and I are grateful for Graham's contribution to the work of the Trust.

In June 2009 the magazine Private Eye made public allegations about potential cases of histopathology misdiagnosis at Bristol Royal Infirmary between 2000 and 2008. The position of the Board is that while there is no evidence to suggest a significant diagnostic error rate in our histopathology services, we want to ensure that patients continue to have full confidence in the services we offer. An independent inquiry was launched in September, chaired by Jane Mishcon from Hailsham Chambers, London, and will conclude its work in 2010. The Board will make the findings from the inquiry public, and will ensure any lessons to be learned are fully implemented across the Trust.

The Trust Board welcomed two new Executive Directors, Alison Moon as Chief Nurse, joining us from Yeovil District Hospital NHS Foundation Trust, and Steve Aumayer as Director of Human Resources and Organisational Development, who came to us from COLT, a major European Business Telecoms provider. I am delighted to have such experienced board members, working with our patients and staff. I would like to formally thank Pat Fields and Alex Nestor for acting up into the roles while we were recruiting Alison and Steve, respectively. Sarah Blackburn resigned as a Non-Executive Director at the end of March 2010 and the Governors' Nominations Committee has started the process to appoint a successor.

It has been a year full of challenges, with an increase in activity and changes to the Trust leadership team. I offer my sincere thanks to all members of staff who continue to work hard every day delivering care to patients. I am confident we will continue to innovate and improve, and will become a stronger Trust for the future. Finally, thank you to my fellow board members and to our Foundation Trust Governors and members for offering support and challenge to the Trust's decision-making and ultimately helping to shape hospital care for the people of Bristol and beyond.



John Savage CBE

Chairman

2 CHIEF EXECUTIVE'S FOREWORD

I have been privileged to act as Chief Executive through the last quarter of 2009/10 and I am pleased to report on the Trust's progress in the year.

Business review

By the end of March 2010, we had delivered a financial out-turn £0.916m million better than our plan. We started the new business year in excellent financial health and in a good position to weather future challenges, through maintaining a focus on improving the efficiency of our services.

The Board is clear that improving quality and increasing productivity go hand in hand and that the more efficiently we manage our internal processes, the better our patient care will be. To that end, we have designed and initiated a programme of service redesign called *Making Our Hospitals Better* to spread learning and best practice across the organisation.

2009 saw a major milestone in the Trust's strategic development plans, with completion in May of the new Bristol Heart Institute, a flagship building bringing together the best in skilled staff, innovative technology and ground-breaking research in specialist facilities for the diagnosis and treatment of heart conditions.

We welcomed Her Royal Highness the Princess Royal in October to officially open this award-winning building, which gave us the additional benefit of creating space in the Bristol Royal Infirmary for the transfer of a number of inpatient wards from the 18th century Old Building. Reproviding the old-style wards in the Old Building and the King Edward VII Building remains a key strategic objective of the Board because it will allow us to introduce significantly improved models of care which will give benefits to the quality of our services and to the experience of our emergency patients.

We continued to work closely with our partners in NHS Bristol, North Bristol Trust and in the University of Bristol and University of the West of England to develop our research portfolio. We appointed the first joint Director of Research across the two hospital Trusts in Bristol and held a very successful research and innovation day in March 2010.

Performance against key priorities

The Trust successfully delivered the majority of waiting time standards last year, including the objective to admit, transfer or discharge at least 98% of accident and emergency patients within four hours of arrival.

However, we under-achieved on some standards for patient access to services, notably:

- treatment times for patients with suspected cancer, where, as a tertiary centre, the Trust receives high numbers of referrals;
- the number of cancelled operations, where we did not meet national standards for minimising the number of operations cancelled at last-minute for non-clinical reasons and for readmitting patients whose operations were cancelled within 28 days.

We have robust action plans in place to address the causes of our under-achievement and to deliver to the required standards in 2010/11.

Patient safety and patient experience

In delivering the Board's commitment to limit the harm done to patients through healthcare-acquired infections, the Trust exceeded not only the nationally assigned reduction in cases of Clostridium Difficile and post-48 hour Methicillin-resistant Staphyloccus Aureus but also our local, more challenging "stretch" targets for both infections.

The Trust focuses heavily on patient safety and has participated in the NHS South West Quality and Patient Safety Improvement Programme. Work is being undertaken within the Trust in the following areas – leadership, general ward, critical care, peri-operative care and medicines management.

Looking ahead

While the new coalition Government has committed to maintain real terms funding growth for the NHS, there will inevitably be pressure to reduce costs at the same time as meeting increased patient expectations and the needs of an ageing population.

Contractual changes in 2010/11 mean the Trust will suffer financially if it does not – working with partners across the health system – successfully manage both elective and emergency activity to the levels set by our NHS commissioners, while delivering services to the required standards. Therefore in 2010/11, the Trust will both continue to improve clinical outcomes and the experience and safety of patients, and focus on:

- operating at maximum efficiency to keep costs down and secure best value of the taxpayer; and
- delivering additional recurring savings, especially through productivity improvements.

Through our *Making Our Hospitals Better* programme, we aim to assist wards and departments to make fundamental changes to the way we provide services, building on a range of productive ward, productive theatre and patient safety initiatives.

At the same time, we expect to bring forward detailed plans for the future Centralisation of Specialist Paediatric Services in Bristol and for redeveloping the Bristol Royal Infirmary, not simply to close old-fashioned ward accommodation but to introduce a configuration of departments and services which will ensure the best quality of care for hospital patients in future generations.

Our ambitions for the future are supported by the dedication of more than 7,500 staff and 11,000 patient and public Foundation Trust members, as well as the goodwill of our many charitable partners, including Above & Beyond and the Grand Appeal, and our wider stakeholders, including our health community colleagues across Bristol and the South West, to whom I give all thanks.

Robert Woolley, Acting Chief Executive

DIRECTORS' REPORT

3 ABOUT OUR PERFORMANCE IN 2009/10

Performance against the Quality of Services assessment during 2009/10

The Trust continued to perform well against most of the national targets, with performance improving in a number of key areas compared with the previous year.

The Trust achieved the A&E four-hour emergency access target and the target level of reduction in Methicillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemias during the year. Fewer operations were cancelled at the last minute for non-clinical reasons than in 2008/09, although the national standard for this target was not achieved.

Performance against the existing and new cancer standards improved significantly in the last quarter of the year, but was not sufficient to achieve the required standard for the year as a whole.

Key national performance targets

Performance standard	Target	Expected Score 2009/10	Confirmed score 2008/09
A&E four-hour emergency access	98.0%	Achieved	Under-achieved
MRSA bacteraemias	Target level of reduction met	Achieved	Under-achieved
Clostridium difficile infections	Target level of reduction met	Achieved	Achieved
Last-minute cancelled operations Re-admission within 28-day following cancellation	0.8% of admissions 95% readmitted	Under-achieved	Under-achieved
Cancer two-week wait (urgent GP referral)	93%	Achieved	Achieved
Cancer 31-day wait diagnosis to treatment	96% first treatment 94% subsequent surgery 98% subsequent drug therapy	Under-achieved	Under-achieved
Cancer 62-day wait referral to treatment	85% GP referrals 90% screening referrals	Under-achieved	Under-achieved
18-week Referral to Treatment Times (RTT)	90% admitted 95% non-admitted	Under-achieved	Achieved
Rapid access chest pain two-week wait	98%	Achieved	Achieved
Revascularisation procedures 13-week wait	99.9%	Achieved	Achieved
Genito Urinary Medicine (GUM) clinics 48-hour access	98%	Achieved	Achieved
Breast feeding rates / mothers not smoking	Improvement on national averages or 2008/09 levels	Achieved	Achieved

The Trust also continued to achieve the target times for the following: the administration of thrombolytic drugs following a heart attack; ethnic and maternity data quality standards; maximum levels of delayed transfer of care; and measures of both patient and staff satisfaction.

Overall, the Trust expects to achieve a rating of 'Good' for its Quality of Services in 2009/10, when the results are published in October, although some target thresholds are still to be published and this assessment may change with further information.

The Trust became a Foundation Trust on 1 June 2008 and our governance and financial risk ratings are shown in the tables below for 2008/09 and 2009/10.

	Annual Plan 2008/09	**Q1 2008-09**	**Q2 2008-09**	**Q3 2008-09**	**Q4 2008-09**
Financial risk rating	None published	4	4	4	4
Governance risk rating		Amber	Amber	Amber	Amber
Mandatory services		Green	Green	Green	Green

	Annual Plan 2009/10	**Q1 2009-10 (one month)**	**Q2 2009-10**	**Q3 2009-10**	**Q4 2009-10 (Trust declared ratings)**
Financial risk rating	4	4	3	4	4
Governance risk rating	Green	Green	Red	Red	Red
Mandatory services	Green	Green	Green	Green	Green

Foundation Trusts are given a rating in the range 1 to 5, with five being the best rating. The financial risk ratings have been consistently '4', except in Quarter 1 2009/10 which was in accordance with the detail of the Annual Plan. In 2008/09, the Trust took action to improve compliance with the target reduction in *Clostridium difficile* (C diff) cases, achieving this from Quarter 3 2008/09 onwards.

Under-achievement against cancer standards contributed to an amber rating during 2008/09. The Trust also under-performed on the accident and emergency (A&E) access target of four hours during Quarter 3 of 2009/10, during the challenging winter months.

Although risks to achievement of the new cancer standards were identified, performance against the cancer standards was not scored in Quarter 1 of 2009/10 by any trust, as the operational thresholds had not been published by the Department of Health.

At this point, the Trust was given a green governance rating. But at the end of Quarter 2, there were emerging risks to A&E four-hour performance, and a self-certified red rating notified that formal regulatory escalation would follow if any trust failed to meet this target in the same quarter in a previous year.

The Trust under-performed on the 31- and 62-day cancer standards, and 18-week Referral to Treatment Times (RTT) in Quarter 3 of 2009/10, and experienced exceptional demand in its A&E department.

An escalation meeting with Monitor took place in January 2010 at which plans to recover 31-day cancer standard, 18-week RTT and A&E four-hour performance were presented.

The Trust is ending the year having met the planned trajectories presented to Monitor.

The Trust is committed to continuing to improve its performance against the 62-day cancer standard during the first quarter of 2010/11, and to achieve compliance for the quarter as a whole.

It achieved the A&E four-hour access target, 31-day cancer standard and the 18-week RTT targets in Quarter 4 2009/10. However while all standards with the exceptions of cancer 62-day were met in Quarter 4 a red governance risk rating continues to apply.

Our achievements

While it has been a challenging year in many ways, the Trust has had much to celebrate.

Last June, the National Institute for Health Research (NIHR) awarded us £1.8m for research into cleft lip and palate, and head and neck cancer. The funding is under the NIHR Programme Grants for Applied Research, which are given to leading applied health research groups tackling areas of priority or need for the NHS.

This research, undertaken with the support of the University of Bristol, is looking at services across England and aims to improve the quality of care for children born with cleft lip and palate and those suffering from head and neck cancer.

In July 2009 Avon Breast Screening, which is hosted by our Trust, celebrated its 20th anniversary and announced it had completed around 450,000 screens on women between the ages of 50 and 70 in the Avon area.

In September, the Board gave approval for the Trust to progress to the detailed design phase for a new ward block, enabling us to move all clinical services out of the Old Building and the King Edward Building, as well as bringing in a new model of care, and to submit a formal planning application. The detailed design phase will conclude in November 2010 and a full business case will be submitted to the Board for approval in December 2010.

The following month our flagship building, the Bristol Heart Institute, was officially opened by HRH The Princess Royal. Then in November it was announced that the Bristol Heart Institute had won a Building Better Healthcare award for Best Use of Visual Art in Healthcare and was commended in two other categories, for Best Hospital Design and Best Interior Design. These were swiftly followed by another accolade, a 2009 blue plaque in the Bristol Civic Society Environmental Awards.

Towards the end of the year, staff were encouraged to apply their experience and knowledge and submit their inventions to the Trust's Bright Ideas competition. Generously supported by our two main charities, Above & Beyond and the Grand Appeal, the inventions were judged by a panel and an awards ceremony was held in December. In addition, two new products have now been launched on to the market – VibraTip, created by Prof Andy Levy, and SafeSit, designed by Jane Bailey.

At the start of December Heart FM held a three-day live broadcast, Bristol's Big Give, from the Children's Hospital and raised more than £50,000. This will be used to fund equipment and enhance facilities for families during their child's stay at the hospital.

In February this year, Professor David Wynick was appointed as joint Director of Research for this Trust and North Bristol Trust, building on our partnership working for research across the city.

In March, the maternity team at St Michael's, was awarded level three standards by the National Health Service Litigation Authority (NHSLA) – the highest level it can award. The Trust is one of only a few in the country to have reached this standard.

This year is also the 200th anniversary of the Bristol Eye Hospital and a series of staff and public events are being held throughout the year, including an academic symposia and nurses' conference. The bicentenary coincides with a programme of refurbishment at the Eye Hospital, which will involve improvements to patient areas.

The Trust is very proud of the innovation and dedication of its staff and knows that these qualities will help it to continue to enhance patient care.

4 OUR FINANCIAL PERFORMANCE

The key highlights for the Trust's financial performance during 2009/10 include:

- Delivery of an income and expenditure surplus of £11.4m before exceptional items (asset impairments of £15.7m) is a net £4.3m deficit after impairment.
- A financial risk rating of '4' which is a very good result and will ensure an 'excellent' rating for the Healthcare Commission Use of Resources assessment will be awarded for 2009/10.
- An EBITDA[1] (operating surplus) of £38.9m (8%);
- Achievement of cash releasing efficiency savings of £11.4m;
- Expenditure on capital schemes of over £24m with slippage of £14m, mainly the Bristol Royal Infirmary Redevelopment, reprovided in the 2010/11 programme;
- A healthy cash position (£37.8m) and a strong Balance Sheet.

The Trust has achieved financial break-even or better (before exceptional items) in each of the last seven years. The results for 2009/10 confirm the Trust has delivered the second year of its financial strategy as a Foundation Trust.

Statement of Going Concern

The Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the Accounts.

Statement of Comprehensive Income (formerly Income and Expenditure)

The Trust reported a deficit, after exceptional items, of £4.292m for the year. The out-turn position is £0.907m better than the Annual Plan EBITDA surplus for the year. A net income and expenditure surplus before exceptional items (ie asset impairments) of £11.4m was achieved compared to the plan of £7.5m. This is due primarily to lower depreciation and trust debt remuneration charges arising from lower fixed asset values and slippage in the Capital Programme.

[1] Earnings Before Interest Taxation Depreciation and Amortisation

Items	Plan for Year £million	Actual Year ended 31st March 2010 £million	Variance Favourable / (Adverse) £million
Operating Income	484.8	485.6	0.8
Operating Expenses	(446.8)	(446.7)	0.1
EBITDA	**38.0**	**38.9**	**0.9**
Depreciation	(19.3)	(17.6)	1.7
Trust Debt Remuneration	(10.8)	(9.6)	1.2
Profit/(loss) on disposal	-	(0.1)	(0.1)
Interest receivable	0.1	0.2	0.1
Interest payable	(0.5)	(0.4)	0.1
Net Surplus before exceptional items	**7.5**	**11.4**	**3.9**
Exceptional item – Fixed Asset impairments	(6.5)	(15.7)	(9.2)
Total Comprehensive Income and Expenditure for the year	**1.0**	**(4.3)**	**(5.3)**

Cash Releasing Efficiency Saving (CRES) plans

The Trust achieved cash releasing efficiency savings in excess of £11.4m in 2009/10. Income generation schemes contributed almost £2.5m. Reductions in pay costs of £2.7m were achieved and a further £6.2m was saved on supplies and services.

Statement of Financial Position (formerly Balance Sheet)

The Trust has a healthy statement of financial position which shows net working capital of £19.118m. The improvement over the year reflects the income and expenditure surplus (before exceptional items) achieved by the Trust. This is, in turn, reflected in Trust balances which show current assets of £71.957m and current liabilities of £58.141m million.

To comply with the requirements of HM Treasury the Trust adopted the 'modern equivalent asset' (MEA) basis for valuing its land and buildings in 2009/10.

The District Valuer completed a valuation on the MEA basis at the start of the year. This exercise resulted in a significant downward valuation of land and buildings by £8.7m and £35.2m, respectively.

This was followed by a further, end of year valuation, by the District Valuer to ensure that closing balances in the Accounts reflected valuations at that time. This resulted in a further reduction in the value of buildings (£32.3m).

The index values at the beginning and end of the year are as follows:

	Index April 2009	Index March 2010
Buildings	245	210
Land	110	110

The Trust's Revaluation and Donated Asset Reserves were used to meet £60.5m of the impairment charge with the balance of £15.7m charged to the Statement of Comprehensive Income.

Cash flow

The Trust ended the year with a cash balance of £37.841m. The cash flow statement in the Annual Accounts shows a £4.520m increase in cash over the year. This is largely due to the following:

- The Trust having a net cash flow from operating activities of £31.917m.
- The Trust received Public Dividend Capital of £7.053m.
  The above is offset by:
- Capital expenditure of £24.348m.
- Public Dividend Capital dividend payment of £9.611m.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's performance is set out in the table below.

Items	**Year ended 31st March 2010**	
	Number	**£'000**
Total non NHS trade invoices paid in the period	170,846	151,010
Total non NHS trade invoices paid within target	154,304	134,742
Percentage of non NHS trade invoices paid within	90.3%	89.2%

Total NHS trade invoices paid in the period	4,129	55,305
Total NHS trade invoices paid within target	3,533	48,878
Percentage of NHS trade invoices paid within target	85.6%	88.4%

In addition to the Code, the Trust is playing its part in supporting the local business community in the light of the economic downturn by paying invoices for small businesses within 10 days where possible.

Capital

The Trust incurred capital expenditure of £24.488m. The table that follows shows a breakdown of capital expenditure on major schemes.

Items	Actual Spend 2009/10	
	£million	£million
Strategic Schemes		
• Bristol Heart Institute	4.325	
• BRI Redevelopment	3.498	
• IM&T Hub and Offices	1.257	
• Other	1.622	10.702
Medical Equipment		5.950
Information technology		2.267
Operational Capital		
• Patient Environment / Upgrades	1.331	
• Works Replacement	2.078	
• Other	2.160	5.569
Total Capital Expenditure 2009/10		**24.488**

Private Patient Cap (see Note 3.3 of the Annual Accounts)

Section 44 of the 2006 Act requires that the proportion of private patient income to total patient related income should not exceed the proportion that was achieved whilst the body was an NHS trust in 2002/03, which was 1.1%. The table below summarises our performance against this requirement.

Item	Year ended 31 March 2010 £million
Private patient income	1.915
Total patient income	375.081
Private patient income as a proportion of total patient related income	0.5%

The Trust operated within the Private Patient Cap in 2009/10.

Prudential Borrowing Limit (PBL)

The Trust is also required to comply and remain within the Prudential Borrowing Limit which is set by Monitor. For 2009/10 this was set at £131.35 million. This represents maximum long term borrowing of £99.6m and an approved working capital facility of £31.75m.

The Trust uses the Education Resource Centre under a Finance Lease arrangement. The liability of £6.446m is a first call against the Trust's Prudential Borrowing Limit.

The Trust's performance against the key ratios on which the Prudential Borrowing Limit is based, is as follows:

Financial ratio	Actual ratios Year ended 31 March 2010	Approved PBL Tier 1 ratios
Minimum dividend cover	4.1x	1x
Minimum interest cover	84x	3x
Minimum debt service cover	67x	2x
Maximum debt service to revenue	0.1%	2.5%

At 31 March 2010, the Trust is performing within all of the approved Prudential Borrowing Limit ratios (see Note 23 of the Annual Accounts).

Financial Risk Rating

Financial risk is assessed by the Trust using Monitor's scorecard. A rating of '5' reflects the lowest level of financial risk and a rating of '1' the greatest. The assessment takes account of four criteria:

1. Achievement of plan;
2. Underlying performance;
3. Financial efficiency; and
4. Liquidity.

The risk rating is forward-looking and is intended to reflect the likelihood of an actual or potential financial breach of the foundation trust's terms of authorisation. The table below set out the Trust performance against the criteria.

Financial Criteria	Metric to be scored	31st March 2010	
		Actual	Rating
Achievement of Plan	EBITDA* Margin	8.02%	3
Underlying performance	EBITDA* Achieved	102%	5
Financial efficiency	Return on Assets	6.51%	5
Financial efficiency	I&E Surplus Margin	2.36 %	4
Liquidity	Liquid Ratio	32.1 days	4
	Overall Rating	4 (actual weighted score = 4.05)	

** Earnings before interest, tax, depreciation and amortisation*

The above table shows the Trust's weighted financial risk score is 4.05 and the overall financial risk rating is 4.

The Trust's activities are incurred under legally binding contracts with PCTs, which are financed from resources voted annually by Parliament. The Trust also has the potential to fund its capital expenditure from funds obtained from within the Prudential Borrowing Limit. The Trust is not exposed to any significant liquidity risks and financial instruments, such as they exist, do not have the ability to change the level of risk faced by the Trust.

Financial outlook

The Trust is planning to achieve the following for 20010/11:

- A surplus on the Statement of Comprehensive Income which represents an EBITDA rate of 7.25%.
- A planned surplus of £6.3 million after impairments of £1.2m.
- A planned cash balance at the year-end of £38.3 million.
- A savings programme of £22 million.
- A capital programme of £28 million.
- A Financial Risk Rating weighted score of 3.65 leading to an overall rating of 4.

This position will be challenging but is deliverable. The planned cash balance needs to be seen in the context of the medium term financial plan which provides for:

- Support for the Capital Programme to undertake major schemes of improvement.
- Management of substantial strategic change in Bristol over the next few years.
- Maintenance of a strong on-going trading position which allows for management of potential downside scenarios in future years.

To achieve the planned surplus the following are required:

- Delivery of the planned savings for 2010/11.
- Conversion of non-recurring savings from 2009/10, into recurring savings.
- Maintenance of strict cost control.
- Delivery of National Performance targets and in particular the avoidance of Service Level Agreement fines.
- Delivery of clinical performance within agreed Contract Limiters to avoid non-payment of activity by Commissioners.
- Proper recording and coding of activity leading to full income recovery.
- Achievement of significant clinical service improvement in a planned and effective manner using lean methodology to enable the delivery of savings.
- Delivery of CQUIN targets agreed with Commissioners.

The year is likely to be affected by the external environment as well as pressures from within the NHS including:

- Access to loan finance from Prudential Borrowing may be difficult.
- Primary Care Trusts are experiencing financial difficulties due to large increases in both elective and emergency activity. Attempts to restrict/cap payment to Trusts are becoming common. Over-performance on Service Level Agreements cannot necessarily be assumed to be funded from Commissioners in future.
- Pressures on spending and delivery of CRES are intensifying and firm control is required to avoid the Trust's current financial position and its medium term plans being undermined.

External Audit

The Trust's External Auditors are the Audit Commission.
Audit fees in relation to the statutory audit of the Trust Accounts for the year ended 31 March 2010 were £58,000 including VAT.

The Trust also asked the Audit Commission to undertake reviews of its 2008/09 Annual Accounts prepared under International Financial Reporting Standards.

The Trust incurred cost of £9,950 for this service and additional costs of £36,050 were incurred for reviews of consultant productivity and ward staffing.

5 QUALITY ACCOUNT: AN OVERVIEW

The Trust's Quality Account, summarised here, is set out as an appendix to this report. This document includes a review of progress against quality objectives for 2009/10 and details of agreed quality objectives for 2010/11. The structure of the Quality Account is based around Lord Darzi's model for Quality (patient safety, patient experience and clinical outcomes and effectiveness), and conforms to guidance issues by the Department of Health and Monitor.

In 2009/10 the Trust has implemented several new patient safety initiatives, enhanced staff training and reviewed and audited existing processes, leading to some important changes. In September 2009, the Trust committed to a five-year programme – Patient Safety First – that involves making clinician-led changes to improve patient safety. A number of work streams have been established to initiate, test and implement these changes and there is a strong emphasis on measuring outcomes.

The Trust's 'zero tolerance' approach to poor infection control practice has also led to a significant reduction in the rates of infection. In 2009/10, the total number of MRSA bacteraemia infections was half that of the previous year, and the total number of C diff infections acquired within the Trust had reduced by almost two-thirds compared to 2008/09.

Ensuring accuracy of information concerning patients' medicines has also been a key objective, leading to improvements in the process of medicines reconciliation for medical admissions. The Trust is currently rolling out an electronic discharge summary which will provide GPs with accurate and timely information about patients when they are discharged from hospital. Further work on insulin management will continue into 2010/11.

The Trust has implemented the World Health Organisation (WHO) Surgical Safety Checklist in its theatres, with subsequent monthly monitoring of compliance – in March 2010 the overall compliance was 91.8%.

The Trust has a low overall Hospital Standardised Mortality Ratio (HSMR), and since December 2009, the Trust has had fewer adverse events – the number of incidents which led to patient harm – than average, when compared to all the other trusts in the South West region.

Feedback from our patients suggests we are making progress in improving their experience at our hospitals. Data from the 2009 National Inpatient Survey showed that the Trust scored higher than the national average for the information it provides to patients about their medication. When asked 'overall, how would you rate the care you received?', 84% of patients rated their care as 'excellent' or 'good'. The Trust continues to rate above the national average for this question.

The privacy and dignity of patients are important priorities and the Trust has introduced several changes, including: signs using images rather than words to indicate male and female facilities; the development of single-sex accommodation; a revised policy on performing last offices; the introduction of a 'modesty gown'; and the piloting of 'do not enter' signs on cubicles and side rooms.

Overall mortality for all cardiac surgery and for coronary artery bypass grafting in particular – the most common operation performed – has been consistently better than the UK average. The Trust is also performing well in other surgical procedures, such

as cataract operations, where 92% of patients achieved a post-operative Snellen visual acuity of 6/12 or better.

In 2010/11, our aim is to build on these improvements and our priorities are as follows:

- To reduce further the incidence of healthcare acquired infections.
- To improve antibiotic prescribing compliance.
- To reduce the number of high-risk medication errors which cause actual harm to patients.
- To reduce hospital acquired thrombosis.
- To increase the level of patient and public involvement in service improvement.
- To meet the requirements of the proposed NICE Quality Standard for Dementia.

6 CONTRACTUAL KEY PERFORMANCE INDICATORS 2009/10

As part of the 2009/10 contract with the lead commissioner, NHS Bristol, the Trust committed to achieve the key national standards, as well as some additional stretch targets (under the Commissioning for Quality and Innovation Framework, CQUINs).

Financial rewards were attached to CQUIN targets (up to a maximum of £1.8 million), and national penalties to non-achievement of Clostridium Difficile (C diff) and 18-week Referral to Treatment Time (RTT) targets.

The potential CQUIN income was conditional upon the Trust achieving key national patient access targets in full. These “gateway” standards related to the reduction in waiting times for accident and emergency, cancer, inpatients and outpatients, with graduated eligibility for full CQUIN payment for targets relating to Choose and Book slot availability, cancelled operations, MRSA bacteraemias and ambulance handovers.

The CQUINS in 2009/10 were chosen to reflect the national priorities but, more specifically, the needs and ambitions of the local community, as set out in the Primary Care Trust and South West Strategic Health Authority’s operating frameworks.

The Trust did not achieve the “gateway” cancer standards in 2009/10, and therefore forfeited this potential additional income.

The introduction of the new cancer standards and changes to the way cancer waiting times were measured nationally brought with it some significant challenges in 2009/10.

The Trust met the two-week maximum wait from urgent GP referral to being seen by a specialist for the year as a whole, following a dip in performance in the first quarter of the year.

However, performance against the 31-day diagnosis to treatment and 62-day cancer referral to treatment standards was less consistent and these targets were not achieved for the year as a whole.

A performance notice was issued to the Trust by NHS Bristol, in response to which regular refreshes of the action plans were provided.

Significant improvements in performance were evident in the last quarter of 2009/10, with all targets being met in the quarter with the exception of the 62-day referral to treatment target for patients referred from a screening programme, and the two-week wait for symptomatic breast patients (cancer not initially suspected).

To consolidate these improvements, the Trust will continue to focus on the potential risks to sustainability that have been identified.

Key risks to target achievement for both the 62-day target for patients referred from national screening programmes and the two-week wait for symptomatic breast patients remain patient choice to delay appointments and key diagnostic tests.

Following analysis of failures to achieve the cancer standards for individual patients, plans have been developed to address delays to cancer pathways that are within the control of the Trust that might otherwise pose a risk to sustainable achievement of these targets.

These actions will improve patient care and also put the Trust on a stronger footing for securing CQUINs income in 2010/11.

The Trust performed very well in 2009/10 against MRSA and C diff targets, with significant reductions in numbers of both.

Targets for 11-week revascularisation and two-week wait for rapid access chest pain referrals were also consistently achieved throughout the year.

Penalties totalling £250,000 were incurred for failing to achieve the national standard for 18-week Referral to Treatment Time (RTT) of 90% of admitted patients, in two months of the year. The 18-week wait for patients not requiring an admission as part of their treatment was achieved for at least 95% of patients in every month in 2009/10.

The Trust achieved the four-hour maximum wait from arrival in an emergency department to discharge, admission or transfer, for more than 98% of patients during the year (including local walk-in centre attendances). This represented a 0.3% improvement in performance compared with the previous year.

There was a 6% increase in emergency admissions over the period, with the increase being most evident in the third quarter of the year, when the 98% standard was not achieved.

The Trust responded to these exceptional levels of emergency admissions by expanding its Medical Assessment Unit (MAU) capacity, in addition to reconfiguring its inpatient wards to provide a dedicated facility for delayed discharges.

The Trust received a performance notice from NHS Bristol after the dip in performance, but was able to report compliance with the standard in the following quarter after a difficult and busy winter period.

To support continued achievement of the 98% standard in 2010/11, the Trust will be focusing efforts on further enhancing the acute medicine model to increase the capacity to admit and assess medical emergencies, together with joint work with local Primary Care Trusts (PCTs) to reduce emergency admissions and enable prompt discharge of patients back to the community with home-based packages of care.

Remedial Clinical Action Plans were requested in-year by NHS Bristol in respect of cancelled operations (1.08% for the year against a target of 1%) and Choose and Book slot availability, where performance in the first four months of the year was below the 90% target, but rates improved considerably in the last eight months of the year, rising to 97-99% in the last six months of the year.

7 ABOUT OUR STAFF

The Trust consults regularly with its employees through informal and formal groups, including the Trust Consultative Committee, the Industrial Relations Committee and the Local Negotiating Committee (medical and dental staff).

Staff and management representatives consult on change programmes, policy development and strategic issues. The Trust takes part in the Annual Staff Attitude Survey and subsequently develops an action plan to improve staff experience.

Staff survey 2009

The 2009 staff survey demonstrated an overall positive move in staff perceptions of working for the Trust.

The Trust scored in the top 20% of all participants for 15 scales and above average for a further eight scales.

These scores covered areas such as feeling valued by colleagues, having an interesting job, Trust commitment to work-life balance and flexible working, appraisal and training, incident reporting and general scales around job satisfaction. The results of the survey are detailed below. The ratings are one a scale of 1-5.

Areas where staff experiences have improved the most in the Trust since 2008:

Area	2009 score	2008 score
% experiencing harassment, bullying or abuse from patients/relative in last 12 months	20% (lower score the better)	27%
Staff intention to leave jobs	2.37 (lower score the better)	2.61
Support from immediate managers	3.74	3.66
% having E&D training in last 12 months	41%	18%

Area where staff experience has deteriorated at the Trust since 2008:

Area	2009 score	2008 score
% experiencing discrimination at work in last 12 months	11% (lower score the better)	7%

Unless stated, the higher the score the better. There are some scores for which a high score would represent a negative finding.

Top four ranking scores

Area	2009 score	2008 score	National 2009 average for acute Trusts	Ranking in 2009
% agreeing they have an interesting job	85%	82%	80%	Highest (best) 20%
Trust commitment to work-life balance	3.54	3.45	3.40	Highest (best) 20%
% using flexible working options	79%	77%	70%	Highest (best) 20%
Support from immediate managers	3.74	3.66	3.60	Highest (best) 20%

Bottom four ranking scores

Area	2009 score	2008 score	National 2009 average for acute Trusts	Ranking in 2009
Availability of handwashing materials	62%	60%	69%	Below (worse than) average
% witnessing potentially harmful errors, near misses or incidents in last month	46% (lower score the better)	43%	37%	Highest (worst) 20%
% experiencing harassment, bullying or abuse from staff in last 12 months	22% (lower score the better)	18%	18%	Highest (worst) 20%
% experiencing discrimination at work in last 12 months	11% (lower score the better)	7%	7%	Highest (worst) 20%

The Trust scored in the lowest 20% of participants for three scales, and below average in a further six areas. These included pressure of work, harassment and bullying from other staff, discrimination in work and the numbers of staff witnessing potentially harmful errors.

The Trust is developing an action plan to ensure we build on the positive movement we have in our scores while tackling the areas where our staff have told us that we need to improve.

This plan will be fully integrated with the roll-out of our new values in the coming months (see **Working Together, Embracing Change, Recognising Success, Respecting Everyone** later in this section).

The Chief Executive holds regular staff meetings and everyone is encouraged to attend. These provide an opportunity for staff to hear about issues affecting the Trust and a chance to contribute their views.

The weekly Trust email bulletin Newsbeat provides a mix of staff and Trust news and information, including an update on performance.

Agendas, minutes and supporting papers from key Trust meetings are available on the intranet. Managers are expected to make key information available to staff through team briefing sessions. Hard copies of documents are available to staff who do not have access to a computer.

The bi-monthly staff magazine Voices has recently been relaunched after a redesign to make it brighter and more relevant.

Staff costs and headcount are detailed in section six of the Accounts.

Statement of approach to equality and diversity

The Trust is committed to eliminating unlawful discrimination, promoting equality of opportunity and providing an environment which is inclusive for patients, carers, visitors and staff.

The Trust aims to provide equality of access to services and to deliver healthcare, teaching and research which is sensitive to the needs of the individual and all communities.

Similarly, the Trust is committed to providing equal access to employment opportunities and an excellent employment experience for all.

The Chief Executive and the Trust Board is ultimately accountable for ensuring that the Trust's commitment to equality and diversity is implemented at all levels of the organisation and that all business is carried out in accordance with the values of the organisation.

The Trust has a public duty in all issues relating to equality and diversity.

The Director of Workforce and Organisational Development is the nominated lead Director for equality and diversity on the Trust Board.

Implementation of the Single Equality Scheme and Action Plan is monitored on a six-monthly basis by the Trust Board.

Statement of compliance with publication duties

The Trust publishes its Valuing Diversity Strategy, Single Equality Scheme (2008-2011), Diversity Monitoring Data (includes staff and patient data), as well as Equality Impact Assessments.

A web audit conducted by the South West Strategic Health Authority confirmed the Trust is compliant.

Action plans and timeframes to address any shortfalls

The Single Equality Scheme is the Trust's public commitment to meet statutory duties required by equality legislation.

The scheme contains detailed action plans on issues affecting all equality and diversity strands. The scheme covers the period 2008-11.

The Trust has made good progress and has completed 32 out of 43 items (74%). Five actions remain outstanding with six also in progress.

These actions will be completed by the end of 2010, although the objective of working with Bristol Primary Care Trust to support the public health agenda and, specifically, health inequalities, is on-going.

The Trust will review the Single Equality Scheme (2008-11) within three years and a report of this review will be made public.

Summary of performance – workforce statistics:

Staff in post diversity profile (data point 1 April 2010)		
Gender	**April 2010**	
	Head count	**%**
Male	1,841	23.04%
Female	6,149	76.96%
TOTAL	**7,990**	**100%**
Ethnicity	**April 2010**	
	Head count	**%**
A White - British	6,221	77.86%
B White - Irish	105	1.31%
C White - any other White background	377	4.72%
D Mixed - White and Black Caribbean	23	0.29%
E Mixed - White and Black African	21	0.26%
F Mixed - White and Asian	19	0.24%
G Mixed - any other mixed background	42	0.53%

H Asian or Asian British - Indian	371	4.64%
J Asian or Asian British - Pakistani	50	0.63%
K Asian or Asian British - Bangladeshi	10	0.13%
L Asian or Asian British - any other Asian background	185	2.32%
M Black or Black British - Caribbean	126	1.58%
N Black or Black British - African	262	3.28%
P Black or Black British - any other black background	29	0.36%
R Chinese	47	0.59%
S Any other ethnic group	101	1.26%
Z Not stated	1	0.01%
TOTAL	**7,990**	**100%**
Disability	**April 2010**	
	Head count	**%**
No	1,294	16.20%
Not Declared	2	0.03%
Undefined	6,625	82.92%
Yes	69	0.86%
TOTAL	**7,990**	**100%**
Age profile	**April 2010**	
	Head count	**%**
16 - 20	111	1.39%
21 - 25	661	8.27%
26 - 30	1,150	14.39%
31 - 35	1,199	15.01%
36 - 40	1,078	13.49%

41 - 45	991	12.40%
46 - 50	934	11.69%
51 - 55	894	11.19%
56 - 60	598	7.48%
61 - 65	286	3.58%
Aged over 65	88	1.10%
TOTAL	**7,990**	**100%**

Analysis of staff

As at 1 April 2010, the split between male and female staff is 23% and 77%, respectively. This figure has not changed from last year.

There has been an increase of one per cent in staff declaring themselves to be white British compared to the previous year.

The number of black and minority ethnic staff in the Trust is 22.14% (this figure includes white Irish and white any other background).

Sixty-nine staff have declared themselves as having a disability as at 1 April 2010, compared to 55 in the previous year. As a percentage of the workforce this is 0.86% and 0.71%, respectively. The Trust continues to encourage staff to declare any disability or impairment.

The number of staff employed in the age group of 16-25 has increased by 62 to 772 from the previous year's figures. This group of staff represents 9.7% of the workforce.

The number of staff aged 56 years or above has slightly decreased from 976 to 949, a reduction of just over 4%.

The management of Trust staff is supported through key performance indicators that are reported to the Board every month.

Key indicators include vacancy and turnover rates, sickness absence rates, appraisal compliance rates, mandatory and statutory training rates and bank and agency usage.

The indicators are analysed and the results used to ensure compliance with national targets and local action plans.

Priorities, monitoring arrangements and targets

Key priorities moving forward will be to ensure that Equality Impact Assessments continue to be developed on all existing and new services and reflect the changing needs of the local community.

All new staff complete the Trust's online equality and diversity training as part of the induction programme and the aim is to increase coverage by 10% year on year and to develop further training programmes for managers.

The Trust will also develop an action plan to reduce the number of incidents of harassment and bullying.

In the second half of the year, Trust Divisions will be required to identify objectives relating to their services, priorities, and patients' needs, which will be used to revise and refresh the Single Equality Scheme 2011-14.

In future, equality and diversity will also form part of the performance management mechanism for Trust Divisional Boards. The Trust will develop a set of key performance indicators at this level over the next six months. The Trust will incorporate these performance indicators into the existing reporting mechanism to the Trust Board.

The Trust understands its obligations to ensure that people with disabilities are given equal opportunity to enter into employment and progress wherever possible.

The Trust complies with the 'Positive about Disabled People' scheme. This scheme commits the Trust to interview all applicants with a disability who meet the minimum criteria for a job vacancy and consider them on their skills, experience and knowledge.

All staff must adhere to the Trust's Equal Opportunities policy and Recruitment policy.

The Trust takes steps through its Redeployment policy to enable employees to remain in employment wherever possible. This includes working closely with the Occupational Health Department, Human Resources and external agencies such as Access to Work.

The Trust is delivering bespoke training for staff who have become disabled, reviewing its approach to this activity and developing it to ensure it is both accessible and delivered in an appropriate way to participants.

The Trust is committed to developing all staff and teaching is provided in different ways to ensure access for all.

The Trust is developing its career pathways and succession planning processes as part of the strategy for 2010-11 to ensure transparency and equity of opportunity for all staff.

All staff are expected to have an annual appraisal in accordance with the Trust's Appraisal policy.

A range of communication channels are used to inform employees of matters of concern to them. This includes information on the Trust intranet, a weekly e-bulletin Newsbeat and information in the staff magazine Voices, as well as information in payslips.

Occupational health service

The Trust's occupational health service is delivered through a partnership organisation, created in 2001 by bringing together the occupational health departments from local acute NHS Trusts, including University Hospitals Bristol.

This partnership provides excellent support to the Trust's employees whose health may be affected by their work or whose ability to work may be affected by health issues. It also provides advice to Trust managers on how best to support staff health in the workplace.

The occupational health department also works in partnership to develop and deliver health initiatives across the Trust and the wider NHS in Bristol.

Occupational health is working with the Trust's health and safety and human resources teams to review and improve existing provision for dealing with the causes and effects of workplace stress.

A safe working environment

The overall strategy for health and safety in the Trust uses The Health and Safety (Guidance) 65: Successful Health & Safety Management, which is implemented in full as a model of safety management systems.

Health and safety systems, practices and processes ensure that all key risks to compliance with the legislation have been identified and addressed.

Health and safety is integral to the Trust's risk management strategy, out of which the three-year Risk Management Training Plan and annual Risk Management Training Needs Analysis have been developed. These encompass statutory and mandatory training, patient safety training and risk management training.

Issues and concerns raised by external audit, external enforcement and assessment agencies (including the Health and Safety Executive, the Healthcare Commission, Willis and the NHS Litigation Authority) are addressed and resolved.

Where any issues or concerns are outstanding, these matters are taken to the Board with appropriate action plans in place to address the issues.

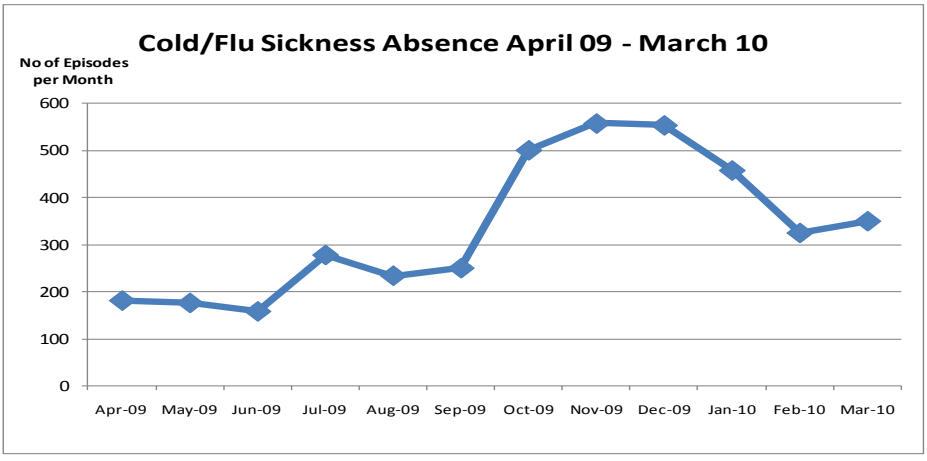
Sickness absence

The Trust-wide sickness absence rate was 4.4% for 2009/10, compared with 4.3% for 2008/9.

Average days lost to sickness per full time equivalent were 9.9 days for 2009/10.

During 2009/10, the Trust revised and improved the sickness absence policy, and briefing sessions were held for all managers.

The underlying reduction in sickness absence was not apparent due to the high levels of absence associated with colds and flu during 2009/10, which are reflected in the graph below.



Working Together, Embracing Change, Recognising Success, Respecting Everyone

During 2009-10 the Trust reviewed its values through the involvement of more than 150 staff, governors and patients. There was a groundswell of opinion to support the review of the values of the Trust.

The new values, it was agreed, should have real meaning, be memorable and staff must be able to live and work by them. This piece of work was undertaken in light of the introduction of the NHS constitution, and would complement each other.

The Trust's new values are:

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

They will become central to organisation change, effective leadership and define what we expect from our staff. We also believe they will enable and empower staff to work together towards shared goals.

The values have been grounded in staff experience, and have been through a thorough consultation process with all staff groups represented.

Going forward, it is vital that the values underpin 'how we do things around here' and work will continue with staff throughout 2010/11 to look at different behaviours that define the values, which will allow staff to take personal responsibility for their own behaviour and challenge unacceptable behaviours in others.

We know that implementing the refreshed values is a step change for all staff. The introduction of the new values will be underpinned by HR support; all the current training courses will be updated and people management training will have a specific section to focus on the behaviours behind the values.

The Trust appraisal system and the NHS Knowledge and Skills Framework have been updated to reflect the values and how staff can work towards achieving them in all aspects of their work.

For all new appointments to the Trust, changes will be made as appropriate to job descriptions and person specifications for staff.

For existing employees, the annual appraisal will be altered to reflect the new values and through the KSF process, and as part of this review the values will be added to all existing job descriptions.

8 OUR WIDER ROLE: THE COMMUNITY, CONSULTATION AND THE ENVIRONMENT

South Bristol Community Hospital

The Trust works in partnership with NHS Bristol and Bristol Community Health to deliver services closer to the patient in the community.

The South Bristol Community Hospital will open in early 2012, when the Trust will transfer patients requiring second stage care, rehabilitation and intermediate care to the new facilities.

The Trust will also become the service provider for day surgery, endoscopy, diagnostics, dental community services and some outpatient services and it is working closely with Bristol Community Health to develop new models of care to improve access to treatment for the population of South Bristol.

Healthy Futures Programme

The Trust also works in partnership with the Primary Care Trust and North Bristol NHS Trust for the provision of services.

To optimise access to care, the Trust is engaged in a number of service review projects and programmes of work to reconfigure services across the community.

The Trust works closely with local Primary Care Trusts through the Healthy Futures Programme. This programme is designed to manage change in service design across the community.

Corporate Social Responsibility

The Trust is committed to doing all it can to help and support the communities it serves – both locally and regionally. Our corporate social responsibility (CSR) activities are important, as we are a major service provider and employer.

As a Foundation Trust, involving the people of Bristol in our plans and offering support whenever and wherever possible is central to all our activities.

Our 11,600 members provide valuable insights into what patients want from our services and how the public view the Trust, our staff and our CSR activities.

The Trust's schools liaison team gives students the opportunity to learn about careers in the NHS by inviting them into hospital to watch healthcare in action. The team is also taking the Trust to the schools, by organising on-site demonstrations and talks by clinicians and other healthcare professionals.

Experts from the Trust are helping to shape and implement community care throughout the city. Working with the Bristol-wide Food and Health Strategy Group, the Trust's Department of Nutrition and Dietetics is helping to reduce disease-related malnutrition in patients.

The team is delivering training on malnutrition to care home staff and community nurses in Bristol and is developing nutrition screening and advice for women who would like to start a family, pregnant women and for children aged five and under.

The dietetics team has also supported Bristol City Council's Children and Young People's Services in ensuring the provision of healthier food in schools and that healthy eating messages are part of the curriculum.

The Trust offers structured work experience programmes that are specifically tailored to the requirements of students who range from GCSE pupils to mature students considering a change of career to the health service.

GCSE students visit various departments within healthcare and other environments to gain a wider understanding of the NHS. Post-16 students benefit from individually tailored programmes according to their career aspirations.

A specially developed programme allows controlled access to restricted theatre areas for A-level students who are hoping to read medicine at university, including shadowing clinicians in a wide variety of clinical areas.

School initiatives with staff ambassadors include activities more directly linked to the national curriculum, with an emphasis on the core subjects of maths, English and science and offering work-related learning for new diplomas.

A schools programme led by the Trust's anaesthetists involves clinical staff visiting a different school in the region for a day each month to strengthen the link between sciences taught in the classroom and how they are applied in hospital.

Another project in partnership with Above & Beyond, one of our charities, enables pupils from the Red Maids School and The Meriton School for young mothers to support our hospitals by holding various fundraising activities.

In addition, pupils from St Matthias Park Pupil Referral Unit who are interested in talking to NHS staff about different careers have visited the Trust this year.

Taster days, workshops, mock interviews and career-based events throughout the year have continued to be offered to many schools and all pupils have the opportunity to become Foundation Trust members, with many joining our Youth Council.

The Trust has strong partnership links with Connexions, the Education Business Partnership and City of Bristol College and Tomorrow's People. The Trust works alongside Tomorrow's People, offering work experience opportunities, mentoring and advice for the long-term unemployed.

Apprenticeships are currently offered in the Estates and Medical Equipment Management Organisation (MEMO) departments and this will be further developed across the Trust in the near future.

Mbarara Links programme

The Trust has continued to reinforce its Links Programme with Mbarara Hospital in Uganda and a team of experts in obstetrics, midwifery, obstetric anaesthesia and fetal medicine from St Michael's Hospital recently visited to share knowledge and forge links between the two maternity institutions.

Staff from Bristol Eye Hospital have also visited and through a Links programme, helped to educate local health workers to support people with treatable eye conditions, such as cataract and refractive problems.

Consultations 2009/10

A number of formal consultations have been undertaken linked to planning applications as part of the Trust's strategic redevelopment work. These consultation meetings, which have involved local residents and a wider audience, include:

- November 2009 – Community involvement meeting with local residents.
- December 2009 – Community involvement public meeting at Bristol Heart Institute.
- March 2010 – Residents' drop-in session at The Ark, Kingsdown, which included feedback forms for residents.
- Quarterly residents' meetings held at the Trust.
- Local residents have also been involved in the Community Involvement Group Consultation Policy.

The Trust has been represented at the majority of Bristol Joint Health and Social Care Scrutiny Commission meetings during 2009/10, enabling us to respond to any committee questions about our clinical services and future plans.

Other public and patient involvement activities

A full range of patient and public involvement activities has taken place across the Trust during 2009/10.

All involvement activities are designed to engage patients, carers and communities in sharing experiences and informing the development of clinical and non-clinical services. Activities take place on Trust premises and in community settings.

In addition, service users attend a range of Trust working groups, including:

Strategic development and corporate activity	
Centralisation of Paediatric Services Communications Group	Part of the Bristol Health Services Plan. Public meetings to inform patients and the public and facilitate engagement in the project.
Redevelopment of Bristol Royal Infirmary	Part of the Bristol Health Services Plan. Public meetings have been held to inform patients and the public and involve them in the project.
Decommissioning of Bristol General Hospital	Ongoing engagement and involvement of service users in change.
South Bristol Community Hospital	Linked to the Bristol General Hospital decommissioning and Trust service developments in South Bristol. Public meetings held to inform patients and public and facilitate involvement in the project.

Physical and Sensory Impairment Group	Patients, Foundation Trust members and third sector groups (eg WECIL and ShopMobility) have been involved in helping to shape and take an active role in the relaunched Physical and Sensory Impairment Group. This group influences developments in both clinical and non-clinical settings.
Use of mobile phones on wards	The recent review of the Trust's policy on the use of mobile phones on wards has been informed by a series of informal ward-based patient interviews across the Trust.
Action for Blind People engagement event	Linked to a patient information project, we supported an Action for Blind People event during 2009. Patients who have suffered sight loss had the opportunity to share their experiences in a medical setting. The outcomes will inform the Trust's redevelopment plans and a separate project on access to outpatient services.
LINks	The Trust is an active participant in the Bristol LINk's Acute Hospital Group. Bristol LINk has two members on the Trust's Involving People Committee.
Division of Women's and Children's Services	
Bristol Maternity Services Review	The Trust is taking an active role in this PCT-led review of services focusing on the Somalian population and maternity services.
Oncology user group	A group chaired by a parent and comprising mostly parents of young patients who are off-treatment. Activities include monthly coffee mornings and information forums.
Disabled Children's Group – advisory group	A multi-disciplinary group including parents. Links to the Bristol Carers Voice (a city council-based group) with a strategic focus.
Vaginal Births after Caesarean (VBAC)	A series of focus groups has been held with women to explore and inform service developments in relation to the care, support and communications channels available to patients.
Council of Bristol Mosques	Ongoing engagement with the Council of Bristol Mosques has resulted in the Council informing a range of service developments including "last offices". This activity extends to a wider faith remit involving the Bristol Multi Faith Forum.

Division of Medicine	
Stroke Interest Group	Looking at issues related to stroke at the Trust, including service development and improvement.
Dermatology Support Group for Psoriasis and Eczema	Member-led group with input from professionals as required.
Bristol Ostomy Self Support Group	Local group for people with a stoma. Includes trained listeners and advisers.
Rheumatology Patient Advisory Group	A group of patients and relatives responsible for initiating positive changes in the rheumatology department.
Division of Surgery Head and Neck	
Collar Group for all Head and Neck patients in Bristol	Ongoing support group for patients who have had treatment for head and neck cancer including individual visits, telephone support and advice.
Uveitis Patient Information Group	Public forum held at Bristol Eye Hospital for Uveitis patients, run and hosted by the national Uveitis Information Group.
Laryngetomy Support Group	An established group – patients and partners meet with staff to share information, ideas and new developments.
Prospect (Urology)	For men who have had or are suffering from prostate cancer (South West branch).
Low Vision Committee	Open committee meetings held at the Bristol Eye Hospital.
Division of Specialised Services	
Implantable Cardioverter Defibrillator (ICD) Patient and Relative Support Group	A support group chaired by a patient representative which any patient with an ICD can attend. The group has developed a video/DVD for ICD patients nationally.
Bristol Heart Institute	Ongoing patient involvement in shaping the design and function of the new unit.

Bristol & South West Haemophilia Group	Part of the National Haemophilia Society, organised and run by patients for patients with haemophilia and related conditions, which provides support and information, organises social events and raises funds.
Cancer Information & Support Centre	Drop-in service for anyone affected by cancer, which offers current information on cancer and treatments. It also offers carers' information and numerous services from outside organisations and the Patient Advice and Liaison Service (PALS), as well as a telephone helpline.
Volunteer visitors to cardiac surgery	Former patients who support new patients prior to cardiac surgery.
Hear Say	The aim of the Hear Say project was to collect patients' opinions and comments of cardiac services at Bristol Heart Institute, to highlight and promote areas of good practice and identify areas that we can change to improve the patient experience.

In addition to involvement through support groups, working groups and focus groups, the Trust has involved patients and the public through the use of surveys and questionnaires.

During 2009/10 a total of 85 local patient surveys were approved by the Trust. The Trust also participated in the 2009 National Inpatient and Outpatient Surveys.

Analysis of the Trust's scores in the National Inpatient Survey for 2008 (published during 2009/10) revealed four key 'drivers' of patients' satisfaction with the treatment and care received at the Trust:

- Confidence and trust in staff;
- Patient and family involvement in care and treatment;
- Staff-patient communication;
- Cleanliness.

A follow-up focus group involving a selection of Foundation Trust members revealed that treating patients with dignity and respect underpinned each of these 'drivers':

> *"It all starts with staff treating the patient like a person – looking them in the eye, acknowledging them, talking to them as an equal – everything else, like feeling involved in treatment to having confidence and trust in the staff starts with this."*
>
> **Foundation Trust member, Focus Group, May 2009**

These key drivers have also been explored in pilots of ward-based satisfaction surveys during 2009/10, as a prelude to the roll-out of the Trust's Patient and Public Involvement Strategy, which started in April 2010.

The new strategy involves most discharged inpatients receiving a detailed postal survey to generate robust and timely patient satisfaction data, which will be used by staff across the Trust to help drive improvements in patient experience.

Patient and visitor comment cards will also be introduced on wards, and other themed surveys will be undertaken by volunteers and Governors using hand-held electronic devices.

Complaints handling

The Trust values the opportunity to learn through feedback from patients via its complaints process and Patient Advice and Liaison Service (PALS). We aim to resolve complaints and concerns as effectively as possible either by putting things right quickly, or through thorough investigations to fully understand issues and identify action to be taken.

Learning from complaints and concerns is reviewed in the wider Trust context, alongside that from other sources such as incidents. This helps us to identify themes where action needs to be taken and to better understand patients' experiences, with the aim of making improvements across all areas of care.

A second annual survey of a random selection of people who had made a complaint or raised a concern was sent out in December 2009, to help us improve our complaints management systems.

Responses were encouraging with the majority of respondents satisfied with the way their complaint was managed, but the survey has highlighted some areas for action. These include improving the way feedback about service developments is communicated and documenting action which has been taken as a result of an individual's complaint.

Patient information

Good information helps patients to understand the risks and benefits of treatment and to make informed decisions about their care.

The Trust currently has a comprehensive resource of more than 1,300 patient information leaflets, many of which are available to the public via the Trust's website.

A selection of our most popular leaflets are now available via the website as mp3 audio downloads.

The Trust's Patient Information Service manages the production of these leaflets, ensuring the content is readable and consistent with requirements set out by the NHS Litigation Authority (looking ahead, the Trust aspires to achieve accreditation under the Department of Health's Information Standard).

Leaflets can also be produced upon request in large type and Braille formats. The Trust continues to provide a comprehensive translating and interpreting service for patients and visitors.

We employ a bank of interpreters, supported by telephone interpreting services (traditionally via Language Line, although we have recently undertaken a pilot with The Big Word in Maternity Services).

During 2009/10 a Kurdish interpreter has joined the bank and the Trust is continuing its efforts to improve patient access to Somali interpreters. Translation of written documents is arranged by our clinical divisions upon request.

Environmental matters

As part of its mandatory duty to address government targets for carbon reduction, the Trust has approved a five-year Carbon Management Plan. The Board has adopted this vision for carbon management:

> *"As a leading employer within Bristol and as a regional player in the healthcare community, this Trust wishes to place itself at the forefront of tackling the effect that the activities of delivering healthcare services have on climate change. By means of a major commitment, over the next five years, to identify unnecessary or excessive sources of carbon emissions in the activities which we undertake and by developing a programme of improvement, running over the next five years, we plan to reduce emissions and make our contribution and set an example to the communities we work within."*

The plan covers the period from 1 April 2006 to 1 April 2014 and commits the Trust to:

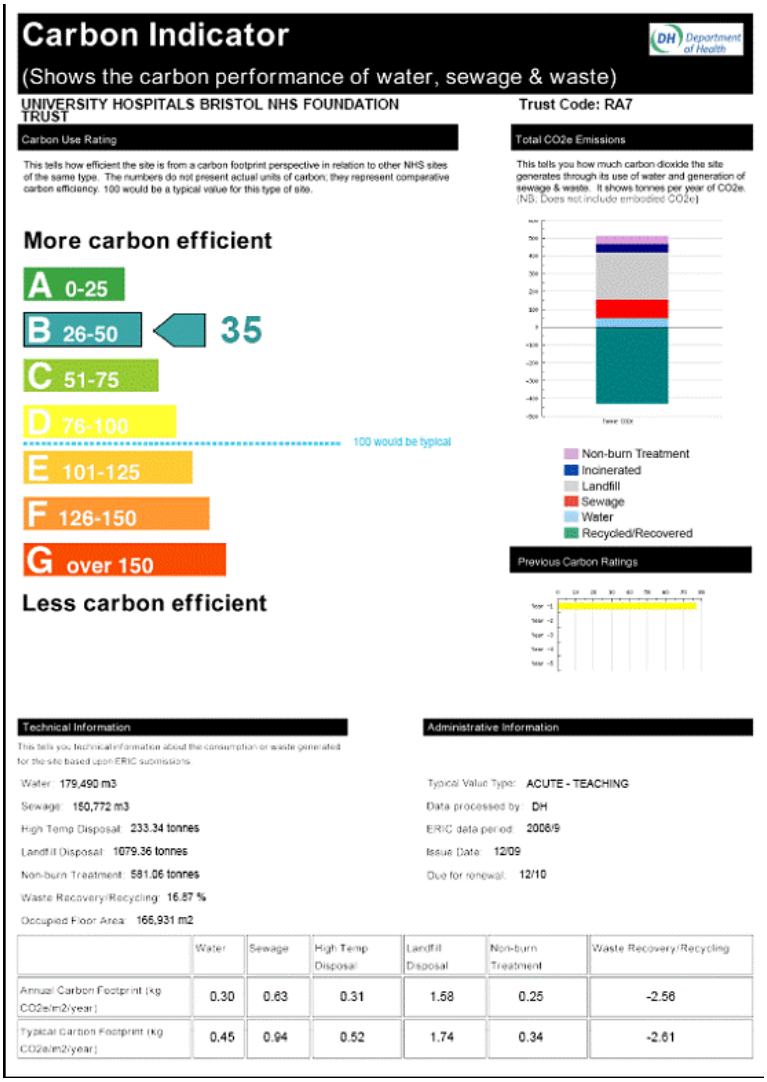
- Reducing CO^2 emissions from its designated activities by 20% from the 2006 baseline by the end of the period.
- Reducing the Trust's energy costs by 17% over that period (at current unit costs).
- Bringing together existing and future carbon management projects into a consistently managed and coherent programme.

The Trust undertook a review of its existing performance with the Carbon Trust, which determined that performance is better than good practice. However, the five-year plan seeks to further improve through the following:

- Behavioural change: Manage the way in which the behaviour of those using our buildings affects the extent of our carbon emissions (switching off and turning down wherever possible).
- Engineering improvement: Further improve the efficiency of the plant and other energy using devices within our buildings.
- Waste minimisation: Further improve our profile by more accurate waste segregation, consideration of the means of disposal (for example incineration or landfill) and reducing waste generation.
- Procurement: Improve the impact which procurement processes have on the Trust's indirect carbon footprint (for example delivery miles, unnecessary and non-recyclable packaging).
- Travel: Require our contractors to use low emissions (through our taxi and patient transport contracts and continued implementation and review of the Trust's travel plan).

Other Key Performance Indicators including information relating to environmental matters

The Department of Health has published Carbon Indicators for various aspects of Trust activity. The first shows the Trust's carbon performance relating to water, sewage and waste. The Trust is at B grade on a scale of A to G, where A is the best performance.



Carbon Indicator

(Shows the carbon performance of water, sewage & waste)

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Trust Code: RA7

Carbon Use Rating

This tells how efficient the site is from a carbon footprint perspective in relation to other NHS sites of the same type. The numbers do not present actual units of carbon; they represent comparative carbon efficiency. 100 would be a typical value for this type of site.

More carbon efficient

A 0-25

B 26-50 35

C 51-75

D 76-100

100 would be typical

E 101-125

F 126-150

G over 150

Less carbon efficient

Total CO2e Emissions

This tells you how much carbon dioxide the site generates through its use of water and generation of sewage & waste. It shows tonnes per year of CO2e. (NB. Does not include embodied CO2e)

Non-burn Treatment
Incinerated
Landfill
Sewage
Water
Recycled/Recovered

Previous Carbon Ratings

Technical Information

This tells you technical information about the consumption or waste generated for the site based upon ERIC submissions

Water: 179,490 m3
Sewage: 150,772 m3
High Temp Disposal: 233.34 tonnes
Landfill Disposal: 1079.36 tonnes
Non-burn Treatment: 581.06 tonnes
Waste Recovery/Recycling: 16.87 %
Occupied Floor Area: 165,931 m2

Administrative Information

Typical Value Type: ACUTE - TEACHING
Data processed by: DH
ERIC data period: 2008/9
Issue Date: 12/09
Due for renewal: 12/10

	Water	Sewage	High Temp Disposal	Landfill Disposal	Non-burn Treatment	Waste Recovery/Recycling
Annual Carbon Footprint (kg CO2e/m2/year)	0.30	0.63	0.31	1.58	0.25	-2.56
Typical Carbon Footprint (kg CO2e/m2/year)	0.45	0.94	0.52	1.74	0.34	-2.61

Carbon management programme

Risk assessments have been conducted to help decide which carbon reduction opportunities should be developed and implemented. A programme of such schemes is funded and being progressed for 2010/11.

Waste management, recycling and sustainability

The Carbon Management Programme includes waste management. Currently there is an underlying trend of an increase in volume, which is associated partly with increased activity.

The increase in recycling is, however, a very positive indicator. The proportion of non-clinical waste recycled has risen from 17% to 24%.

A new domestic waste contract began in April 2010 and will offer further opportunities to bring in additional waste streams, in particular plastics and cans.

This further increase in recycling will result in less domestic waste being sent to landfill. Staff working in all Trust premises will be able to contribute to this initiative.

Energy management and carbon reduction

The reduction in the use of energy is core to the Carbon Management Programme.

An extensive programme of fitting low energy lighting, particularly in common areas which are in use 24 hours a day, seven days a week, has been undertaken and will continue in 2010/11.

The installation of movement sensors in many areas is also reducing energy use, and also reinforces the message to staff that lights do not need to be on all the time.

Clinical and domestic waste				
	2008/2009		**2009/2010**	
	Tonnage and rate / tonne	**Cost**	**Tonnage and rate / tonne**	**Cost**
Clinical Waste for Incineration	233 @ £528	£123,024	266 @ £580	£154,416
Clinical Waste for Alternative Technology	578 @ £347	£200,566	598 @ £362	£216,476
Domestic Waste for Landfill	1,083 @ £95	£102,885	1,203 @ £101	£121,178
Domestic Waste Recycled	230 @ £32	£7,360	389 @ £24	£9,137
TOTAL	**2,124 tonnes**	**£433,835**	**2,456 tonnes**	**£501,207**

A major staff awareness programme, The Big Green Scheme, has been launched, which has included the recruitment of Green Champions to help spread awareness about how to make a difference.

At the end of the financial year, the Trust had more than 200 Green Champions.

Water and Energy Use and Costs 2008/09 and 2009-10				
	Volume 2008-09	**Volume 2009-10**	**Cost 2008-09**	**Cost 2009-10**
Water	191,413 m^3	204,350 m^3	£315,195	£351,245
Electricity	21,201,446 kWh	22,049,207 kWh	£2,396,423	£1,975,420
Gas	59,852,711 kWh	68,746,403 kWh	£1,768,362	£1,519,387
Other Energy (Oil)	2,233,307 kWh	315,637 kWh	£97,886	£14,951

This table shows energy use rising due to the opening of the Bristol Heart Institute.

This will be offset as plans to rationalise the estate are rolled out, and as a result consumption will fit within the overall target.

Procurement and the environment

During the year, two of our principal suppliers of goods and services, the laundry contractor Sunlight and the patient food supplier, Tillery Valley Foods have both won awards for their delivery of carbon reduction programmes.

9 TEACHING AND RESEARCH

Research and Development 2009/10

In the last year, the Trust has worked with its partner universities and NHS Trusts in the region to develop a shared strategy, and establish common goals and aspirations for clinical and health services research.

The Trust, NHS Bristol, Avon and Wiltshire Mental Health Partnership, North Bristol NHS Trust and the University of Bristol (UoB) and the University of the West of England (UWE) are working together to maximise their joint research potential by forming a pan-Bristol health research and innovation collaboration, called BRIG-H (Bristol Research and Innovation Group for Health).

A Joint Director of Research role across the two acute NHS trusts was created, and Professor David Wynick took up the post in March 2010. The year culminated with the official launch of BRIG-H at the Bristol Research and Innovation Symposium 2010, held at the end of March.

The event showcased the many existing fruitful collaborations between the six partner members of BRIG-H, highlighted the new infrastructure and joint processes which are being developed to further facilitate collaborative working and ended by setting out an exciting agenda for BRIG-H over the next two years.

Research at the Trust continues with total funding from the Local Comprehensive Research Network exceeding £4m. In the South West the Trust has recruited the most patients into complex clinical trials this year, driving next year's recruitment-based funding allocation to the highest in the region.

Further funding from the network has been targeted at developing infrastructure to allow the Trust to meet the Department of Health's targets to increase recruitment into trials over future years. This will offer patients in Bristol and the region the chance to participate in high quality research, providing the evidence for the best available treatments.

The opening of the new Bristol Heart Institute in 2009 has provided state-of-the-art clinical and research facilities in cardiac services. These trials continue to make up a large proportion of the Trust's research portfolio under the umbrella of the National Institute for Health Research's Biomedical Research Unit (BRU).

The five themes within the BRU focus on transferring discoveries and developments from the laboratory to the bedside, to provide new treatments which will benefit patients.

Research includes investigating whether stem cells can be used to stimulate regeneration of damaged heart muscle; how damage to veins transplanted to the heart for bypass surgery can be reduced, thus improving outcomes; and whether using a different route to access the heart for surgery improves outcomes for patients.

This builds on the world class research over the last few years which has brought us 'Off-Pump Coronary Artery Bypass' (OPCAB), a surgical technique whereby surgeons operate on the beating heart, removing the need to stop the heart or use a heart-lung

bypass machine, along with the optimisation of surgical techniques in paediatric and adult cardiac surgery techniques.

Professor Gianni Angelini's recent joint appointment with UoB and Imperial College London is already starting to facilitate collaborations and further development of joint projects between London and Bristol.

To further advance and facilitate translational research the Trust, in partnership with UoB, has recently started on the Clinical Research and Imaging Centre, located next to St Michael's Hospital.

The centre is jointly funded by the two organisations and will allow researchers access to a unique facility which will house a high field strength Magnetic Resonance Imaging (MRI) scanner, suitable for research in adults and children with a range of conditions, along with a dedicated sleep lab and clinical research rooms, all linked to the hospital.

The centre will open at the end of 2010, and is another example of how the Trust is working with our BRIG-H partners in moving research from the laboratory into the clinical setting.

Work has now begun in earnest on the two National Institute for Health Research (NIHR) programme grants awarded to the Trust in the previous year, with recruitment into trials within those programmes proceeding well.

The Blood Conservation Programme, led by cardiac surgeon Mr Gavin Murphy, is made up of a number of projects which aim to predict more accurately when blood transfusions are required.

Blood is a scarce resource which is heavily used for transfusions in cardiac surgery and other specialties. This programme of research aims to provide the evidence which will permit more informed decision-making prior to transfusion, leading to improved outcomes for patients and more efficient use of donated blood.

Professor Andy Ness is leading a programme of research to improve the quality of care for children born with cleft lip and palate and those suffering from head and neck cancer. Within the programme he and his team will review the existing evidence and carry out observational research and trials to develop new evidence to inform the provision of future care for these two groups of patients.

The Trust's partnership with the Department of Social Medicine at the University of Bristol resulted in a number of successful NIHR Research for Patient Benefit grant applications last year, and these projects have now started in cancer and surgery.

Additional successful bids include the award of a Health Technology Assessment grant to undertake a trial in children with cystic fibrosis. Respiratory paediatrician Dr Simon Langton Hewer is the principal investigator of this £1.5m multi-centre trial investigating the best treatment for lung infection in children and adults suffering from cystic fibrosis. The study aims to establish the best way of eradicating infection and delaying long term infections.

Dr Haidong Liang, a clinical scientist, has been awarded three NIHR Invention for Innovation grants. Dr Liang will work with Cardiff University, University of Bristol,

University of Bath, National Physical Laboratory as well as industry and other partners, focus on optimising ultrasound technology to produce better diagnostic information.

Teaching

As a teaching hospital Trust, we support the training and teaching of undergraduates, newly qualified members of staff, and the ongoing education of clinical and other staff at all levels.

The Trust has particularly strong partnerships with the Severn Deanery, University of Bristol and the University of West of England, which it values highly and will continue to develop.

Further education partnerships are being strengthened, including collaborative working with the City of Bristol College and involvement in the South Bristol Academy.

There are many other partnerships which support the teaching and learning culture we foster, including partnerships with other NHS organisations, Bristol City Council, other higher and further education providers within the South West, universities such as Keele, Exeter and Bath on leadership development, new independent sector providers, and the voluntary sector and social services.

NHS FOUNDATION TRUST CODE OF GOVERNANCE

10 ABOUT THE TRUST'S MEMBERSHIP

Membership report

The Trust is committed to the Foundation Trust model of local accountability through its members and Governors, by building on its strong patient and public involvement relationships and partnership working.

The Trust has increased its membership and continues to work towards the aim of ensuring its total membership is representative of the communities it serves, and that those who join as members have opportunities to be actively engaged with the Trust and the work of the Membership Council.

The Trust has five membership constituencies:

- Public Bristol constituency;
- Public North Somerset constituency;
- Public South Gloucestershire constituency;
- Patient constituency with four groups: Patients from tertiary areas, local patients, carers of patients 16 years and over, and carers of patients under 16 years;
- Staff constituency with four groups: Medical and dental; nursing and midwifery; other clinical healthcare professionals; and non-clinical healthcare professionals.

Public constituencies

Eligibility for public membership is open to those who live in Bristol, North Somerset or South Gloucestershire and who are not eligible to become a member of the Trust's staff or patient constituencies, are not members of any other constituency and are four years of age and above. Public membership is by opting in, that is to say, by application.

Patient constituency

Eligibility for the patient constituency is open to all those who are recorded on the Trust's Patient Administration System as having attended the Trust as a patient within the preceding three years, and/or who are neither eligible to become a member of the staff constituency nor under four years of age.

There are four groups within this constituency: patients from tertiary areas, local patients, carers of patients 16 years and over, and carers of patients under 16 years. However, once eligibility for patient membership has expired, members can be switched to the public constituency, if eligible. Patient membership is by opt-in.

Staff constituency

The staff constituency is made up of people who are employed under a contract with the Trust for at least 12 months and whose place of work is at the Trust, contractors who work full-time at the Trust, registered volunteers with the Trust and who are at least 16 years of age.

The staff constituency has four groups: medical and dental, nursing and midwifery, other clinical healthcare professionals and non-clinical healthcare professionals.

Staff membership is by an opt-out and Trust staff are automatically made members on appointment. Information on opting out of the scheme is included in induction packs and on the intranet.

Volunteers must apply to become a member.

Membership size and movements

The changes in membership size throughout 2009/10 and estimated growth for 2010/11 are shown in the table below.

Public constituency	**Last year**	**Next year 2011 (estimated)**
At year start (1 Apr 2009)	4,643	5,781
New members	1,557	614
Members leaving	419	400
At year end (31 March 2010)	5,781	5,995
Patient constituency		
At year start (1 Apr 2009)	5,760	5,821
New members	904	686
Members leaving	843	400
At year end (31 March 2010)	5,821	6,107
Staff constituency		
At year start (1 Apr 2009)	8,680	8,016
New members	1,203	1,090
Members leaving	1,867	1,303
At year end (31 March 2010)	8,016	7,803
Total members	March 2010 19,618	March 2011 19,905

The Trust's public and patient membership grew from 10,403 to 11,602 and staff membership was retained at nearly 100% with only two staff opting out. Public and patient membership increased by 11.5% in 2009/10.

The combined public, patient and staff membership as of 31 March 2010 stands at 19,618. This has been achieved by promoting Foundation Trust membership to patients and their carers in a variety of ways including in hospital outpatient areas and at member events.

The number of public and patient members leaving during 2009/10 was 1,262. The membership register has been frequently data cleansed to help in identifying members who have moved out of the catchment area or who have died.

Patient members who were no longer eligible for the patient constituency were switched to the public constituency, if eligible. A number of tertiary patient members were no longer eligible for membership.

Analysis of current membership

The profile of membership at the end of 2009/10 is shown in the table below:

Public constituency	**No. of members**	**Eligible membership**
Age (years):		
0-16	452	143,200
17-21	286	691,800
22+	5,043	
Ethnicity:		
White	5,001	782,000
Mixed	65	12,000
Asian/Asian British	143	19,000
Black/Black British	134	13,000
Other	438	9,000
Socio-economic groupings:		
ABC1	4,228	463,421
C2	935	121,343
D	187	132,156
E	431	118,080
Gender:		
Male	2,490	411,000
Female	3,291	424,000

Public constituency	No. of members	Eligible membership
Age:		
0-16	346	104,273
17-21	127	27,944
22+	5,348	304,961

Developing a representative and engaged membership in 2009/10

The Board of Directors and the Membership Council share the aim of developing an engaged membership by ensuring that members are involved in service developments.

To further this aim and to maintain a representative membership, the Membership Development Strategy and Patient and Public Involvement Strategy provide a framework for engaging members and the wider community, building membership numbers and supporting the governors.

Public, patient and staff members have been involved in various activities such as the opening of the Bristol Heart Institute, a dementia awareness event, a route map for health event, Patient Environment Action Team (PEAT) audits, a project team for the Bristol Haematology and Oncology Centre, nominations for Governor elections and Governor constituency meetings.

Our Governors have been involved in many activities within the Trust, including project teams, service improvement groups and strategy workshops.

At the end of March 2009, we recognised that the largest under-represented group of members was young people.

The young persons' involvement lead and the membership manager developed a membership package to address this and attract new young members from diverse backgrounds. This included:

- 'My Hospital My Say' events: Two events for young members have been held to tell us how they want to be involved in the hospitals.
- Youth Council: The Youth Council meets monthly and reports directly to the Governors Involvement Sub Group and to the Membership Council. Three Youth Council members have nominated themselves in the Governor elections taking place in the first quarter of 2010/11. The work with the Youth Council is ground-breaking for a Foundation Trust.
- Mystery shopping: A mystery shopping event for young people was held where they tested the services of six hospitals.
- Improving services: The Youth Council and young members have been involved in making suggestions on improving hospital food, commenting on patient leaflets, creating a newsletter for young people, attending the PEAT audit at the Bristol Royal Hospital for Children and conducting a survey of young members.

Evaluation of 2009/10 steps to achieve a representative membership

Membership has increased in specifically-targeted, under represented areas:

- The number of public and patient young members aged four to 16 has increased by 102% and the number of those aged 17 to 21has increased by 53%. These significant increases reflected the successful joint work carried out by the membership manager, work experience and schools liaison co-ordinator and young persons' involvement lead.
- The number of members of Asian, Black and mixed ethnicity has increased by 36%, 52% and 62%, respectively. These were mainly young members recruited though work with young people and outreach work, particularly with the Somali community and the local faith leaders.

Elections

No Governor elections took place during 2009/10 as those Governors who chose to stand down during the year were able to be replaced through voting conducted for the 2008 elections in accordance with the Trust's constitution.

Elections have taken place in early 2010/11, with the notice of elections having been posted in March 2010 for 14 Governor seats.

Membership Strategy for 2010/11

The Trust's Membership Development Plan for 2010/11 has been approved by the Board and Membership Council.

This sets out a detailed schedule of member recruitment and engagement events for 2010/11, to supplement the Trust's long-term aim to embed membership in all the Trust's development activities.

Progress against this plan during 2009/10 has been monitored by the Governor Involvement Group, the Trust's Involving People Committee which report into the Membership Council and Governance and Risk Management Committee, respectively.

During 2010/11, the key objectives are:

- To achieve a modest increase in membership of the public and patient constituencies by 500, split proportionately across the constituencies. This plan is in addition to replacing those members who have left, estimated to be 800. This is in accordance with our Membership Strategy to focus on engagement in years two and three of Foundation status. We will continue to focus on recruiting membership in under-represented groups, specifically children and young people**.** We will do this by building on the successes of the Youth Council and our work experience and schools liaison programmes in 2009/10 to increase the membership of children and young people.

- To focus membership recruitment on under-represented groups from Black and Minority Ethnic communities by strengthening links with key members of these communities as set out in the Trust's Patient and Public Involvement Strategy. We recognise the need to continue to work towards long-term engagement of these communities and will do this by encouraging membership as a vehicle for their views to be heard.

- To maintain staff membership at 95% or higher, and recognise the need to work with staff Governors to improve membership involvement in all our staff groups. The Foundation Trust Network commissioned Foundation Trust Staff Governor Study will be used as the framework to achieve this.

- To continue to engage members by providing a range of involvement opportunities, including member events shaped by our Governor Involvement Group and members' special interests.

- To deliver the elections for 14 Governor places.

Nominations Committee

The Governor Nominations Committee is a formal committee of the Membership Council whose role is to make recommendations to the council regarding the appointment of the Chairman and Non-Executive Directors and their respective terms and conditions of office, including remuneration.

The Nominations committee also leads on the process for evaluating the performance of the Chairman and Non-Executive Directors.

The committee made no new Non-Executive Director appointments in 2009/10, but recommended the reappointment of Emma Woollett as Non-Executive Director and Deputy Chair for a further term of office from 1 January 2010, and John Savage as Chairman for a further term of office from 1 December 2009. Both reappointments were subsequently approved by the Membership Council.

The Trust has an agreed job description for the post of Chairman of the Trust, which includes in the person specification reference to the need for candidates to be able to devote the necessary time to the role. The Nominations Committee keeps this factor under review in the appointments and appraisal processes.

In addition, during 2009/10 the committee commissioned an external appraisal of the Trust Board, the outcome of which was discussed with the committee and will be taken forward by the Chairman during 2010/11.

Nominations and Appointments Committee Meetings 2009/10 – attendance record

Meetings held June 2009, July 2009, Sept 2009, Dec 2009, Jan 2010 and March 2010 (six in total)

Name	Title/constituency	Number attended
Chair: John Savage	Chairman	4/4
Ian Fairbairn	Senior Independent Non-Executive Director	2/2
Governors:		
David Clark	Public Governor: South Gloucestershire	5/6

Elizabeth Corrigan	Public Governor: North Somerset	2/6
Clive Hamilton	Patient Governor: Local Patients	2/2
Jeanette Jones	Partnership Governor: Joint Union Committee	3/6
Philip Mackie	Patient Governor: Carer of patient under 16 years	4/6
Philip Quirk	Staff Governor: Clinical Healthcare Professionals	4/6
Sylvia Townsend	Appointed Governor: Bristol City Council	2/4
Karen Smith	Local Patient Governor	3/3
In attendance:		
Anne Reader	Assistant Director of Governance and Risk Management	6/6

Register of interests

To view the register of interests for our Membership Council, please contact the membership office. Contact details can be found below.

Contacting the Trust

Members wishing to communicate with directors and elected members of the Membership Council and anyone interested in finding out more about membership should contact:

Membership Office
University Hospitals Bristol NHS
Foundation Trust
Freepost UH Bristol FT Office
BS1 3NU
Telephone: 0117 342 3764
Email: foundationtrust@uhbristol.nhs.uk

Membership Council attendance

April 2009 to March 2010: Six meetings (April, May, July, October and February 2010, ordinary meetings, and the Annual Members Meeting in September 2009)

Constituency	Name	Actual / possible attendance
Public Governors		
Public South Gloucestershire	Mrs Patricia Robinson	5/6
Public South Gloucestershire	Mr David Clark	4/6
Public North Somerset	Mrs Elizabeth Corrigan	5/6
Public North Somerset	Mrs Anne Ford	5/6
Public Bristol	Ms Heather England	5/6
Public Bristol	Mrs Mo Schiller	6/6
Public Bristol	Mr Jason Edgar	6/6
Public Bristol	Mr George Wynne Willson	4/6
Public Bristol	Mrs Elizabeth Obileye	6/6
Patient Governors		
Patient governors from tertiary areas	Mr Des Osborne	5/6
Patient governors from tertiary areas	Mr Roger Loodmer (joined July 09)	1/2
Patient governors from tertiary areas	Mrs Rosemary Chalmers (left May 09)	1/1
Local patients governors who live in Bristol, North Somerset and South Gloucestershire	Prof Christine Webb (left Aug 09)	2/3
Local patients governors who live in Bristol, North Somerset and South Gloucestershire	Mr David Aldington (joined Oct 09)	1/2
Local patients governors who live in Bristol, North Somerset and South Gloucestershire	Mrs Pam Yabsley	5/6
Local patients governors who live in Bristol, North Somerset and South Gloucestershire	Mrs Anne Skinner	4/6
Local patients governors who live	Mr Allan Attwood	5/6

Constituency	Name	Actual / possible attendance
in Bristol, North Somerset and South Gloucestershire		
Local patients governors who live in Bristol, North Somerset and South Gloucestershire	Mr Clive Hamilton (Lead Governor)	6/6
Local patients governors who live in Bristol, North Somerset and South Gloucestershire	Dr Karen Smith (joined May 2009)	3/5
Carers of patients 16 years and over	Mrs Wendy Gregory	4/6
Carers of patients 16 years and over	Mrs Sylvia Smith	0/6
Carers of patients under 16 years	Mr Philip Mackie	4/6
Carers of patients under 16 years	Mrs Lorna Watson	5/6
Staff Governors:		
Non-clinical Healthcare Professional	Mr Chris Swonnell (joined July 09)	3/3
Non-clinical Healthcare Professional	Ms Jan Dykes	4/6
Other Clinical Healthcare Professional	Mr Phil Quirk	5/6
Medical and Dental	Mr Jim Catterall	3/6
Nursing and Midwifery	Ms Wendy Hurn	1/6
Nursing and Midwifery	Ms Belinda Cox	6/6
Appointed Governors		
Bristol City Council	Cllr Sylvia Townsend - Councillor (joined July 09)	2/4
Bristol City Council	Cllr Bill Payne (left June 09)	2/2
University of Bristol	Prof Massimo Pignatelli - Head of Clinical Science	1/6
University of the West of England	Prof John Duffield - Pro Vice-Chancellor and Executive Dean	1/6
Bristol Primary Care Trust	Deborah Lee - Director of Commissioning	1/6

Constituency	Name	Actual / possible attendance
North Somerset Primary Care Trust	James White – Non Executive Director	2/6
South Gloucestershire Primary Care Trust	Dr Chris Payne - Director of Public Health and Children's commissioning lead	1/6
Partnership Organisations		
Joint Union Committee	Jeanette Jones - Representative	6/6
Great Western Ambulance Trust	John Newman – Non Executive Director	0/6
Avon and Wiltshire Mental Health Trust	Jane Britton - Deputy Director of Integrated Governance	0/6
Community Groups	Andrew Yerbury	1/6
Voluntary Groups	Frank Palma	2/6
Chairman		
John Savage	Chair	6/6
Directors		
Irene Gray	Chief Operating Officer	5/6
Graham Rich	Chief Executive (left December 09)	5/5
Alison Moon	Chief Nurse (joined July 2009)	3/4
Jonathan Sheffield	Medical Director	4/6
Robert Woolley	Director of Corporate Development (Acting Chief Executive from December 2009)	6/6
Steve Aumayer	Director of Workforce and Organisational Development (joined July 2009)	2/4
Paul Mapson	Director of Finance	2/6
Non Executive Directors		
Emma Woollett	Deputy Chair	4/6
Iain Fairbairn	Senior Independent Director	4/6
Paul May	Non Executive Director	2/6
Kelvin Blake	Non Executive Director	4/6

Constituency	Name	Actual / possible attendance
Lisa Gardner	Chair of the Finance Committee	2/6
Selby Knox	Non Executive Director	2/6
Sarah Blackburn	Chair of the Audit Committee (joined June 2009)	2/4
Patsy Hudson	Chair of the Audit Committee (left May 2009)	0/2

List of Governors, constituency and term

In 2009/10 the Membership Council comprised the following Governors and was chaired by John Savage.

Constituency	Name	Length of appointment	Elected / Appt'd / Partn'p
Public Governors			
Public South Gloucestershire	Patricia Robinson	June 2008-May 2010	Elected
Public South Gloucestershire	David Clark	June 2008-May 2010	Elected
Public North Somerset	Elizabeth Corrigan	June 2008-May 2011	Elected
Public North Somerset	Anne Ford	June 2008-May 2011	Elected
Public Bristol	Heather England	June 2008-May 2011	Elected
Public Bristol	Mo Schiller	June 2008-May 2011	Elected
Public Bristol	Jason Edgar	December 2008-May 2011	Elected
Public Bristol	George Wynne Willson	June 2008-May 2010	Elected
Public Bristol	Elizabeth Obileye	June 2008-May 2010	Elected
Patient Governors			**Elected**
Patient governors from tertiary areas (who live in the rest of England and Wales)	Roger Loodmer	July 2009 -May 2010	Elected

Constituency	Name	Length of appointment	Elected / Appt'd / Partn'p
Patient governors from tertiary areas (who live in the rest of England and Wales)	Des Osborne	August 2008-May 2010	Elected
Local patient governors who live in Bristol, North Somerset and South Gloucestershire	Karen Smith	May 2009-May 2010	Elected
Local patient governors who live in Bristol, North Somerset and South Gloucestershire	Allan Attwood	June 2008-May 2010	Elected
Local patient governors who live in Bristol, North Somerset and South Gloucestershire	Clive Hamilton (vice Chairman and Lead Governor from 29 October 2009)	June 2008-May 2010	Elected
Local patient governors who live in Bristol, North Somerset and South Gloucestershire	Pam Yabsley	June 2008-May 2011	Elected
Local patient governors who live in Bristol, North Somerset and South Gloucestershire	Anne Skinner	June 2008-May 2011	Elected
Local patient governors who live in Bristol, North Somerset and South Gloucestershire	David Aldington	November 2009-May 2011	Elected
Carers of patients 16 years and over	Wendy Gregory	June 2008-May 2010	Elected
Carers of patients 16 years and over	Sylvia Smith	June 2008-May 2010	Elected
Carers of patients under 16 years	Philip Mackie	June 2008-May 2011	Elected
Carers of patients under 16 years	Lorna Watson	June 2008-May 2011	Elected
Patient governors from tertiary areas (who live in the rest of England and Wales)	Rosemary Chalmers	June 2008-May 2009.	Elected
Local patients governors who live in Bristol, North Somerset and South Gloucestershire	Christine Webb	June 2008-August 2009.	Elected
Local patient governors who live in Bristol, North Somerset	Heather Saunders	June 2008-March 2009	Elected

Constituency	Name	Length of appointment	Elected / Appt'd / Partn'p
and South Gloucestershire			
Staff Governors:			**Elected**
Non-clinical Healthcare Professional	Chris Swonnell	July 2009-May 2011	Elected
Non-clinical Healthcare Professional	Jan Dykes	June 2008-May 2011	Elected
Other Clinical Healthcare Professional	Phil Quirk	June 2008-May 2010	Elected
Medical and Dental	Jim Catterall	June 2008-May 2011	Elected
Nursing and Midwifery	Wendy Hurn	June 2008-May 2010	Elected
Nursing and Midwifery	Belinda Cox	June 2008-May 2010	Elected
Non-clinical Healthcare Professional	Martin Long	June 2008-June 2009	Elected
Appointed Governors			
Bristol City Council	Cllr Sylvia Townsend	June 2009- May 2011	Appointed
Bristol Primary Care Trust	Deborah Lee – Director of Commissioning	June 2008-May 2011	Appointed
North Somerset Primary Care Trust	James White – Non Executive Director	December 2008-May 2011	Appointed
South Gloucestershire Primary Care Trust	Dr Chris Payne – Director of Public Health and Children's commissioning lead	June 2008-May 2011	Appointed
University of Bristol	Prof Massimo Pignatelli – Head of Clinical Science	June 2008-May 2011	Appointed
University of the West of England	Prof John Duffield – Pro Vice-Chancellor and Executive Dean of the Faculty of Health & Life Sciences	June 2008-May 2011	Appointed

Constituency	Name	Length of appointment	Elected / Appt'd / Partn'p
Bristol City Council	Cllr Bill Payne	June 2008- May 2009.	Appointed
Partnership Organisations			
Avon and Wiltshire Mental Health Trust	Jane Britton - Deputy Director of Integrated Governance	June 2008-May 2011	Partnership
Great Western Ambulance Trust	John Newman – Non Executive Director	June 2008-May 2011	Partnership
Joint Union Committee	Jeanette Jones – Representative	June 2008-May 2011	Partnership
Voluntary Groups	Frank Palma	June 2008-May 2011	Partnership
Community Groups	Andrew Yerbury	August 2008-March 2010. Position vacant.	Partnership

No governor elections were held in 2009/10.

11 ABOUT THE BOARD OF DIRECTORS

Trust Board – current Directors

John Savage – Chairman

John Savage was appointed as Chairman of the University Hospitals Bristol NHS Foundation Trust on 1 December 2006.

From 1989, he was full-time Chief Executive of the Bristol Initiative and, from February 1993, Chief Executive of the Bristol Chamber of Commerce and Initiative, after the merger of these two bodies.

In September 1994 he became Chief Executive of Business West, the new joint operating company of the Chamber and Business Link West.

He was awarded the CBE for service to Business and Regeneration in the 2006 New Year Honours List.

He is Chairman of the Churches Council for Social Responsibility, a board member of the Regional Development Agency and was Chairman of the South West Learning and Skills Council from inception until its recent closure.

He has gained a broad range of business experience over a period of more than 40 years.

Robert Woolley – Acting Chief Executive/Director of Corporate Development

Robert was educated at St Paul's School, London, and Lincoln College, Oxford, and holds an MBA with distinction from Bath University.

He joined the NHS as a strategic planner at the Royal London NHS Trust in 1992. At Barts and the London NHS Trust, he rose to be assistant director for the project to re-develop the Royal London Hospital before becoming general manager for children's services across the City and East London in 1996 and later of clinical support services across St Bartholomew’s, the Royal London and the London Chest Hospitals.

Robert joined the Board of United Bristol Healthcare Trust as Director of Performance Management in 2002, co-ordinating the achievement of key standards for patient access.

He took the Corporate Development portfolio in 2004, since when he has overseen the £18 million expansion and refurbishment of the Bristol Dental Hospital, the construction of the new £60 million Bristol Heart Institute and the development of the Trust’s 10 year strategic plan.

He was project director for the successful application for Foundation Trust status in 2008.

Robert was appointed Acting Chief Executive in December 2009.

Irene Gray - Chief Operating Officer

Irene trained as a nurse in Manchester from 1972 to 1975, specialising in care of the elderly and rehabilitation. She was a ward sister and specialist adviser in this field until 1986 when she was appointed to her first Executive Director position at the Christie Hospital in Manchester as the Director of Nursing.

Over the past 24 years Irene has held six executive roles including Director of Nursing at Leicester Royal Infirmary, Guy's & St Thomas' NHS Foundation Trust, and Surrey & Sussex Healthcare NHS trust.

Irene was also Regional Director of Nursing and Education in the West Midlands and CEO of the Nurse Directors Association UK.

Irene has played key national roles and influenced the development and delivery of policy and is interested in leadership and change management.

She joined the University Hospitals Bristol NHS Foundation Trust as the Chief Operating Officer in March 2008 and is responsible for operational performance and service development and delivery across the Trust.

Irene was awarded an MSc from Nottingham University in 1997 and holds honorary Chairs in Nursing at three universities.

Steve Aumayer - Director of Workforce and Organisational Development (appointed July 2009)

Steve joined University Hospitals Bristol on 25 June 2009 and brings with him a wealth of senior Human Resources experience from a variety of sectors.

Over the course of his career, Steve has worked extensively within consulting, retail banking and the telecommunications sectors.

Prior to joining the Trust, Steve spent eight years working in telecoms, as the Managing Director of Human Resources for COLT, a major European Business Telecoms provider, as UK Human Resources Director at Orange, and jointly leading a venture between Orange and Vodafone working on network sharing.

Steve has also held roles as a director at Deloitte and Touche, at Hay Management Consultants and at Bristol and West.

Steve's career started with a commission in the Royal Navy where he graduated from Britannia Royal Naval College in Dartmouth and then went on to be a navigation officer.

Jonathan Sheffield - Medical Director

Dr Jonathan Sheffield became Medical Director of the Trust on 1 September 2004.

Jonathan will already be known to many within the Trust through his work with Avon, Somerset and Wiltshire Cancer Services.

He qualified in 1981 from Dundee Medical School and worked at Nottingham Hospital and St Mark's Hospital in London, among others, during his trainee years.

In 1994, he was appointed as a Consultant Histopathologist, with a special interest in gastrointestinal disease.

He is a member of the Department of Health Cancer Task Force and has previously been Chair of the Regional Modernisation Cancer Task Force.

Paul Mapson – Director of Finance

Paul Mapson joined the NHS as a National Finance Trainee in 1979. He became a fully qualified accountant in 1983 and has undertaken a wide variety of roles within the NHS in the acute sector.

Paul has seven years experience at Board level including significant experience in the management of capital projects, specialised commissioning, systems development, information technology and procurement.

Before joining the Trust in 1991 as Deputy Finance Director, Paul held posts in Somerset, Southmead and Frenchay.

He was appointed Director of Finance in October 2002.

Alison Moon – Chief Nurse (appointed June 2009)

Alison joined the NHS in 1980 and qualified as a Registered Nurse at Frenchay Hospital, Bristol.

She has a wealth of experience as a clinical and leader in both secondary and primary care and has previously held roles of Director of Nursing and Clinical Governance at Yeovil District Hospital NHS Foundation Trust and at Bristol North Primary Care Trust.

Alison has a proven record for improving standards of care – putting the patients first, delivering service improvements, influencing change and pioneering new roles both locally and nationally.

She was awarded an MA for Management in 1999 from the Bristol Business School.

Alison has a passion from improving the experience of our patients through staff reaching their potential and being valued for the contribution they make.

She joined the Trust in July 2009 and in addition to being the Chief Nurse and Professional Lead for the Allied Health Professionals, Alison has the Governance Director role for University Hospitals Bristol NHS Foundation Trust.

Emma Woollett – Non-Executive Director

Emma was first appointed as a Non-Executive Director in January 2006 and was reappointed as Vice Chair for three years from January 2010.

She has worked in both the private and public sectors and has held senior level management positions in marketing and business development. She was Marketing Director for Kwik Save Stores, following its merger with retailer Somerfield plc.

She left Somerfield in 2001 to set up a freelance management consultancy practice, providing analytical advice to NHS organisations on capacity planning and waiting list management.

Prior to joining Somerfield, Emma spent a number of years as a management consultant for PricewaterhouseCoopers, working worldwide on projects for utility companies looking to develop more commercial approaches within a public sector environment.

She started her career in the oil industry and has degrees in Physics and International Relations from Cambridge University.

Emma is Chair of the Audit and Assurance Committee.

Lisa Gardner – Non-Executive Director

Lisa Gardner was appointed to the role of Non-Executive Director on 1 June 2007.

She has acquired a broad range of business experience over almost 20 years and the post held during that time include finance director of both Aardman Animations Limited and Business West Bristol.

She qualified as a chartered accountant in 1992 after gaining a BA Honours degree in accounting and finance at Kingston University. Her current role is as an associate in a local chartered accountant's practice.

Lisa is also Chair of the Finance Committee at the Trust and sits on the Audit and Assurance Committee.

She also sits on the Watershed's Trust and Trading Companies Boards and has just finished her term as a Parent Governor at Westbury Park Primary School, where she was also Chair of the Finance Committee there.

Lisa was the Financial Director at Aardman for 11 years and since then has worked in the Finance Director role at Business West and in the retail industry.

Iain Fairbairn – Non-Executive Director

Iain Fairbairn's four-year term of office began on 1 December 2007.

He is the Senior Independent Director at the Trust, a member of the Audit and Assurance Committee, and a member of the Clinical Ethics Advisory Group.

He was formerly a commercial solicitor, in legal practices in both the City of London and Bristol, which included more than 20 years' experience of offering property, commercial, planning and construction advice to the NHS, covering Private Finance Initiative projects, the establishment of NHS trusts and joint working between the NHS and other public and private bodies.

He is the founder and developer of a care village for the elderly in Cornwall, which includes a nursing home, and he is a director of a not-for-profit social enterprise to support women and their families through the menopause.

Iain gained an honours degree in law at University College London before qualifying as a solicitor in 1979.

Selby Knox - Non-Executive Director

Professor Selby Knox began his four-year term of office on 1 February 2008 as a Non-Executive Director of the Trust.

Professor Knox retired in August 2008 from the position of Pro Vice-Chancellor of the University of Bristol.

He was a member of the university's senior management team, with responsibility for oversight of finance and estates, and of the Faculties of Medicine and Dentistry and Medical Sciences.

He was chair of the budget and capital prioritisation committees, and a member of the University Council and its finance, estates and audit committees.

He obtained a BSc in 1966 and a PhD in 1969, both from the University of Bristol. He returned there as lecturer in 1972 after postdoctoral research at the University of California, Los Angeles, and was awarded a DSc by the University of Bristol in 1985.

He was promoted to Reader in 1983 and to Professor in 1990 and from 1992 to 2001 was Head of the School of Chemistry.

From 1996 to 2004, Professor Knox held the Alfred Capper Pass Chair of Chemistry, which he relinquished on being appointed Pro Vice-Chancellor.

Professor Knox's research in organometallic chemistry attracted several awards from the Royal Society of Chemistry and visiting professorships in North America and Europe.

Paul May - Non-Executive Director

Paul May is a public sector strategic consultant who brings 30 years' experience at the highest levels in local government and further education.

He was the Chief Executive of Wansdyke District Council, and then North Somerset Council for nearly 20 years.

He was also the Executive Director of the Learning and Skills Council in the West of England, and Chief Executive of the Further Education Bureaucracy Reduction Group for England.

His projects as a consultant include working on the Framework for Excellence quality system for further education and re-shaping the structure of the South West's Learning and Skills Council.

He also took a lead role for the Sexual Assault Referral Centre for Avon and Somerset, helping agencies to work more closely together to improve the experience for victims of this crime. He is now working to help the communities of Devon and Cornwall developing Sexual Assault Referral Centres.

Paul was appointed Non-Executive Director to the Trust on 1 November 2008.

Kelvin Blake - Non-Executive Director

Kelvin is a senior manager working for BT and leads a number of high profile customer transformational programmes.

Kelvin is also a member of the BT South West Regional Board. The work of the board is to ensure BT is represented across the region in business and community activities. It is also responsible for delivering BT strategic goals including super fast broadband and Digital Britain.

Previously, he has worked for RTZ, Post Office Counters and Royal & Sun Alliance.

Kelvin is also a trustee of two charities. The Vassal Centre Trust is a local charity that manages barrier free workspace in Bristol primarily for the use of organisations that provide services to disabled people. And the Spinal Injuries Association (SIA) is the leading national charity for spinal cord injured people.

Kelvin is a former Bristol City Councillor. He represented Filwood ward, in the south of the City, and during his time as a councillor he was Chair of Regeneration and a member of the cabinet.

Kelvin is a member of the Finance Committee and also chairs the Organ Donation Committee.

Former Board members 2009/10

Sarah Blackburn - Non-Executive Director and Audit Committee Chair (June 2009-March 2010)

Sarah Blackburn holds a doctorate in business administration from Brunel University (Henley Management College). She is a fellow of both the Institute of Chartered Accountants in England and Wales and the Institute of Internal Auditors.

She is Chief Executive of the Wayside Network – a consultancy specialising in governance, risk management and the development of assurance services.

Over the course of some 20 years in assurance, Sarah has been director of internal audit and risk management in three FTSE 100 companies and one public service organisation.

She is a Non-Executive Director and Audit Committee Chairman at the Identity and Passport Service where she also chairs the Data Governance Board Sub-Committee.

She was a Commissioner (Non-Executive Director) at the Healthcare Commission from its inception until its abolition and she chaired its Audit Committee and an expert reference group on Governance. She also served on the Investigations Committee.

Sarah has a special interest in access to diagnosis and effective treatment for adults and children living with primary and secondary lymphoedema.

Sarah Blackburn was appointed as a Non-Executive Director of the Trust on 1 June 2009 and resigned in March 2010.

Graham Rich - Chief Executive (October 2007-December 2009)

Graham Rich qualified in medicine and undertook variety of hospital clinical roles as part of GP training. He worked in the Department of Health in performance management and has undertaken roles at both Chief Executive and Director level within primary care and commissioning sector.

He has spent 12 years at board level within the NHS and 24 years in healthcare.

Previously he was a member of Department of Health on long term conditions.

Member of the Foundation Trust Network Board. Senior Medical Officer at the Department of Health in performance management.

Graham has worked in the USA with Jackson Hole Group on managed care and system reform, and in strategy consultancy with Boston Consulting Group.

He has been director of Commissioning and Primary Care, Newcastle and North Tyneside Health Authority, Chief Executive of West Hull Primary Care Trust and Chief Operating Officer of the Trust, before being appointed Chief Executive in October 2007.

Pat Fields - Acting Chief Nurse (March-June 2009)

Pat is a Registered Nurse and has worked clinically in surgical nursing before entering a variety of general management roles. She undertook the leadership programme for Executive Nurse Directors at the King's Fund.

Pat joined the Bristol and Weston Health Authority in 1977 as a Nursing Officer for the General Surgical Unit, which also covered cardiac and intensive care services.

Her other roles have included Associate General Manager covering trauma and orthopaedics and General Manager for anaesthetics and intensive care.

Throughout this period, Pat continued in her role as Professional Advisor to the Director of Nursing.

Following a restructure in 1996, she became Head of Nursing for the Bristol Royal Infirmary and Bristol General Hospital. She has been Deputy Director of Nursing since 1998.

In March 2009, Pat was appointed to the role of Acting Chief Nurse for the Trust.

Alex Nestor - Acting Director of Workforce and Organisational Development (November 2008-July 2009)

Alex joined the NHS in 1988 as a workforce information officer, becoming qualified in Human Resources at the University of West England in 1993.

In 2000, she completed a Masters in International Strategic HRM.

She is now a Fellow of the Chartered Institute of Personnel and Development and in 2003 completed the NHS Excellence in Leadership programme at the University of Manchester.

Alex has previously held a range of human resource roles in the South West, including Human Resources Manager at North Bristol NHS Trust and at the Royal United Hospital, Bath.

Alex was appointed to the Trust in 2003 as Assistant Director of Human Resources, and became Head of Human Resources/Deputy Director of Workforce Development in 2004.

She became Acting Director of Workforce and Organisational Development in November 2008.

Patsy Hudson - Non-Executive Director and Audit Committee Chair (December 2000-May 2009)

Patsy qualified as a nurse in the 1960s and worked for the Family Planning Association in a variety of roles. She was lecturer in Government and Politics at St Alban's College of Further Education between 1979 and 1985, and was appointed as District Manager for Oxfam in 1986. She was selected as one of Oxfam's first Equal Opportunities trainers in late 1980s.

She was Oxfam's regional retail manager for the South West and South Wales from 1996 to 2000 and was a board member of Avon and Somerset Probation Board between 2001 and 2007. She also chaired Victim Support Avonvale from 2004 to 2008.

Chair of Audit and Assurance Committee at the Trust, Patsy has also chaired the Judicial Appointments Committee Panel for the appointment of judges since January 2008.

Board of Directors

The Board of Directors is legally accountable for the overall performance of the Trust. It is made up of the Chair John Savage, seven Non-Executive Directors (one vacant post at the time of writing) and seven Executive Directors, including the Chief Executive.

The Board is responsible for setting and realising the vision of the Trust. Board members are responsible for the overall future of the Trust and the services it provides. They agree strategy and direction, oversee performance in all functions and ensure that the services provided give value for money.

The Board ensures that services provided by the Trust are evidence-based, safe, underpinned by quality, meet the needs of patients, are cost-effective, and meet the needs of carers, the wider community and partner organisations. In doing so, the Board of Directors ensures that the Trust maintains compliance with its Terms of Authorisation and all statutory obligations.

The Trust Board is supported by internal executive bodies, including the Trust Executive Group, and the Trust Operational Group. The Board works as the overall strategy body for the Trust, drawing on the support of the executive teams.

The executive groups take forward to the Board and deliver the Trust's agreed strategies, financial and activity plans. The Board oversees and challenges the delivery of the Trust's targets and its performance against national standards.

Chaired by the Chief Executive, the Trust Executive Group comprises the Executive Directors, Heads of Clinical Division and service heads, so it a key meeting-point for the Trust's clinical and general management.

In this meeting, key issues and strategies, the basis for more detailed operating and financial planning, accommodation and staffing configurations are discussed and agreed. The implications of current performance information are discussed and high level actions agreed.

The Academic Trust Executive Group meets quarterly and conducts the Trust's relationship with its academic partners for research and teaching activities. A Research Committee further supports this, overseeing progress with the Research & Development Strategy.

The Trust Operational Group is chaired by the Chief Operating Officer and comprises Heads of Nursing and Divisional Managers and focuses on scrutinising the performance and the implementation arrangements of decisions affecting several divisions. It leads on the allocation of capital and revenue funding streams.

The Board confirms that so far as each Director is aware, the NHS Foundation Trust's auditor is aware of all relevant audit information. Each Director has 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 NHS Foundation Trust's auditor is aware of that information.

Board meetings are held monthly in public and the papers and dates of future meetings are available on the Trust's website. Governors are actively encouraged to attend Board meetings and many Non-Executive Directors attend meetings of the Membership Council (Board of Governors). There are regular informal meetings between Non-Executive Directors and Governors; Governors also engage with the work of the Trust through three sub-committees of the Membership Council.

The Board is supported by a Finance Committee, as well as Audit and Assurance and Remuneration Committees which have their own sections in this report. The terms of reference and delegated authority for each of these are kept under review.

The external facilitator's report in connection with the Board's effectiveness review commented, *"Based on detailed consideration of the evidence collected, it is the authors' overall opinion that the UH Bristol board has considerable strengths. It has a highly effective chair, a committed, knowledgeable, assertive, well-balanced group of Non-Executive Directors and a talented group of Executive Directors. Two of the Executive Directors volunteered that this was the best board they had worked on.*

"In relation to the Non-Executive Directors, the Executive Directors consider, and the evidence of our work leads us to agree, that they are a strong group, asking probing questions, providing support and bringing a variety of strengths to the board."

Towards the end 2009/10, the Governor Nominations Committee considered performance evaluation of the Chair and Non-Executive Directors and commissioned independent external assistance for this task, to include the performance of the whole Board, which was concluded in March 2010.

The Trust considers all of its Non-Executive Directors to be independent in that there are no relationships or circumstances that are likely to affect their judgement as evidenced through their declarations of interest set out below.

Newly appointed Non-Executive Directors serve a three year term and will be subject to particularly rigorous performance evaluation towards the end of their term, prior to consideration for reappointment by the Membership Council for further terms for up to nine years in total.

The Board has reviewed its compliance with the principles and the provisions of the Code of Governance and considers that it is compliant in all material respects.

Further detail is given in a separate section of this report.

Directors' attendance at Trust Board meetings
April 2009 – March 2010

Name	Apr 2009	May 2009	Jun 2009	Jun 2009	Jul 2009	Aug 2009	Sep 2009	Oct 2009	Nov 2009	Dec 2009	Jan 2010	Feb 2010	Mar 2010
Aumayer, Steve						✓	✓	✓	✓	✓		✓	✓
Blackburn, Sarah			✓	✓		✓	✓		✓	✓		✓	✓
Blake, Kelvin	✓	✓		✓	✓	✓		✓	✓		✓	✓	✓
Fairbairn, Iain		✓	✓	✓	✓	✓	✓	✓		✓	✓		✓
Fields, Pat	✓		✓	✓									✓
Gardner, Lisa	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gray, Irene	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Hudson, Patsy	✓	✓											
Knox, Selby	✓	✓		✓		✓		✓	✓	✓	✓	✓	
Mapson, Paul	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
May, Paul	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Moon, Alison					✓	✓		✓	✓	√	✓	✓	✓
Nestor, Alex	✓	✓	✓	✓	✓								
Rich, Graham	✓	✓	✓	✓	✓	✓	✓	✓	✓				
Savage, John	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Sheffield, Jonathan	✓	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓
Woollett, Emma	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Woolley, Robert	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓	✓

Grey shading indicates that the person was not eligible to attend a particular meeting.

Register of Interests 2009/2010

Name	Position held	Relevant business interests	Other interests
		(state "none" if no interests)	
Aumayer, Steve	Director of Workforce and Organisational Development	Company Secretary, Eskimokids Ltd, a children's shop and hairdresser's. There are no financial business or time conflicts with this Trust.	None
Blackburn, Sarah	Non-Executive Director	Director, the Wayside Network Limited (GP services in secure environments), Director Lymph Control Limited (importer of low level laser therapy units)	Director, the Institute of Internal Auditors - UK and Ireland (professional body); Non-Executive Director, Identity and Passport Service (UK Government agency)
Blake, Kelvin	Non-Executive Director	Full-time Programme Director for BT	Trustee of the Spinal Injuries Association; Trustee of the Vassall Centre Trust; Member of the Labour Party; Member of Unite the Union; Member of CONNECT Union
Fairbairn, Iain	Non-Executive Director	H&I Partnership Limited - owned jointly with spouse (consultancy operating in the field of care and accommodation of the elderly.)	Very minor shareholding (192) shares in Tribal Group Ltd.
Fields, Pat	Acting Chief Nurse	None	None
Gardner, Lisa	Non-Executive Director	None	Governor - Westbury Park Primary School; Director - Watershed Arts Trust; Partner in an internet business mainly selling children's wear - www.chillicrush.co.uk
Hudson, Patsy	Non-Executive Director	None	Panel Chair for the Judicial Appointments Commission; Coach and Mentor

Name	Position held	Relevant business interests	Other interests
Knox, Selby	Non-Executive Director	Paid work, chairing monthly meeting of the Redundancy Committee, University of Bristol	None
May, Paul	Non-Executive Director	Managing Director for Skills Partnership - public sector strategic consultancy	Bristol University Committees (Estates and Risk Management)
Mapson, Paul	Director of Finance	None	None
Moon, Alison	Chief Nurse	None	None
Nestor, Alex	Acting Director of Workforce and Organisational Development	None	Provision of HR advice to Abbott Burke Associates; Provision of HR advice to Devon Local Medical Committee
Rich, Graham	Chief Executive	Spouse is a GP and senior lecturer in Department of Primary Care, University of Bristol; Member Common Purpose Advisory Group for the Bristol Area; Board member Foundation Trust Network	None

Name	Position held	Relevant business interests	Other interests
Savage, John	Chairman	Business West, Executive Chairman; The Grand Appeal, Trustee; West of England Partnership, Vice Chairman; South West Learning and Skills Council Board, Chairman; South West Regional Development Agency, Board Member; SWERDA Regional Infrastructure Fund Advisory Board, Member; Destination Bristol, Joint Chairman; Bristol Harbourside Sponsors Group, Chairman; The Churches Council for Industrial and Social Responsibility, Chairman; Business Link Northern Arc, Board Member; Bristol Cultural Development Partnership Limited, Financial Director; West of England Connexions, Board Member; South West Chambers of Commerce Limited, Board Member.	Enuresis Resource and Information Centre (ERIC) - Treasurer; Young Bristol, Vice President; Bristol Society, Secretary and Treasurer; Bristol Choral Society, Patron and Vice-President; The Bristol Partnership, Chairman.
Gray, Irene	Chief Operating Officer	Honorary Positions: Professor of Nursing – Wolverhampton University Professor of Nursing – South Bank University Professor of Nursing – Kings College London	None
Sheffield, Jonathan	Medical Director	None	None
Woollett, Emma	Non-Executive Director/Vice-Chair	Management consultancy for NHS organisations outside the South West	Trustee of Above & Beyond Charities
Woolley, Robert	Acting Chief Executive/ Director of Corporate Development	None	Board Member, Science City, Bristol. Member, Common Purpose Advisory Group.

12 AUDIT AND COUNTER-FRAUD

The Audit and Assurance Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

In particular, the committee reviews the adequacy of:

- All risk- and control-related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the Standards for Better Health and Care Quality Commission registration standards), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the controls in place and the appropriateness of the disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

The committee can seek reports and assurances from Directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

Attendance at Audit and Assurance Committee meetings 2009/10

Name	June 2009	June 2009 (Accounts)	September 2009	December 2009	January 2010	March 2010
Aumayer, Steve			✓			✓
Blackburn, Sarah (Chair, 2009/10)	✓	✓	✓	✓	✓	✓
Fairbairn, Iain	✓	✓				✓
Gardner, Lisa	✓	✓	✓	✓	✓	✓
Gray, Irene					✓	
Mapson, Paul	✓	✓	✓	✓	✓	✓
May, Paul	✓		✓	✓	✓	
Moon, Alison			✓	✓		✓

Name	June 2009	June 2009 (Accounts)	September 2009	December 2009	January 2010	March 2010
Rich, Graham	✓	✓	✓	✓		
Sheffield, Jonathan			✓		✓	✓
Woollett, Emma	✓	✓	✓	✓		
Woolley, Robert		✓			✓	✓

Members of the committee (Non-Executive Directors) are shown in bold. Executive Directors attending the meetings in accordance with the business of the committee on each occasion are also shown. Grey shading indicates that an individual was not eligible to attend a meeting.

Internal Audit

The Head of Internal Audit has unrestricted access to the chair of the committee for confidential discussion. The committee ensures that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the committee, Chief Executive and Board. This is achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the internal audit strategy, operational plan and more detailed programmes of work, ensuring this is consistent with the audit needs of the organisation as identified in the Assurance Framework.
- Consideration of the major findings of internal audit's work (and management's response), and ensure co-ordination between the internal and external auditors to optimise audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of internal audit.

External Audit

The External Auditor also has unrestricted access to the chair of the committee for confidential discussion. The committee reviews the work and findings of the external auditor and considers the implications and management's response to their work. This is achieved by:

- Consideration of the appointment and performance of the external auditor in line with the Code of Conduct for Foundation Trusts.
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the Trust's Annual Plan, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review all external audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

Financial reporting

The committee reviews the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- The wording in the Statement on Internal Control and other disclosures relevant to the terms of reference of the committee.
- Changes in, and compliance with, accounting policies and practices.
- Unadjusted mis-statements in the financial statements.
- Major judgemental areas.
- Significant adjustments resulting from the audit.
- Instances where competitive tendering or competitive quotation requirements have been waived or where approval has been given to a tender invitation to a firm not on the approved list. This should include consideration of Directors' interests in potential contracts.
- Special payments, compensations and losses.

The committee ensures the Standing Financial Instructions and Standing Orders are maintained and are kept up to date, with an annual review of instances where exceptions to the rules have been made.

The committee also ensures that the systems for financial reporting to the Board, including those of budgetary control, are subject to regular quarterly review as to completeness and accuracy of the information provided to the Board.

Other assurance functions

The committee reviews the findings of other significant assurance functions, both internal and external to the organisation, and considers the implications to the governance of the Trust.

These may include any reviews by the Department of Health arm's length bodies or regulators or inspectors (eg Care Quality Commission, NHS Litigation Authority, Counter Fraud Service) and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies etc).

Independence of the External Auditor in providing non-audit services

The Membership Council has approved a policy for the commissioning of additional work by the Trust from its appointed auditor.

The policy sets out the circumstances of when this is appropriate and refers to the Trust's Standing Financial Instructions (procurement rules) as the means by which contracts for any such work must be let.

The Membership Council has approved a statement setting out when it is considered appropriate to engage the appointed auditor on non-audit work.

The auditor has procedures for concluding whether possible non-audit work could compromise his independence, or be perceived to compromise it.

In line with the Auditing Practice Board's ethical standards, if he cannot put in place appropriate safeguards, he will not bid for the work.

Policies on counter-fraud and corruption

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

The Trust encourages members of staff to report reasonable suspicions of irregularity as set out in its Speaking Out Policy (commonly known as a 'whistle-blowing policy') and in the Standing Financial Instructions, and has declared that there will be no adverse consequences for an individual member of staff who genuinely does so.

Counter-fraud awareness is regularly raised via the Trust's communication systems which include posters in workplaces and the dissemination of Counter Fraud Newsletters.

Guidance for staff, which includes details of the Counter Fraud Strategy and Policy, is also available on the Trust's intranet, along with contact details for the Local Counter Fraud Specialist and the NHS Fraud and Corruption reporting line.

The Trust works closely with local counter fraud specialists to implement the Counter Fraud and Security Management Service's national strategy on countering fraud in the NHS and to ensure the Trust is working with the local counter fraud specialist in fully complying with Secretary of State's directions. Work is carried out across the seven generic areas of counter fraud activity:

- Creating an anti-fraud culture;
- Deterrence;
- Preventing fraud;
- Detecting fraud;
- Investigation;
- Sanctions;
- Redress.

REMUNERATION

13 REMUNERATION COMMITTEE

Remuneration for senior managers

Details of remuneration for all directors of the Trust are set out in full in section 6.6 of the Annual Accounts. The remuneration of Executives is determined annually by the Trust's Remuneration Committee using guidance from the Department of Health. Remuneration is based on national guidance, rather than performance. Performance is not currently a factor in remuneration of senior management.

All contracts for directors are permanent, with a six-month notice period on either side. Termination payments are in accordance with normal rules on notice and redundancy payment; there are no special provisions. All other Trust employees (except non-executive directors) are subject to national terms and conditions of employment, including pay. This is considered when determining the pay increase (if any) for directors. All directors and senior managers have standard contracts.

The Trust's Remuneration Committee decides the pay, allowances and other terms and conditions of the executive directors annually, using guidance issued by the Department of Health. Remuneration is based on national guidance, not performance. No significant awards have been made to directors and there has been no bonus payment. The committee comprises the chair, a committee chair and the non-executive directors of the Trust. In 2009/10 the uplift applied was 1.5 per cent of salary from April 2009.

Remuneration Committee membership
Chairman and Non-Executive Directors, as detailed below.

Remuneration Committee advisers: the chief executive and the director of workforce and organisational development give advice to the committee.

Attendance – Remuneration Committee 2009/10

Name	27/05/09	28/10/09	25/01/10	29/03/10
Sarah Blackburn			✓	✓
Kelvin Blake	✓	✓	✓	✓
Iain Fairbairn	✓	✓	✓	✓
Lisa Gardner	✓	✓		✓
Patsy Hudson	✓			
Selby Knox	✓	✓	✓	
Paul May	✓	✓	✓	✓
John Savage	✓	✓	✓	✓
Emma Woollett		✓	✓	✓

Robert Woolley, Acting Chief Executive

Directors' Remuneration

No Directors received any other remuneration or benefits in kind during either period.

Salaries and Allowances	**12 Months to 31 March 2010**	10 Months to 31 March 2009
	Salary	Salary
	(bands of £5000) £000	(bands of £5000) £000
Chair		
John Savage	50-54	40-44
Executive Directors		
Graham Rich, Chief Executive (until 22 December 2009)	120-124	140-144
Robert Woolley, Acting Chief Executive (from 23 December 2009)	35-39	n/a
Robert Woolley, Director of Corporate Development (until 22 December 2009)	85-89	95-99
Jonathan Sheffield, Medical Director	190-194	145-149
Paul Mapson, Director of Finance	120-124	105-109
Irene Gray, Chief Operating Officer	110-114	95-99
Steve Aumayer, Director of Workforce and Organisational Development (from 6 July 2009)	80-84	n/a
Alex Nestor, Acting Director of Workforce and Organisational Development (from 3 November 2008 until 5 July 2009)	20-24	35-39
Alison Moon, Chief Nurse (from 13 July 2009)	80-84	n/a
Patricia Fields, Acting Chief Nurse (from 23 March 2009 until 12 July 2009)	25-29	0-4

Anne Coutts, Director of Workforce and Organisational Development (until 2 November 2008)	n/a	50-54
Lindsey Scott, Chief Nurse and Director of Governance (until 22 March 2009)	n/a	95-99
Non-executive Directors		
Sarah Blackburn (from 1 June 2009)	10-14	n/a
Kelvin Blake (from 1 November 2008)	10-14	5-9
Iain Fairbairn	15-19	10-14
Lisa Gardner	15-19	10-14
Patsy Hudson (until 31 May 2009)	0-4	10-14
Selby Knox	10-14	10-14
Paul May (from 1 November 2008)	10-14	5-9
Emma Woollett	15-19	10-14

No Directors received any other remuneration or benefits in kind during either period.

Pension Benefits for the year ended 31 March 2010	Real increase in pension at age 60 at 31 March 2010 (bands of £2,500)	Real increase in lump sum at age 60 at 31 March 2010 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2010 £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Real Increase in Cash Equivalent Transfer Value £000	Employer funded contribution to growth in CETV £000
Graham Rich, Chief Executive (until 22 December 2009)	0-2.4	2.5-4.9	45-49	145-149	907	791	76	53
Robert Woolley, Director of Corporate Development (until 22 December 2009, then acting Chief Executive)	2.5-4.9	10-12.4	30-34	90-94	590	476	91	63
Jonathan Sheffield, Medical Director	5-7.4	17.5-19.9	70-74	220-224	1,547	1,285	198	138
Paul Mapson, Director of Finance	(0-2.4)	(0-2.4)	45-49	145-149	1,089	988	52	36
Irene Gray, Chief Operating Officer	(0-2.4)	(0-2.4)	50-54	150-154	1,124	1,032	41	29
Steve Aumayer, Director of Workforce and Organisational Development (from 6 July 2009)	2.5-4.9	n/a	0-4	n/a	29	n/a	29	21
Alex Nestor, Acting Director of Workforce and Organisational Development (until 5 July 2009)	0-2.4	0-2.4	15-19	50-54	237	178	13	9
Alison Moon, Chief Nurse (from 13 July 2009)	2.5-4.9	10-12.4	30-34	95-99	571	431	85	59
Patricia Fields, Acting Chief Nurse (until 12 July 2009)	0-2.4	2.5-4.9	35-39	110-114	939	757	41	28

Pension Benefits for the year ended 31 March 2009 **Name and title**	**Real increase in pension at age 60 at 31 March 2009**	**Real increase in lump sum at age 60 at 31 March 2009**	**Total accrued pension at age 60 at 31 March 2009**	**Lump sum at age 60 related to accrued pension at 31 March 2009**	**Cash Equivalent Transfer Value at 31 March 2009**	**Cash Equivalent Transfer Value at 31 May 2008**	**Real Increase in Cash Equivalent Transfer Value**	**Employer funded contribution to growth in CETV**
	(bands of £2,500)	**(bands of £2,500)**	**(bands of £5,000)**	**(bands of £5,000)**	**£000**	**£000**	**£000**	**£000**
Graham Rich, Chief Executive	5-7.4	17.5-19.9	45-49	135-139	791	535	246	172
Jonathan Sheffield, Medical Director	0-2.4	2.5-4.9	60-64	190-194	1,285	959	306	214
Anne Coutts, Director of Workforce and Organisational Development (until 2 November 2008)	(0-2.4)	(0-2.4)	30-34	100-104	698	565	61	43
Lindsey Scott, Chief Nurse and Director of Governance (until 22 March 2009)	0-2.4	2.5-4.9	35-39	110-114	678	514	149	105
Paul Mapson, Director of Finance	0-2.4	0-2.4	45-49	140-144	988	739	234	164
Irene Scott, Chief Operating Officer	5-7.4	15-17.4	45-49	140-144	1,032	681	337	236
Robert Woolley, Director of Corporate Development	2.5-4.9	10-12.4	25-29	75-79	476	297	173	121
Alex Nestor, Acting Director of Workforce and Organisational Development (from 3 November 2008)	0-2.4	5-7.4	10-14	35-39	178	100	37	26
Patricia Fields, Acting Chief Nurse (from 23 March 2009)	0-2.4	0-2.4	30-34	90-94	757	533	6	4

Real increases and Employer's contributions are shown for the time in post where this has been less than the whole year. Figures in (brackets) indicate reductions.

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

NHS FOUNDATION TRUST CODE OF GOVERNANCE

PRINCIPLES OF THE CODE OF GOVERNANCE

The Board of Directors considers that it was throughout the year fully compliant with the Principles of the NHS Foundation Trust Code of Governance. This is demonstrated by the narrative set out below.

1. The Board

The Trust is a public benefit corporation as described in the NHS Act 2006.

The Board of Directors of University Hospitals Bristol NHS Foundation Trust is responsible for ensuring proper standards of corporate governance are maintained.

The Board is currently made up of the Chairman, seven Executive Directors and seven Non-Executive Directors and is collectively responsible for the success of the Trust.

The Board meets regularly and has a formal schedule of matters specifically reserved for its decision. The Board delegates other matters to the Executive Directors and other senior management. The Board has approximately 12 scheduled meetings each year.

The Directors are given accurate, timely and clear information so that they can maintain full and effective control over strategic, financial, operational, compliance and governance issues. The Directors have a range of skills and experience and each brings independent judgement and considerable knowledge to the Board's discussions and determinations.

The Trust has arranged appropriate insurance cover in respect of legal proceedings and other claims against its Directors.

Details of the composition of the Board and the experience of the Directors are contained within the Annual Report which also includes information about the standing committees of the Board and the membership of those committees.

Arrangements have been put in place by which the Trust's employees may in confidence raise concerns about matters of concern to them. These arrangements are covering in the Trust's "Speaking Out Policy" commonly known as a "Whistle Blowing Policy".

The Chairman of the Board's Audit and Assurance Committee and the Senior Independent Director are each available for direct access by Directors and other senior managers if they have concerns which they feel unable to raise with other members of the Board.

The schedule of matters reserved for the Board, the roles and responsibilities of the Chairman and Chief Executive and the terms of reference for the Board's sub committees are available on the Trust's website and are available for inspection at the Trust's offices.

2. The Membership Council

The Membership Council is responsible for representing the interests of NHS Foundation Trust members and stakeholder organisations in the governance of the Trust and exercises certain statutory powers such as the appointment of Non-Executive Directors and the External Auditor.

The Membership Council is made up of the Trust Chairman, and governors as follows: Nine elected public members, 12 elected patient/carer members, six elected staff members and 11 appointed stakeholder representatives.

The Membership Council meets formally five times a year. Its sub-committee, the Nominations Committee meets regularly and three other sub-committees also meet.

Details of the composition of the Membership Council and attendance at meetings are contained within the Annual Report. A Senior Independent Non-Executive Director has been selected and is available to the Governors as required.

3. Independent Professional advice

All of the Directors and Governors of the Membership Council have access to the Assistant Director of Governance and Trust Secretary who have delegated responsibility from the Chief Nurse for ensuring that Board and Membership Council procedures are followed and that applicable laws and regulations are complied with.

4. Performance Evaluation

The Board keeps under continuous review its performance and that of its committees and individual Directors.

The appraisal of the Chairman is carried out on behalf of the Membership Council by governors and the Senior Independent Director.

The appraisal the Non-Executive Directors is carried out by the Chairman on the basis of the process set out by the Governors.

The appraisal of the Chief Executive is carried out by the Chair. The appraisal of the Executive Directors is carried out by the Chief Executive.

5. Relations with Members

The Board recognises the importance of good communications with Members of the Trust. The Annual Public Meeting in September 2009 was used as an opportunity to communicate with Members in addition to regular communications and involvement events.

The Board continues to develop its relationship with the Membership Council. A majority of the Directors attend meetings of the Membership Council and provide regular updates and reports.

Governors who sit on the Membership Council are encouraged to attend Board meetings.

The Annual Plan submitted to Monitor has been formulated with the input of the Governors' Strategy Sub-Group and has regard to the views of the Membership Council.

6. Auditor Independence and Objectivity

The Membership Council has approved the re-appointment of the Audit Commission as Trust's External Auditor until April 2013. The Membership Council has approved a protocol to govern the commissioning non-audit services from the Appointed Auditor, the Audit Commission in order that the Auditor may maintain the necessary degree of independence and objectivity.

7. Going Concern

The Board confirms that it is satisfied that the Trust has adequate resources to continue in operation for the foreseeable future.

8. Internal Control

The Board is committed to managing risk and to controlling its activities in a manner which enables it to fulfil its terms of authorisation obligations and ensure compliance with applicable laws and regulations while avoiding or reducing risks which could cause loss or reputational damage.

To achieve this, the Board has established a process for the identification evaluation and management of risks as part of a comprehensive assurance framework which is regularly reviewed by the Audit and Assurance Committee and reported to the Board.

The Trust's activities are conducted within a clear accountability framework underpinned by policy statements, written procedures and manuals. This ensures that there are written policies and procedures to identify and manage risk.

Compliance with policies and procedures is the responsibility of all managers. The Board is not aware of any material exceptions to its policies.

The Board has established a management structure that clearly defines roles, responsibilities and reporting lines. Delegated authorities are documented and communicated.

The performance of the Trust's activities is reported regularly to the Trust Executive Group and to the Board. Performance trends and forecasts as well as actual performance against standards, budgets and prior periods are closely monitored.

Financial information is prepared in accordance with appropriate accounting policies which are applied consistently.

The effectiveness of the Trust's internal control system is reviewed regularly by the Board, its committees, senior management and Internal Audit. Internal Audit reports regularly to the Board's Audit and Assurance Committee.

The Board has adopted core values communicated to all staff and a code of conduct relating to the conduct of its activities subscribed to by all Board directors.

PROVISIONS OF THE CODE

The Board of Directors considers that it was throughout the year fully compliant with the Provisions of the NHS Foundation Trust Code of Governance with the following **exceptions**.

The paragraphs are numbered to correspond with the provisions of the Code.

A.1.3 Appraisal of the Chair

In an NHS Foundation Trust, the authority for appointing and dismissing the Chair rests with the Board of Governors (Membership Council in University Hospitals Bristol). The appraisal of the Chair is therefore carried out for and on behalf of the Membership Council with the support of a senior independent appraiser who reviews the Chairman's performance against agreed objectives and discusses development needs, involving the Nominations Sub-Committee of the Membership Council where appropriate, before reporting the outcome of the full appraisal process to the Nominations Sub-Committee. The Nominations Committee Sub-Committee in turn reports to the Membership Council.

Given the role of the Membership Council, (presided over by the Chair), in appointing and setting the remuneration of the Non-Executive Directors, it is inappropriate for the Non-Executive Directors (whether or not led by a senior independent director) to evaluate the Chairman's performance. This does not of course preclude the Non-Executive Directors being consulted as part of the process carried out for and on behalf of the Membership Council.

C.1.1, C1.2 and C.1.9 Nominations Committees

There is a Nominations Sub-Committee of the Membership Council and a Board Remuneration Committee which incorporates the roles set out in the Code for a Board Nominations Committee.

The Nominations Sub-Committee of the Membership Council is responsible for the identification and nomination of Non-Executive Directors, including the Chairman, and for making recommendations to the Membership Council as to their terms and conditions of employment. The terms of reference of the Nominations Sub-Committee of the Membership Council were reviewed during 2009/10.

The Board Remuneration Committee is mandated to review and decide the remuneration and allowances and the other terms and conditions of office of the Executive Directors.

The Non-Executive Directors appoint or remove the Chief Executive. The Chief Executive, in consultation with the Chair and Non-Executive Directors, appoints or removes the Executive Directors.

C.2.1 Chief Executive and Executive Director Terms of Appointment

The Trust does not use fixed term appointments in this regard as the insecurity of tenure is considered incompatible with the overriding need to attract and retain high calibre candidates.

C.2.3 Information about elected Governors standing for re-election

The Trust agrees that the attendance record at formal meetings of the Membership Council is relevant and will be made available to members when elected Governors are due to stand for re-election.

The Trust's position is that attendance at other events organised by the Trust for governors should not be reported. In the interests of recruiting a diverse and representative Membership Council, the Trust recognises that elected members will come from a wide variety of backgrounds and will be able to devote different amounts of time to the role, in addition to the minimum required to attend formal meetings. Potential representatives whose time commitment is restricted should not be deterred from standing for election if they are not able to attend all optional events.

E.2.3 External professional advice on remuneration for the Chairman and Non-Executive Directors

The Membership Council did not consult specific external professional advisers to market test the remuneration levels of the Chairman and other Non-Executive Directors. The recommendations made to the Membership Council were based on independent advice and guidance as issued from time to time by appropriate bodies such as the Foundation Trust Network, which provides benchmarked and externally validated guidance relevant to Foundation Trusts.

Schedule A Disclosure of Corporate Governance Arrangements

Information provided by Board to Governors

The Board does not submit papers to the Membership Council "accompanying a resolution to re-appoint a Non-Executive Director" since this is the role of the Nominations Sub-Committee of the Members' Council.

Board information to Members

The Board does not submit papers to Members "accompanying a resolution to elect or re-elect a Governor". Biographical details and information about the attendance of existing Governors at Membership Council meetings is included in the information accompanying ballot papers sent on behalf of the Trust to its members by the independent returning officer and is not the subject of a Board resolution.

14 Quality Account 2009/10

Contents:

Page

Part 1

Signed statement from the Chief Executive

Part 2

A. Priorities for improvement – report on quality objectives for 2009/10:

1. Healthcare acquired infection rates
    - MRSA
    - C diff
2. Patient Safety First Campaign
    - Executive Leadership Walk Rounds
    - General Ward Observation Chart
    - Medicines Management
    - Peri-operative Care
3. Human Factors Training in High Risk Procedures
4. Patient Experience
5. Clinical Outcomes

B. Priorities for improvement – plans for 2010/11:

1. To reduce further the incidence of healthcare-acquired infections
2. To improve antibiotic prescribing compliance
3. To reduce the number of high risk medication errors which cause actual harm to patients
4. To reduce Hospital Acquired Thrombosis
5. To increase the level of patient and public involvement in service improvement
6. To meet the requirements of the proposed NICE Quality Standard for Dementia

C. Statements of assurance from the Board

1. ‘Review of services’

2. Participation in Clinical Audit and National Confidential Enquiries
3. Participation in Clinical Research
4. CQUIN framework
5. Care Quality Commission registration and reviews
6. Data quality

Part 3

Other information – overview of the quality of care

Patient Safety

i. Hospital Standardised Mortality
ii. Adverse Event Rate
iii. Primary Percutaneous Coronary Intervention call to balloon time
iv. Information received by patients about their medication

Patient Experience

i. Privacy and dignity (including single sex accommodation)
ii. Complaints
iii. Staff-patient communications
iv. 'Overall, how would you rate the care you received?'

Clinical Effectiveness

i. Nutritional care
ii. NICE guidance implementation
iii. Adult Cardiac Surgery Outcomes
iv. Paediatric Cardiac Surgery Outcomes
v. Cataract Surgery Outcomes
vi. Adult Intensive Care
vii. Oesophageal Cancer Outcomes
viii. Patient Reported Outcome Measures (PROMs)

Performance against key national priorities and National Core Standards 58

National Staff Survey indicators

Annex – Third party statements

Part 1 Statement on quality from the Chief Executive

This is the second annual quality report produced by the University Hospitals Bristol NHS Foundation Trust. This Quality Account follows on from the commitments to quality outlined in last year's report. The Trust is committed to demonstrable improvement in the three areas of Patient Quality as defined by Lord Darzi in 'Our NHS, Our Future', namely, Patient Safety, Patient Experience and Clinical Outcomes.

In October 2009, a combined meeting of staff and Governors discussed core divisional metrics for quality. These metrics are now reported in a monthly dashboard for the Trust Board. The Trust has extended its involvement in quality initiatives by joining the South West Strategic Health Authority Quality and Patient Safety Improvement Programme. Data on patient safety are now submitted to the Institute for Health Improvement allowing us to benchmark against other acute Trusts within the South West.

This year, the Trust is particularly proud of the dramatic reduction in Clostridium difficile and MRSA Hospital Acquired Infections. The Trust's Hospital Standardised Mortality Ratio has also shown improvements throughout the year, and is significantly better than the national average.

The Trust has also shown that Patient Experience can be measured routinely. The data guide staff in identifying deliverable improvements in patient care. A pilot programme for regular patient experience tracking is now being rolled out to include all inpatients. The Trust would particularly like to thank the Governors for their input and assistance in delivering this project.

Clinical Outcomes have been a focus for the Trust since the Inquiry into Children's Heart Surgery. This Quality Account includes 'snapshots' of data gathered from key services: Adult and Paediatric Cardiac Surgery, Oesophageal Cancer Surgery, Adult Intensive Care, and Eye Surgery.

In the course of the year, allegations appeared in 'Private Eye' regarding Histopathology reporting outcomes. The Trust has commissioned a wide-ranging independent inquiry which, later this year, will report on both the allegations and improvements that could prevent future doubts regarding our services.

I would like to thank NHS Bristol and the Local Involvement Networks and Overview and Scrutiny Committees of Bristol and South Gloucestershire for their diligent review of our Quality Account and helpful suggestions on improvements. I would also like to thank all the contributors for their rapid response to tight deadlines, in particular Chris Swonnell for his diligent editorial hand. Last, but by no means least, a big thank you to the Trust's Governors who have helped the Trust to shape its future quality programme and have freely given their time and commitment.

As Acting Chief Executive of the Trust, I confirm that, to the best of my knowledge, the information presented in this document is accurate. I hope you enjoy reading this Quality Account and welcome any comments you may have.

Robert Woolley, Acting Chief Executive

Part 2 Priorities for improvement and statements of assurance from the board

A Priorities for improvement - report on quality objectives for 2009/10

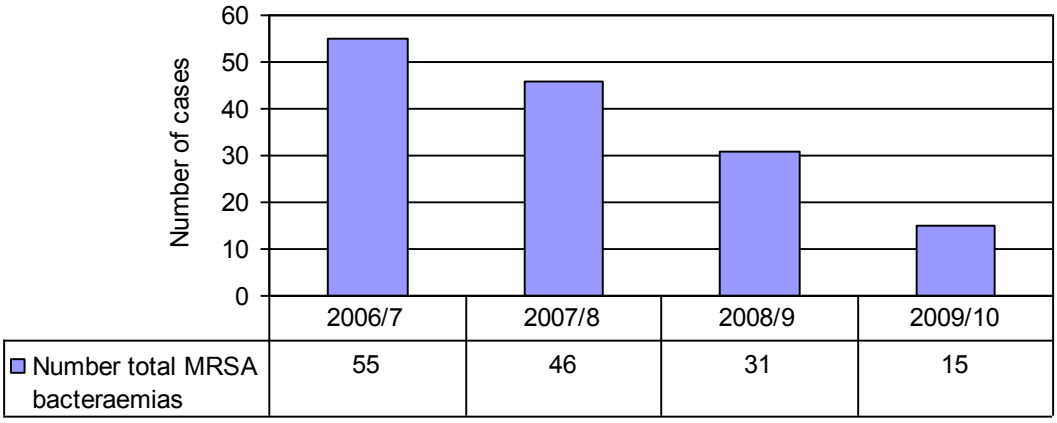
1 Healthcare acquired infection rates

Prevention of infection has consistently been a key priority for the Trust. The Trust has a 'zero tolerance' approach to poor infection control practice and to infections that can be avoided. While nationally the key priorities have been to reduce MRSA (Meticillin resistant *Staphylococcus aureus*) and C diff (*Clostridium difficile*) our approach has been, and will continue to be, to reduce all avoidable infections. One of the Trust's key objectives for 2009/10 was to improve patient safety by further reducing the incidence of healthcare-associated infection.

MRSA

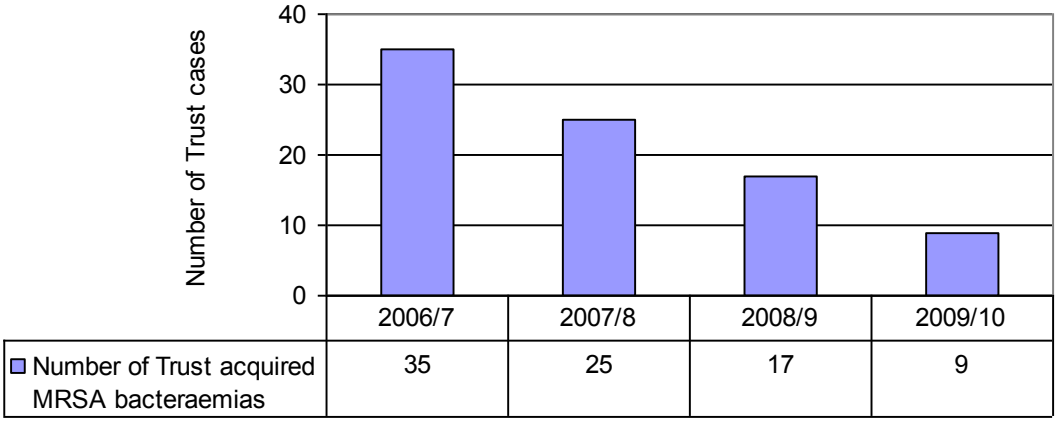
Our aim for 2009/10 was to reduce the number of MRSA blood-stream infections to no more than 20 cases. As this target number includes cases of infection that are present on admission to hospital a target was also set to reduce the number of infections acquired within the hospital.

Total number of MRSA bacteraemias



In 2009/10 the total number of MRSA bacteraemia infections has halved compared to the previous year. This has been achieved by working closely with colleagues in the community to ensure specific groups of patients at more risk of infection receive appropriate care and management both in the community and when admitted to hospital.

Number of Trust acquired MRSA bacteraemias



The number of infections acquired within the Trust was also reduced by almost a half compared to the previous year. This reduction has been achieved through the following:

- A thorough investigation of each case to identify learning and actions to prevent future cases.
- Testing all eligible patients before planned admissions for surgery or other procedures for MRSA. Since December 2009 testing has also been carried out on most patients who are admitted to hospital in an emergency.
- Testing patients who are in hospital for a month or longer for MRSA.
- Improving methods for identifying patients with MRSA so appropriate management and treatment to prevent further infection to themselves and to others can be arranged.

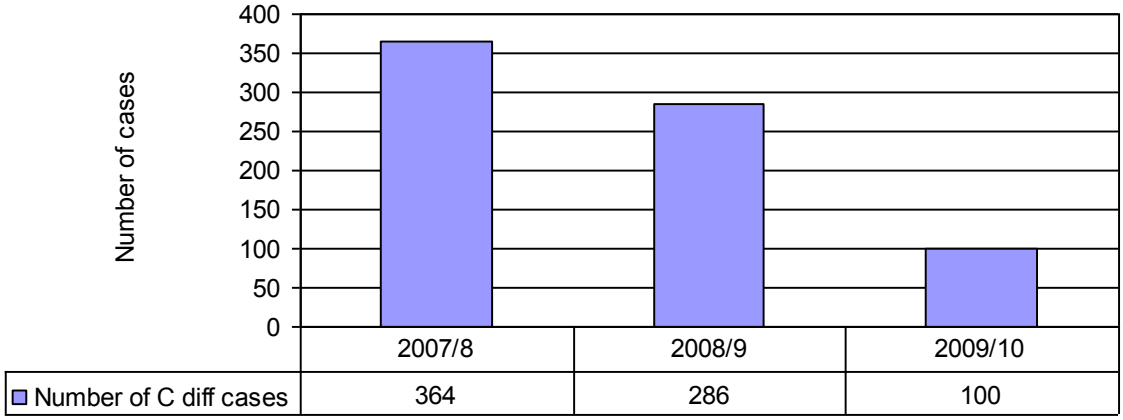
Clostridium difficile

Our aim for 2010 was to reduce the number of C diff infections acquired within the Trust to no more than 180 cases.

In 2009/10 the number of C diff infections reduced by almost two thirds compared to the previous year. This reduction has been achieved by:

- Thorough review of every new infection to identify learning and actions to prevent future cases.
- Dedicating a specialist isolation ward to caring for patients with C diff.
- Closely monitoring cleaning, hand washing and how doctors, nurses and other staff wear and remove gloves and aprons.
- Reducing the use of antibiotics that are more likely to lead to C diff infection.

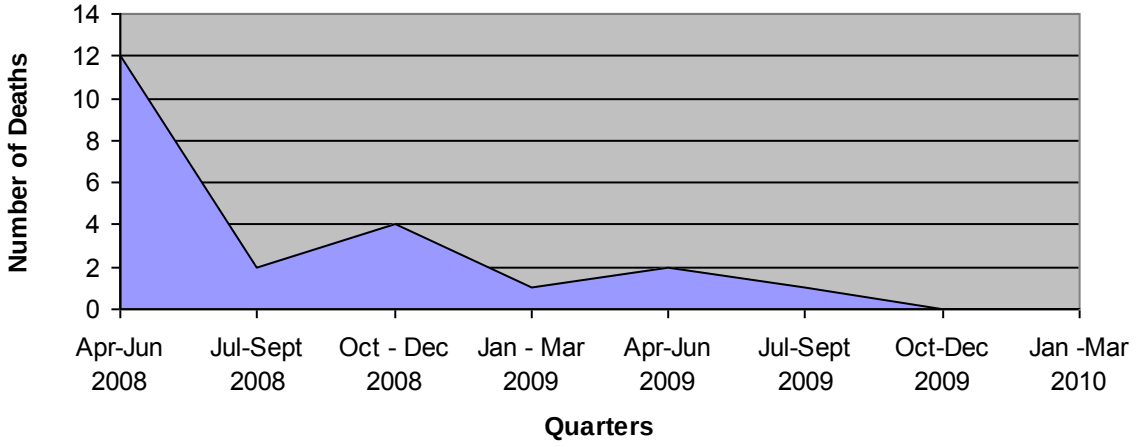
Number of C diff cases



In addition to reducing the spread of C diff efforts have been concentrated on making sure patients with the infection receive the highest standard of care. A key marker to the success of the programme to reduce C diff infection is to reduce the number of deaths where the infection is the primary cause of death.

This data is routinely collected and a serious untoward incident alerts sent to the local Primary Care Trust. This year there have been three such alerts, with none from infection acquired since June 2009. The one death in the second quarter of the year related to a patient admitted in extremis from a community hospital.

Deaths in Hospital Where *Clostridium difficile* is primary cause on death certificate.



2 Patient Safety First Campaign

The Trust committed to continuing its participation in the Patient Safety First campaign in 2009/10. The programme is divided into a number of work-streams for safety culture and leadership, critical care, general wards, operating theatres and medicines management.

In September 2009 the Trust joined a five year programme along with all the acute hospital trusts in the South West Region.

This programme develops the principles underpinning patient safety improvement encompassed in the national Safer Patients Initiative and Patient Safety First.

The programme involves making changes to improve patient safety driven by clinical staff and implemented after a process of small-scale tests of change to ensure they will be effective.

There is also a strong emphasis on measurement to check for impact on patient safety.

All the work-streams focus on effective communication between clinical staff and with patients to promote an active safety culture.

The adult critical care team have been awarded National Patient Safety Agency funding to carry out a staff safety culture survey in the Intensive Care Unit.

i. Executive Leadership Walk Rounds

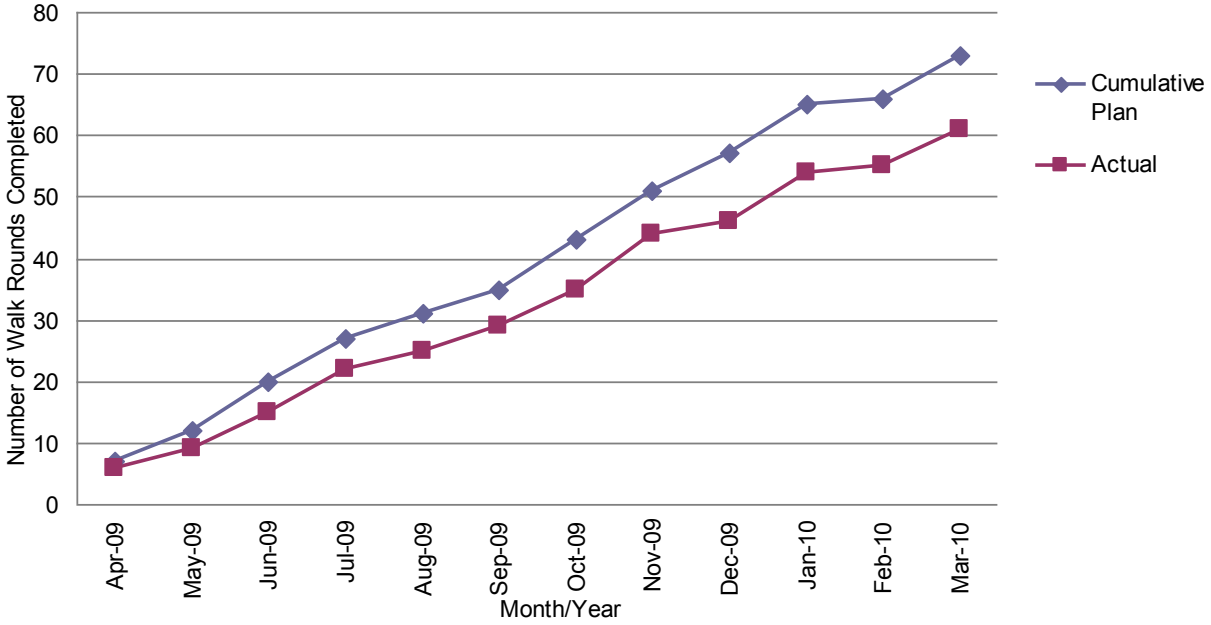
The Executive “Walk Round” programme has been in place for over three years.

During 2009/10 the target was for each Executive Director to carry out at least one patient safety walk round per month.

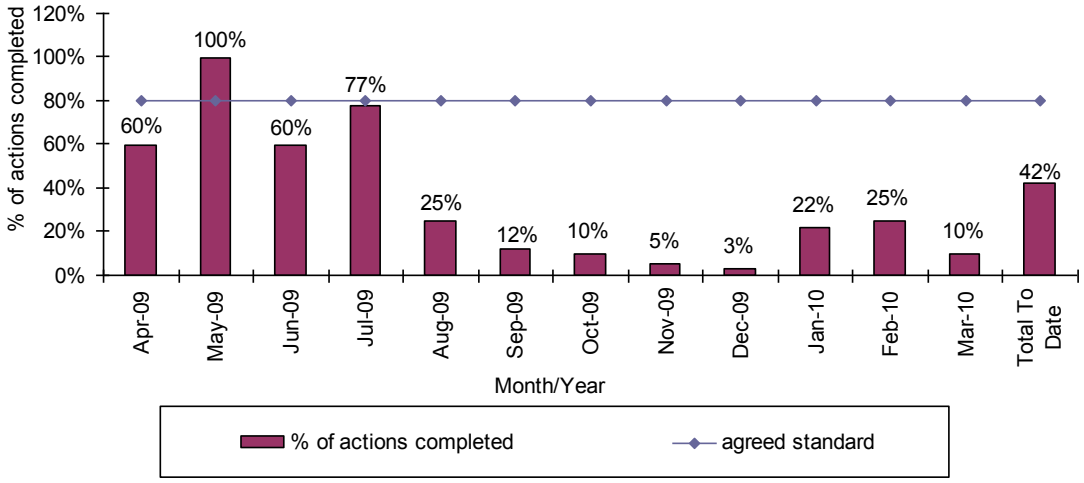
Actions are agreed as a result of each walk round visit and the Trust’s target is to complete these actions within two months of identification.

Members of the Estates and Facilities management team now attend each walk round to ensure minor estates issues can be addressed quickly.

Executive Safety Walk Rounds April 2009 to December 2010
Planned v Actual



Executive Safety Walk Round Actions January 2009 to March 2010
Identified v Completed



Overall aim: 80% of actions to be completed within two months of the Executive Safety Walk Round.
i.e. at the 1st August 2009 80% of actions completed up to and including May 2009

The low completion rate of actions identified in February and March 2010 is partially explained by these actions not being listed for completion until the end of April and May 2010 respectively. In 2010/11 the Trust is committed to improving the rate of Actual verses Planned Walk Rounds and early completion of identified actions: from May 2010 onwards, data regarding Executive Walk Rounds is being included in monthly Board reports, enabling public scrutiny.

ii. General Ward Observation Chart

All inpatients have an early warning score when they have observations of condition for prompt detection of deterioration.

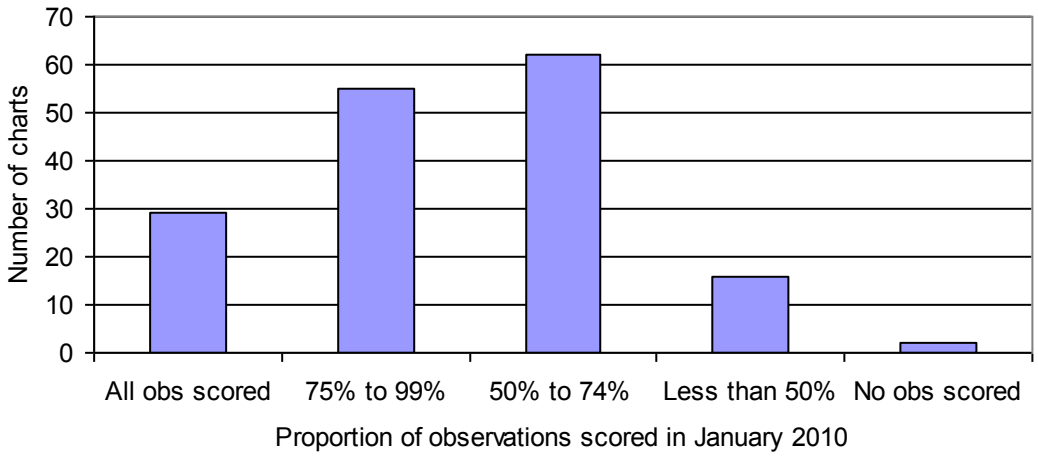
A process for seeking urgent review is in place and audits are carried out quarterly with case note reviews monthly.

The first step in ensuring that timely and appropriate senior review occurs in deteriorating patients is to ensure the observations are completed and recorded in full.

Audits undertaken in 2009/10 have resulted in a plan for 2010/11 with a renewed focus on the completion of Observation Charts and the action required when a patient requires an urgent review.

This will be achieved through further staff training: training on the use of Observation Charts is now included in resuscitation training, clinical staff induction and update training.

Proportion of observations scored on charts



iii. Medicines Management

During 2009/10 there has been a focus on improving safety by ensuring accuracy of information concerning medicines when patients move from one healthcare setting to another.

There have been major improvements in the process of medicines reconciliation for medical admissions, and the Trust is currently implementing an electronic discharge letter to provide accurate and timely information to GPs.

There has also been an emphasis on the management of high risk medicines, with attention focussed on training, management and monitoring of anticoagulation, and improvements in the prescribing of insulin in diabetic patients.

A safe ‘insulin prescribing bundle’ is being implemented, and this will link with further work on insulin management in 2010/11, together with extension of

medicines reconciliation and the avoidance of missed or delayed doses of medication.

iv. Peri-operative Care

During 2009/10, the Trust achieved its aim to implement the World Health Organisation (WHO) Surgical Safety Checklist in all its theatres with subsequent monthly monitoring of compliance.

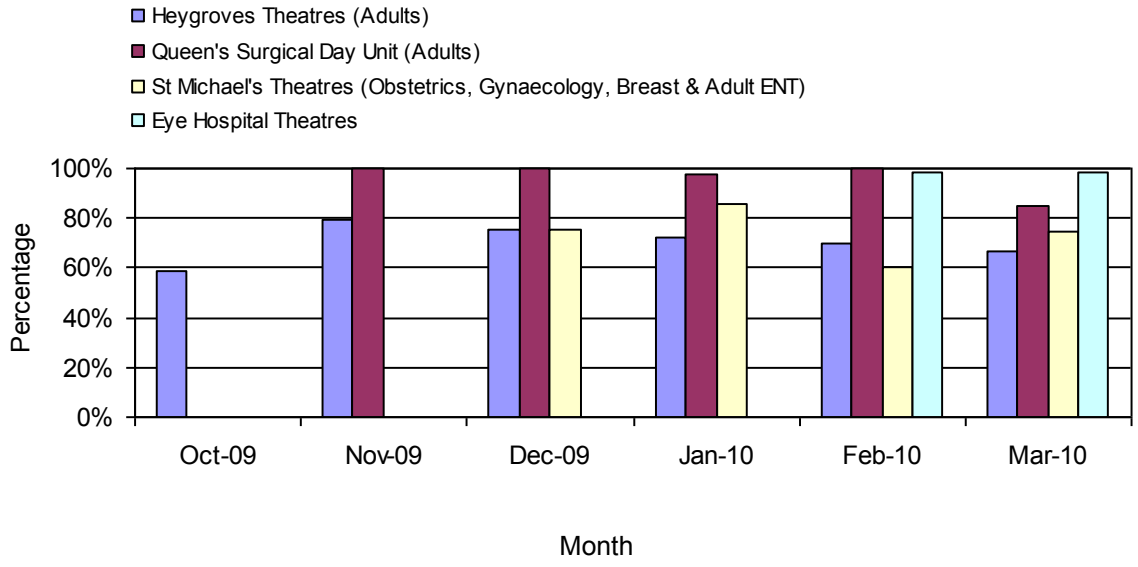
Use of the checklist has been identified as a quality priority by the Trust's Governors. Current overall compliance within the Trust's theatres is 91.8% (March 2010).

Reasons for the recent dip in performance in the Queens Surgical Day Unit, and consistently lower performance in Heygroves and St Michael's theatres, are being explored with the clinical specialty teams who use the theatres.

A modified version of the checklist is now being developed for use for life saving emergency surgery situations such as category 1 caesarean sections.

For 2010/11, NHS Bristol has set the Trust a target of achieving 90% compliance in the use of the WHO Surgical Safety Checklist. This is included in the CQUIN performance incentive scheme which forms part of the Trust's annual contract.

Compliance with WHO Surgical Safety Checklist



Two directly related metrics are regularly tracked by the Trust: mortality and adverse events. These are reported in Part 3 of the Quality Account.

3. Human Factors Training in High Risk Procedures

Human Factors and Team Management Training originated in the aviation industry and considers ways in which environmental and human factors influence clinicians' behaviours in ways which may affect the performance of teams and safety of patients.

The Trust has invested in the development of Human Factors and Team Management Training for high risk procedures using the Bristol Simulation Centre. For 2009/10 the Trust has set an objective to train relevant staff in the skills of effective Human Factors and Team Management which will allow teams to function better and prevent errors during paediatric and adult cardiac surgery.

This involves the use of High Fidelity Simulation and the Orpheus Perfusion Simulator in the native Theatre environment.

During 2009/10, two pilot training sessions were delivered at the Bristol Royal Hospital for Children with the aim of briefing team members and familiarising them on the use of Orpheus and Sim Baby™ (a high fidelity manikin) as part of Human Factors Training in Paediatric Cardiac surgery.

The first live run of this training session was scheduled for 27 May 2010 in Cardiac Theatres at the Bristol Royal Hospital for Children: the number of attendees will be a maximum of 10 and will include scrub nurses, anaesthetic nurses, perfusionists and anaesthetists.

Further sessions will be scheduled throughout the year 2010 with the potential of training up to 40 multi-professional team members.

In addition to this training, other Human Factors Training sessions were delivered at the Simulation Centre during 2009/10, including: Radiotherapy Human Factors Training (four sessions, including 60 staff); F2 doctors regional Human Factors Training (two sessions reaching 60 doctors).

Plans are also being considered to pilot a Student Perfusionist training day at the Simulation Centre using the Orpheus Simulator and Sim Baby™, with a view to marketing this for national access.

4. Patient Experience

In 2008 the Trust participated, through its Haematology and Oncology Centre, in a national patient experience pilot programme, led by McKinsey and partly sponsored by Monitor.

While the majority of patients' feedback regarding their care was previously positive, the programme enabled improved understanding of what more could be done for patients using 'real time' feedback.

The success of the initial programme and the engagement and enthusiasm of staff is reflected in the ongoing work in response to patients' feedback throughout 2009/10.

This included: a new patient information booklet; the continued use of patient comment boards (responses from the staff team are put on boards for everyone to see); the installation of individual patient entertainment systems funded by the Friends of the Oncology Centre, providing free television and radio access to all patients; improvements in bathroom and toilet facilities for patients; a review of car parking; a review and rescheduling of clinic times to reduce clinic delays (currently in progress).

The completion of the 'Refresh' programme in September 2010 to improve the patient environment, with an increase in clinic rooms, will allow a complete

review of clinic timings. Training sessions will be held for all staff to improve communication between teams and with patients and carers

In its Quality Report for 2008/9, the Trust set out proposals to extend the patient experience project, initially to Maternity and Obstetric Services. Unfortunately funding has not been identified for this, however some of the project's methodologies will be adopted as part of the Trust's Patient and Public Involvement Strategy for 2010-12.

The Trust has undertaken extensive background planning to enable the roll-out of this strategy from 1st April 2010 (more details in Part 3 of this Quality Account).

5. Clinical Outcomes

The development of increasing openness in Clinical Outcomes is an essential step in the improvement of clinical care and re-assurance to the public. During the past year the Trust has continued to collect and audit data in a wide range of specialties: examples are included in Part 3 of this Quality Account.

The Trust also responds to data requirements as required for service development initiatives. The services will continue to develop outcome metrics both at local, regional and national levels in order to demonstrate quality.

During 2010/11, the Trust will be developing quality 'dashboards' at Board and Divisional level – clinical outcome/effectiveness measures (details to be determined) will form a key part of this work.

The Board has approved the creation of a new Quality Committee later in 2010. This committee – which will be a sub-committee of the Board, led by a Non-Executive Director – will work closely with the Trust's Clinical Effectiveness and Clinical Audit Committees to establish a system of routine reporting of clinical outcomes measures at Board level.

B Priorities for improvement – plans for 2010/11

1. To reduce further the incidence of healthcare-acquired infections

&

2. To improve antibiotic prescribing compliance

Rationale for selection as a key quality objective:
Reduction of healthcare-acquired infection should be at the heart of any trust's plans for improving quality and safety. Patients and the public rightly have high expectations and this topic is key to their confidence in our services. The Trust's Governors have expressed an expectation that infection control – and specifically antibiotic prescribing compliance – is a key feature of the Trust's Quality Account.

For 2010/11 the objective for MRSA is to reduce the rate of infection to below 0.026 per 1,000 bed days. This means no more than six hospital acquired cases in the year.

This will be achieved by:

- Continuing to test patients admitted for planned surgery
- Continuing to extend testing for patients admitted in an emergency so that all emergency patients are screened for MRSA by the end of March 2011
- Ensuring that staff carry out care of drips and catheters to the highest standard by making sure the latest policy guidance is available and being followed (through monthly monitoring)
- Ensuring that patients with MRSA are being cared for and managed in the correct way, through a combination of audit and monitoring, as well as regular clinical reviews by infection control nurses and matrons
- Improve hand washing by ongoing monthly education and awareness activities culminating in a major Trust-wide event to coincide with Global Hand Hygiene awareness day in October 2010, and by providing small bottles of alcohol gel to staff who visit a number of wards

For 2010/11 the objective for C diff is to reduce the rate of infection to below a rate of 0.28 per 1,000 bed days; this means no more than 72 cases in the year.

This will be achieved by:

- Continuing the intensive daily management of patients with C diff using the specialist isolation unit and other single rooms
- Continuing to closely monitor cleanliness, hand washing, use of gloves and aprons and care of patients in isolation for infections

- Ensuring that patients who could have C diff infection are identified early and managed appropriately to prevent infection to other patients and reduce the chance of their developing serious infection
- Ensuring that antibiotics are correctly used and prescribed (see below)

In 2009/10, 1,580 patients had a blood stream infection either on admission to, or whilst they were a patient in, the Trust. For 2010/11 our objective is to reduce all hospital acquired blood stream infections by 25%. This will be achieved by:

- Introducing regular reporting and investigation of all hospital acquired blood stream infections in the same manner as MRSA infections by the end of June 2010
- Ensuring staff carry out care of drips and catheters to the highest standard and monitored regularly as for MRSA

Infections of the urine system are common in hospitalised patients and are often related to the presence of a catheter. For 2010/11 the objective is to reduce the number of urine infections associated with catheters to no more than two per 100 admissions. This will be achieved by:

- Introducing an ongoing programme of regular surveillance for catheter associated urine infection
- Nurses carrying out additional checks on catheters daily and removing them if they are no longer needed
- Further training of staff in catheter insertion and management
- Considering the benefit of the latest technology in silver coated catheters

Progress with plans to implement all of the above will be monitored by the Infection Control Committee and the Trust Board on a quarterly basis. The number of MRSA and C diff infections will be monitored by the Trust Board and the number of other infections will be monitored quarterly by the Infection Control Committee and the Trust Board.

The infection control improvements will be led by the Director of Infection Prevention and Control supported by a team of nine Specialist Infection Control and Wound Care Nurses. Senior Nurses and Matrons across the Trust will be active in leading the improvements, specifically those related to clinical practice and to cleanliness. The Trust has Infection Control Link Nurses in all wards and departments of the Trust who play an active role in education, training and monitoring of clinical practice.

All new Trust staff attend infection control training when they starting work as well as attending ongoing update training; this training ensures staff are informed of the required actions and responsibilities to make these improvements. Specific education and training programmes for key staff are also being implemented.

Antibiotic Prescribing

The Trust has formed a multidisciplinary board whose task is to ensure full implementation and policing of the Trust policy for antibiotic prescribing. In 2010/11 this board, chaired by the Trust's Deputy Medical Director, will look

initially at antibacterial prescribing, and will then develop a consensus within the Trust regarding antiviral and antifungal medication prescribing, ensuring consistency across the organisation.

The initial thrust of work will be to write to all medical staff emphasising the importance of this topic in their delivery of patient care. In addition, the Trust's antibiotic prescribing policy will be issued in the form of a small practical 'credit card' memorandum to all relevant medical staff. This will be included in induction for all new medical staff appointed to the organisation. Once all staff have been informed and reminded of the policy, a 'zero tolerance' approach will be adopted to non compliance. This will involve the support of Pharmacy, and the board has already rolled out this information via the regular pharmacy meetings. Each Clinical Division has appointed a Champion for this cause and performance will be reported to the Trust Board.

3. To reduce the number of high risk medication errors which cause actual harm to patients

Rationale for selection as a key quality objective:
Incidents involving medicines were the third largest group (9%) of all incidents reported to the National Patient Safety Agency (NPSA) in the most recent NPSA report (Safety in Doses; 2009); 96% of these incidents were of low harm or no harm but medication incidents have the potential for causing severe harm. Within the Trust, 17% of reported patient safety incidents are currently medicine related.

The Trust reviews medication-related patient safety incidents through a subgroup of its Medicines Governance Group. Lessons are learned, and improvements are implemented. The level of reporting does not necessarily indicate a higher frequency of medication related incidents than the national average, but it provides a wealth of information to enable organisational learning.

Reducing the number of high risk medication errors which cause severe patient harm is a key Trust priority, and the work to achieve this has focussed to date upon learning lessons, implementing improvements in the management of high risk medications, development of medicines reconciliation, and implementation of NPSA alerts and reports. This has been ongoing in conjunction with national and regional patient safety improvement initiatives.

Reductions in harm will result from both implementing NPSA guidance and applying improvement methodology to continue addressing the priorities described above. Measurement will include medicines reconciliation implementation and the quality of anticoagulation management, together with audit of implementation of NPSA guidance. A focus upon these issues and continued learning and implementation from medication related incidents locally will be the process for improving medication safety.

The reporting of clinical incidents will continue to be encouraged. Measures of incident reporting will be reviewed in order to understand the organisational impact. The following parameters will therefore be recorded:

- The total number of medication incidents reported per quarter; this should be maintained (target: not less than 90% of the number for the previous quarter)
- The total number of reports of major and catastrophic harm should not increase; this has been recorded as 5, 6, 3 and 1 per annum for years 2006-2009 respectively (stretch target: zero)
- The total number of moderate harm incidents to reduce; these have been recorded as 47, 49, 42, 48 per annum for years 2006-2009 respectively (target: less than 12 per quarter; stretch target: fewer than 10 per quarter)
- The proportion of moderate, major and catastrophic harm medication incidents reduces (target: numerator = number of catastrophic, major and moderate harm medication related incidents reported; denominator = total number of medication related incidents reported; percentage to reduce on a quarterly basis)

The plan to achieve improvement will address the range of medication safety workstreams detailed above, reporting to the Medicines Governance Group every two months.

4. To reduce Hospital Acquired Thrombosis

Rationale for selection as a key quality objective:
Venous Thromboembolism (VTE) is a significant cause of mortality, long term disability and chronic ill health. It is estimated that there are 25,000 deaths from VTE each year in hospitals in England. VTE is the subject of a national CQUIN (Commissioning for Quality and Innovation) target and has been selected by our Governors for inclusion in the Quality Account.

The Trust's target for 2010/11 is to assess at least 90% of adult inpatients for their risk of developing VTE.

During the past year, the Trust Executive Group has made VTE risk assessment an organisational imperative. A Venous Thromboembolism Prevention Policy, which reflects NICE Clinical Guideline 92, has been ratified. All Clinical Divisions have nominated VTE clinical champions. VTE risk assessment has also been a focus of Patient Safety Executive walk rounds.

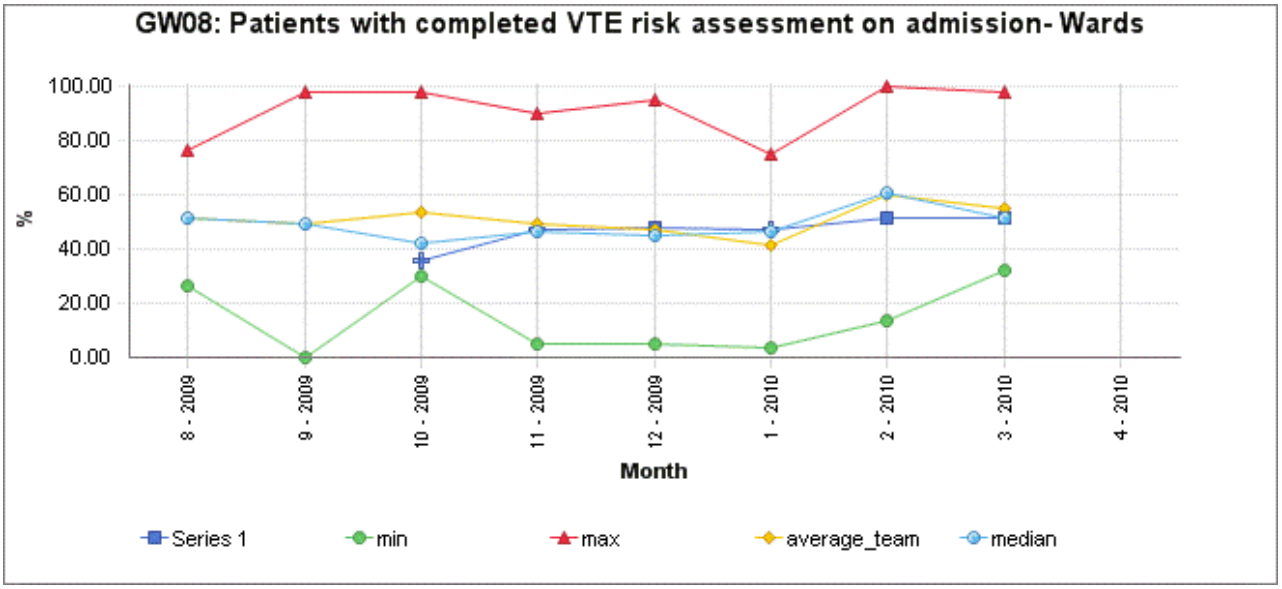
In 2010/11 the Trust will adopt the following measures in order to achieve the stated objective and the related CQUIN target:

- A prescription chart with an integral risk assessment has been developed and will be rolled out in May 2010
- VTE training will include slots on the Foundation Programme for medical staff and the roll out of the Department of Health e- learning tool to medical, nursing and pharmacy staff
- The VTE patient information leaflet will be updated in May 2010; information about VTE prevention will be added to the Bed Head Services. A patient Governor has joined the Thrombosis and Anticoagulation committee. Outreach presentations on VTE prevention have been organised during 2010-2011 to patient link groups to raise awareness

- Ward pharmacists currently audit five prescription charts per week per clinical area for VTE risk assessment and thromboprophylaxis prescribed. This data will be analysed in pharmacy and made available to Divisional Boards via the VTE clinical champions. This measure will enable VTE champions to support areas of poor compliance by challenging local practice. In addition a monthly case note review process has commenced in 2010 examining risk assessment and prescription of thromboprophylaxis. Ultimately the e–handover project will enable data on risk assessment and thromboprophylaxis to be stored on the patient administration system.
- This data is monitored monthly by The Trust Executive Group and reported externally as part of The South West Quality and Patient Safety Programme on a monthly basis.
- A baseline report of outcome data using clinical coding will run concurrently in terms of incidence of VTE in a primary episode of care and readmission within three months of discharge with a primary diagnosis of VTE. These episodes will also be reported as a clinical incident and will be investigated using Root Cause Analysis at Divisional level. A reciprocal arrangement has been agreed with North Bristol NHS Trust to ensure all incidents involving patients who did not have their primary episode of care in whichever trust they are presenting at are copied to the neighbouring trust for shared learning.
- VTE champions will oversee qualitative audits undertaken by Foundation Doctors and ensure the results and actions are agreed by The Thrombosis and Anticoagulation Committee.
- VTE training will include slots on the Foundation Programme for medical staff and the roll out of the Department of Health e- learning tool
- An externally funded VTE Project Nurse (0.4 WTE) has been appointed for one year to support the above plans
- Further support and the opportunity for collaborative working are provided by The BNSSG Health Community VTE Prevention Strategy Group. An action plan has been created and representatives from the group have attended UH Bristol's Thrombosis and Anticoagulation Committee.

VTE Risk Assessment – relative performance across the

South West Region



This graph has been produced by The South West Quality and Patient Safety Programme and illustrates venous thromboembolism risk assessment from all trusts in the South West Region. The progress of the Trust (marked as 'Series 1') reflects the median.

5. To increase the level of patient and public involvement in service improvement

Rationale for selection as a key quality objective:
University Hospitals Bristol NHS Foundation Trust is committed to providing a high quality, patient-focused healthcare service that meets the needs of a diverse population. It is essential that we use patient feedback in order to understand the patient experience and deliver services which are truly patient-centred.

The Trust will implement its Patient and Public Involvement Strategy for 2010-12, including systems for obtaining comprehensive feedback from patients about their experience of our services.

There are five elements to our strategy:

a. To collect robust patient experience metrics via a regular postal survey of discharged inpatients
b. To develop a proactive programme of Trust survey activities using electronic hand-held survey devices
c. To give patients, relatives, visitors and carers the opportunity to comment on the inpatient experience via comments cards available on each ward
d. To explore new and innovative ways of allowing patients and the public to give feedback about our services

e. To continue to engage the local community in matters that affect them and the Trust

Implementation of the strategy will provide the Trust with a range of important feedback which can be used to drive improvements in our services:

Daily	Inpatients will complete exit cards at point of discharge from wards, enabling wards to make improvements in 'real-time'
Monthly	Discharged inpatients will receive a detailed postal survey. The results of this survey will be used to generate monthly reports for Trust and Divisional Boards.
Bi-monthly	Governors and volunteers will undertake targeted surveys using hand-held electronic devices
Quarterly	Data from the postal survey will be available at ward level
Annual	The National Inpatient Survey will become a measure of how effective our strategy has been, rather than an improvement tool in itself

The Trust will place particular emphasis on regular monitoring of five questions from the National Inpatient Survey which have been selected to form a national CQUIN (Commissioning for Quality and Innovation) target:

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

6. To meet the requirements of the proposed NICE Quality Standard for Dementia

Rationale for selection as a key quality objective:
The term Dementia covers a range of progressive, terminal brain conditions which affects more than 73,000 people in the South West of England. This number is set to increase by 40% to 102,000 by 2021. There is increasing national recognition of the importance of ensuring the highest possible standards of assessment and care for patients with dementia in hospital.

Standards of care should mean something to patients, reflecting the care they received and the clinical outcomes that matter to them. In late 2009 NICE began to develop a comprehensive range of metrics for the NHS, known as "quality standards". NICE quality standards are intended to provide a clear description of what a high quality service should look like, enabling organisations to aspire and progress to improve quality and achieve excellence. They are intended to support benchmarking of current performance against evidence based measures of best practice and to identify priorities for improvement.

NICE quality standards will be developed in parallel with clinical guidelines, and where possible will match key criteria from existing national audits. There are four quality standards currently in development; stroke, dementia, venous thromboembolism and neonatal care, with an anticipated 150 further standards to be published over the next five years. Each quality standard will comprise a number of quality statements that address an important aspect of service structure, process or outcome. When fully developed, the standards will represent a 'bank' of quality metrics against performance can be measured. Work has already begun within the Trust to identify which quality statements are directly relevant to our services, how the necessary data will be collected and the frequency with which it will be reported.

The draft quality standard for dementia (published for consultation in November 2009), comprises 18 quality statements. Not all 18 quality statements relate directly to practice within the Trust – for example the primary diagnosis and initial treatment of dementia is led by Primary Care and the Avon and Wiltshire Mental Health Partnership NHS Trust. However, patients with dementia can be admitted to the Trust for a variety of non-dementia reasons, such as a fracture following a fall. Six of the 18 draft quality statements are directly relevant to the Trust: performance against the final published metrics will be reported annually, reported to the Trust's Clinical Effectiveness Committee.

C. Statements of assurance from the Board

1. Review of services

During 2009/10, the University Hospitals Bristol NHS Foundation Trust provided clinical services in 63[2] specialties via five clinical Divisions (i.e. Medicine; Surgery Head & Neck Services; Women's & Children's Services; Diagnostics and Therapies; and Specialised Services).

During 2009/10 the Trust Board has reviewed selected high-level quality indicators (e.g. infection control, HSMR) as part of monthly performance reporting. The Trust also receives information relating to the review of quality of services in all specialties via, for example, the Clinical Audit Annual Report. The income generated by University Hospitals Bristol NHS Foundation Trust services reviewed in 2009/10 therefore in these terms represents 100% of the total income generated from the provision of NHS services by the Trust for 2009/10. For 2010/11, however, review of services at Divisional level and by the Trust Board will be greatly enhanced through the development and implementation of quality metrics 'dashboards'.

[2] Based upon the Trust's Statement of Purpose, which is in turn based upon the Mandatory Goods and Services Schedule of the Trust's Terms of Authorisation with Monitor

2. Participation in clinical audits and national confidential enquiries

University Hospitals Bristol NHS Foundation Trust has a comprehensive clinical audit programme which incorporates national and local projects. There are many national clinical audits currently in progress covering the services that the Trust delivers. These are either funded by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), or funded through other means; either Royal Colleges or other professional bodies.

For the purpose of the Quality Account, the National Clinical Audit Advisory Group (NCAAG) has published a list of national audits and confidential enquiries, participation in which is seen as a measure of quality of any trust clinical audit programme. This list is not exhaustive, but rather aims to provide a baseline for trusts in terms of number of percentage participation. The detail which follows relates to this list.

Participation relating to national clinical audits outlined by NCAAG

During 2009/10, 33 national clinical audits and seven national confidential enquiries related to NHS services that the University Hospitals Bristol NHS Foundation Trust provides.

During that period University Hospitals Bristol NHS Foundation Trust participated in 97% of national clinical audits and 100% of 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 University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2009/10 are listed in the table below along with the national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust participated in during 2009/10.

National Clinical Audits	Eligible	Participated
Paediatric Intensive Care Audit Network	Yes	Yes
Vascular Surgical Society of Great Britain & Ireland - Vascular	Yes	Yes
National Neonatal Audit Project	Yes	Yes
National Diabetes Audit	Yes	Yes
Intensive Care National Audit & Research Centre - Case Mix	Yes	Yes
National Elective Surgery Patient Reported Outcome Measures	Yes	Yes
Adult Cardiac Interventions: Coronary Angioplasty	Yes	Yes
Congenital Heart Disease	Yes	Yes
National Joint Registry: Hip and Knee Replacements	Yes	Yes
Renal Registry: Renal Replacement Therapy	Yes	Yes
National Lung Cancer Audit (NLCA)	Yes	Yes
National Bowel Cancer Audit (NBOCAP)	Yes	Yes
National Head and Neck Oncology Audit (DAHNO)	Yes	Yes
Adult Cardiac Surgery: CABG & Valve Surgery	Yes	Yes

Myocardial Infarction National Audit Project (MINAP)	Yes	Yes
National Heart Failure Audit	Yes	Yes
National Hip Fracture Database	Yes	Yes
NHS Blood & Transplant: Potential Donor Audit	Yes	Yes
National Kidney Care Audit	Yes	Yes
National Sentinel Stroke Audit	Yes	Yes
National Audit of Dementia	Yes	Yes
National Falls and Bone Health Audit	Yes	Yes
National Comparative Audit of Blood Transfusion: changing		
Blood collection process	Yes	Yes
Audit of the use of red cells in neonates & children	Yes	Yes
British Thoracic Society: Respiratory diseases		
Adult Asthma Audit	Yes	Yes
Paediatric Asthma Audit	Yes	Yes
Paediatric Empyema Audit	Yes	Yes
College of Emergency Medicine: pain in children; asthma;		
Pain in Children	Yes	Yes
Asthma	Yes	Yes
Fractured Neck of Femur	Yes	Yes
National Mastectomy and Breast Reconstruction Audit (MBR)	Yes	Yes
National Oesophago-gastric Cancer Audit	Yes	Yes
Continence Care Audit	Yes	Yes
Trauma & Audit Research Network: Severe Trauma	Yes	No
Pulmonary Hypertension Audit	No	N/A
NHS Blood & Transplant: intra-thoracic; liver; renal transplants	No	N/A
NAPTAD: anxiety and depression	No	N/A
National Confidential Enquiries	**Eligible**	**Participated**
Parenteral Nutrition	Yes	Yes
Emergency and Elective Surgery in the Elderly	Yes	Yes
Peri-operative Care	Yes	Yes
National maternal and perinatal mortality surveillance	Yes	Yes
Obesity in Pregnancy Enquiry Project	Yes	Yes
Child mortality surveillance	Yes	Yes
Child head injury enquiry	Yes	Yes

University Hospitals Bristol Foundation is not currently participating in the Trauma and Audit Research Network (TARN) project. Unlike the other audits listed above, TARN requires local funding - not only in terms of registration but also in terms of administrative support for data collection and data entry. The Trust is currently reviewing how future participation in TARN might be funded.

Participation in other national clinical audits

Although not highlighted as priorities by NCAAG, the Trust participated in a number of other national audits during 2009/10 that clinical staff considered important in driving up the quality of patient care.

These are listed below:

Other National Clinical Audits
Central Cardiac Audit Database/Heart Rhythm UK - Cardiac Rhythm Management
Central Cardiac Audit Database/British Heart Foundation - Cardiac Rehabilitation
The Arrhythmia Alliance - National Audit of Arrhythmia Nurse Services
British Orthodontic Society **-** National Audit of Mini Screws/Temporary Anchorage Devices (TADs)
Health Protection Agency - Surgical Site Infection Surveillance
British Society of Gastroenterologists/Joint Accreditation Group - Global Rating Scale for Endoscopy Services
Royal College of Physicians - National Chronic Obstructive Pulmonary Disease
Royal College of Physicians - United Kingdom National Inflammatory Bowel Disease
NHS Diabetes - National Diabetes Inpatient Audit
British Renal Society - Retrospective Audit of Anaemia in Paediatric Patients with Stage 5 Chronic Kidney Disease
National Audit of Referrals to the Paediatric Orthopaedic Department for Patients with Suspected Malignancy
Obstetrics Transfusion and Iron Survey (OTIS)
NHS Cancer Screening Programme - National Audit of Invasive Cervical Cancers
Department of Health - National Health Promotion in Hospitals (NHPH) Audit
National Royal College of Radiologists - National Audit of Diagnostic Adequacy, Accuracy and Complications of Image-Guided or Assisted Liver Biopsy
National Royal College of Radiologists - Single Fraction Radiotherapy for Bone Metastases Audit
National Royal College of Radiologists - Malignant Spinal Cord Compression Audit
National Royal College of Radiologists - Late Effects of Chemo-Radiotherapy Audit
National Royal College of Radiologists - Head and Neck Cancer Pre-Treatment

Coverage

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust participated in, and for which data collection was completed during 2009/10, 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 Audits (NCAAG)	Submitted/Required
Paediatric Intensive Care Audit Network	633/633 (100%)
Vascular Surgical Society of Great Britain & Ireland -	118/118 (100%)
National Neonatal Audit Project	1835/1835 (100%)
National Diabetes Audit	393*
Intensive Care National Audit & Research Centre - Case	422*
National Elective Surgery Patient Reported Outcome	201/287 (70%)
Adult Cardiac Interventions: Coronary Angioplasty	989/989 (100%)
Congenital Heart Disease	606*
Renal Registry: Renal Replacement Therapy	55/55 (100%)
National Lung Cancer Audit (NLCA)	107/180 (59%)
National Bowel Cancer Audit (NBOCAP)	113/96 (117%)
Adult Cardiac Surgery: CABG & Valve Surgery	1406/1406 (100%)
Myocardial Infarction National Audit Project (MINAP)	746*
NHS Blood & Transplant: Potential Donor Audit	105*
National Audit of Dementia	Pilot stage - 10/10
National Comparative Audit of Blood Transfusion:	
Blood collection process	25/40 (63%)
Audit of the use of red cells in neonates & children	38/40 (95%)
British Thoracic Society: Respiratory diseases	
Adult Asthma Audit	10/10 (100%)
Paediatric Asthma Audit	10/10 (100%)
Paediatric Empyema Audit	10/10 (100%)
College of Emergency Medicine: pain in children; asthma;	
Pain in Children	50/50 (100%)
Asthma	50/50 (100%)
Fractured Neck of Femur	50/50 (100%)
National Mastectomy and Breast Reconstruction Audit	98/98 (100%)
National Oesophago-gastric Cancer Audit	484/600 (81%)
National Continence Care Audit	43/80 (50%)
National Confidential Enquiries	**Submitted/Required**
Parenteral Nutrition (NCEPOD)	42/53 (79%)
Emergency and Elective Surgery in the Elderly (NCEPOD)	6/12 (50%)
Peri-operative Care (NCEPOD)	143/151 (95%)
National maternal and perinatal mortality surveillance (CEMACE)	Maternal deaths: 1/1 (100%) Stillbirths: 23/23 (100%) Neonatal deaths: 37/43
Obesity in Pregnancy Enquiry Project (CEMACE)	71/71 (100%)
Child mortality surveillance (reported to the Child Death Overview Panel)	Child deaths: 33/33 (100%) during the year 2009

Child head injury enquiry (CEMACE)	70/70 (100%)
Other National Clinical Audits	**Submitted/Required**
Central Cardiac Audit Database/Heart Rhythm UK -	771/771 (100%)
British Heart Foundation - National Audit of Arrhythmia	1664*
Health Protection Agency - Surgical Site Infection	216/289 (78%)
NHS Diabetes - National Diabetes Inpatient Audit	597/785 (76%)
British Renal Society - Retrospective Audit of Anaemia in Paediatric Patients with Stage 5 Chronic Kidney Disease	55/55 (100%)
Department of Health - National Health Promotion in	100/100 (100%)
National Royal College of Radiologists - National Audit of	50/50 (100%)
National Royal College of Radiologists - Malignant Spinal	10/10 (100%)

* No baseline requirement identified by audit/unable to determine baseline from Hospital Episode Statistics

Review of clinical audit reports

The reports of nine national clinical audits were reviewed by the Trust, through its Clinical Divisions, in 2009/10 and University Hospitals Bristol NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided[3]. The key findings and actions from these audits will be reported to the Trust Board through our Clinical Audit Annual Report.

- *National Bowel Cancer Audit (NBOCAP)*
  To decrease the time patients are waiting for flexi-sigmoidoscopy appointments, one dedicated slot on the colorectal surgeon endoscopy list will be held open on a Monday to accommodate those patients requested at the multi-disciplinary meeting the previous Friday. To facilitate the booking of staging investigations on the same day, bookings for these procedures will be completed at the same time to improve correlation and to help avoid patients having to come in on numerous occasions. To help decrease the time that patients wait for their outpatient appointment, the number of outpatient slots available in clinic will be increased. A 'team' approach to data capture has been agreed to ensure that we are submitting quality data for all our patients. Monthly data validation lists are being circulated to help identify missing data and to make the process more robust.

- *National Lung Cancer Audit (NLCA)*
  To help ensure that General Practitioners are informed of a new diagnosis of cancer within 24 hours of diagnosis, the Lung Multi-Disciplinary Team (MDT) has reviewed the current arrangements and devised a letter template to support the process. It is now the role of the MDT Co-ordinator that when a diagnosis has been agreed at MDT the letter template is completed and sent. The Lung MDT has reviewed the initial part of the patient pathway to provide a Two Stop Clinic: this was introduced to provide patients with rapid access to diagnostic services. To facilitate this, the Lung Team reviewed the start of the original patient pathway to review patients at clinic on a Monday morning, followed by same day CT scan in the afternoon and bronchoscopy on the

[3] It should noted national clinical audits do not necessarily report on an annual basis

Tuesday or Thursday with results of all investigations being discussed at the Friday MDT meeting. To help increase Thoracic Surgery capacity, a new system of protected beds has now been piloted which allows the Thoracic Surgery Team to bypass the normal bed control procedure and use the designated beds to improve patient flow from referral to admission, surgery and discharge.

- *National comparative audit of blood collection process*
  The Trust will continue to ensure that staff are trained and competency tested on the correct process of blood collection to ensure safe transfusion practice.

- *National Health Promotions in Hospital (NHPH) Audit*
  The Trust is working closely with Bristol Public Health to help develop a Bristol-wide health promotion strategy. Ongoing work is underway in conjunction with the Bristol Stop Smoking Team to provide brief intervention training to staff as well as working with the Pre-operative assessment Clinic to develop lifestyle questionnaires. The Trust is in the process of implementing the Department of Health 'Stop Smoking in Secondary Care' Pilot.

- *Health Protection Agency Surgical Site Infection Surveillance*
  The Trauma & Orthopedic Department has funded the post of a part time audit nurse to improve data capture and robustness allowing us to better monitor the quality of care this group of patients receives.

- *National Neonatal Audit Programme (NNAP)*
  The aim of this audit is to assess whether babies requiring neonatal care received consistent care across England and Wales. Results show that our neonatal intensive care unit has achieved high rates of compliance in a number of areas. 100% of all babies between 26 and 28 weeks gestation received surfactant (allowing them to breath more easily), compared to the required national standard of 90%. 91% of babies had their retinopathy of prematurity screening in accordance with national guidelines and 100% of babies <33 weeks' gestation received their mother's milk. 81% of babies <28 weeks had their blood pressure taken within the 1st hour after birth. A number of actions have been implemented as a result of this audit. The unit has incorporated a dedicated neonatal nurse and weekly clinic in order to increase the percentage of babies <1501g or gestation age at birth <32+0 weeks undergoing retinopathy of prematurity screening as nationally recommended. To help increase the percentage of babies who are treated along the normal neonatal care pathway except where clinically indicated, the Trust has agreed and funded a plan to increase the capacity of the Neonatal Intensive Care Unit. A full time information manager has been appointed to improve data quality.

- *UK comparative Audit of Upper Gastrointestinal Bleeding and the use of Blood*
  The national audit recommendations regarding blood, platelet and the use of Fresh Frozen Plasma have been incorporated into the Trust's 'bleed' integrated care pathway.

- *The National Clinical Audit of Falls & Bone Health in Older People*
  The ortho-geriatric consultant review is in the process of being extended to cover all wards so as to pick up outlying patients who may not be on a dedicated trauma ward. A pilot study of direct admissions to trauma wards

from Accident & Emergency is currently underway and a hip fracture clerking proforma is being developed to help record key relevant patient information on admission. The current pathways for patients that have fallen have been improved; the current assessment tool has been updated and validated through the 'Falls' group. The Trust is also trying to improve access to theatre for Trauma patients by developing daily trauma lists.

- *National Renal Registry*
  The renal registry report provides data on children receiving renal replacement therapy in paediatric nephrology centres in the UK. Data completeness from the renal unit at the Bristol Royal Hospital for Children compared favourably with other centres. Achievement of audit standards was reported for blood pressure control, anaemia, calcium and phosphate. Blood pressure was below the target of the 95th centile in 84% of transplant patients compared with 82% in the UK as a whole, and in 65% of dialysis patients compared with 71% in the UK. Haemoglobin was in the target range in 48% of transplant patients and 45% of dialysis patients compared with 44% and 42% respectively in the UK. Figures for the achievement of target levels of calcium and phosphate compared to the UK as a whole were 76% (73% UK) and 38% (50% UK). Consultants now receiving monthly reports of performance against the audit standards.

The reports of 226 local clinical audits were reviewed by the University Hospitals Bristol in 2009/10. Summary outcomes and actions reports of completed audits are routinely reviewed by the Trust's Governance and Risk Management Committee (Executive sub-committee of the Trust Board). The following list represents a selection of the actions the Trust will be taking in response to recent local clinical audits in order to improve the quality of healthcare provided to patients:

- *The use of cephalosporins, quinolones and clindamycin within the Bristol Royal Infirmary*
  All Trust guidelines containing recommendations as to the use of these antibiotics are to be reviewed to ensure that the recommendations are still current. The Trust antibiotic prescribing policy and departmental guidelines will be amended to ensure that the microbiology department is consulted in the care of all known or suspected patients with C diff infection.
- *Chest ultrasound for pleural effusion*
  Funding for portable ultrasound devices has been agreed and the machines purchased. Training in the use of ultrasound is now a mandatory part of respiratory physician training.
- *An audit of Antenatal Haemoglobinopathy request*
  The number of staff able to authorise haemoglobinopathy results has increased allowing more timely processing of the reports.
- *A re-audit of physiotherapy management of the general medical patient*
  A medical mobility screening tool will be introduced and made available in all ward folders. Teaching sessions covering respiratory assessment are to be introduced into the induction programme for new staff.
- *A re-audit of blood transfusion requests within the emergency department*
  Teaching sessions highlighting the importance for taking consent for blood transfusions have been implemented. These sessions also highlight the issue of 'special circumstances' related to blood transfusion e.g. patients who are Jehovah's Witnesses.

- *Auditing the care of peripheral cannulae*
  Responsibility for completing care plans during shifts now lies with a designated member of the nursing team identified at during nursing handover.
- *Is the General Practitioner being notified of a patients diagnosis of skin cancer by the next day?*
  A new form of documentation system has been introduced to help speed up this process.
- *Management of patients with Parkinson's Disease*
  The Parkinson's Disease Society has agreed to fund a nurse specialist as highlighted as best practice within current NICE guidance.
- *A retrospective audit of late complications of Endoscopic Retrograde Cholangiopancreatography*
  An integrated care pathway has been created for the treatment of these patients. This includes guidance on patient preparation, day case and nurse led discharge along with a customised referral form.
- *Do Cystic Fibrosis patients have chest x-rays, liver ultrasound and DEXA scans on an annual basis?*
  The annual review and scan requesting process has now been standardised. Ultrasound and DEXA scanning can now be booked on the same day so as to minimise the disruption to patients.
- *Identification of potential/obligate haemophilia carriers*
  The proforma for nurse and consultant led review has been updated to include any areas to help identify potential carriers and to discuss genetic mutation analysis and family screening.
- *Isotopes/thyroid and patient preparation prior to Radioiodine Ablation*
  A radiographer checklist for the preparation of radioiodine treatment has been introduced. Closer working with the Biochemistry Department has been established; regular lists of names and dates of admission of patients are sent to allow more efficient timing of results.
- *Temozolomide for newly diagnosed high grade glioma*
  Pharmacists now book the second post-radiotherapy appointment at first clinic to ensure treatment starts within four weeks of radiotherapy.
- *Out of hour's telephone calls on Ward 61*
  A dedicated clinician has been identified to act as an acute admissions lead within the service. A dedicated area is planned for these acute admissions.
- *Glaucoma outpatient follow up appointments at the Bristol Eye Hospital*
  The Trust's local protocol has been adapted the ensure follow up intervals match those outlined in NICE guidance.
- *Bristol Eye Hospital Accident & Emergency Breaches*
  Staffing within the Emergency Department has been increased with the addition of a Primary Care Fellow. Corneal and external eye disease primary care clinics have been introduced with the provision for training shared care optometrists.
- *Head & Neck cancer; General Practitioner and patient communication*
  A standardised letter template is in the process of being created so that more Multi-Disciplinary Team letters include the required information on staging and treatment.
- *An audit of the use of the South West network integrated care pathway (ICP) for children with diabetic ketoacidiosis*
  The current pathway has been re-written to take into account findings from the audit.

- *Thromboprophylaxis in the post partum period*
  The caesarean section form has been revised to help ensure that all emergency caesarean sections are prescribed five days of clexane post-operation.

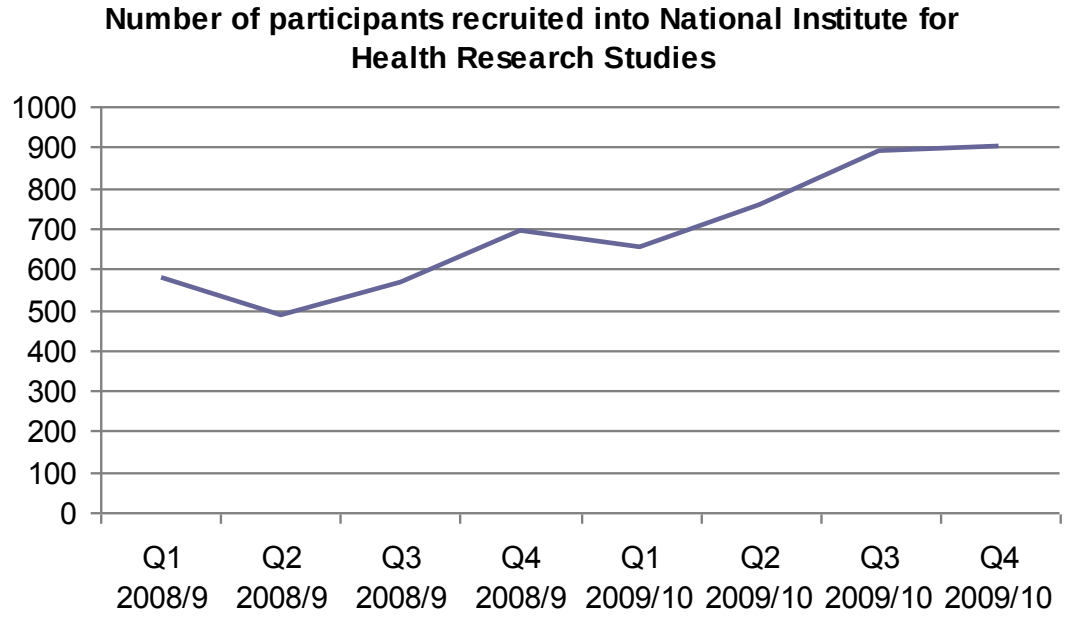
Local Clinical Audit Programme

Local clinical audits are carried out by individual healthcare professionals and clinical teams evaluating aspects of care that they have selected as being important to local clinical practice. Each year the Trust undertakes an extensive consultation process to determine priorities for clinical audit. This involves seeking the views of Commissioners, Trust Members, service users and Trust leads for governance and assurance as well as consultation with staff in the Clinical Divisions. In prioritising topics for local audit we consider guidance included that issued by the National Institute for Health and Clinical Excellence (NICE), the National Patient Safety Agency and NCEPOD (National Confidential Enquiry into Patient Outcome & Death). Priorities may also focus on audits identified through commissioning (e.g. the Commissioning for Quality and Innovation framework or other quality schedules) or those identified through Care Quality Commission Registration Standards. We also encourage projects which have patient involvement and multi-professional working, those which involve joint working with other trusts and organisations, and appropriate re-audits.

During 2009/10 University Hospitals Bristol NHS Foundation Trust had over 350 local clinical audit projects either in progress or completed. Of those audits that were completed and where areas for improvement were identified, 193/199 (97%) had an action plan produced. Of all completed audits, 202/226 (89%) had a written report.

3. Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the University Hospitals Bristol NHS Foundation Trust in the period April 1st 2009 to March 31st 2010 that were recruited during that period to participate in research approved by a research ethics committee was 7212. The Trust has demonstrated its commitment to recruiting patients into clinical research over the last few years with Bristol Haematology and Oncology Centre performing as one of the highest recruiting centres to clinical trials in one of the highest performing cancer networks in England. The Trust's recruitment into National Institute for Health Research (NIHR) studies has increased over the last eight quarters, demonstrating commitment to improving quality of care to the population of Bristol and the South West and to improving the Region's health.



The University Hospitals Bristol was involved in conducting 648 clinical research studies during the reporting period. Of these, 49% were funded by the National Institute for Health Research or partner organisations. 19% were commercially sponsored and fully funded, and 8% were funded in part or wholly by a commercial grant. National systems were used to manage the studies in proportion to risk. Of the 177 studies given permission to start using national systems, 64% were given permission by an authorised person less than 30 days from receipt of a valid complete application. In the last three years 1379 publications have been generated, helping to improve patient outcomes and experience across the NHS.

4. CQUIN framework (Commissioning for Quality and Innovation)

The amount of potential income in 2009/10 for quality improvement and innovation goals was £1.8 million. This was conditional upon achieving key national access targets in full.

Associated payment in 2009/10 was nil.

A proportion of University Hospitals Bristol Foundation Trust's contracted income in 2009/10 was dependent upon us achieving stretch targets for improvements in quality and innovation goals, as agreed between the provider and its Commissioners through the CQUIN payment framework. This potential income was conditional upon achieving key national patient access targets in full. Further detail of the 2009/10 agreed goals and new goals agreed for 2010/11 is available upon request from the Commissioning Team.

The NHS South West CQUIN payment framework required provider organisations to demonstrate that they were meeting the key existing commitments and national priorities set out in the Operating Framework in NHS South West for 2009/10 in order to qualify for CQUIN payments for achievement of locally agreed stretch targets. These "gateway" standards related to the reduction in waiting times for accident and emergency, cancer, inpatients and outpatients, with graduated eligibility for full CQUIN payment for targets relating

to Choose & Book slot availability, cancelled operations, MRSA bacteraemias and ambulance handovers.

The CQUINS in 2009/10 were chosen to reflect the national priorities but, more specifically, the needs and ambitions of the local community, as set out in the Primary Care Trust and South West Strategic Health Authority's operating frameworks.

The Trust did not achieve the "gateway" cancer standards in 2009/10, and therefore forfeited this potential additional income. Action was taken during the year to address the failure to comply with these national access standards, to improve patient care and also to put the Trust on a stronger footing for securing CQUINs income in 2010/11.

5. Care Quality Commission registration and reviews

The University Hospitals Bristol NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without compliance conditions.

The Care Quality Commission has not taken enforcement action against the University Hospitals Bristol during 2009/10. The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period. The Commission has yet to commence its programme of periodic reviews and hence the Trust has yet to be reviewed in this manner.

During 2009/10 two 'outlier alerts' were received from the Care Quality Commission:

The first of these related to concerns about possible high mortality associated with the use of stents: highly complex procedures which are performed regularly in seriously ill patients. A review of the 17 cases which triggered the alert revealed a spread across a range of aspects of hospital care including Neonatal Medicine and Palliative Cancer care. An analysis supervised by the Medical Director revealed that in eight of the 17 cases the death was not as a result of a stent complication and had been miscoded. These included, for example, Gullet stents which are placed to provide relief from obstructing cancers which work for up to a year but eventually re-block with tumour growth through natural progression of the disease. Coding clerks have since received training to ensure correct codes are assigned in future.

The second outlier alert related to concerns about possible high rates of Maternal Lacerations for data covering the period October 2008 to September 2009. The Trust undertook an audit of its Hospital Episode Statistics data which confirmed that coding was accurate. The Trust also undertook a thorough review of perineal trauma data for the year in question which confirmed that rates of trauma were well within published ranges and reflect good practice.

6. Data quality

The University Hospitals Bristol NHS Foundation Trust submitted records during 2009/10 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was: 98.7% for admitted patient care; 99.6% for outpatient care; and 93.5% for accident and emergency care.
- Which included the patient's valid General Practice code was: 100% for admitted patient care; 100% for outpatient care; and 100% for accident and emergency care.

(Data source: NHS Information Centre, SUS Data Quality Dashboard, April 2009 – January 2010 as at Month 10 inclusion date)

The Trust's score for 2009/10 for Information Quality and Records Management assessed using the Information Governance Toolkit was 82.5%.

The University Hospitals Bristol was subject to the Payment by Results clinical coding audit during the reporting period (2009/10) by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding were:

- Primary procedures coded incorrectly: 7.5%
- Primary diagnoses coded incorrectly: 16.7%

Explanatory note for the clinical coding audit:

- As per Audit Commission advice; results should not be extrapolated further than the actual sample audited
- The following specialties/areas were reviewed in the sample:
    - General Medicine (100 sets of notes)
    - Cardiology (100 sets of notes)
    - Healthcare Resource sub-chapter "BZ Eyes and periorbital procedures and disorders" (70 sets of notes)
    - Healthcare Resource Group (HRG) "PA26B Other Gastrointestinal or metabolic disorders without complications" (30 sets of notes)

Part 3 Other information

Overview of the quality of care

Rationale for choice of measures:
In addition to the quality objectives – for 2009/10 and the year ahead – reported by the Trust in Part 2 of this Quality Account, the Trust has identified a number of other key topics and measures which help to tell the Trust's 'quality story' for 2009/10. These topics and measures have been identified for each of the three dimensions of quality: patient experience, patient safety, and clinical outcome/effectiveness. The choices reflect a number of quality priorities which have been identified in discussion with the Trust's Governors, specifically: antibiotic prescribing compliance; communication with patients about their medication; staff-patient communication in general; same-sex accommodation; and nutritional care. This part of the Quality Account includes clinical outcome data relating to five specific clinical areas: adult and paediatric heart surgery, cataract surgery, intensive care, and oesophageal cancer. These are high-profile topics, of considerable interest to patients and the public, where there is a significant degree of confidence in the data presented.

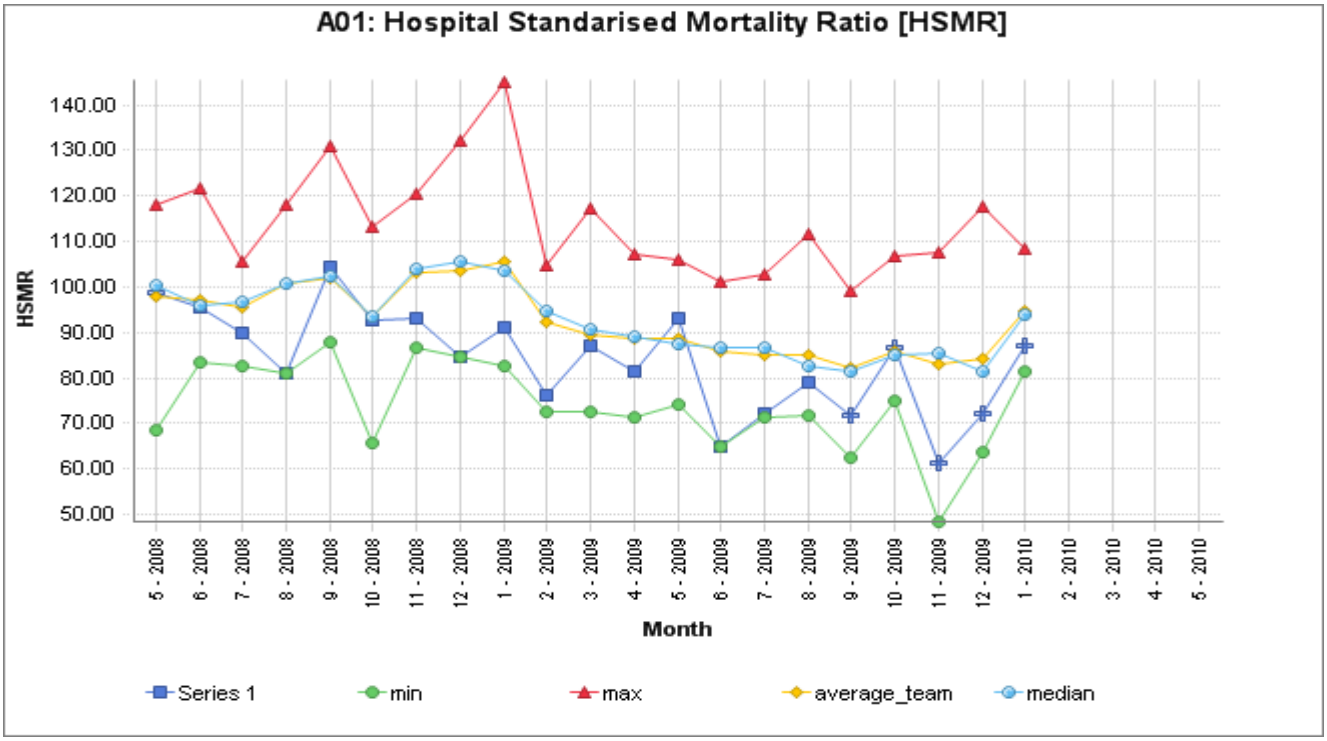
Patient Safety

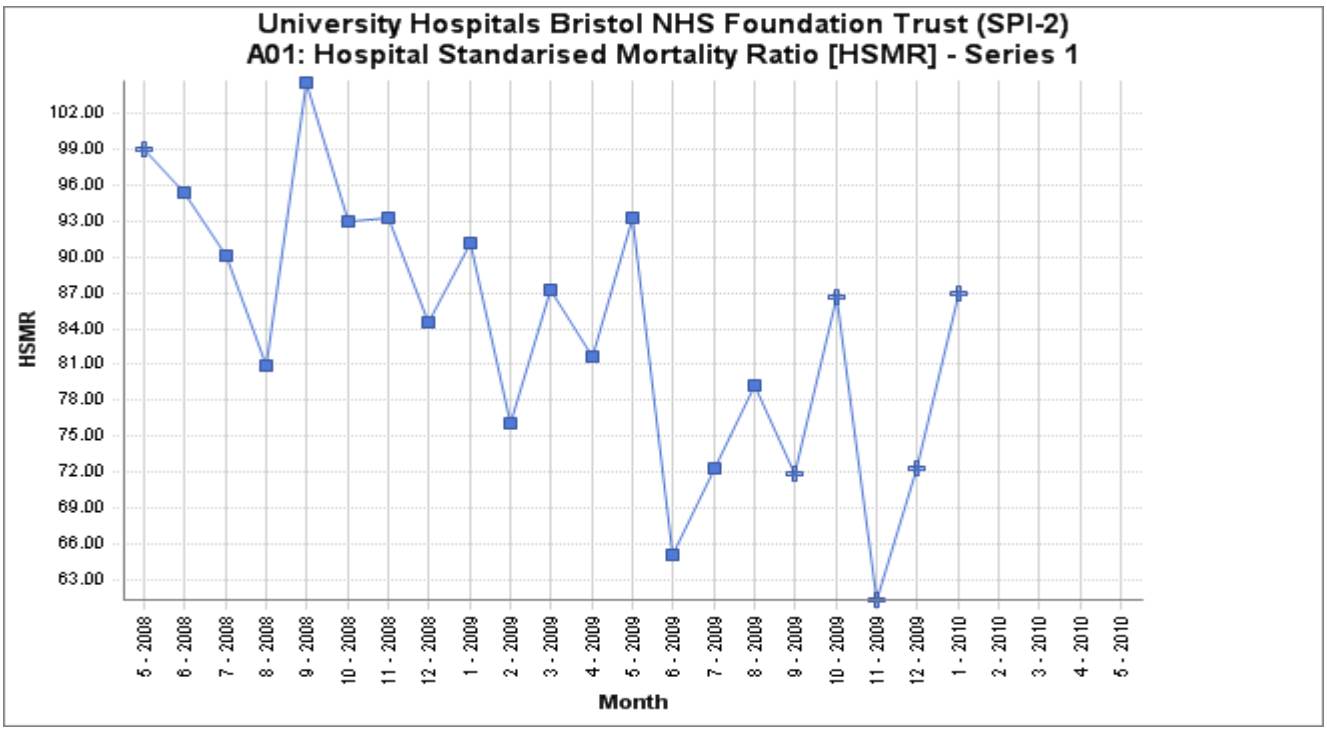
i. Hospital Standardised Mortality Ratio

During 2009/10 reports from the Mid Staffordshire NHS Foundation Trust have emphasised the use of Hospital Standardised Mortality as an indicator of overall Quality performance in the Trust. The Trust Board has received monthly updates on the Hospital Standardised Mortality Ratio for several years.

An overall aim of the South West Quality and Patient Safety Programme is a reduction in mortality (15%) over the next five years. Hospital Standardised Mortality is calculated through the number of hospital deaths and the number of hospital discharges. This data is fed through national Hospital Episode Statistics (Imperial College) who collate the data for all trusts and then publish a benchmark standard with which trusts can compare themselves. Data is always available two months in arrears to allow for this benchmarking process to take place. The data is also scrutinised by the Care Quality Commission who issue alerts if there are any exceptional high mortality alerts for an individual trust. These alerts consist of either a trust-wide alert or Specialty or procedure specific alerts. Trusts have a duty to investigate and respond to these alerts.

The graph below shows how the Trust ('Series 1') compares to all other hospital trusts in the South West Region.





Data source: HES data set (analysis by Dr Foster unit, Imperial College London)

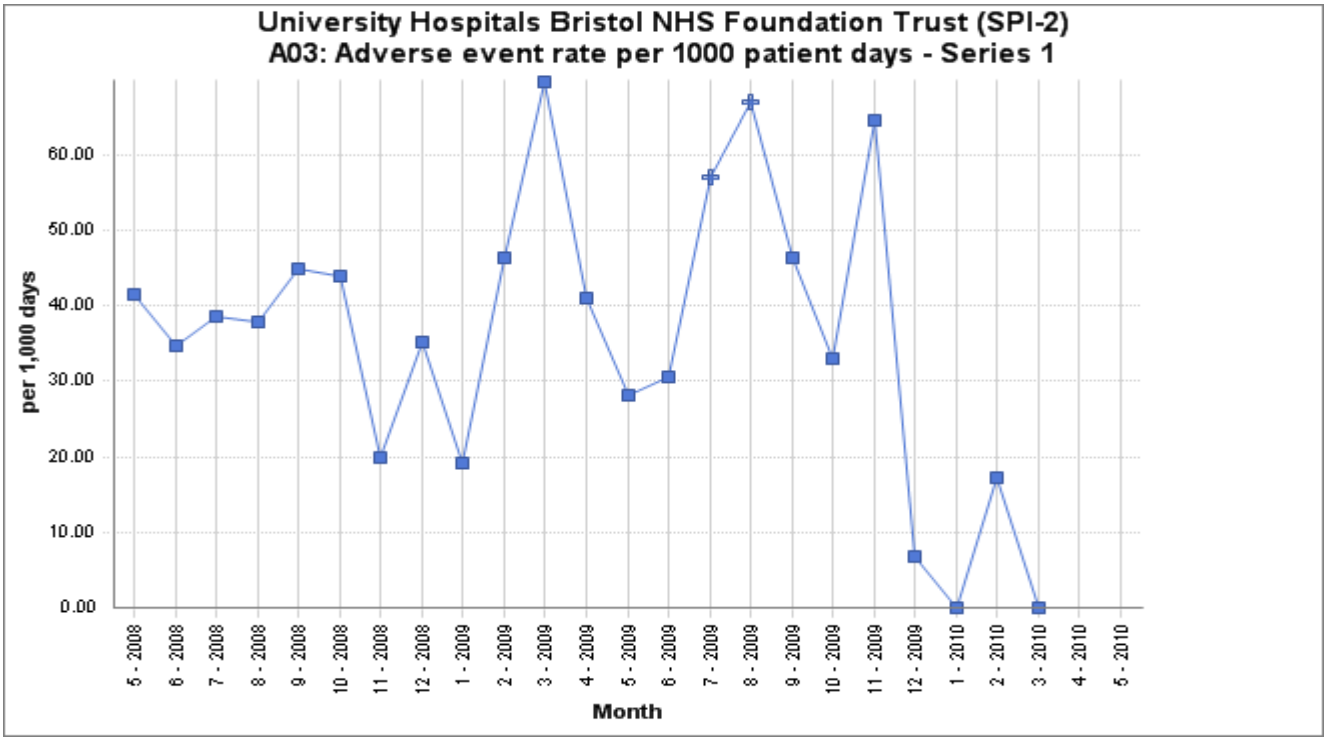
The University Hospitals Bristol has a low overall Standardised Hospital Mortality Ratio which has continued to show a gradual reduction throughout 2009/10. There was one alert for high mortality received by the Trust related to a procedure code which related to complications from interventional procedures. Formal investigation revealed clinical coding errors rather than a genuine cause for concern (a more detailed explanation is provided in Part 3 of the Quality Account).

ii. Adverse Event Rate

A further aim of the South West Quality and Patient Safety Programme is a reduction in adverse events (30%) over the next five years.

The Global Trigger Tool is a method of gauging patient harm in addition to incident reporting. It involves the use of regular case note reviews using a standardised proforma to identify if an adverse event has occurred. The review is conducted by clinical staff to determine the level of any harm detected. Since November 2009, 20 sets of adult and child case notes have been reviewed by the Trust each month. Since December 2009 the Trust has had fewer adverse events than average when compared to all other trusts in the South West region.

Adverse Event Rate (Global Trigger Tool)



The Trust reported zero 'Never Events' during 2009/10.

iii. Primary Percutaneous Coronary Intervention call to balloon time

In the treatment of ST elevated myocardial infarction (STEMI) by Percutaneous Coronary Intervention (PCI), any delay in the performance of the PCI is associated with a worse outcome for the patient. These patients undergo Primary PCI (PPCI) and account for approximately 32% of the Trust's PCI activity. The call to balloon time measures the response of the hospital system from the time a patient calls an ambulance for help until the start of the procedure. This call to balloon time comprises of a number of factors: the ambulance response time; the time taken to transfer the patient to hospital; the time taken to get the patient to the catheterisation laboratory once in hospital; and the time it takes to access the artery, cross the blockage with a wire and inflate a balloon.

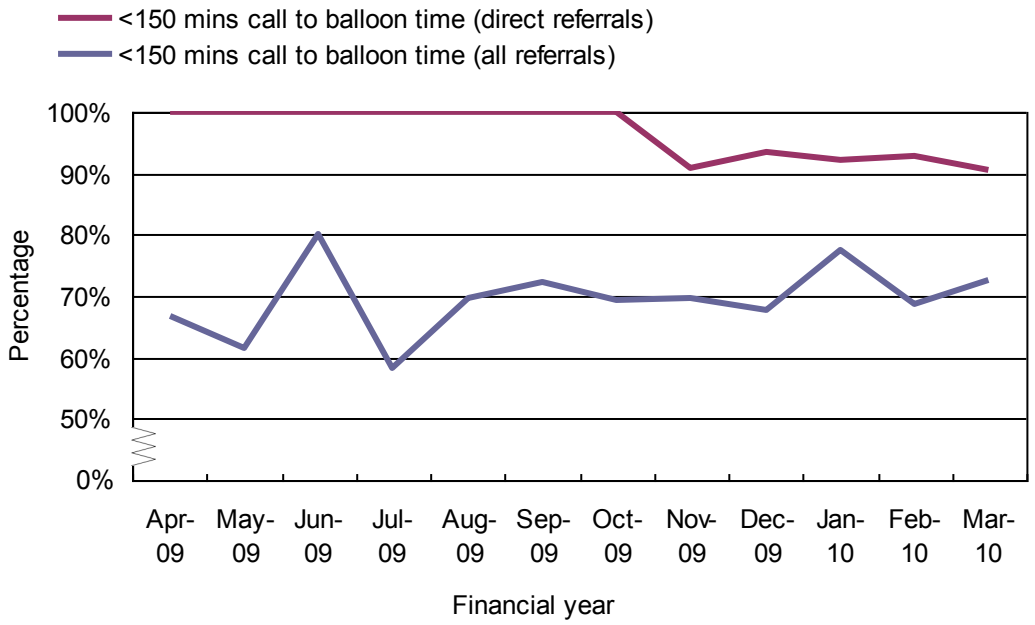
The Care Quality Commission has developed a performance indicator relating to the treatment of this subset of patients. The graph below shows the percentage of patients undergoing PPCI whose call to balloon time is within 150 minutes. Some patients are classified as direct referrals: this is where the ambulance crew decide that the patient is suitable for PPCI.

The team is made aware in advance and prepare for the admission; the patient then goes directly from the ambulance into the lab.

Currently, 33% of these PPCI patients are classified as direct referrals. For indirect referrals, a number of delays should be taken into account: this can be difficult diagnostic steps or even admissions in other hospitals.

In addition, delays are also experienced when patients are initially admitted to A&E, due to necessary diagnostic steps and arranging porters to transfer the patient. The graph below shows call to balloon performance for those patients directly referred as well as for all referrals (direct and indirect).

Percentage of patients experiencing an acute heart attack who received primary PCI within 150 minutes of calling for professional help



Data source: local MINAP and CARDDAS databases, cross-referenced with data held by the Great Western Ambulance Trust.

It should be noted that the total number of patients being directly referred is relatively small. Since September 2009, the Trust has only failed to meet the target for one case each month despite an increase in numbers seen, however because of the numbers of patients involved, this has an exaggerated affect on the percentages reported.

iv. Information received by patients about their medication

The annual National Inpatient Survey includes three questions relating to information given to patients about their medication:

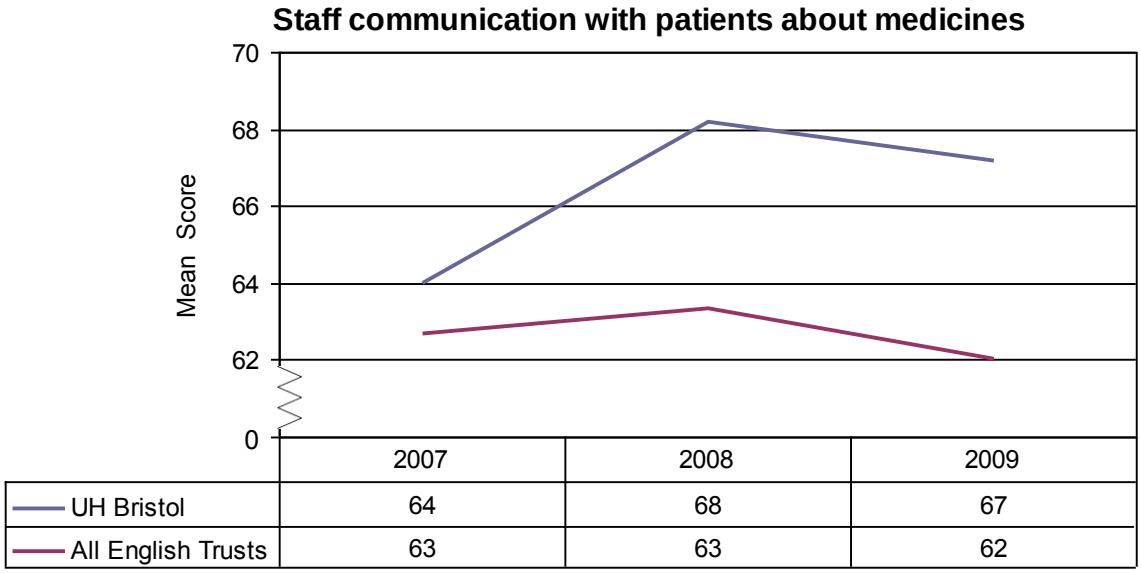
- Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Were you told how to take your medication in a way you could understand?

The table below shows the Trust's scores for the past three years.

	2007	2008	2009
Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand? (Yes, completely)	76%	80%	81%
Did a member of staff tell you about medication side effects to watch for when you went home? (Yes, completely)	38%	42%	40%
Were you told how to take your medication in a way you could understand? (Yes definitely)	78%	82%	80%
Mean	*64%*	*68%*	*67%*

The Trust's aggregated score ('mean') from the three measures is better than the national average.

In order to enable provision of appropriate information to patients concerning medication, a checklist has been designed as a tool for nurses to use when patients are discharged from hospital. This is placed in the discharge medication bag by Pharmacy, enables the nursing staff to address the key priorities, and is provided to the patient on discharge. This then signposts patients to the appropriate contact number if further information is required from Pharmacy.



Patient Experience

i. Privacy and dignity (including single sex accommodation)

While many patients tell us that the care they receive in the Trust is good or excellent, we can and must continue to work hard to ensure excellence in all

aspects of patient care. Ensuring patients' privacy and respecting their dignity is of great importance to the Trust.

It is a top priority for all staff on a daily basis and impacts enormously on the patient experience. The specific issue of same sex hospital accommodation has been highlighted by the Trust's Governors for inclusion in this year's Quality Account.

The Trust's Privacy and Dignity Group was established in 2008. Membership consists of mostly nursing staff from each of the Trust's Clinical Divisions, with additional representatives from Estates and Facilities, all with a shared passion for ensuring that a patient's right to privacy and dignity is fully embedded across the Trust.

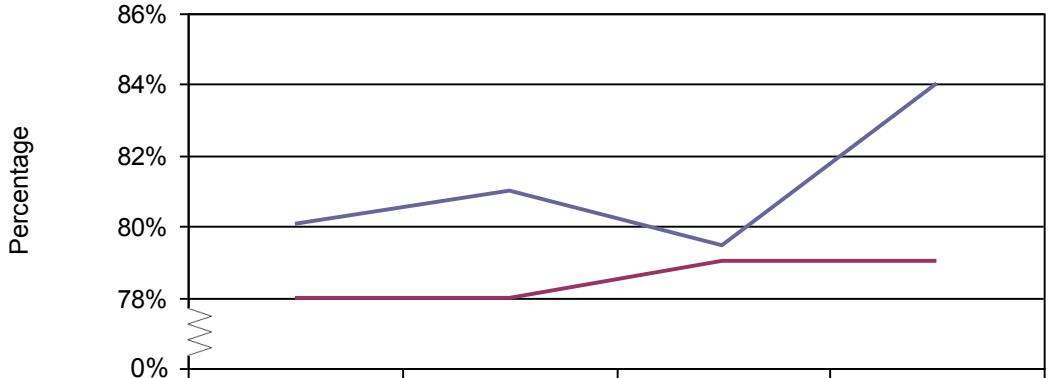
The group has implemented a number of initiatives over the last few years, with the aim of improving patients' experience whilst receiving care from the Trust, including:

- Pictorial signage indicating male and female bathroom and toilet facilities: this has been established across the Trust and is particularly important for patients whose first language is not English and to support patients who may be disorientated following admission.
- The development of a single sex accommodation leaflet for patients explaining how the NHS and UH Bristol is working to provide same-sex accommodation.
- Audits which have identified that the care of a patient after they have died could be improved, ranging from performing last offices to how property is packed and given to relatives. In February 2010, a revised Trust policy and procedure for care of a patient's body after death was launched, with over 100 staff attending a drop-in event at the Trust's Education Centre.

A 'modesty gown' has been introduced in some key clinical areas and there is more that can be done. The new Ben de Lisi gown, which has recently received much press attention is being considered along with other options, with a view to introducing gowns which are comfortable, maintain modesty and are practical in a hospital setting.

Integral to any of these changes is patient feedback: results from National Inpatient Surveys over the last few years indicate that we are making progress.

Patients saying they were treated with respect & dignity at all times during their inpatient stay



	2006	2007	2008	2009
UHB	80%	81%	79%	84%
All English Trusts	78%	78%	79%	79%

There are areas where we know we can further improve care and the Privacy and Dignity Group is currently working on a number of key projects, including:

- A pilot of “Do Not Enter” signs on Ward 2 to ensure staff think before entering closed curtains/doors has been evaluated positively by staff and patients. This will be rolled out across the Trust.
- Audit feedback highlighted that the property bags used to return deceased patients’ belongings are not ideal and do not convey the necessary respect and dignity. The Group has contacted the King’s Fund, currently considering the topic of property bags, and offered the Trust to be part of any future pilot project.

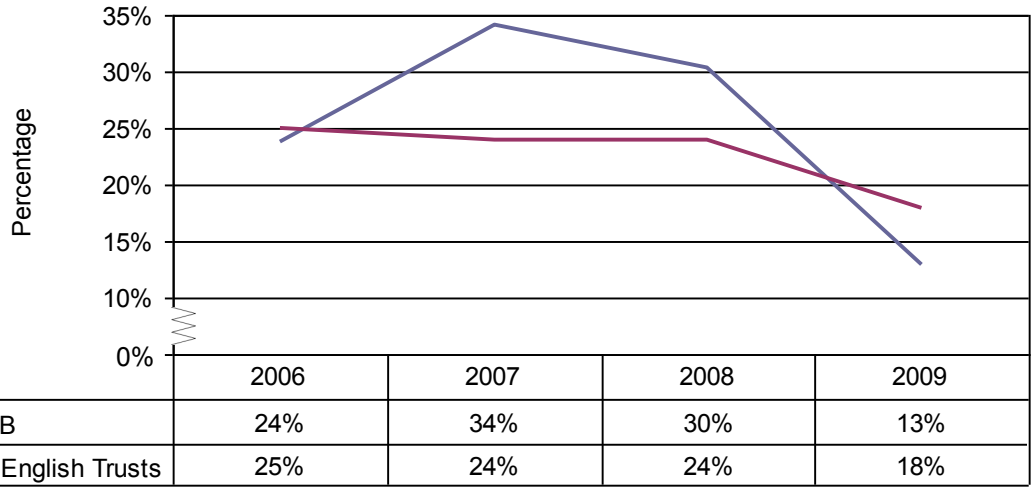
The NHS Constitution is clear that all patients have a right to privacy and dignity. Ensuring that hospitals provide same-sex accommodation is a core part of this right.

Over the last few years and in particular this last year, the University Hospitals Bristol has worked hard to improve facilities for patients, including:

- Upgrading wards to make sure that they comply with the same-sex standards set out by the Department of Health
- A bathroom and toilet replacement programme to ensure that our facilities are of a high standard
- Providing designated male and female bathrooms and toilets in all ward areas, which are clearly marked using pictorial signs
- Providing a patient information leaflet to indicate the work the Trust has been doing to provide same-sex accommodation as well indicating when this may not be possible and why.

Another important change the Trust has recently implemented, following patient feedback and audit results is designated male and female assessment units, i.e. where patients are often first admitted. This is an aspect of care where it is recognised that improvements can be made: any changes will ensure an improved patient experience in the future.

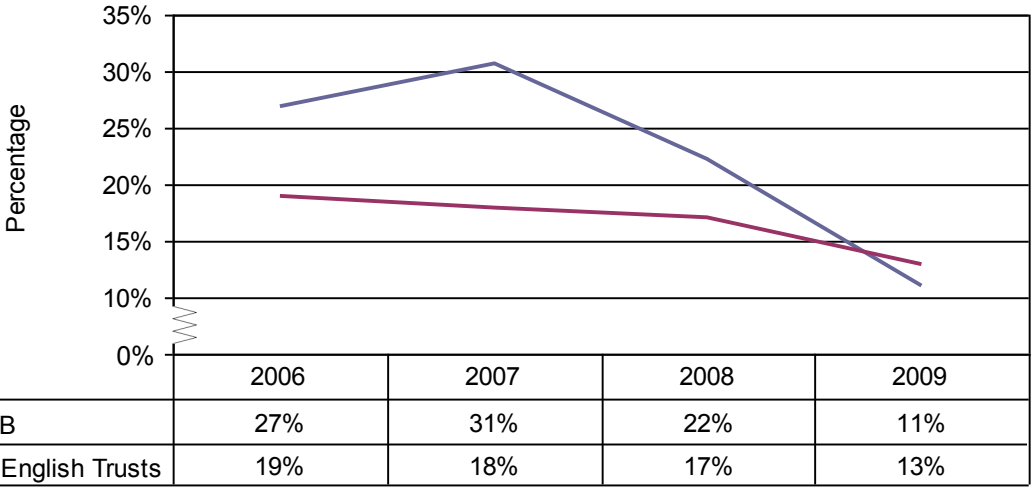
Patients who shared a sleeping area with patients of the opposite sex on the first ward they were admitted to



	2006	2007	2008	2009
UHB	24%	34%	30%	13%
All English Trusts	25%	24%	24%	18%

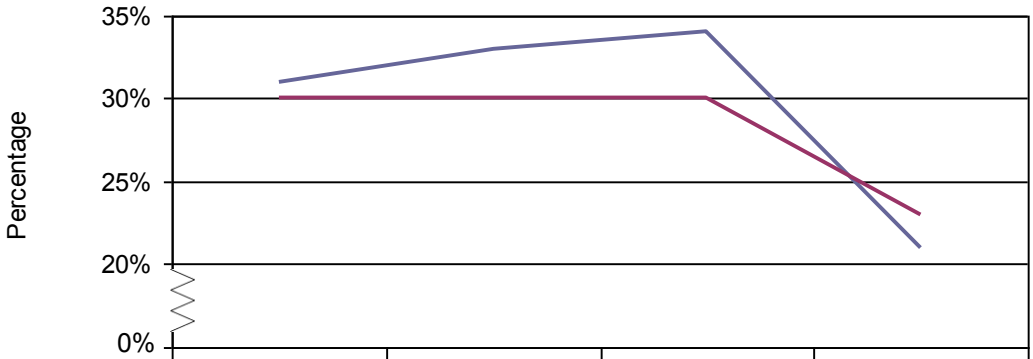
Other feedback received over the last few years from patient surveys shows good progress in this important area and is shown in the graphs below.

Patients who shared a sleeping area with patients of the opposite sex on any subsequent wards they stayed on



	2006	2007	2008	2009
UHB	27%	31%	22%	11%
All English Trusts	19%	18%	17%	13%

Patients who had to use the same bathing / shower area as patients of the opposite sex during their inpatient stay



	2006	2007	2008	2009
UHB	31%	33%	34%	21%
All English Trusts	30%	30%	30%	23%

These graphs indicate that the Trust has made significant improvement over the last four years despite some environmental challenges such as the Bristol Royal Infirmary Old Building, which make it more difficult to achieve excellence in this area. With a planned new ward block due to open at the Bristol Royal Infirmary in 2014, the Trust is confident about being able to provide the most up to date facilities that patients want and deserve: in the meantime, the concerted effort to upgrade and improve existing ward areas with continue.

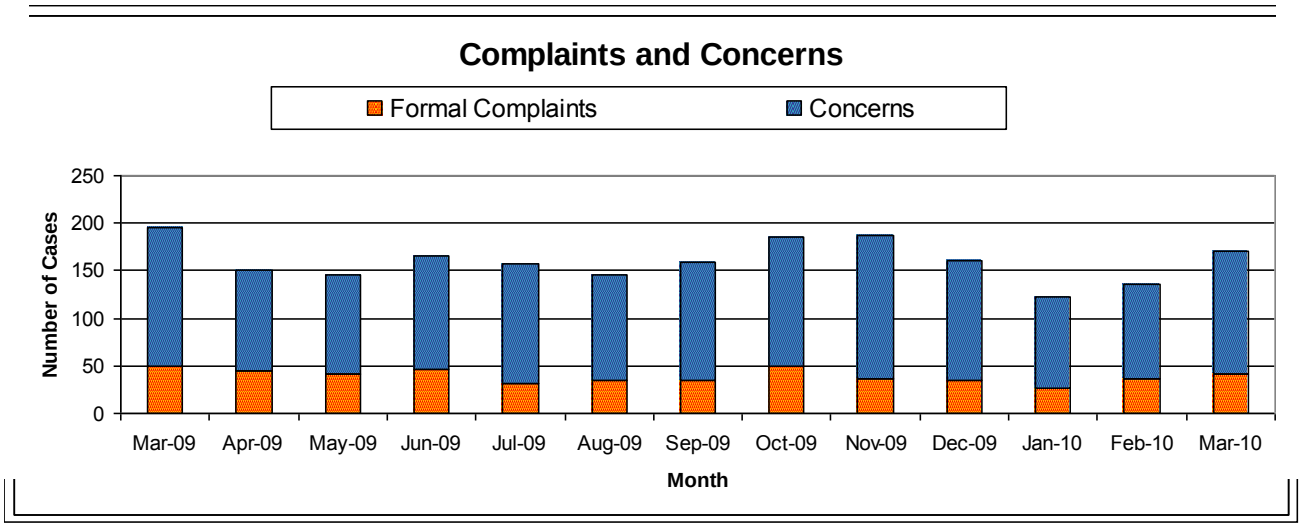
Patient Environment Action Team (PEAT) inspections for 2009/10 gave Bristol General Hospital and Bristol Haematology and Oncology Centre an 'Excellent' rating for Privacy and Dignity; Bristol Royal Infirmary, St Michael's Hospital, Bristol Royal Hospital for Children, and Bristol Eye Hospital, were rated as 'Good'.

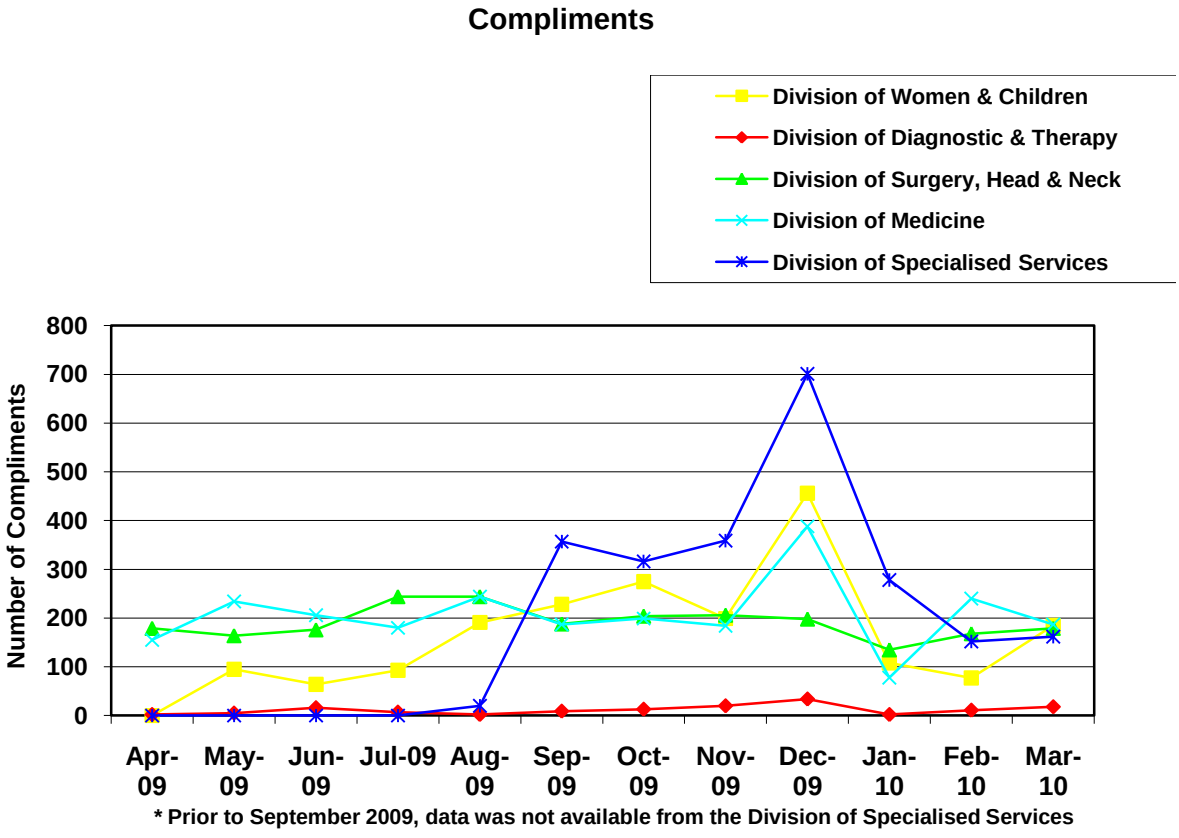
ii. Complaints

The number of formal complaints received during 2009/10 averaged 38 per month and totalled 455 for the full year, a significant reduction of 107 compared to 2008/9.

The flexibility of the new complaints system introduced in April 2009, in response to the new Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, provides for a more responsive and proportionate approach to complaints resolution by putting things right quickly for complainants wherever possible. This has resulted in an increase in the numbers of concerns (previously called 'informal complaints') which were addressed in this manner.

The monthly average number of complaints and concerns together during 2009/10 was 157, a reduction on average of 53 per month compared to the second half of the previous year. The number of compliments received in 2009/10 has increased on average from 600 to 890 per month, although this figure should be viewed with caution as reporting systems have improved in-year. A small number of dissatisfied complainants were able to seek a review of their complaint by the Parliamentary and Health Service Ombudsman under the new Complaints Regulations 2009.





Data source: Ulysses Safeguard

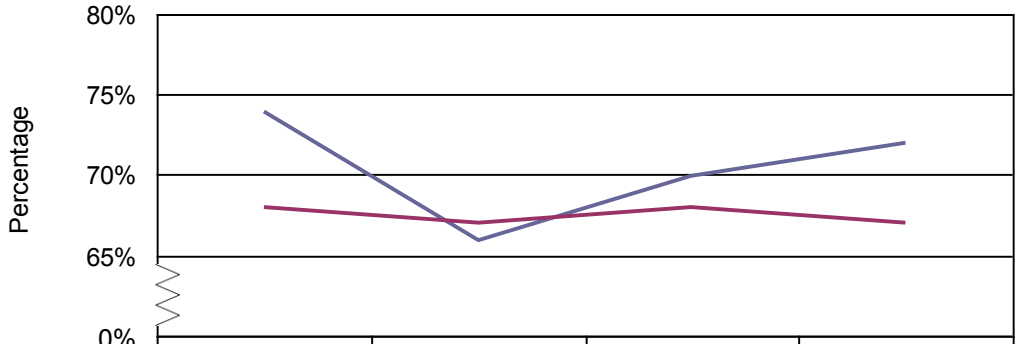
iii. Staff-patient communications

The Trust's Governors have highlighted this topic for inclusion in this Quality Account. Poor communication between staff and patients is responsible for the majority of complaints made to the Trust. Good communication is fundamental to the Trust's activity.

The three graphs that follow include data taken from the annual National Inpatient Survey. The first two graphs relate to communication with doctors and nurses when patients had important questions to ask (responses shown are for patients who replied "Yes, always").

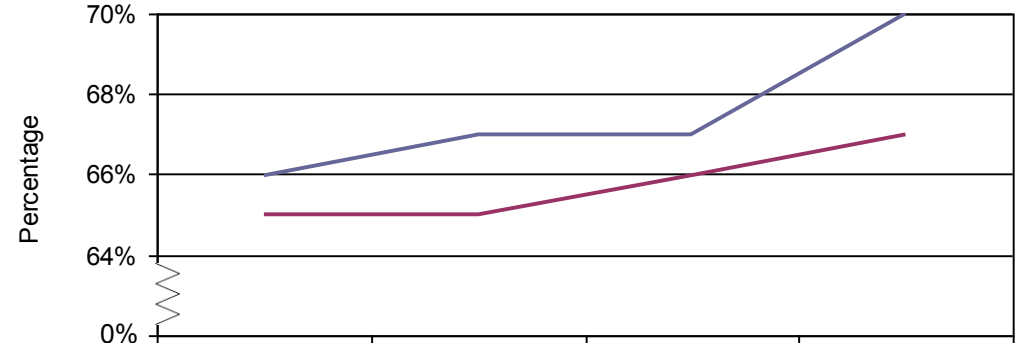
The data suggests that the Trust's performance is similar to the national average for NHS Trusts.

Patients who always understood the answer doctors gave to their important questions



	2006	2007	2008	2009
UH Bristol	74%	66%	70%	72%
All English Trusts	68%	67%	68%	67%

Patients who always understood the answer nurses gave to their important questions

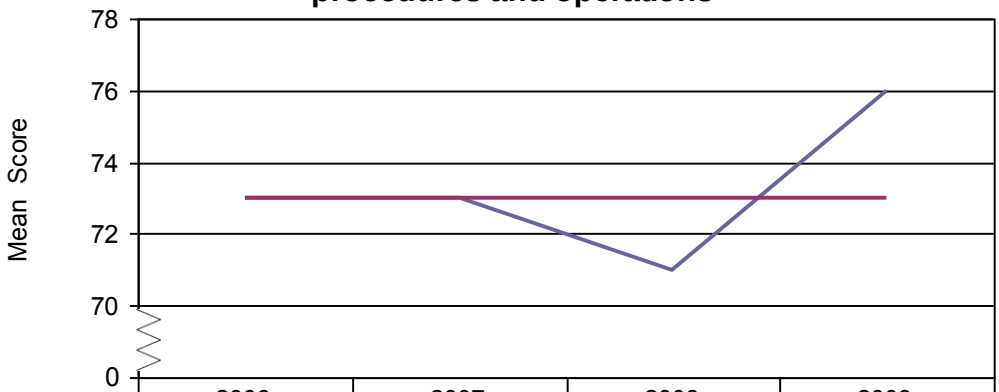


	2006	2007	2008	2009
UH Bristol	66%	67%	67%	70%
All English Trusts	65%	65%	66%	67%

The third graph shows an aggregated (mean) score based on seven staff-patient communication questions taken from the National Inpatient Survey:

- Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?
- Beforehand, did a member of staff explain what would be done during the operation or procedure?
- Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?
- Beforehand, were you told how you could expect to feel after you had the operation or procedure?
- Before the operation or procedure, were you given an anaesthetic or medication to put you to sleep or control your pain?
- Before the operation or procedure, did an anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?
- After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?

Staff- patient communication with patients about medical procedures and operations



	2006	2007	2008	2009
UHB Average	73	73	71	76
All English Trusts	73	73	73	73

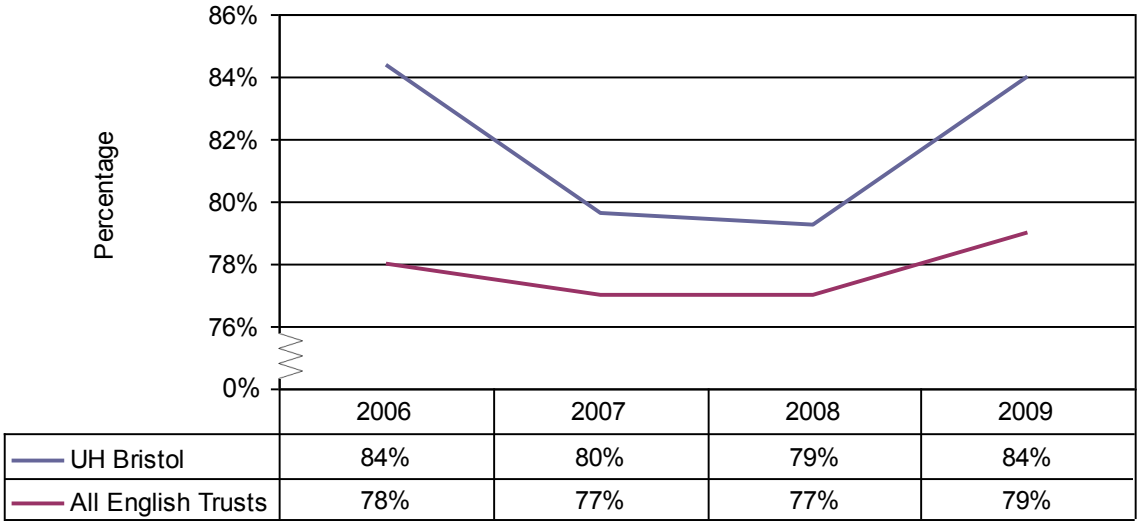
The Trust's performance is slightly better than the national average. Awareness of the critical importance of staff-patient communication is currently being raised in a variety of ways including:

- Re-introducing 'Treating People Well' training to induction for general staff induction.
- A review of medical staff training courses to identify opportunities to raise awareness of the importance of communication with patients.
- Training for Trust managers about Equality and Diversity
- Actions to ensure that people attending outpatient.
- Incorporation of key messages in leadership development programmes.
- The launch of the Trust's revised Values.

iv. 'Overall, how would rate the care you received?"

In the same way that the HSMR (Hospital Standardised Mortality Ratio) provides an important overall measure of clinical effectiveness, this question from the annual National Inpatient Survey provides a useful global measure of patient experience, benchmarked against other NHS trusts, year-to-year. The graph that follows shows that in 2009 84% of inpatients rated their care as "excellent" or "good", a return to a similarly high rating in 2006. The Trust also continues to rate above the national average for this question.

Patients saying their care was excellent or good



	2006	2007	2008	2009
UH Bristol	84%	80%	79%	84%
All English Trusts	78%	77%	77%	79%

Clinical Effectiveness

i. Nutritional care

The Trust has been striving to drive up standards in nutritional care for many years. For example:

- A 'Food as Treatment' Policy has been in place since 2000 Policy
- The Trust employs a Full-time Food Policy Manager and Dietetic Assistant
- Wards are audited four times a year using Patient Environment Action Team (PEAT) criteria - providing up to the minute data on nutritional care and allows Modern Matrons and Dietetic Managers to target resources to support improved performance at ward level
- Key Performance Indicators (KPIs) have been developed to meet the '10 Key Characteristics' of good nutritional care to hospitals
- Patients are surveyed about their experience of hospital food by Hotel Services on a quarterly basis
- Dieticians visit wards on a daily basis to identify any lapses in nutritional care

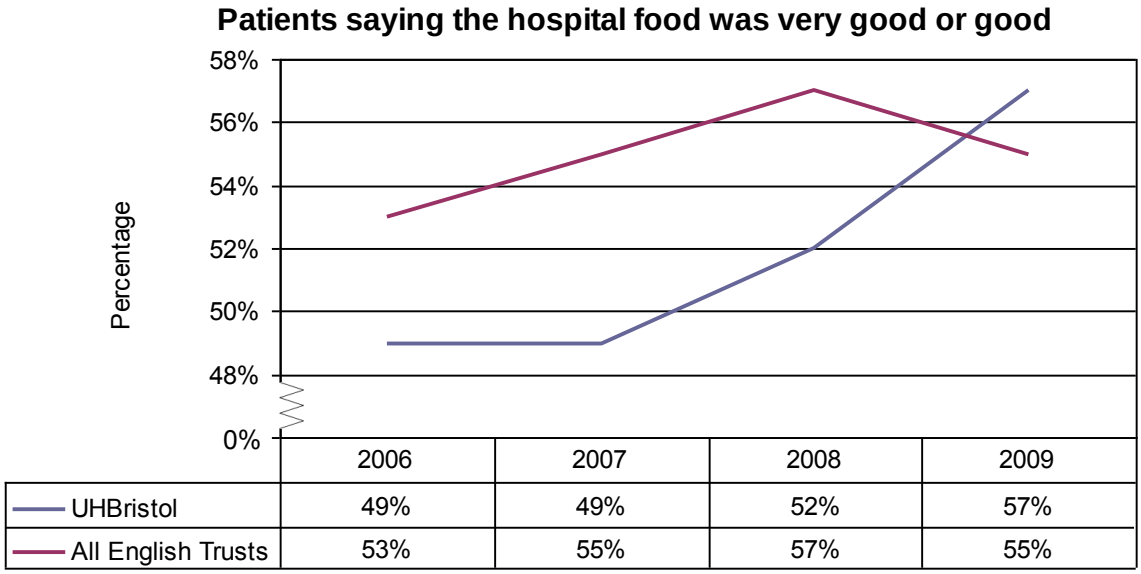
Complaints about food quality are at their lowest level in five years. The Trust has further invested in its Food Policy Service and is now the only Trust in the UK employing a full-time Food Policy Manager and Assistant. The Food Policy Manager is a member of a national strategic task force on patient feeding which is working towards adopting the Trust's Food Policy as a model for Food Service and provision across the NHS.

The Trust declared itself compliant with the Care Quality Commission's Core Standard for Food (C15) during 2009/10.

Notwithstanding this, in January 2010, the Trust took the step of declaring non-compliance with the Care Quality Commission's new, more demanding and outcome-based, Registration Standard for Nutrition (Outcome 5), for the following reasons:

- One of the stated expectations of the Nutrition standard is that healthcare providers should be operating 'Protected Mealtimes' schemes. Protected Mealtimes are periods on a hospital ward when all non-urgent clinical activity stops, during which times patients are able to eat without being interrupted and staff can offer assistance. To date, the Trust has introduced protected mealtimes at the Bristol General Hospital, and this will be extended to all other hospitals by the end of 2010
- The Trust uses standardised care plans for nutritional support and follows a system which aims to provide high risk patients with individualised care plans devised by registered dieticians. However a recent internal audit has highlighted inconsistent practice. The Trust has responded to this by creating a working party which will develop new paperwork for screening and care planning on admission to facilitate and standardise nutritional care. This paperwork is currently in the process of being introduced into adult services.
- All patients receive basic nutritional screening upon admission to hospital, however audit data from December 2009 indicated that only 64% of patients were receiving detailed screening for risk of malnutrition within 24 hours of admission. The Trust has instigated a plan to improve this and has set a target of 90% to be achieved at the Bristol Royal Hospital for Children by December 2010, and in all other hospitals by September 2010.

Results from the 2009 National Patient Survey suggest a continuing upward trend, with 57% of patients reporting that hospital food was "very good" or "good".



	2006	2007	2008	2009
UHBristol	49%	49%	52%	57%
All English Trusts	53%	55%	57%	55%

Patient Environment Action Team (PEAT) inspections for 2009/10 rated Food at the Bristol General Hospital, Bristol Eye Hospital, and Bristol Haematology and Oncology Centre as 'Excellent'; and the Bristol Royal Infirmary, St Michael's Hospital and Bristol Royal Hospital for Children as 'Good'.

ii. NICE guidance implementation

The NHS National Institute for Health and Clinical Excellence (NICE) was launched in 2000, with a remit to develop evidence-based guidance for patients, health professionals, and the wider NHS community. NICE guidance is informed by the latest research from the UK and worldwide, and is agreed by national guideline development teams comprising representatives from patient support groups, GPs, hospital consultants, nursing and other NHS professions. NHS Trusts are expected to develop services in line with the recommendations by NICE, and are subject to regular inspection to ensure that is the case. In addition, the NHS Constitution provides a legal right for patients to be offered drugs that have been approved by NICE where their doctor recommends them.

Our approach to implementing NICE Guidance

The Trust begins preparation well before guidance is published. When NICE produces draft guidance, the Trust ensures relevant staff are informed and start considering how the guidance will affect local practice, e.g. opening new clinics, employing additional specialist staff or purchase specialist equipment. Where the guidance is a technology appraisal, the latest NICE-approved drugs can be more expensive than existing treatments.

The majority of NHS budgets are set annually, so the earlier these changes are planned for, the Trust and its PCT partners can quickly identify where and how these costs will be met. Following the publication of guidance, a mixture of self-assessment, reviews of local guidelines and pathways, and results from clinical audits are used to assess overall compliance with guidance recommendations.

Where significant non-compliance is identified that will adversely affect patient care, this is formally registered as a clinical risk: the Trust will work with clinicians and, where appropriate, external NHS partners, to ensure that this is addressed and resolved.

NICE Technology appraisal guidance

The cost of NICE-approved drugs can be very high, so detailed plans, agreed with our PCT partners, are developed to identify how many patients are expected to be treated. Increasingly these drugs are administered in the patient's home, rather than requiring repeated hospital visits.

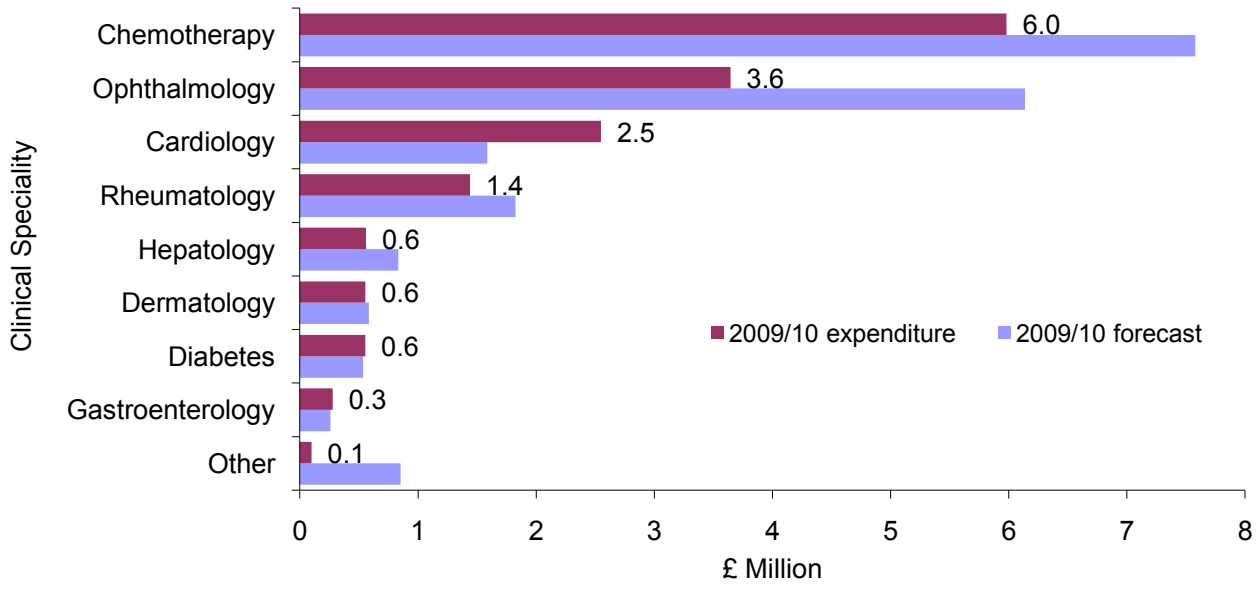
Each year a ring-fenced budget is set aside to fund NICE-approved drugs, although estimating future drug costs a long way in advance can be challenging. For 2009/10 the NHS across Bristol set aside approximately £30m to fund all NICE-approved drugs, of which approximately £20m was expected to be used within the Trust.

The end of year position is that the Trust will have spent approximately £16m (lower than expected). This notional underspend is due to a number of factors: some drugs that might have been approved by NICE have in fact not been, or were approval later than expected.

The true usage for some high cost drugs has been less than originally forecast. The speciality breakdown is provided on the following page.

During 2009/10 NICE published 17 new technology appraisals, all of which are relevant to services directly provided by the Trust. In 14/17 (82%) appraisals the drug was approved by NICE. In partnership with PCT colleagues agreed funding was put in place for all 14 drugs.

NICE Technology Appraisals: usage



Data source: local NICE database

NICE Clinical Guidelines

NICE clinical guidelines are more comprehensive in scope, and address wide aspects of prevention, diagnosis and/or treatment of a target condition.

Depending on the topic, clinical guidelines may be more or less relevant to primary care, specialist mental health services, or acute trusts.

During 2009/10 NICE published 13 clinical guidelines, of which 11 are either fully or partially relevant to services provided by the Trust. These 11 clinical guidelines taken together comprise 644 separate recommendations, of which a subset of 74 (11%) have been identified by NICE for priority implementation.

To date, partial or full assessments of compliance have been completed against 8/11 (73%) relevant guidelines issued during 2009/10, although two of the clinical guidelines not yet assessed were published late March 2010.

With respect to the full 644 recommendations identified, assessment has been received on 465 thus far; 90 are considered not-applicable to the Trust, and of the remaining 375, 358 (95%) are currently compliant.

With respect to the subset of 74 recommendations identified by NICE for priority implementation, 51 assessments have been received; 14 are considered not-applicable to the Trust, and of the remaining 37, the Trust is compliant with 30 (79%).

NICE Case Study: Lenalidomide for the treatment of Multiple Myeloma

This is the story of how one particular drug was introduced into practice in Bristol.

Lenalidomide (Revlimid®) was developed by the US pharmaceutical company Celgene Corp, and from 2004 began to be used as an experimental treatment for a range of inflammatory disorders and cancers.

In May 2006 the drug gained limited US FDA approval for treatment of multiple myeloma, a rare cancer of the bone marrow which has an average prognosis of about four years.

By 2007, the early results from research trials were thought to be promising, and in July 2007 the Department of Health referred lenalidomide to NICE for consideration under its technology appraisal programme, even though the drug had yet to be given either a full UK or EU licence.

The detailed review into the clinical and cost effectiveness was commissioned by NICE in May 2008, leading to the first draft guidance issued for consultation in October 2008.

NICE considered the cost-effectiveness of the drug to be relatively poor as it did not extend life significantly, and they did not recommend the drug. The draft guidance disappointed patients and clinical haematologists alike, and many responded during the consultation.

In early January 2009 NICE changed its own rules by which drugs given to terminally ill patients were evaluated. The first drug to be considered under these new rules was lenalidomide.

In late January 2009 NICE released its second draft guidance, which now took greater account of the extra value placed by patients on those few extra months of life gained, and their updated draft now recommended the drug.

From February 2009 onwards the Trust began estimating the likely cost of implementation, in consultation with local clinical haematologists.

The third and final draft guidance was published by NICE for consultation in April 2009, at which point the Trust, PCTs and the regional cancer network agreed to a fast-track implementation. By this time a number of local patients were waiting to receiving the drug under exceptional funding mechanisms agreed with PCTs.

The Trust then developed a comprehensive implementation plan that outlined how we would prescribe the drug.

As lenalidomide is chemically similar to thalidomide, we were also obliged to put in place a risk prevention programme for patients.

The technology appraisal guidance (TA171) was published by NICE on 24 June, 2009.

The standard expectation for technology appraisal guidance is that Trusts should offer approved drugs within three months of approval.

Due to our extensive preparatory work in the preceding months, the PCTs signed the funding approval that same day, and Trust began offering the drug as recommended by NICE with immediate effect.

Our local treatment protocols have been updated, and relevant staff trained in the drug delivery. The estimated cost for implementing this guidance at the Trust is £780k per year, and to date we have treated 14 Bristol patients with the drug.

There have been a number of national and local lessons associated with the implementation of this guidance.

NICE is working hard to shorten the time it takes to develop their guidance, and now place more weight on short extensions of life that a new drug may offer.

NICE has also agreed with the pharmaceutical industry a mechanism by which patients with very rare cancers can be offered new drugs that have yet to be proven fully effective, ahead of a formal review of NICE.

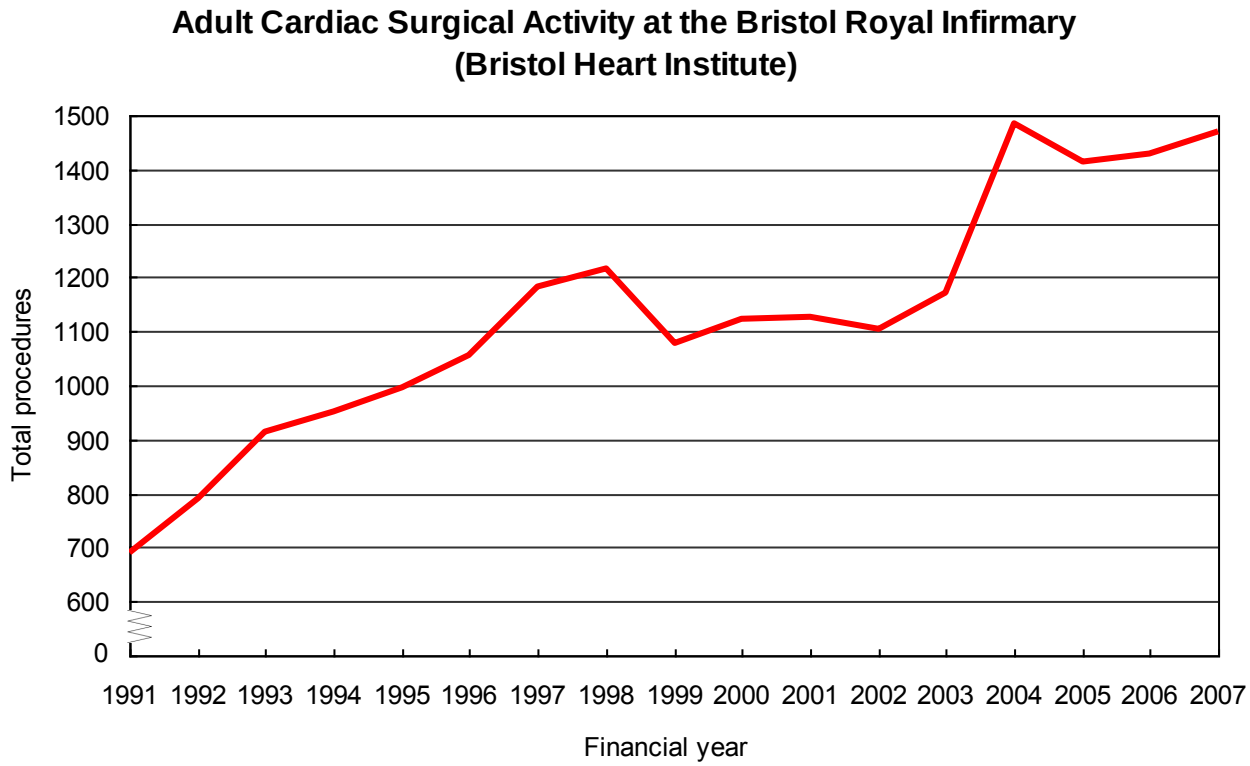
The Trust and local PCTs have agreed fast-track implementation of a number of other NICE-approved drugs when no alternatives exist and patients are at the end of life.

iii. Adult Cardiac Surgery Outcomes

Following the Bristol Heart Inquiry it was clear that a reliable and robust method of data collection was required for outcomes after adult cardiac surgery.

The Trust has maintained a comprehensive cardiac surgical database for the past 15 years, enabling comparison of outcomes for patients undergoing cardiac surgery against national and international benchmarks.

About 1,500 surgical operations per annum take place at the Bristol Heart Institute, making it one of the largest centres in the UK.

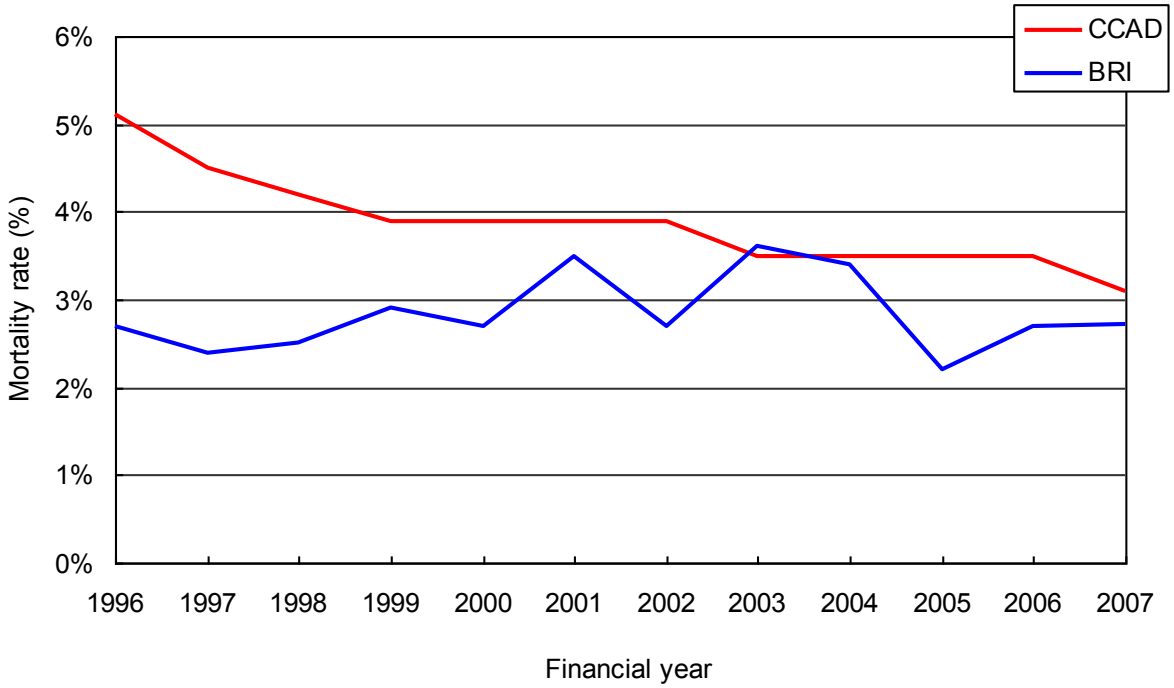


The Trust has openly published its cardiac surgery outcomes for more than a decade, and has assisted in the development and presentation of surgeon-specific outcomes data on the Care Quality Commission website.

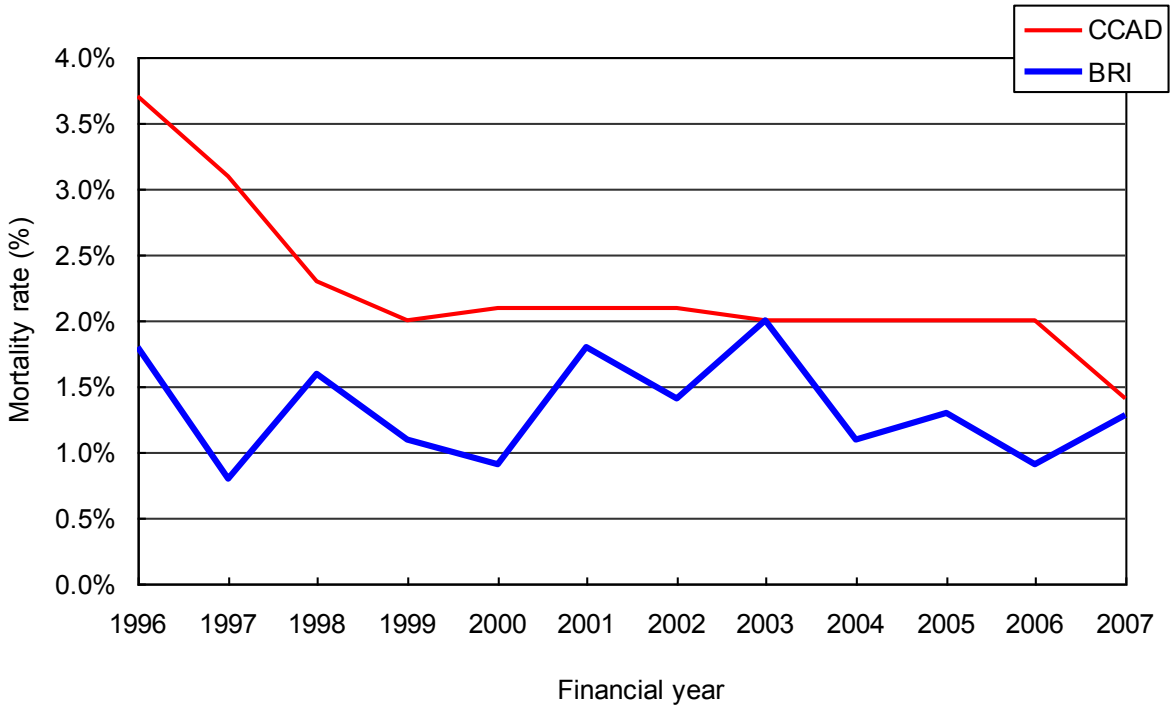
The Trust is able to reassure patients, their families, and the professionals involved in cardiac surgery that outcomes at the Bristol Heart Institute are comparable with, or better than, national and international benchmarks.

Overall mortality for all cardiac surgery and for coronary artery bypass grafting in particular - the commonest operation performed - has been consistently better than the UK average.

Mortality following Cardiac Surgery - All Procedures



Mortality following Coronary Artery Bypass Graft



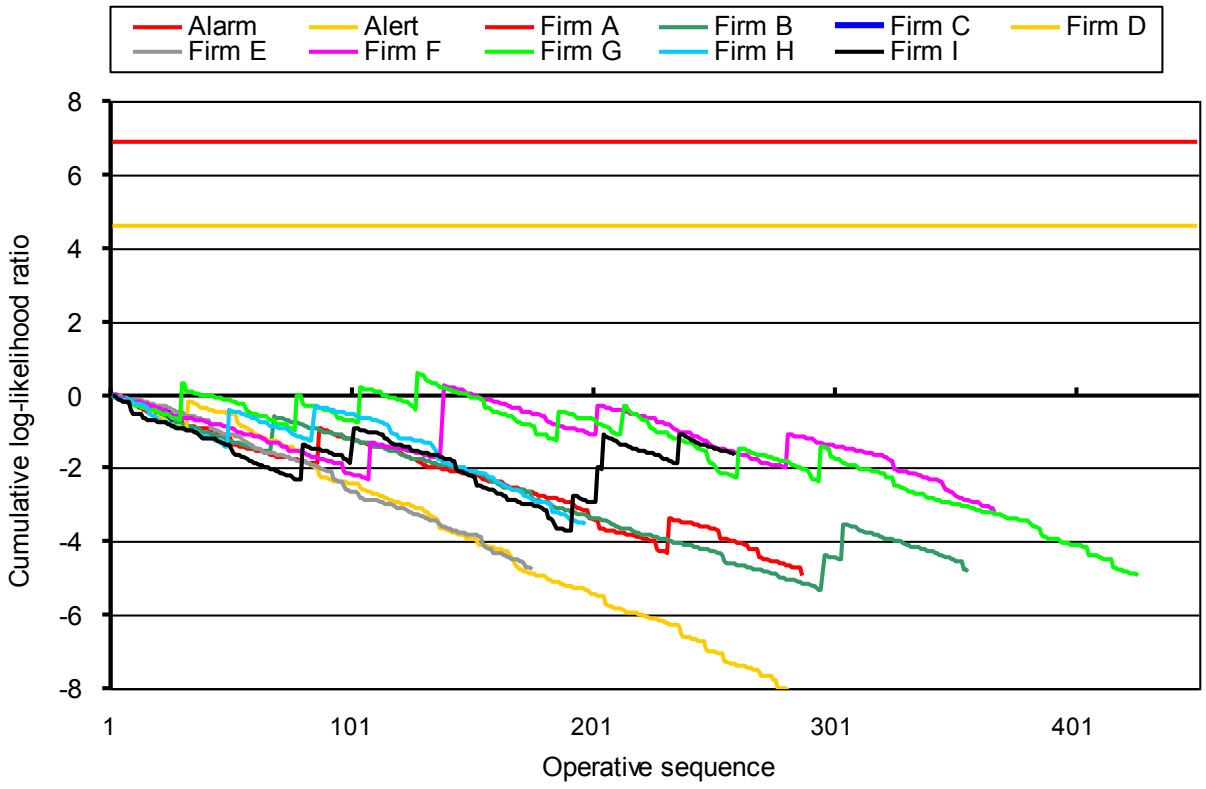
In the above figures, BRI represents the Trust's performance; CCAD (the Central Cardiac Audit Database) shows equivalent national data.

The Trust has also developed techniques for the sequential analysis of surgical performance.

The graph that follows shows observed and predicted outcomes for cardiac surgery.

The horizontal alert lines in the upper part of the graph are the levels at which an alert would be triggered: lines progressively moving away from the alert lines indicate that patient outcomes are better than expected.

Sequential plot of observed outcome against expected outcomes for individual firms

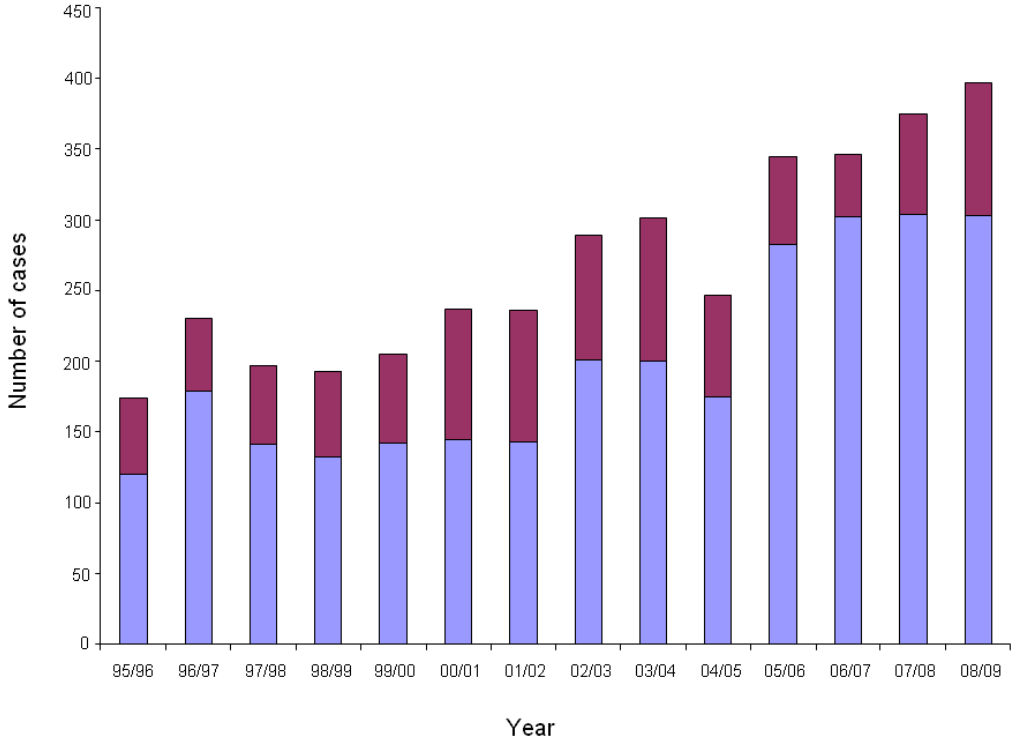


iv. Paediatric Cardiac Surgery Outcomes

Paediatric cardiac surgery transferred in 1995 from the Bristol Royal Infirmary to the Children's Hospital on St Michael's Hill and from there to the new Bristol Royal Hospital for Children site in Upper Maudlin Street in 2001.

These moves have allowed the department to expand and develop such that the number of cases performed annually has increased year on year (see graph below).

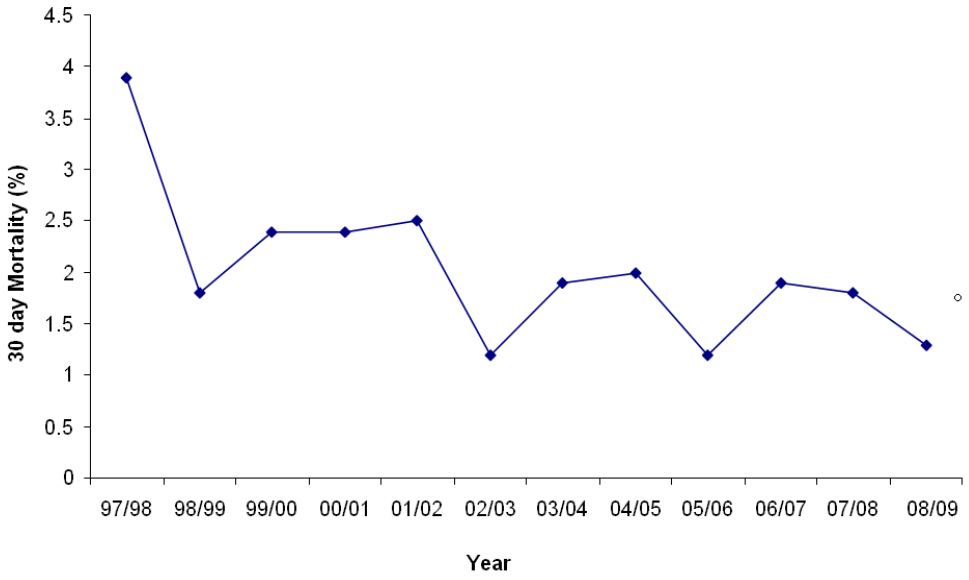
As well as a progressive increase in the number of cases referred from physicians around the region there was an increase in the number of cases in 2002 when the cardiac surgical centre in Cardiff closed down and the cases requiring surgery from South Wales were referred to Bristol.



While the annual caseload of congenital heart operations has increased, the number of paediatric operations (blue/light shading) performed over the last three years has remained relatively static. The significant increase in numbers has been in adult patients (red/dark shading) who have congenital heart disease. This is an increasing proportion of the workload as patients who underwent cardiac surgery when they were young progress into adulthood.

Associated with this increasing workload, the overall risk of congenital cardiac surgery has fallen over the same time period despite the complexity of procedures increasing such that the mortality risk over the last few years has been constant at 1-2% (see following graph).

Overall mortality rate by year



Quoting crude mortality data can be misleading as there is no consideration within these data for case mix (ie a centre which only performed easy cases will appear to perform very well).

Unlike in adult cardiac surgery where there are a small number of well defined operations, it is hard to standardise a congenital unit's practice as there are many different types of operation performed.

In addition, though a child may be born with a particular heart abnormality they may have many other congenital abnormalities.

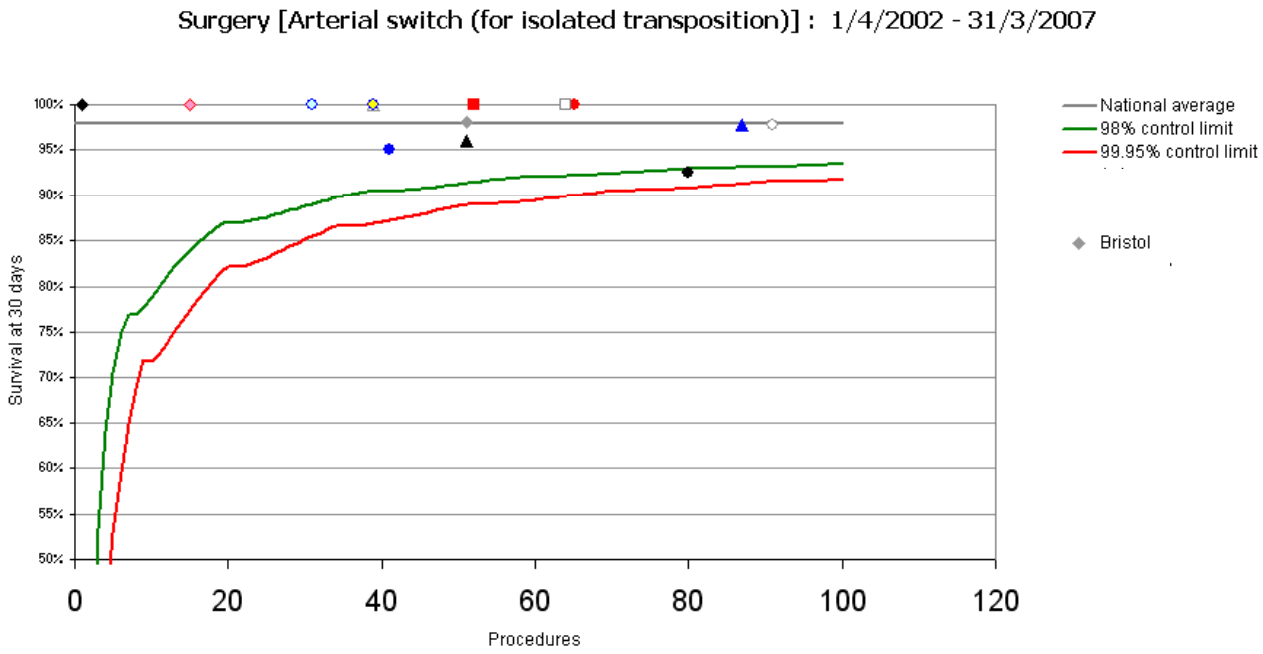
Therefore to compare the quality of two centres, some means of assessing the contributions of the risk of these other abnormalities to the heart abnormality is essential. This is a highly complex process and is being addressed currently using what is called the Aristotle system. One of the Trust's congenital cardiac surgeons is involved in this international initiative.

A national database has been established to monitor the results for all congenital cardiac surgical operations performed in the UK – the Central Cardiac Audit Database (CCAD) – and to provide information to patients and parents/guardians of patients so that they can make an informed decision about their cardiac care.

This is centrally funded and provides fully validated outcome data for all the centres. In an attempt to permit valid comparisons between units a number of 'benchmark' procedures have been identified where the definition of the abnormality is clear enough to prevent other factors influencing the outcome; forty-eight such procedures have been identified.

Of these, the results for the arterial switch procedure are potentially of greatest interest to patients and public as this subject was a focus of the Bristol Heart Inquiry and therefore an area of intense scrutiny for the Trust.

CCAD outcome data for the arterial switch procedure



The graph above shows the most recent data currently available. Further information can be found at http://www.ccad.org.uk/congenital. The results for Bristol are shown as the gray diamond on the graph. The graph demonstrates that the results for Bristol over this period reflect the UK national average.

Currently a designation process is being carried out across the country to continue to improve the quality of care offered to patients with congenital heart disease. The process aims to reduce the number of centres in which this highly complex work is performed so that each centre performs more procedures

v. Cataract Surgery Outcomes

The Trust provides a comprehensive cataract service for the people of Bristol, North Somerset and South Gloucestershire. The number of cataract procedures performed annually at the Bristol Eye Hospital has doubled in the past decade, reaching a total of 5052 cases in 2009/10.

The Trust has significantly improved the patient cataract pathway by working collaboratively with local primary care trusts. In 2009/10 more than 90% of patients were assessed and received their surgery within 18 weeks from referral to treatment, achieving the Department of Health's target.

The Bristol Eye Hospital's One Stop Cataract Clinic has meant that on the day of surgery, in 2009/10:

- 99.9% of all cataract procedures were carried out by phaco-emulsification and lens implantation
- 98.4% of all cataract surgeries were carried out as a day case procedure
- 96% of all cataract surgeries were carried out under local anaesthesia.

These statistics reflect best practice as specified in the Royal College of Ophthalmologists Cataract Guidelines (2004).

The Bristol Eye Hospital has also played a major role in the development of cataract outcome standards at local, national and international level through continuous prospective data acquisition via the cataract electronic patient record. In doing so, the Trust has contributed more than 20% of all cataract outcome records on the UK's Cataract National Dataset Electronic Multi-Centre Audit database.

The following outcomes relate to the 5052 cataract operations undertaken in 2009/10:

Visual Acuity Outcomes:

- 92% of patients achieved a post-operative Snellen visual acuity of 6/12 or better i.e. to UK driving standard. This figure reflects the UK national average (also 92%)
- 87% of eyes were within 1 dioptre of predicted postoperative refractive outcome and 64% within 0.5 dioptres. The national benchmark standards for refractive outcomes are 85% and 55% respectively, i.e. the Trust's outcomes compare favourably

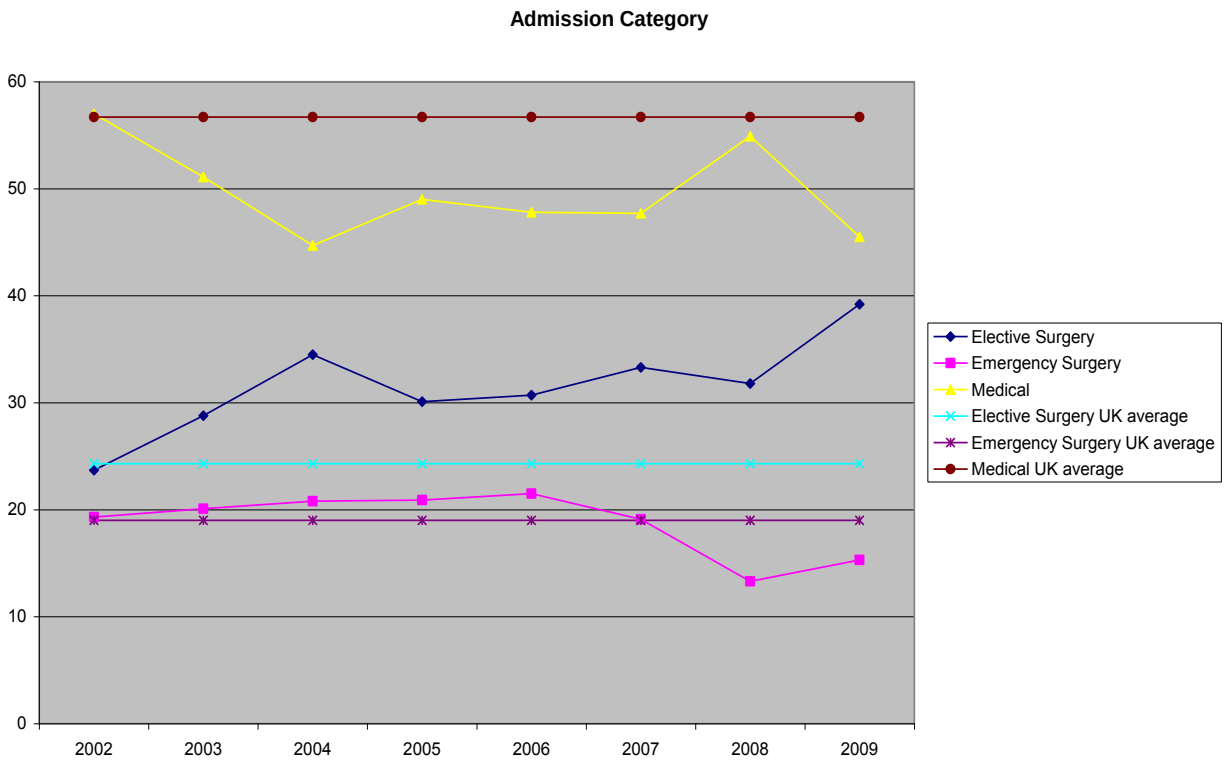
Complication rates:

- Posterior capsule rupture and vitreous loss: 1.7% (UK average 1.92%)
- Dropped nucleus: 0.1% (UK average 0.2%)
- Endophthalmitis: 0.02% (published UK surveillance data, 2004, 0.13%)

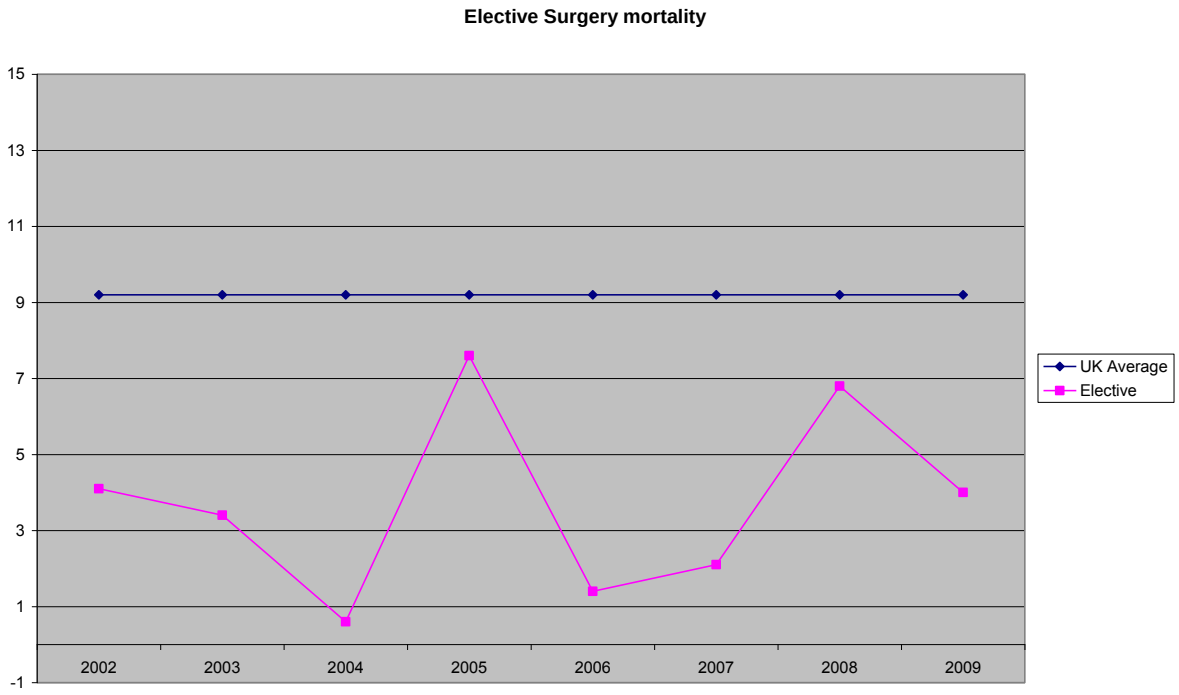
vi. Adult Intensive Care

The Adult Intensive Care Unit at the Bristol Royal infirmary has 15 beds: nine level three (intensive care) and six level two (high dependency). The Unit collects comprehensive and accurate data on all patients via the Innovian and ward watcher computer systems. Data is then sent for validation by the Intensive Care National Audit and Research Centre (ICNARC) of which the unit was a founder member.

About 1,000 patients are admitted to the unit each year. The graph below shows that the elective surgical admission rate is increasing, reflecting the complex surgery performed at the Trust.

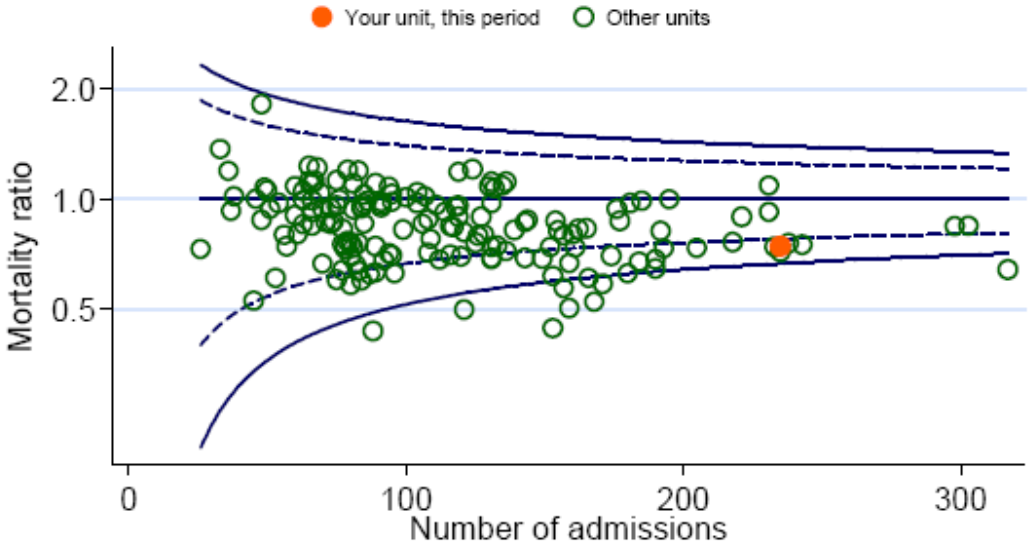


The following graph shows that mortality figures for the Trust's Intensive Care Unit are significantly better than the UK national average.



Intensive Care Outcomes are validated by ICNARC and the standardised mortality ratio of hospital outcome is used to describe outcome. The UK average is consistently above 1.0 (SMR for intensive care UK is validated against APACHE II, which is an international score whose average is 1.0).

The Trust obtains comparative data for quartiles each year that can be compared with other units in the ICNARC case mix data program. The graph that follows shows that the Intensive Care Unit is among the top five UK units for admission numbers and that our Standardised Mortality Ratio is between 1 and 2 standard deviations better than UK average.



vii. Oesophageal Cancer Outcomes

The oesophago-gastric surgical unit at the Trust comprises a team of five surgeons providing expertise in the local and tertiary care of benign and

malignant upper Gastro-Intestinal diseases. One example of this team's work is oesophageal cancer.

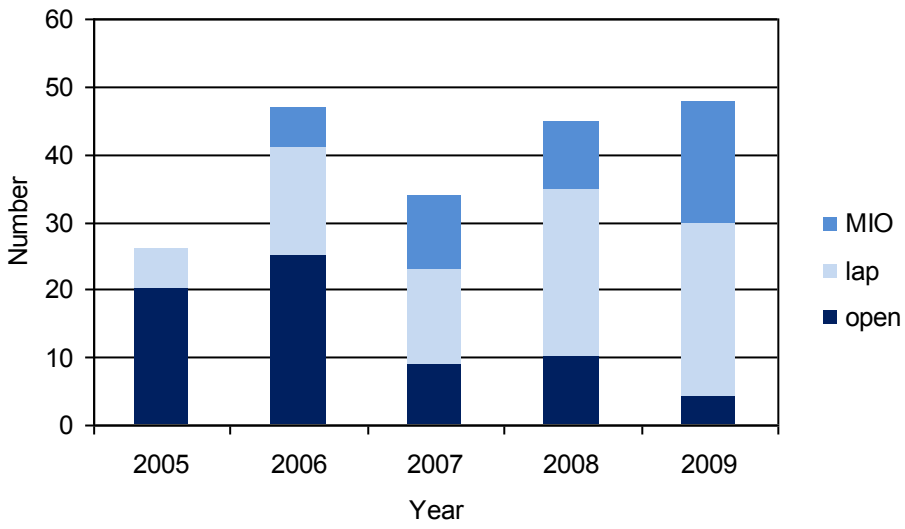
A comprehensive surgical database of all patients scheduled for oesophagectomy has been maintained since 2007.

Bristol is the surgical centre for the Avon Somerset and Wiltshire Cancer Network.

Major cancer surgery has been centralised in the Bristol Royal Infirmary since 2008 as per the Improving Outcomes Guidance for Upper GI Cancer. The team includes an in-reach surgeon from the Royal United Hospital, Bath.

The graph that follows shows the numbers of procedures performed each year, divided by the surgical approach ('MIO' = minimally invasive oesophagectomy; 'lap' = laparoscopically assisted oesophagectomy; open= open oesophagectomy).

Oesophagectomy Activity at the Bristol Royal Infirmary



Oesophagectomy is a long and complex operation that typically lasts between five and seven hours. Uniquely, over the past five years, 50% of procedures have been jointly undertaken by two or more consultant surgeons at the Bristol Royal Infirmary.

Pre- and post-operative care is shared between the team and there is a '24/7' consultant rota for inpatient care.

Selection of patients for surgery is undertaken within the weekly multi-disciplinary cancer team meeting which involves specialist radiologists, physicians, pathologists, nurses and oncologists.

Oesophageal surgery is high risk because of the magnitude and complexity of the procedure. Outcomes published in the recent National Oesophageal Audit (www.ic.nhs.uk/org) show in-hospital mortality rates of 5.0% (3.8-6.4%, 95% confidence intervals).

When we look at the in-hospital mortalities that have occurred in Bristol we see that our figures are better than the published national average with four deaths occurring over five years in some 210 operations, 1.9% (0.5%-4.9%; 95% confidence intervals).

Other important clinical outcomes are complications including re-operation rates and length of hospital stay. In Bristol, serious complications occur in 20% of patients, which is comparable to national audit.

Pathological details provide outcomes that show surgery has been properly performed and meets accepted standards to optimise long-term survival with radical excision of the cancer.

This is partly assessed by reporting the number of lymph nodes excised and the rates of R1 resections.

Outcomes of oesophagectomy for cancer

	All patients n=210
Complications	
Minor	65 (32.5)
Major	40 (20.0)
Number of re-operations (%)	30 (15)
Median length of stay in days (IQR)	13 (11-19)
Median number of excised lymph nodes (IQR)	24 (19-32)

In addition to undertaking standard open oesophageal surgery in Bristol there have been innovations with minimal access techniques. These have been introduced within a governance framework and the outcome data collected contemporaneously. There have been over 150 minimally invasive procedures undertaken and the outcome data from these selected patients is similar to that achieved by open surgery. Indeed most oesophagectomies in Bristol are performed with minimally invasive techniques and this has the potential to speed post operative recovery.

Patient reported outcomes in oesophageal cancer

In Bristol an international tool for assessing patient reported outcomes in oesophageal cancer has been developed and validated (EORTC QLQ-OES18, Blazeby et al *EJC* 2003). Using these questionnaires we have monitored outcomes of oesophageal surgery from the patients' point of view. Results have been published in academic journals, showing that survivors of surgery have some residual quality of life problems (Lagergren et al, *Cancer* 2007) and this information may be used to inform patients of the likely long-term outcomes they may experience.

viii. Patient Reported Outcome Measures (PROMs)

Since 1 April 2009 the Trust has issued Patient Reported Outcome Measures (PROMs) questionnaires to patients undergoing surgery for groin hernias and varicose veins.

In the first publication of national participation rates, the Trust achieved an excellent participation rate compared with national and local peer groups. For Groin Hernias, the Trust's participation rate[4] was 71.8% (148/206), compared to a national average of 47.8%, and for Varicose Veins the Trust's participation rate was 60.7% (71/117), compared to a national average of 35.6%.

The participation rate is defined as the number of valid 'Q1' pre-operative questionnaires received, divided by the number of Full Consultant Episodes. The reported participation rates provide an estimate of the true rate, as in many cases patients will complete the Q1 questionnaire weeks in advance of the operation.

Use of PROMs questionnaires is a contractual obligation and participation rates are reported to our host commissioner, NHS Bristol, on a monthly basis. The target participation rate is 80%, based on the results of the PROMs national pilot studies. The Trust has initially asked patients attending a pre-operative clinic appointment to complete a PROMs questionnaire. However not all eligible PROMs patients attend for pre-operative assessment and the Trust is therefore exploring the option of distributing questionnaires to the patients on the day of their procedure.

Performance against key national priorities and National Core Standards

During 2009/10 the Trust successfully achieved challenging reductions in MRSA (*Methicillin Resistant Staphylococcus Aureus*) bacteraemias and C diff (*Clostridium difficile)* infections, along with maintaining compliance with the screening of elective patients for MRSA.

It also delivered key national waiting time standards for emergency access within four hours, elective admissions, new outpatient, and urgent suspected cancer referrals, heart procedures, and prompt access to chest pain and genito-urinary medicine clinics.

Delayed transfers of care for patients awaiting a bed as part of follow-on care outside of an acute hospital setting, remained low in 2009/10, and well within the nationally set thresholds.

The national 18-week referral to treatment waiting times standard was achieved for three quarters of the year for patients needing an admission, and in every quarter for direct access audiology and patients whose treatment, where required, was undertaken in outpatient settings.

Several measures of quality of care showed improvements in the year relative to 2008/09.

[4] For the period April-November 2009

Performance against the target time spent on a stroke unit, and reperfusion times for patients suffering a heart attack improved relative to the previous year, but the thresholds for achieving these standard are still to be confirmed by the Care Quality Commission.

Breastfeeding rates also improved and non-smoking rates of mothers at the time of delivery stayed consistently high.

Despite improvements in 2009/10 over previous years the Trust did not meet national standards for minimising the number of operations cancelled at the last minute for non-clinical reasons, and for re-admitting patients whose operations were cancelled within 28 days.

This standard is significantly reliant upon the pressures imposed by emergency demand, which in 2009/10 was significantly above that of previous years.

While significant strides were made in the second half of the year, the Trust did not fully achieve the 31-day diagnosis to treatment and 62-day referral to treatment cancer standards. However, the progress made in particular during quarter 4 of 2009/10 will provide a solid foundation for full achievement of all cancer standards in 2010/11.

The two-week wait target for breast patients for whom cancer was not initially suspected came into effect in the last quarter of the year.

The Trust still has challenges in consistently achieving this standard. However, for this and other areas where challenges and risks remain, we have robust action plans in place to address the causes of under-achievement and to deliver the required standards in 2010/11.

Full details of the Trust's performance are set out in the table Key national priorities from the Department of Health's Operating Framework on the next page.

	Domain		Target	Target	2009/10	Forecast level of achievement	Notes
Existing Commitments	Health and WellBeing	1	GUM Offer Of Appointment Within 48 Hours	98%	**100.0%**	**Achieved**	
		2	Data Quality on Ethnic Group	85%	**88.8%**	**Achieved**	
	Clinical Quality	3A	60 Minute Thrombolysis Call To Needle Time	68%	**100.0%**	**Under-achieved**	
		3B	Primary PCI - 150 Minutes Call To Balloon Time	To be confirmed	**69.2%**		Target threshold still to be confirmed but expected to be around 75%.
	Patient Focus and Access	4	Delayed Transfers Of Care (Acute)	3.50%	**1.03%**	**Achieved**	
		5	Emergency Care 4 Hour Throughput (including WIC)	98%	**97.98%**	**Achieved**	Achievement of 98% expected to be confirmed by the end of April when PCT re-submit Walk in Centre attendances
		6	Elective Breaches of 26 Weeks	0.03%	**0.01%**	**Achieved**	
		7	New Outpatients (GP/GDP) Breaches of 13 Weeks	0.03%	**0.02%**	**Achieved**	
		8	Revasc Breaches of 13 Weeks	0.10%	**0.0%**	**Achieved**	

	Domain		Target	Target	2009/10	Forecast level of achievement	Notes
		9	Rapid Access Chest Pain 2 Week Wait	98%	**100.0%**	**Achieved**	
		10A	Number of Last Minute Cancelled Operations	0.80%	**1.08%**	**Under-achieved**	
		10B	28 Day Readmissions	95%	**92.3%**		
National Priorities	Health and WellBeing	11 A	Infant Health - Mothers Who Are Not Smokers At Delivery	87.9%	**87.9%**	**Achieved**	
		11 B	Infant Health - Mothers Initiating Breastfeeding	71%	**76.3%**		
	Clinical Quality	12	Participation in Heart Disease Audits	Not published	To be confirmed	**Achieved**	Results of special data collection exercises to be confirmed later in the year
		13	Engagement in Clinical Audits	Not published	To be confirmed	**Achieved**	Results of special data collection exercises to be confirmed later in the year
		14	Stroke Care	Not published	**66.1%**	**Achieved**	Target threshold still to be confirmed.
		15	Maternity Data Quality Indicator	Not published	To be confirmed	**Achieved**	Indicator to be confirmed.
	Safety	16	Infection Control - MRSA Bloodstream Cases Against Trajectory	0	**-8**	**Achieved**	15 cases against a target of 23

	Domain		Target	Target	2009/10	Forecast level of achievement	Notes
		17	Infection Control - C.diff Infections Against Trajectory	0	**-141**	**Achieved**	100 cases against a target of 241
	Patient Focus and Access	18 A	Referral To Treatment Admitted Under 18 Weeks	90%	**90.3%**	**Under-achieved**	Target met in three out of four quarters
		18 B	Referral To Treatment Non Admitted Under 18 Weeks	95%	**97.6%**		Target met in all quarters; Direct access audiology 18-week target also achieved each quarter.
		19 A	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	**93.5%**	**Failed**	
		19 B	Cancer - Urgent Referrals Seen In Under 2 Weeks (breast - not initially thought to be symptomatic)	93%	**34.5%**		Target came into effect in Q4 2009/10
		20 A	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	**96.0%**	**Under-achieved**	March figures still to be confirmed
		20 B	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	**99.5%**		March figures still to be confirmed
		20	Cancer - 31 Day Diagnosis To Treatment	94%	**92.0%**		March figures still to be

	Domain		Target	Target	2009/10	Forecast level of achievement	Notes
		C	(Subsequent - Surgery)				confirmed
		21 A	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	**79.8%**	**Under-achieved**	March figures still to be confirmed
		21 B	Cancer 62 Day Referral To Treatment (Screenings)	90%	**87.1%**		March figures still to be confirmed; target threshold still to be confirmed.
		21 C	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	**94.7%**		March figures still to be confirmed
		22	Patient Experience	Not published	To be confirmed	Achieved	Scores of survey to be confirmed
		23	NHS Staff Satisfaction	Not published	To be confirmed	Achieved	Scores of survey to be confirmed

Please note: Indicators that have the same number but a different letter after them (e.g. 10A, 10B) represent combined indicators that are considered together by the Care Quality Commission (CQC)

Key national priorities from the Department of Health's Operating Framework

18 weeks

The Trust achieved an 18-week referral to treatment time (RTT) for 90% of admitted patients across three quarters of the year. A financial penalty was incurred from NHS Bristol for not achieving the standard for two months. The 18-week wait for patients not requiring an admission as part of their treatment was achieved for at least 95% of patients in every month in 2009/10. Achievement at a specialty level for both admitted and non-admitted pathways was less consistent, and remains an area of focus for improvement in 2010/11.

Four hour Emergency Access

The Trust achieved the four hour maximum wait from arrival in an emergency department to discharge, admissions or transfer, for over 98% of patients during the year (including local Walk in Centre attendances). This represents a 0.3% improvement in performance compared with the previous year. There was a 6% increase in emergency admissions over the period, with the increase being most evident in the third quarter of the year, when the 98% standard was not achieved.

The Trust responded to these exceptional levels of emergency admissions by expanding its Medical Assessment Unit capacity, in addition to reconfiguring its inpatient wards to provide a dedicated facility for delayed discharges. The Trust received a performance notice from NHS Bristol after the dip in performance, but was able to report compliance with the standard in the following quarter following a difficult and busy winter period.

To support continued achievement of the 98% standard in 2010/11 the Trust will be focusing efforts on further enhancing the acute medicine model to increase the capacity to admit and assess medical emergencies, together with joint work with local Primary Care Trusts to reduce emergency admissions and enable prompt discharge of patients back to the community with home based packages of care.

Cancer

The introduction of the new cancer standards, and changes to the way cancer waiting times were measured nationally, brought with it some significant challenges in 2009/10.

The Trust met the two week maximum wait from urgent GP referral to being seen by a specialist, for the year as a whole, following a dip in performance in the first quarter of the year.

However, performance against the 31 day diagnosis to treatment and 62 day cancer referral to treatment standards was less consistent and these targets were not achieved for the year as a whole.

As a result the gateway for CQUIN rewards was not met. A performance notice was issued to the Trust by NHS Bristol, in response to which regular refreshes of the action plans were provided.

Significant improvements in performance were evident in the last quarter of 2009/10, with all targets being met in the quarter with the exception of the 62 day referral to treatment target for patients referred from a screening programme, and the two week wait for symptomatic breast patients (cancer not initially

suspected). To consolidate these improvements the Trust will continue to focus on the potential risks to sustainability that have been identified.

Key risks to target achievement for both the 62 day target for patients referred from national screening programmes, and the two week wait for symptomatic breast patients, remains patient choice to delay appointments and key diagnostic tests.

Following analysis of failures to achieve the cancer standards for individual patients, plans have been developed to address delays to cancer pathways that are within the control of the Trust that might otherwise pose a risk to sustainable achievement of these targets.

Choose and Book

During the first four months of the year the Trust was not meeting the national target for the availability of appointments on the national Choose and Book system.

The Trust therefore received a performance notice from NHS Bristol. The national standard is for appointment slots to be available 90% of the time when a patient attempts to book a first outpatient appointment.

In July 2009 the Trust changed the way it makes appointments available to Choose and Book, following the good practice identified in another trust in the South West Region.

Since then the Trust has achieved the national standard for slot availability each month, and since October, 97% of patients have been able to book an appointment on first attempt.

Cancelled operations

During the year the Trust cancelled 1.08% of operations on the day of the procedure for non-clinical reasons: fewer than in the previous year.

However, the levels of cancellation are still above the national standard of 0.8%, and the local Primary Care Trust's own target of 1.0%, for which the Trust received a performance notice at the end of the second quarter of the year.

Bed pressures, and the need to operate upon emergency patients, remain the leading causes of last-minute cancellations of surgery. Improving performance against this important indicator of both patient experience and efficiency of service remains a key area of focus for 2010/11.

Core Standards

The Trust is fully compliant with the Care Quality Commission's Core Standards for Better Health.

There was extensive Board involvement in the process for gaining assurance on these standards during 2009/10.

Following review by the Governance and Risk Management Committee and Audit and Assurance Committee, the Trust Board met on 30 November 2009 and agreed a mid-year declaration of 'Compliant' in relation to all those Standards for which a declaration was required.

The Trust had previously declared non-compliance with Core Standard 4c Decontamination for the year 2008/9: key aspects of the associated action plan were completed during the first quarter of the year as planned, and the Trust was not required to make a declaration on this Standard for 2009/10 as this was deemed by the Care Quality Commission to be covered by the Trust's successful registration under the Hygiene Code.

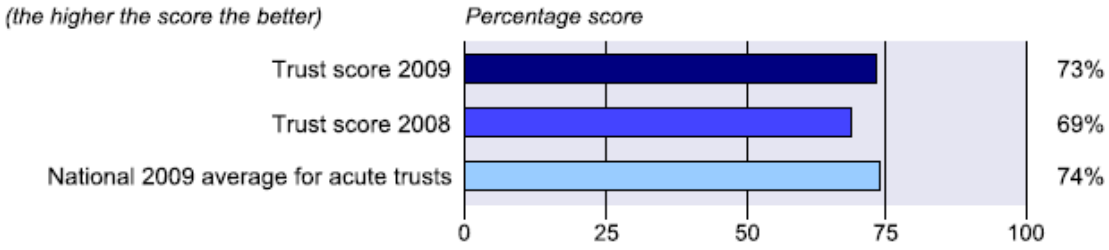
The Trust continued to monitor compliance with the Core Standards - by exception - for the remainder of the year 2009/10, in parallel with preparation for Registration with the Care Quality Commission.

National Staff Survey indicators

Trusts are encouraged by the Department of Health to include in their Quality Accounts data from specific indicators (questions) which appear in the annual National Staff Survey.

These indicators demonstrate in part how quality of care within our organisation is viewed by its workforce. Relevant results from the 2009 survey are presented below.

KEY FINDING 1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

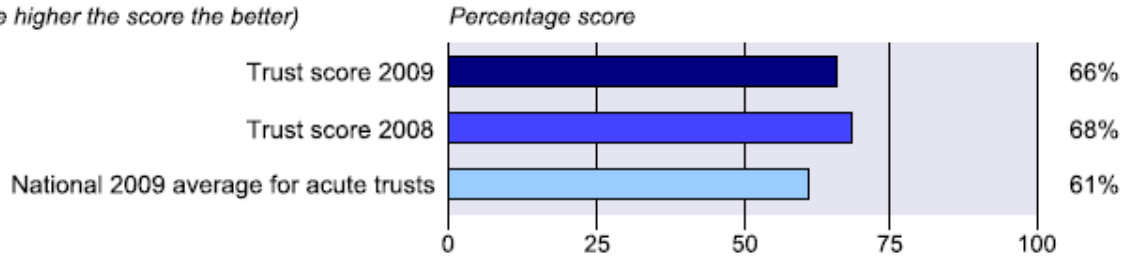


73% of staff in the trust agreed with at least two of the following three statements: that they are satisfied with the quality of care they give to patients; that they are able to deliver the patient care they aspire to; and that they are able to do their job to a standard they are personally pleased with.

- The trust's score of 73% was average when compared with trusts of a similar type.
- It has not changed significantly since the 2008 survey when the trust scored 69%.

KEY FINDING 33. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



66% of staff at the trust agreed with at least two of the following three statements: that they are able to make suggestions to improve the work of their team; that there are frequent opportunities for them to show initiative in their role; and that they are able to make improvements at work.

- The trust's score of 66% was in the highest (best) 20% when compared with trusts of a similar type.
- It has not changed significantly since the 2008 survey when the trust scored 68%.

KEY FINDING 34. Staff job satisfaction

(the higher the score the better)

Staff were asked questions about how satisfied they are with various aspects of their job including: recognition for good work; support from their immediate manager and colleagues; freedom to choose methods of working; amount of responsibility; opportunities to use their skills; and the extent to which the trust values their work. Possible scores range from 1 to 5, with 1 representing very dissatisfied staff and 5 representing very satisfied staff.

- The trust's score of 3.56 was in the highest (best) 20% when compared with trusts of a similar type.
- It is also a statistically significant increase since 2008 (i.e. a better score than in 2008) when the trust scored 3.50.

The Trust is currently seeking to develop linked and themed reporting of findings from the National Patient and Staff Surveys.

Annex - Third party statements

i. Statement from the Membership Council of the University Hospitals Bristol NHS Foundation Trust

The Membership Council of University Hospitals Bristol NHS Foundation Trust received the Quality Accounts Document on 27 May 2010. The Governor Group, through its' Quality Sub-group, has contributed suggestions for inclusion in the Quality Account based on their perception of the views of the Trust's Membership. Patient Safety issues have been the main focus of the suggestions put forward including the control of hospital acquired infections and venous thromboembolism, drug prescribing safety, surgical safety checklist, antibiotic compliance and nutritional standards. The Trust has included these in the Account although it is noted that there is no requirement in the procedure for governors to be consulted. The Membership Council has considered the Quality Account and believes it to be a fair and balanced story of quality at University Hospitals Bristol NHS Foundation Trust.

ii. Statement from NHS Bristol

NHS Bristol has taken the opportunity to review the Quality Account prepared by University Hospitals Bristol NHS Foundation Trust for 2009/10.

In a shared vision to maintain and continually improve the quality of services, NHS Bristol and University Hospitals Bristol NHS Foundation Trust have worked in collaboration to establish a comprehensive quality framework that includes nationally mandated quality indicators alongside locally agreed quality improvement targets. The national NHS contract and Commissioning for Quality and Innovation (CQUIN) scheme provide further support for ensuring robust quality measures are in place.

There are robust arrangements in place with University Hospitals Bristol NHS Foundation Trust to agree, monitor and review the quality of services, covering the key quality domains of safety, effectiveness and experience of care. This is managed through the Clinical Quality Review Group that meets monthly, with representation from senior clinicians and managers from both University Hospitals Bristol NHS Foundation Trust and NHS Bristol along with GP colleagues, to review, monitor and provide assurance in relation to quality of care.

Through the quality framework for 2009/10 University Hospitals Bristol NHS Foundation Trust have been seen to improve the safety, effectiveness and patient experience of their services across a wide range of specialities, a number of the key improvement areas are described in this Quality Account. NHS Bristol have also received assurance throughout the year from University Hospitals Bristol NHS Foundation Trust in relation to key quality issues, both where performance has improved and where it occasionally fell below expectations with remedial plans put in place and learning shared wherever possible.

The priorities for 2010/11 have been developed in partnership and NHS Bristol endorses the proposals set out in the Quality Account.

NHS Bristol can confirm that we consider that the Quality Account contains accurate information in relation to the quality of services they provide to the residents of Bristol and beyond. NHS Bristol have had discussions with

University Hospital Bristol on the content of their Quality Account, the majority of these suggestions have been included.

The accuracy of the data has been checked and concords with the data and information that has been supplied by them during the year.

iii. Statement from Bristol Local Involvement Network

Bristol LINk welcomes this opportunity to comment on these Quality Accounts. We have been mindful of the effects of Hospital Acquired Infections on patients as part of our work plan and are assured by the efforts being made to improve procedures by the Trust to lower the rate of infection incidences. In addition, we note the Trust's low mortality statistics and hope this continues to move downwards. We feel this is significant in view of the adverse reports concerning the Mid Staffs NHS Foundation Trust and other NHS Trusts during the last year.

Another item on our workplan is hospital food, particularly nutrition and hydration. We have had discussions with the Trust's Food Policy Manager and her team regarding these and are therefore aware of the work being done to make improvements and we note that the number of complaints about this at its lowest level for 5 years. However, we hope that the work to improve the inconsistent practice to provide individualised care plans for nutritional support will be completed in the near future.

As information supplied to patients on discharge is another of our concerns, we acknowledge that the Trust is implementing improvements in medicine management which will include an accurate discharge letter to GPs.

We note with regret the failure of the Trust in meeting cancer care standards and look forward to improvements being made in 2010/2011 for full achievement of all cancer standards.

In the area of patient experience we note the efforts to provide single sex accommodation and are aware of the difficulties the Trust faces with their present buildings to complete this. However, we feel this is an important challenge to be overcome to provide the privacy and dignity that patients should have.

We have been engaged with the Trust providing information from the public and patients under its Patient & Public Involvement Strategy and look forward to continuing this feedback at patient experience committees and through the LINk's various working groups. We will continue to use the experience of our participants to inform the Trust to help improve its activities to ensure good patient experience.

iv. Statement from South Gloucestershire Local Involvement Network

South Gloucestershire LINk welcomes the opportunity to comment on UHB Bristol NHS Foundation Trust Quality Account 2009/2010 and believes that the account gives a comprehensive coverage of services.

The Trust is to be commended on reducing healthcare acquired infection rates, in particular, the joint work with community colleagues to halve MRSA bacteraemia infections. However, the LINk note that it is stated that to reduce the spread of C diff the Trust have 'concentrated efforts on making sure that patients with the

infection receive the “highest standard of care” ’. The LINk believes it is a priority that ALL patients, with, or without any infection, receive “the highest standard of care”. The LINk is also concerned that, although the Trust have a very comprehensive audit programme, data capture in respect of surgical site infections is not 100%. It is, therefore, pleasing to note that further reduction of the incidence of healthcare acquired infections is a priority for the Trust during 2010/2011. Patients are likely to be concerned about, and would be interested to know more about, surgical site infection rates and the actions being taken, or planned, to reduce the rates.

The LINk note that the Trust’s other priorities for improvement cover areas that the LINk believe are of concern for local people, such as reducing hospital acquired venous thromboembolism. However, the LINk would like assurance that the work planned to be taken forward to reduce the number of high risk medication errors will also embrace patient experience concerns; such as paying attention to medication issues at times of transfer of care, and preventing the omission or delay of administration of medicines where the timing of doses given is crucial for patients.

The LINK would also wish to see the proposed comprehensive strategy to increase the level of patient and public involvement in service improvement to ensure it is developed with a particular emphasis on patient experience. However, it is heartening to see that there has been a reduction in the number of formal complaints received, and that there has been a rise in the number of compliments received by the Trust during 2009/10.

It is noted that the Trust’s Governors include nutritional care as one of their quality priorities. Nutritional care is of considerable interest to patients, their carers and families, as well as the public, especially in light of the findings of, and media comment about, the Robert Francis Inquiry into Mid-Staffordshire NHS Foundation Trust. Therefore it is refreshing to see an open and honest account of the reasons why the Trust has declared non-compliance with the Care Quality Commission’s new Registration Standard for Nutrition (Outcome 5). However, the LINk seeks assurance that the targets set by the Trust to rectify the situation are met by due dates, and the LINk also wishes to be assured that adequate oral hydration for patients is considered part of the Trusts approach to nutritional care.

iv. Statement from Bristol Overview and Scrutiny Committee

Due to the timing of the General Election and the requirement for scrutiny commissions to be reconstituted at the start of the new municipal year, the Bristol Health and Social Care Scrutiny Commission has stated that it will not be formally commenting on this year’s Quality Account.

The Trust’s Medical Director will however be attending the Commission on 15 June, at which time the Commission has stated its wish to explore ways in which it could engage with the process of developing the Quality Account in future.

iv. Statement from South Gloucestershire Overview and Scrutiny Committee

To follow.

University Hospitals Bristol NHS
NHS Foundation Trust

Accounts for the year ended 31 March 2010

Paul Mapson
Director of Finance CPFA

Trust HQ
Finance Department
Marlborough Street
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BRISTOL BS99 1YF

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Accounts for the year ended 31 March 2010

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31st March 2010 have been prepared by the University Hospitals Bristol NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Services Act 2006.

Signed .....
Robert Woolley,
Acting Chief Executive

Statement of Comprehensive Income for the year ended 31 March 2010

	Note	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
OPERATING INCOME			
Income from activities	3	375,081	293,632
Other operating income	4	110,561	87,018
TOTAL OPERATING INCOME		485,642	380,650
Operating expenses	5-6	(480,089)	(362,729)
OPERATING SURPLUS		5,553	17,921
FINANCE COSTS			
Finance income	9.1	209	901
Finance costs	9.2	(459)	(705)
Finance expense unwinding discount on provisions	18	(7)	-
Public dividend capital dividends payable		(9,588)	(9,217)
Net finance costs		(9,845)	(9,021)
SURPLUS (DEFICIT) FOR THE YEAR/PERIOD		(4,292)	8,900
OTHER COMPREHENSIVE INCOME/(EXPENDITURE)			
Revaluation losses on property plant and equipment		(60,488)	(26,713)
Revaluation losses on intangible assets		-	(191)
Receipt of donated assets		248	532
Depreciation /impairment/disposal of donated assets		(1,397)	(2,041)
Other gains and losses		-	21
TOTAL COMPREHENSIVE INCOME/(EXPENDITURE) FOR THE YEAR/PERIOD		(65,929)	(19,492)

Please note:

a) All income and expenditure is derived from continuing operations.

b) The reported deficit of £4.3m for the year ending 31st March 2010 represents a net surplus of £11.4m before exceptional items (asset impairments of £15.7m). The outturn position is £0.9m better than the planned EBITDA (earnings before interest, taxation, depreciation and amortisation) surplus for the year.

c) The reported total comprehensive income and expenditure in 2008-09 was £19.358m. The introduction of the holiday pay accrual, to deliver conversion to reporting under the International Financial Reporting Standards, resulted in an increase in the total comprehensive expenditure by £0.134m for the year.

d) The notes on pages 6 to 49 form part of these accounts.

Statement of Financial Position as at 31 March 2010

	Note	31 March 2010 £000	31 March 2009 £000	01 June 2008 £000
NON CURRENT ASSETS				
Intangible assets	10	2,129	2,565	2,834
Property, plant and equipment	11	284,415	353,158	366,971
TOTAL NON CURRENT ASSETS		286,544	355,723	369,805
CURRENT ASSETS				
Inventories	12	5,782	5,624	5,463
Trade and other receivables	13	24,944	21,556	25,156
Other financial assets	14	-	147	7,555
Cash and cash equivalents	19	41,231	33,321	11,246
TOTAL CURRENT ASSETS		71,957	60,648	49,420
CURRENT LIABILITIES				
Trade and other payables	15	(41,412)	(42,504)	(38,618)
Borrowings and bank overdrafts	15	(3,530)	(116)	(528)
Provisions	18	(625)	(326)	(1,565)
Other liabilities	16	(12,574)	(14,039)	(6,871)
TOTAL CURRENT LIABILITIES		(58,141)	(56,985)	(47,582)
TOTAL ASSETS LESS CURRENT LIABILITIES		300,360	359,386	371,643
NON CURRENT LIABILITIES				
Trade and other payables	15	-	-	-
Borrowings	17	(6,306)	(6,446)	(13,648)
Provisions	18	(286)	(296)	(322)
TOTAL NON CURRENT LIABILITIES		(6,592)	(6,742)	(13,970)
TOTAL ASSETS EMPLOYED		293,768	352,644	357,673
TAXPAYERS' EQUITY				
Public dividend capital		191,011	183,958	169,015
Revaluation reserve		71,685	122,443	149,156
Donated asset reserve		10,847	13,302	14,811
Other reserves		85	85	85
Income and expenditure reserve		20,140	32,856	24,606
TOTAL TAXPAYERS' EQUITY		293,768	352,644	357,673

Please note:

a) The accounts on pages 2 to 49 were approved by the Board on 4 June 2010 and signed on its behalf by:

Signed …… Date 4 June 2010…….

Robert Woolley, Acting Chief Executive

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2010

Changes in Taxpayers' equity in the current year	Public Dividend Capital £000	Revaluation Reserve £000	Donated Asset Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	Total £000
At 01 April 2009	183,958	122,443	13,302	85	32,856	352,644
Surplus (deficit) for the period	-	-	-	-	(4,292)	(4,292)
Revaluation/impairment gains and losses on property plant and equipment and intangible assets	-	(59,182)	(1,306)	-	-	(60,488)
Movement in donated assets reserve	-	-	(1,149)	-	-	(1,149)
Public dividend capital received	7,053	-	-	-	-	7,053
Public dividend capital repaid	-	-	-	-	-	-
Other recognised gains and losses	-	(4,336)	-	-	4,336	-
Other transfers between reserves	-	12,760	-	-	(12,760)	-
At 31 March 2010	191,011	71,685	10,847	85	20,140	293,768

Changes in Taxpayers' equity in the previous year	Public Dividend Capital £000	Revaluation Reserve £000	Donated Asset Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	Total £000
At 01 June 2008	169,015	149,156	14,811	85	24,126	357,193
Surplus for the period	-	-	-	-	8,900	8,900
Revaluation/impairment gains and losses on property plant and equipment and intangible assets	-	(26,904)	-	-	-	(26,904)
Movement in donated assets reserve	-	-	(1,509)	-	-	(1,509)
Public dividend capital received	17,027	-	-	-	-	17,027
Public dividend capital repaid	(2,084)	-	-	-	-	(2,084)
Other recognised gains and losses	-	-	-	-	21	21
Other transfers between reserves	-	191	-	-	(191)	-
At 31 March 2009	183,958	122,443	13,302	85	32,856	352,644

Please note:

a) Other reserves comprise a non-distributable reserve relating to the non cash transfer of Engineering Stock from NHS Supplies (South & West), now NHS Supply chain in 1993/94. No transfers are made to this reserve.

b) The Modern Equivalent Asset (MEA) valuation of the Trust's land and buildings was completed by the District Valuer as at 1 April 2009. This generated a review of the revaluation reserve balance and the resultant increase of that balance, by £12.76m, reflects the sum of the calculated value of the reserve for each of the Trust's non-current assets.

Statement of Cash Flows Year Ended 31st March 2010

	Note	Year ended 31 March 2010	10 Months ended 31 March 2009
		£000	£000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus from continuing operations		5,553	17,921
OPERATING SURPLUS		5,553	17,921
NON CASH INCOME AND EXPENDITURE			
Depreciation and amortisation	10-11	17,592	14,672
Impairments	11	15,743	591
Loss on disposal of non-current assets		64	-
Transfer from donated asset reserve		(1,371)	(1,036)
Movements in balances			
(Increase)/decrease in trade and other receivables	13	(3,388)	3,368
(Increase)/decrease in other assets	14	147	-
(Increase)/decrease in inventories	12	(158)	(161)
Increase/(decrease) in trade and other payables	15	(1,092)	13,128
Increase/(decrease) in other liabilities	16	(1,465)	-
Increase/(decrease) in provisions	18	289	(1,265)
Other movements in operating cash flows		3	-
NET CASH GENERATED FROM OPERATIONS		31,917	47,218
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		217	613
Purchase of property, plant and equipment	11	(24,335)	(28,213)
Purchase of intangible assets	10	(13)	-
Sales of property, plant and equipment		-	62
NET CASH USED IN INVESTING ACTIVITIES		(24,131)	(27,538)
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		7,053	17,027
Public dividend capital repaid		-	(2,084)
Loans repaid		-	(7,500)
Capital element of finance lease rental payments		(116)	(92)
Interest paid		-	(374)
Interest element of finance leases		(459)	(483)
PDC dividends paid		(9,611)	(11,061)
Cash flows from other financial activities		(133)	
NET CASH GENERATED USED IN FINANCING ACTIVITIES		(3,266)	(4,567)
INCREASE IN CASH AND CASH EQUIVALENTS		4,520	15,113
***CASH AND CASH EQUIVALENTS AT START OF YEAR/PERIOD**	19	33,321	18,208
***CASH AND CASH EQUIVALENTS AT END OF YEAR/PERIOD**	19	37,841	33,321

Please note:

a) Bank overdrafts are included as part of cash and cash equivalents for cash flow reporting purposes(*).

Notes to the Accounts

1. Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *NHS Foundation Trust Financial Reporting Manual* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual 2009-10* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual* to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts. The comparative figures from the year ended 31 March 2009; and for the balances identified as at 1 June 2008 are restated, where necessary, to comply with the International Financial Reporting Standards and the Financial Reporting Manual.

1.1 Consolidation

Subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

Where subsidiaries' accounting policies are not aligned with those of the Trust, then amounts are adjusted during consolidation where the differences are material.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution e.g. share dividends are received by the Trust from the associate.

Associates which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Joint ventures

Joint ventures are separate entities over which the Trust has joint control with one or more other parties. The meaning of control is the same as that for subsidiaries.

Joint ventures are accounted for by using the equity method.

Joint ventures which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Joint operations

Joint operations are activities which are carried on with one or more other parties but which are not performed through a separate entity. The Trust includes within its financial statements its share of the activities, assets and liabilities.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. 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 conditions of sale have been met, and is measured as the sums due under the sale contract. Income from partially completed spells is calculated on a pro-rata basis based on the expected length of stay.

1.3 Expenditure on Employee Benefits

Employee Benefits
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.

An assessment of annual leave owing to staff at 31st March 2010 has been calculated using a sample of 400 staff across all divisions and all staff groups. As staff have personal annual leave years, the number of hours taken has been compared with the pro-rated allocation of hours to the 31st March. The average annual leave owed to staff groups in the sample has been used to calculate the total number of hours owed to all staff in post in March 2010. An average hourly cost has been applied to each staff group to calculate the cost of annual leave owed.

Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found at the NHS Pensions website www.pensions.nhsbsa.nhs.uk. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for any NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

The NHS pension scheme is subject to a full valuation every four years by the Government Actuary. The latest published valuation relates to the period to 31 March 2004. The notional deficit for the scheme was £3.3 billion according to that valuation. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis. Employer contribution rates are reviewed every four years, following the scheme valuation. Following the last valuation, the employer contribution rates were set at 14% of pensionable pay. From 1 April 2008, employees' pay contributions are set on a tiered scale between 5% and 8.5% of their pensionable pay.

Employer's pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, Plant and Equipment

Recognition
Property, Plant and Equipment is capitalised where:

- individually its cost is in excess of £5,000; or
- it forms a group of similar assets with an aggregate cost in excess of £5,000 (where the assets have an individual cost in excess of £250, are functionally interdependent, have broadly similar purchase dates, are expected to have similar lives and are under single management control); or
- it forms part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of individual or collective cost; ***and***
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential is provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably.

Where a significant asset, for example a building, includes a number of components with different economic lives, then these components are treated as separate assets within the buildings classification and depreciated over their own useful economic lives.

Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value.

Land and buildings
All land and buildings are revalued using professional valuations every five years and in addition a three yearly interim valuation is also carried out. Internal reviews and additional valuations (if appropriate) are completed in the intervening years. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last asset valuations were undertaken in 2009 as at the prospective valuation date of 1 April 2009. The results of this valuation are reflected in the 2009/10 accounts.

In accordance with guidelines issued from the Department for Health any new valuations carried out post 1 April 2008 are completed on a Modern Equivalent Assets (MEA) basis. Valuations undertaken prior to this date were valued at either a depreciated replacement cost or an existing use basis.

Assets in the course of construction are initially recorded at cost and then valued by professional valuers as part of the five or three-yearly valuation, or when they are brought into use, or where the capitalised value exceeds £250K.

Residual interests in off-balance sheet private finance initiative (PFI) properties are included in assets under construction within tangible fixed assets at the amount of unitary charge allocated for the acquisition of the residual with an adjustment. The adjustment is the net present value of the change in the fair value of the residual as estimated at the start of the contract and at the Statement of Financial Position date.

Other assets
Assets with estimated economic lives of less than 10 years are considered to be short life assets. These are held at depreciated historical cost which is considered to be an appropriate proxy for current value.

Assets with estimated economic lives of more than 10 years are considered to be medium/long life assets. These are initially recorded at cost and then their values are updated annually using appropriate indices to reflect fair value (net current replacement cost).

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment, which has been reclassified as 'Held for Sale', ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in 'off-balance sheet' (Statement of Financial Position) PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining useful life of the asset as assessed by the NHS Foundation Trust's professional valuers. Leaseholds are depreciated over the primary lease term. Other items of property, plant and equipment are depreciated on a straight line basis over their estimated remaining useful lives, as assessed by the Trust.

Revaluation and impairment
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-balance sheet' (Statement of Financial Position) by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17. The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the effective interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised where they have a cost in excess of £5,000, where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated intangible assets

Internally generated intangible assets such as goodwill, brands, customer lists and similar items are not capitalised. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

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

Measurement
Intangible assets (except for emission allowances – see note below) are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value.

Intangible assets with estimated economic lives of less than 10 years are considered to be short life assets. These are held at amortised historical cost which is considered to be an appropriate proxy for fair value. Intangible assets with estimated economic lives of more than 10 years are considered to be medium/long life assets. These are initially recorded at cost and then their values are updated annually using appropriate indices to reflect fair value.

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Allowances granted under the EU green house gas emission scheme are held at fair value. Changes to fair value are recognised in the Statement of Comprehensive Income as an item of "other comprehensive income", except for impairments which are recognised in operating income.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits (except for emission allowances – see below).

Purchased computer software licences are amortised over the shorter of the term of the licence and their estimated economic lives. Emission allowances are not amortised as they are used to extinguish liabilities arising under the scheme.

1.7 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of inventories.

1.9 Financial instruments (financial assets and liabilities)

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.10 below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement
Financial assets are categorised as 'Fair value through income and expenditure', loans and receivables or 'Available-for-sale financial assets'. Financial liabilities are classified as 'Fair value through income and expenditure' or as 'Other financial liabilities'.

Financial assets and financial liabilities at 'Fair value through income and expenditure'
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date. Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to 'Finance Costs'. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices where possible, otherwise by valuation techniques including using recent arm's length market transactions between knowledgeable, willing parties if available, reference to the current fair value of another instrument that is substantially the same, discounted cash flow analysis and option pricing models. If there is a valuation technique commonly used by market participants to price the instrument and that technique has been demonstrated to provide reliable estimates of market prices, the Trust will use this technique.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision. The allowance/provision is then used to write down the carrying amount of the financial asset, at the appropriate time, which is determined by the Trust on a case by case basis.

1.10 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to 'finance costs' in the Statement of Comprehensive Income.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.11 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 18.3.

Non-clinical risk pooling
The NHS Foundation 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 when the liability arises.

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 22.1 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 22.2, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

1.13 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the NHS Foundation Trust's predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is paid over 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. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General. Average relevant net assets are calculated as a simple average (mean) of opening and closing relevant net assets.

1.14 Value Added Tax

Most of the activities of the NHS Foundation 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.

1.15 Corporation Tax

NHS foundation trusts are potentially liable to corporation tax in certain circumstances. A review of other operating income is performed annually to assess any potential liability in accordance with the guidance on the HM Revenues and Customs website. As a result of this review, the Trust has concluded that there is no corporation tax liability for the period ended 31 March 2010.

1.16 Foreign Exchange

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in note 28 to the accounts, in accordance with the requirements of HM Treasury's *Financial Reporting Manual*.

2. Segmental Analysis

The Trust has two reportable operating segments: Healthcare and Skills for Health.

The Healthcare segment delivers a range of healthcare services, predominantly to primary care trusts and to the South West Strategic Health Authority Specialist Commissioning Group. The Trust has a number of directorates, all of which operate in the healthcare segment. These directorates are used for internal management purposes and divide the healthcare and other services of the Trust into various medical and surgical specialties. While these are reported on internally for financial and activity purposes, they have been consolidated, as permitted by IFRS 8 paragraph 12, into Trust wide figures for these accounts.

Skills for Health is the sector skills council for the health sector, ensuring that a skilled, flexible and productive workforce is developed, to improve the quality of health and healthcare. All income is received from external customers, i.e. there is no intra segment trading. The significant majority of income for Healthcare is derived from primary care trusts. The significant majority of income for Skills for Heath is received from the Department for Health. The aggregate income, retained surplus and net assets for the two segments reconciles to the Trust's primary statements.

Year ended 31 March 2010	**Healthcare £000**	**Skills for Health £000**	**Total £000**
Income	453,280	32,362	485,642
Retained surplus (deficit) for year	(4,309)	17	(4,292)
Net assets at 31 March 2010	293,768	-	293,768
Ten months ended 31 March 2009			
Income	355,538	25,112	380,650
Retained surplus for the period	8,650	250	8,900
Net assets at 31 March 2009	352,644	-	352,644

3. Income

3.1 Income from activities

	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Acute trusts:		
Elective income	86,244	79,061
Non elective income	106,049	93,879
Outpatient income	51,823	38,586
Accident and emergency income	10,115	7,075
Other NHS Clinical income *	118,823	73,260
All Trusts:		
Private patients	1,915	1,710
Other non-protected clinical income	112	61
TOTAL	375,081	293,632

*Significant items comprise:

Critical care beddays	£31.526m
'Payment by results' exclusions	£15.800m
National Institute for Health and Clinical Excellence (NICE)	£15.658m
Bone marrow transplants	£9.815m
Excess beddays	£8.339m
Radiotherapy courses	£7.821m
Diagnostic imaging	£6.528m
Direct access	£4.569m
Regular day attenders	£2.626m
'At cost' contracts	£2.232m

3.2 Income by type

	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Income from activities		
NHS Foundation Trusts	14	-
NHS Trusts	774	23
Strategic Health Authorities	-	-
Primary Care Trusts	361,916	263,328
Department of Health	178	21,615
Non-NHS Private Patients	1,915	1,710
Non-NHS Overseas Patients	105	53
NHS Injury Scheme	796	567
Other**	9,383	6,336
Total	375,081	293,632

**Significant items comprise:

Territorial Bodies (Health Commission Wales)	£8.333m
Bodies outside of Whole of Government Accounts	£0.944m

3.3 Mandatory and non mandatory split of income from activities

The majority of the Trust's income should be derived from prior agreements, including contracts and agreed intentions to contract with service commissioners. This is described as mandatory income. Of the total income from activities, £366.1m (2009 £288.4m) is mandatory and £9.0m (2009 £5.3m) is non-mandatory.

3.4 Private patient cap

Section 44 of the 2006 Act requires that the proportion of private patient income to total patient related income should not exceed the proportion that was achieved whilst the body was an NHS trust in 2002/03, which was 1.1%.

	Year ended 31 March 2010	10 Months ended 31 March 2009
	£000	£000
Private patient income	1,915	1,710
Total patient income	375,081	293,632
Proportion	0.5%	0.6%

The Trust's private patient cap was not exceeded in the year ended 31 March 2010 or the 10 months ended 31 March 2009.

4. Other operating income

	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Research and development	8,614	6,057
Education training and research	39,357	31,505
Charitable and other contributions to expenditure	953	518
Transfers from the donated asset reserve	1,370	1,036
Non-patient care services to other bodies	49,325	39,822
Other*	10,942	8,080
TOTAL	110,561	87,018

*The 'Other' category above comprises mainly:

Distinction awards granted from the Department of Health	£3.614m
Patient transport	£2.058m
Income generation	£1.958m
Rental income from operating leases	£0.831m
Catering	£0.819m
Staff accommodation rentals	£0.452m

The Trust's income includes an element that might be classified as 'commercial' and might be subject to corporation tax in future years. This income totals £1.958m and comprises mainly the sale of child-care vouchers (£0.824m), operations of the Medical Equipment Management Organisation (£0.700m) and car park receipts (£0.355m).

4.1 Operating lease income

	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Rents recognised as income	831	1,018
TOTAL	831	1,018

4.2 Future minimum lease payments due to the Trust

	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Future minimum lease payments due		
- not later than one year	153	157
- later than one year but not later than five years	422	556
- later than five years	78	750
TOTAL	653	1,463

5. Operating Expenses

5.1 Operating expenses comprise:

	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Services from other NHS Foundation Trusts	373	197
Services from NHS Trusts	7,095	4,064
Services from other NHS bodies	3,244	3,547
Purchase of healthcare from non NHS bodies	1,493	2,571
Executive directors costs	1,111	970
Non executive directors costs	160	127
Staff costs	293,548	232,327
Drug costs	33,622	26,189
Supplies and services:		
- Clinical	47,140	34,015
- General	6,930	5,369
Establishment	7,557	6,280
Transport	333	301
Premises	15,396	13,104
Bad debts	2,075	218
Depreciation of property plant and equipment	17,003	14,176
Amortisation of intangible assets	589	496
Impairment of property plant and equipment	15,742	472
Impairment of intangible fixed assets	-	61
Auditor's remuneration;		
- Audit services – statutory audit	58	67
- Other services	46	18
Clinical negligence	6,236	2,769
Loss on disposal of property, plant & equipment	64	58
Other*	20,274	15,333
TOTAL	480,089	362,729

*Other expenditure includes the following:

External contractors	£8.381m
Training , courses and conferences	£6.840m
Research costs	£0.964m
Consultancy costs	£0.828m
Legal fees	£0.532m

There is no limitation of liability in respect of audit services.

Notes to the Accounts

5.2 Operating Leases

Operating expenses include:

	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Operating lease payments	796	332
	796	332

There are no non-cancellable operating leases for land and buildings. Future minimum lease payments due under other non-cancellable operating leases are as follows:

Future minimum lease payments	31 March 2010 £000	31 March 2009 £000
not later than one year	785	230
later than one year but not later than five years	1,831	363
later than five years	3,712	-
TOTAL	6,328	593

The old Bristol Children's Hospital and associated premises at St. Michaels Hill Bristol were sold to the University of Bristol on 28 February 2002. The Trust continues to occupy the following areas of the hospital and the premises at St. Michaels Hill under 'peppercorn' operating leases with the University of Bristol.

Premises	Lease Term	Termination Date
Residential Family Accommodation Royal Fort Road, Bristol	25 years	28 February 2027

6. Staff Costs and Numbers

6.1 Staff Costs:

	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Salaries & wages	241,951	179,494
Social security costs	20,123	19,056
Employer contributions to NHS Pension Scheme	27,356	25,633
Agency contract staff	5,739	9,359
TOTAL	295,169	233,542

In 2009-10, the Trust made £0.125m contributions to the NHS Pension Scheme in respect of executive directors

6.2 Average Number of Employees

	Year ended 31 March 2010 Number	10 Months ended 31 March 2009 Number
Medical and dental staff	917	873
Ambulance staff	-	-
Administration and estate staff	1,370	1,520
Healthcare assistant & other support staff	757	705
Nursing, midwifery & health visiting staff	2,567	2,477
Nursing, midwifery & health visiting learners	7	4
Scientific, therapeutic and technical staff	1,059	1,096
Social care staff	-	-
Bank and agency staff	444	449
TOTAL	7,121	7,124

Numbers are expressed as average whole time equivalents for the period.

6.3 Employee Benefits

There were no non-pay benefits that were not attributable to individual employees.

6.4 Management Costs

	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Management costs	16,645	13,737
Income	485,645	380,650
Percentage of Income	3.4%	3.6%

Management costs are as defined as those on the Management Costs Website:
www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en.

6.5 Retirements due to Ill Health

During the year ended 31 March 2010 there were 8 (2009: 14) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill-health retirements will be £0.45m (2009: £0.65m). The cost of these ill health retirements will be borne by the NHS Business Services Authority – Pensions Division.

6.6 Directors Remuneration

Salaries and Allowances	**12 Months to 31 March 2010**	10 Months to 31 March 2009
	Salary	Salary
	(bands of £5000) £000	(bands of £5000) £000
Chair		
John Savage	50-54	40-44
Executive Directors		
Graham Rich, Chief Executive (until 22 December 2009)	120-124	140-144
Robert Woolley, Acting Chief Executive (from 23 December 2009)	35-39	n/a
Robert Woolley, Director of Corporate Development (until 22 December 2009)	85-89	95-99
Jonathan Sheffield, Medical Director	190-194	145-149
Paul Mapson, Director of Finance	120-124	105-109
Irene Gray, Chief Operating Officer	110-114	95-99
Steve Aumayer, Director of Workforce and Organisational Development (from 6 July 2009)	80-84	n/a
Alex Nestor, Acting Director of Workforce and Organisational Development (from 3 November 2008 until 5 July 2009)	20-24	35-39
Alison Moon, Chief Nurse (from 13 July 2009)	80-84	n/a
Patricia Fields, Acting Chief Nurse (from 23 March 2009 until 12 July 2009)	25-29	0-4
Anne Coutts, Director of Workforce and Organisational Development (until 2 November 2008)	n/a	50-54
Lindsey Scott, Chief Nurse and Director of Governance (until 22 March 2009)	n/a	95-99
Non-executive Directors		
Sarah Blackburn (from 1 June 2009)	10-14	n/a
Kelvin Blake (from 1 November 2008)	10-14	5-9
Iain Fairbairn	15-19	10-14
Lisa Gardner	15-19	10-14
Patsy Hudson (until 31 May 2009)	0-4	10-14
Selby Knox	10-14	10-14
Paul May (from 1 November 2008)	10-14	5-9
Emma Woollett	15-19	10-14

No Directors received any other remuneration or benefits in kind during either period.

Pension Benefits for the year ended 31 March 2010

Name and title	Real increase in pension at age 60 at 31 March 2010	Real increase in lump sum at age 60 at 31 March 2010	Total accrued pension at age 60 at 31 March 2010	Lump sum at age 60 related to accrued pension at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real Increase in Cash Equivalent Transfer Value	Employer funded contribution to growth in CETV
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Graham Rich, Chief Executive (until 22 December 2009)	0-2.4	2.5-4.9	45-49	145-149	907	791	76	53
Robert Woolley, Director of Corporate Development (until 22 December 2009, then acting Chief Executive)	2.5-4.9	10-12.4	30-34	90-94	590	476	91	63
Jonathan Sheffield, Medical Director	5-7.4	17.5-19.9	70-74	220-224	1,547	1,285	198	138
Paul Mapson, Director of Finance	(0-2.4)	(0-2.4)	45-49	145-149	1,089	988	52	36
Irene Gray, Chief Operating Officer	(0-2.4)	(0-2.4)	50-54	150-154	1,124	1,032	41	29
Steve Aumayer, Director of Workforce and Organisational Development (from 6 July 2009)	2.5-4.9	n/a	0-4	n/a	29	n/a	29	21
Alex Nestor, Acting Director of Workforce and Organisational Development (until 5 July 2009)	0-2.4	0-2.4	15-19	50-54	237	178	13	9
Alison Moon, Chief Nurse (from 13 July 2009)	2.5-4.9	10-12.4	30-34	95-99	571	431	85	59
Patricia Fields, Acting Chief Nurse (until 12 July 2009)	0-2.4	2.5-4.9	35-39	110-114	939	757	41	28

Notes to the Accounts

Pension Benefits for the 10 months ended 31 March 2009

Name and title	Real increase in pension at age 60 at 31 March 2009	Real increase in lump sum at age 60 at 31 March 2009	Total accrued pension at age 60 at 31 March 2009	Lump sum at age 60 related to accrued pension at 31 March 2009	Cash Equivalent Transfer Value at 31 March 2009	Cash Equivalent Transfer Value at 31 May 2008	Real Increase in Cash Equivalent Transfer Value	Employer funded contribution to growth in CETV
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Graham Rich, Chief Executive	5-7.4	17.5-19.9	45-49	135-139	791	535	246	172
Jonathan Sheffield, Medical Director	0-2.4	2.5-4.9	60-64	190-194	1,285	959	306	214
Anne Coutts, Director of Workforce and Organisational Development (until 2 November 2008)	(0-2.4)	(0-2.4)	30-34	100-104	698	565	61	43
Lindsey Scott, Chief Nurse and Director of Governance (until 22 March 2009)	0-2.4	2.5-4.9	35-39	110-114	678	514	149	105
Paul Mapson, Director of Finance	0-2.4	0-2.4	45-49	140-144	988	739	234	164
Irene Scott, Chief Operating Officer	5-7.4	15-17.4	45-49	140-144	1,032	681	337	236
Robert Woolley, Director of Corporate Development	2.5-4.9	10-12.4	25-29	75-79	476	297	173	121
Alex Nestor, Acting Director of Workforce and Organisational Development (from 3 November 2008)	0-2.4	5-7.4	10-14	35-39	178	100	37	26
Patricia Fields, Acting Chief Nurse (from 23 March 2009)	0-2.4	0-2.4	30-34	90-94	757	533	6	4

Real increases and Employer's contributions are shown for the time in post where this has been less than the whole year. Figures in (brackets) indicate reductions.

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

Notes to the Accounts

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. In some cases, the real increase in the CETVs show a significant difference, when comparing this year's values with last year's. This difference is due to a change in the factors used to calculate CETVs, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for CETV's (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine cash equivalent transfer values (CETV) from Public Sector Pension Schemes came into force on 13 October 2008.

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

Notes to the Accounts

7. Better Payment Practice Code

7.1 Measure of Compliance

	Year ended 31 March 2010		10 Months ended 31st March 2009	
	Number	£000	Number	£000
Total Non NHS trade invoices paid in the period	170,846	151,010	164,295	153,269
Total Non NHS trade invoices paid within target	154,304	134,740	145,624	138,608
Percentage of Non NHS trade invoices paid within target	90.3%	89.2%	88.6%	90.4%
Total NHS trade invoices paid in the period	4,129	55,306	3,135	38,536
Total NHS trade invoices paid within target	3,533	48,878	2,484	32,948
Percentage of NHS trade invoices paid within target	85.6%	88.4%	79.2%	85.5%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

Included within Finance Costs (note 9.2) is £0.001m (2009: £0.002m) arising from claims made under this legislation. No other compensation was paid to cover debt recovery cost under this legislation.

8. Loss on Disposal of Fixed Assets

The loss on the disposal of fixed assets of £0.064m (2009: loss of £0.058m) related exclusively to non-protected assets. There were no protected assets disposed of during the period.

9. Finance

9.1 Finance Income

	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Interest on loans and receivables	165	473
Other	44	428
TOTAL	209	901

9.2 Finance costs

	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Department of Health loan	-	300
Finance leases	459	403
Other	-	2
TOTAL	459	705

Notes to the Accounts

9.3 Impairment

Net impairment of property plant and equipment and intangibles	Year ended 31 March 2010 £000	10 Months ended 31 March 2009 £000
Changes in market price	76,231	28,442
Loss or damage from normal operations	-	-
TOTAL	76,231	28,442

Of the net impairments arising during the year £15.743m (2009: £0.53m) was charged to the income and expenditure account and £60.488m (2009: £27.91m) was charged to the revaluation and donated asset reserves.

10. Intangible assets

	Software licences £000	Other £000	Total £000
Cost at 1 April 2009	3,016	288	3,304
Additions	13	140	153
Disposals	-	-	-
Cost at 31 March 2010	**3,029**	**428**	**3,457**
Accumulated amortisation at 1 April 2009	678	61	739
Impairments	-	-	-
Charged during the year	589	-	589
Disposals	-	-	-
Accumulated amortisation at 31 March 2010	**1,267**	**61**	**1,328**
Net book value at 01 June 2008	**2,834**	**-**	**2,834**
Net book value at 31 March 2009			
Purchased	2,338	-	2,338
Donated	**-**	**-**	**-**
Funded from Government Grant	**-**	227	227
Restated net book value at 31 March 2009	**2,338**	**227**	**2,565**
Net book value at 31 March 2010			
Purchased	1,762	-	1,762
Donated	-	-	-
Funded from Government Grant	**-**	367	367
Total net book value at 31 March 2010	**1,762**	**367**	**2,129**

Other intangibles assets are emission allowances granted under the EU Emissions Trading Scheme. These allowances are held at fair value.

10.1 Economic life of intangible assets

The remaining maximum and minimum economic lives of intangible assets held by the Trust are as follows

Asset Type	Minimum Life	Maximum Life
Software (purchased)	1 year	4 years
Other (purchased)	1 year	1 year

11. Property, plant and equipment

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation at 1 April 2009	38,341	218,173	6,010	67,016	81,408	769	15,925	1,924	429,566
Additions – purchased	-	-	-	24,335	-	-	-	-	24,335
Additions – donated	-	-	-	-	248	-	-	-	248
Impairments charged to revaluation reserve	(8,935)	(79,381)	382	522	(424)	-	(98)	(11)	(87,945)
Impairments recognised in operating expenses	(378)	(14,521)	(844)						(15,743)
Reclassifications	-	68,389	135	(81,576)	10,539	71	2,060	382	-
Revaluation surpluses	652	8,142	355	-	-	-	-	-	9,149
Disposals	-	-	-	-	(3,059)	(410)	(2,550)	(34)	(6,053)
At 31 March 2010	**29,680**	**200,802**	**6,038**	**10,297**	**88,712**	**430**	**15,337**	**2,261**	**353,557**
Accumulated depreciation at 1 April 2009	-	8,591	298	-	55,810	511	10,129	1,069	76,408
Charged during the year	-	8,971	307	-	5,820	54	1,621	230	17,003
Impairments	-	-	-	-	-	-	-	-	-
Reversal of Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation surpluses	-	(17,562)	(605)	-	(245)	-	(57)	162	(18,307)
Disposals	-	-	-	-	(2,971)	(410)	(2,547)	(34)	(5,962)
At 31 March 2010	**-**	**-**	**-**	**-**	**58,414**	**155**	**9,146**	**1,427**	**69,142**
Net book value at 01 June 2008	**42,577**	**234,971**	**6,983**	**47,404**	**27,579**	**220**	**6,361**	**876**	**366,971**
Net book value at 31 March 2010									
Purchased	29,680	187,595	6,038	10,297	27,389	275	6,191	729	268,194
Donated		7,833			2,909			105	10,847
Finance leases		5,374							5,374
Total at 31 March 2010	**29,680**	**200,802**	**6,038**	**10,297**	**30,298**	**275**	**6,191**	**834**	**284,415**
Net book value at 31 March 2009									
Purchased	38,341	193,617	5,712	67,016	22,057	258	5,758	598	333,357
Donated	-	9,466	-	-	3,541	-	38	257	13,302
Finance leases		6,499							6,499
Total at 31 March 2009	**38,341**	**209,582**	**5,712**	**67,016**	**25,598**	**258**	**5,796**	**855**	**353,158**

Valuation of Non Current Assets - Property Plant and Equipment

An external valuation of all land and buildings was completed during the year (valuation date 1st April 2009 on a depreciated replacement cost, Modern Equivalent Asset Valuation (MEA) basis.

The valuation was carried out by the District Valuer on "an existing site" basis and has resulted in a decrease in the Trust's Assets of £43.883m. An additional revaluation of the Trust's operational buildings at the 31st March 2010 resulted in a further decrease of £32.348m.

Other classes of property plant and equipment were last valued formally in 2008-09. The change in value of these assets in 2009-10 has been estimated by using valuation indices for the year.

The Revaluation Reserve, amounting to £71.685m, reflects the increased carrying amount of purchased property plant & equipment over its depreciated historic cost.

The Revaluation and Donated Asset Reserves incurred a charge of £60.488m as a result of this reduction with the remaining £15.743m being charged to operating expenditure during the year.

The Bristol Dental Hospital buildings are owned by the University of Bristol. The Trust's ongoing access to the healthcare facilities provided by the hospital and future economic benefits from the Trust's capital investment in the hospital have been confirmed by the University of Bristol in a Memorandum of Understanding.

11.1 Economic life of property, plant and equipment

The remaining maximum and minimum economic lives of property, plant and equipment assets held by the Trust are as follows:

Asset Type	Minimum Life	Maximum Life
Buildings excluding dwellings	6 years	44 years
Dwellings	13 years	35 years
Plant and machinery	1 year	9 years
Transport equipment	1 year	6 years
Information technology	1 year	6 years
Furniture and fittings	1 year	5 years

11.2 Net book value of assets held under finance leases

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

	Buildings excluding dwellings £000	Total £000
Cost or valuation at 1 April 2009	6,802	6,802
Impairments charged to revaluation reserve	(1,428)	(1,428)
Cost or valuation at 31 March 2010	**5,374**	**5,374**
Accumulated depreciation at 1 April 2009	303	303
Provided during the year	330	330
Revaluation surplus	(633)	(633)
Accumulated depreciation at 31 March 2010	**-**	**-**
Net Book Value at 31 March 2010	**5,374**	**5,374**
Net Book Value at 31 March 2009	**6,499**	**6,499**

11.3 Net book value of land building and dwellings

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

	31 March 2010 £000	31 March 2009 £000
Freehold	231,146	247,136
Long leasehold	5,374	6,499
TOTAL	236,520	253,635

11.4 Protected and non-protected assets

Details of land, buildings and dwellings which are protected/non-protected are as follows:

	31 March 2010 £000	31 March 2009 £000
Protected assets	191,920	187,559
Non protected assets	92,495	165,599
TOTAL	284,415	353,158

11.5 Net book value of land building and dwellings – where the Trust is the lessor

The Trust leases out certain buildings or parts of buildings under operating leases. The carrying amount of buildings leased out in part, or their entirety was as follows:

	31 March 2010 £000	31 March 2009 £000
Cost	623	1,283
Depreciation	-	-
Net book value	623	1,283
Depreciation charged for the year/period	32	-

12 Inventories

	31 March 2010 £000	31 March 2009 £000	01 June 2008 £000
Raw materials and consumables	5,782	5,624	5,463
TOTAL	**5,782**	**5,624**	**5,463**

		(10 months)
Inventories recognised as an expense in the year	68,211	55,919
Impairments	-	-
TOTAL	**68,211**	**55,919**

13 Trade and Other Receivables

	31 March 2010 £000	31 March 2009 £000	01 June 2008 £000
Amount falling due within one year:			
NHS receivables	16,314	8,868	16,519
Other receivables	8,912	7,312	6,429
Provision for impaired receivables	(3,111)	(1,364)	(1,268)
PDC receivable	23	-	
Prepayments and accrued income	2,806	6,740	3,476
Total falling due within one year:	**24,944**	**21,556**	**25,156**

Provision for irrecoverable debts (impairment of receivables):	**31 March 2010 £000**	**31 March 2009 £000**
Balance at start of year (period)	**1,364**	**1,216**
New Provisions	2,719	389
Utilised in year	(328)	(70)
Reversed in year	(644)	(171)
Balance at end of year (period)	**3,111**	**1,364**

Ageing of impaired receivables	**31 March 2010 £000**	**31 March 2009 £000**
By up to three months	1,556	153
By three to six months	590	231
By more than six months	965	980
TOTAL	**3,111**	**1,364**

Ageing of non-impaired receivables past their due date	**31 March 2010 £000**	**31 March 2009 £000**
By up to three months	7,994	3,999
By three to six months	1,203	187
By more than six months	510	497
Total	**9,707**	**4,683**

14 Other financial assets

	31 March 2010 £000	31 March 2009 £000	01 June 2008 £000
Amount falling due within one year	-	147	7,555
TOTAL	**-**	**147**	**7,555**

Notes to the Accounts

15. Trade and Other Payables

	31 March 2010 £000	31 March 2009 £000	01 June 2008 £000
Amount falling due within one year:			
NHS payables	12,217	11,596	5,624
Capital payables	1,880	1,609	1,992
Other payables	11,313	16,122	16,183
Accruals	16,002	13,177	14,819
TOTAL	**41,412**	**42,504**	**38,618**

Outstanding pension contributions of £3.529m (2008-09 £3.374m) are included within the NHS payables totals above.

15.1 Borrowings and bank overdrafts -

Amounts falling due within one year:			
Bank overdrafts	3,390	-	38
Loan – Current Instalment	-	-	394
Finance lease obligations	140	116	96
TOTAL	**3,530**	**116**	**528**

16. Other liabilities

	31 March 2010 £000	31 March 2009 £000	01 June 2008 £000
Amount falling due within one year:			
Deferred income	12,207	14,039	6,871
Deferred government grants	367	-	-
TOTAL	**12,574**	**14,039**	**6,871**

17.1 Borrowings

	31 March 2010 £000	31 March 2009 £000	01 June 2008 £000
Amount falling due within one year:			
Loan	-	-	7,106
Finance lease obligations	6,306	6,446	6,542
TOTAL	**6,306**	**6,446**	**13,648**

17.2 Finance Lease Obligations

	31 March 2010 £000	31 March 2009 £000
Payable:		
Not later than one year	575	575
Later than one year but not later than five years	2,300	2,300
Later than five years	7,715	8,294
Sub-Total	10,590	11,169
Less finance charges allocated to future periods	(4,144)	(4,607)
Net Obligation	6,446	6,562

17.3 Net Finance Lease Obligations

	31 March 2010 £000	31 March 2009 £000
Payable:		
Not later than one year	140	116
Later than one year but not later than five years	802	705
Later than five years	5,504	5,741
Net Obligation	6,446	6,562

17.4 Finance Lease Commitments

There are no finance lease commitments at 31 March 2010.

18. Provisions for Liabilities and Charges

	Legal Claims £000	Other £000	Total £000
At 1 June 2008			1,887
At 1 April 2009	519	103	622
Arising during the period	224	153	377
Utilised during the period	(83)	-	(83)
Reversed unused	(40)	(40)	(80)
Unwinding of discount	7		7
Market value adjustment	-	68	68
At 31 March 2010	627	284	911
Expected timing of cashflows:			
Within 1 year	341	284	625
1 – 5 years	106	-	106
Over 5 years	180	-	180
TOTAL	627	284	911

18.1 Legal Claims

The provision for legal claims at 31 March 2010 includes the following:

a) Provision for Staff Injuries
A staff injuries provision of £0.301m (2009: £0.32m) in respect of staff injury allowances payable to the NHS Pensions Agency.

b) Provision for Liabilities to Third Parties
A provisions for liabilities to third parties of £0.286m (2009: £0.20m) representing the excess payable by the Trust, under the NHS Litigation Authority (NHSLA) Liabilities to Third Parties Scheme.

18.2 Other Provisions

Other provisions at 31 March 2010 of £0.284m (2009: £0.10m) relate to the charge for carbon emissions under the EU Emissions Scheme. This provision is stated at market value.

18.3 Clinical Negligence

The NHS Litigation Authority has included a £42.78m provision, in its accounts (2009: £31.28m) in respect of clinical negligence liabilities of the Trust.

19. Cash and cash equivalents

	31 March 2010 £000	31 March 2009 £000	01 June 2008 £000
Cash with the government banking service	41,177	33,201	11,189
Commercial cash at bank & in hand	54	120	57
Total cash and cash equivalents	**41,231**	**33,321**	**11,246**

The Trust's bank overdraft forms an integral part of cash management and therefore for the purposes of the cash flow statement it has been included within cash and cash equivalents as follows:

	31 March 2010 £000	31 March 2009 £000	01 June 2008 £000
Total cash and cash equivalents	41,231	33,321	11,246
Bank overdraft	(3,390)	-	(38)
Total cash and cash equivalents	**37,841**	**33,321**	**11,208**

20. Capital Commitments

There were no commitments, in excess of £1m per scheme, under capital expenditure contracts at 31 March 2010 (2009: £5.56m).

21. Post-Statement of Financial Position (SoFP) Events

There are no post-Statement of Financial Position (SoFP) events that have a material impact on the Trust's Accounts necessitating disclosure or adjustment to the Accounts.

22. Contingencies

22.1 Contingent Assets

The Trust has no contingent assets at 31 March 2010 (2009: £nil).

22.2 Contingent Liabilities

Contingent liabilities at 31 March 2010 comprise:

Bristol Education Centre Reviewable Rent
The Trust pays an annual rent of £0.575m for the lease of the Bristol Education Centre. In addition, an annual "reviewable" rent, equal to 5% of the Market Rental Value of the premises is payable (currently £0.034m per annum). This rent is reviewed periodically in accordance with the lease terms. The Market Rental Value of the premises over the remaining period of the lease and hence the Trust's financial liability cannot be determined with any certainty.

Equal Pay Claims
The NHS Litigation Authority is co-ordinating a national approach to the litigation of equal pay claims and is providing advice to the Trust. The likely outcome of these claims and hence the Trusts financial liability, if any, cannot be determined until these claims are resolved.

Other Contingencies
The Trust has contingent liabilities relation to any new claims arising under the NHS Litigation Authority's "Liability to third Parties" and "Property Expenses" schemes. The contingent liability will be limited to the Trust's excess for each new claim.

23. Prudential Borrowing Code

The Trust is required to comply and remain within the Prudential Borrowing Limit (PBL). This is made up of two elements:

a. the maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's compliance framework determines one of the ratios and therefore can impact on the long term borrowing limit.
b. the amount of any working capital facility approved by Monitor.

Further information on the Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

At the 31 March 2010 the Trust's Prudential Borrowing Limit was £131.35m (2009: £88.65m). This represents maximum long term borrowing of £99.60m (2009: £56.90m) and an approved working capital facility of £31.75m (2009: £31.75m). At 31 March 2010 the Trust had £6.446m (2009: £6.562m) outstanding for long term borrowings, and had utilised £nil (2009: £nil) funds from its working capital facility.

The Trust's performance against the key ratios on which the Prudential Borrowing Limit is based, was as follows:

Financial ratio	Actual ratios year ended 31 March 2010	Approved PBL ratios year ended 31 March 2010	Actual ratios 10 months ended 31 March 2009	Approved PBL ratios 10 Months ended 31 March 2009
Minimum dividend cover (multiple)	4.1x	>1x	3.9x	>1x
Minimum interest cover (multiple)	84x	>3x	51.1x	>3x
Minimum Debt service cover (multiple)	67x	>2x	5.1x	>2x
Maximum debt service to revenue	0.1%	<2.5%	1.9%	<3%

At 31 March 2010 the Trust was performing within all of the approved PBL ratios.

24. Related Party Transactions

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

During the year none of the Board members or members of the key management staff or parties related to them has undertaken any material transactions with the University Hospitals Bristol NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. Entities where income or expenditure, or outstanding balances as at 31 March 2010, exceeded £500,000 are listed below.

Notes to the Accounts

	31 March 2010 £m		2009/10 £m		2008/09 (10 months) £m	
	Receivables	Payables	Income	Expenditure	Income	Expenditure
Avon and Wiltshire Mental Health Partnership NHS Trust			0.88		0.94	
NHS Bath and North East Somerset			12.76		11.41	
NHS Birmingham East and North			0.73			
NHS Bristol	5.53	1.76	249.49	0.96	155.04	9.09
Central Manchester University Hospitals NHS Foundation Trust			0.64			
NHS Cornwall and the Isles of Scilly			1.22		2.45	
NHS Devon			2.26		4.75	
NHS Dorset			0.83		0.99	
East of England SHA						0.51
NHS Gloucestershire			7.14		8.54	
Gloucestershire Hospital NHS Foundation trust						0.59
Great Western Ambulance Service NHS trust				1.84		1.56
NHS Hampshire			1.01		0.71	
Health Commission Wales			10.22		4.35	
Health Protection Agency				2.68		2.10
NHS Blood and Transplant				6.20		4.47
NHS Litigation authority				6.24		2.77
NHS Purchasing and Supply Agency		0.77		10.15		6.12
North Bristol NHS Trust	1.40	1.86	3.22	3.85	5.17	4.78
NHS Business Service Authority Pension Division		3.53		41.58		25.63
NHS North Somerset	2.27		42.57		35.46	
North West SHA			5.75	2.10	7.25	
Pennine Acute Hospitals NHS Trust				0.84		
NHS Plymouth Teaching					0.78	
Royal United Hospitals Bath Trust						0.52
NHS Somerset			15.69		17.02	
NHS South Gloucestershire	1.66		32.48		27.71	
South West SHA			38.43		28.19	
NHS Swindon			2.62		2.67	
Taunton and Somerset NHS Foundation Trust					0.58	
Torbay Care Trust					0.71	
Weston Area Health NHS Trust			0.93		1.51	0.61
NHS Wiltshire			6.64		6.62	
Yorkshire and the Humber SHA			1.01		1.88	

In addition the Trust has had a number of material transactions with other Government Departments and other central and local government bodies. Most of these transactions have been with:

	31 March 2010 £m		2009/10 £m		2008/09 (10 months) (£m)	
	Receivables	Payables	Income	Expenditure	Income	Expenditure
HM Revenue and Customs	0.67			75.94		60.16
University of Bristol			2.91	6.13	2.20	5.61

The Trust has also received capital payments from a number of charitable funds, including Above and Beyond Charities. Neither members of the Trust Board nor any employees of the Trust are Trustees of Above and Beyond Charities. The Audited Accounts of Above and Beyond Charities can be obtained from:

Above and Beyond Charities,
The Abbot's House,
Blackfriars,
Bristol
BS1 2NZ

25. Private Finance Transactions

At 31 March 2010 the Trust has no PFI schemes (2009: none).

26. Pooled Budget Projects

The Trust is party to a Pooled Budget arrangement with Bristol North PCT, Bristol South & West PCT, North Bristol NHS Trust, Bristol City Council, North Somerset Council and South Gloucestershire Council for the management and prevention of delayed discharges from hospitals. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006. The Pool is hosted by the Councils. The Trust makes no contribution to the Pooled Fund but receives income in the form of reimbursement payments which are paid where the level of delayed discharge exceeds an agreed threshold and it serves a Section 2 Notice and Section 5(3) Notice on the Council. For the year ended 31 March 2010 the total income amounted to £0.01m (2009: £0.01m).

A Memorandum Note of Accounts for the Pooled Fund is prepared by Bristol City Council and included in the Councils Statutory Annual Accounts.

27. Financial Instruments

FRS 29," Financial Instruments: Disclosures", requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

Because of the continuing service provider relationship that the Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 29 mainly applies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within the parameters defined formally within the Trusts' Treasury Management Policy, which has been approved by the Board of Directors. Treasury activity is subject to review by the Trust's internal auditors.

Market risk

Market risk is the possibility that the fair value or cash flows of a financial instrument may fluctuate due to market prices. Market risk can be subdivided into two areas: interest rate and currency.

Interest rate risk
The Trust is able through its Prudential Borrowing Limit to borrow from Government for capital expenditure subject to affordability as confirmed by the Strategic Health Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

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.

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 May 2009 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

Liquidity Risk`

The Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government subject to an agreed limit and compliance with the Prudential Borrowing Code. Details of the Trust's performance against the Prudential Borrowing Code are shown in note 23.

27.1 Financial Instruments by currency

Financial Assets	**31 March 2010 £000**	**31 March 2009 £000**
Currency		
Denominated in Sterling	64,973	53,147
TOTAL	64,973	53,147

Financial Liabilities Currency	**31 March 2010 £000**	**31 March 2009 £000**
Denominated in Sterling	42,742	40,631
TOTAL	42,742	40,631

The Trust has negligible foreign currency income or expenditure.

27.2 Financial instruments by category

Financial assets per Statement of Financial Position (SoFP)	**Total 31 March 2010 £000**	**Total 31 March 2009 £000**
NHS debtors	16,314	8,868
Other debtors	8,912	7,312
Other financial assets	-	147
Accrued income	1,627	4,863
Provision for irrecoverable debts	(3,111)	(1,364)
Cash at bank and in hand	41,231	33,321
Total	64,973	53,147

Loans and receivables are held at amortised cost.

Financial liabilities per Statement of Financial Position	Total 31 March 2010 £000	Total 31 March 2009 £000
Bank overdraft	3,390	-
NHS creditors	12,329	11,596
Capital creditors	1,880	1,609
Other creditors	4,761	9,899
Accruals	16,002	13,177
Finance lease obligations	4,380	4,350
Total at 31 March 2009	42,742	40,631

Financial liabilities are held at amortised cost.

27.3 Fair Values

At 31 March 2010 and 31 March 2009 there was no significant difference between the fair value and the carrying value of any of the Trust's financial instruments.

27.4 Maturity of financial assets

At 31 March 2010 and 31 March 2009 all financial assets were due within one year.

27.5 Maturity of financial liabilities

	31 March 2010 £000	31 March 2009 £000
Less than one year	38,497	36,393
In more than one year but not more than two years	153	130
In more than two years but not more than five years	554	491
In more than five years	3,538	3,617
Total	42,742	40,631

28. Third Party Assets

At 31 March 2010 the Trust held £nil (2009: £nil) cash at bank and in hand which relates to monies held by the Trust on behalf of patients.

29. Intra-Government Balances

At 31 March 2010	Receivables: amounts falling due within one year £000	Receivables: amounts falling due after more than one year £000	Payables: amounts falling due within one year £000	Payables: amounts falling due after more than one year £000
Foundation Trusts and NHS Trusts	2,965	-	4,077	-
Department of Health	170	-	-	-
Strategic Health Authority	300	-	32	-
Primary Care Trusts	12,779	-	3,295	-
RAB Special Health Authorities	29	-	811	-
NHS WGA bodies	71	-	4,002	-
TOTAL NHS	16,314	-	12,217	-
Other WGA bodies	28	-	-	-
TOTAL at 31 March 2010	16,342	-	12,217	-

At 31 March 2009	Receivables: amounts falling due within one year £000	Receivables: amounts falling due after more than one year £000	Payables: amounts falling due within one year £000	Payables: amounts falling due after more than one year £000
Foundation Trusts and NHS Trusts	3,028	-	5,139	-
Department of Health	192	-	59	-
Strategic Health Authority	1,055	-	682	-
Primary Care Trusts	4,537	-	1,237	-
RAB Special Health Authorities	42	-	4,045	-
NHS WGA bodies	14	-	434	-
TOTAL NHS	8,868	-	11,596	-
Other WGA bodies	1,131	-	6,399	-
TOTAL at 31 March 2009	9,999	-	17,995	-

30. Losses and Special Payments

There were 483 cases of losses and special payments totalling £0.10m paid during the period ended 31 March 2010 (2009: 487 cases totalling £0.096m).

Statement of the Chief Executive's responsibilities as the Accounting Officer of University Hospitals of Bristol 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 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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor"). Under the NHS Act 2006, Monitor has directed the University Hospitals Bristol NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Bristol 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 NHS foundation trust Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, 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 Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; 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 Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Signed

Robert Woolley, Acting Chief Executive Date: 4 June 2010

Statement of Directors' responsibility in respect of Internal Control

1. Scope of Responsibility

As Accounting Officer I have responsibility for maintaining a sound system of internal control that supports the achievements 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.

As Accounting Officer since December 2009, I met on a regular basis with the Chairman of the Trust and reported on a monthly basis to the Board. In addition, I or my predecessor met regularly at Chief Executive Officer level with the lead commissioning Primary Care Trust for the University Hospitals Bristol NHS Foundation Trust as well as with other health community partners. Regular meetings were held with the Strategic Health Authority and contact maintained with politicians from both local and national government.

The Trust Board met monthly in public. Strategic seminars and briefings for Board Directors were also held regularly. A monthly performance report is issued publicly and is available on the Trust's Internet site www.uhbristol.nhs.uk. The Trust Executive Group includes Executive Directors and the five Clinical Heads of Division.

Divisional Review meetings were held in May and October 2009 and monthly financial and operational reviews have been undertaken with all Divisions.

The Board approved the Trust's income and expenditure budget in March 2009 and the Monitor Annual Plan submission in May 2009. The reported earnings before interest, tax, depreciation and amortisation surplus for the year is £907k greater than the Annual Plan forecast.

The Trust has a Finance Committee (a sub-committee of the Board) which meets on a monthly basis throughout the year. Membership comprises Non-Executive and Executive Directors of the Board. The Committee does not detract from the Board's key and overarching responsibilities, but provides the opportunity for increased scrutiny and time to be spent on finance issues.

Throughout 2009/10 the Trust has worked to achieve its financial target surplus for the year whilst delivering the national targets and effective healthcare. The Trust achieved cash releasing efficiency savings of £11.4m against a plan of £14.9m. For 2010/11 and beyond the outlook is more challenging with the prospect of lower levels of growth moneys for the NHS, coupled with higher levels of efficiency savings and demand for services alongside significant service changes locally.

The Trust has maintained a satisfactory liquidity position throughout 2009/10 and at the year-end has a liquidity ratio of 32 days.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- **identify and prioritise the risks to the achievement of the policies, aims and objectives of University Hospitals Bristol NHS Foundation Trust,**
- **evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.**

The system of internal control has been in place in University Hospitals Bristol NHS Foundation Trust for the financial year 2009/10 and up to the date of approval of the annual report and accounts.

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 in to 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.

3. Capacity to handle risk

a. Leadership:

The overall responsibility for managing risk rests with the Chief Executive who also chairs the Governance and Risk Management Committee, which includes Executive Directors as well as specialist advisers from within the Trust. Minutes of this Committee are reported to the Board and to the Audit & Assurance Committee. Risk management is a priority throughout the organisation and the Board is formally appraised of all risks throughout the organisation including clinical, non-clinical, information and financial, through the various Board committees properly constituted within the Trust.

In particular the Audit & Assurance Committee receives the minutes of the Governance and Risk Management Committee in order to consider further significant concerns with respect to high level risks that may have been raised. Divisional Risk Registers have been embedded within the systems of management in Divisions and exception reports are reported to the Board via the Governance and Risk Management Committee. Divisions report in full on their Divisional Risk Register to the Governance and Risk Management Committee on a rotational basis.

The Corporate Risk Register has been maintained and is reviewed by the Trust Board on a quarterly basis. The Clinical Risk Assurance Committee is chaired by the Medical Director who reports regularly to the Governance and Risk Management Committee. Integrated Performance Reports on the Trust's governance and assurance activities are prepared monthly and these are considered by the Board.

b. Risk management:

During 2009/10 the Trust has continued to work with Divisions to strengthen their risk management arrangements. This has included developing the system of risk management with each Division having in place appropriately trained and experienced risk leads and risk assessors and with Divisional Risk Registers which are considered by Divisional Boards and reflect and drive their agendas. The highest residual risks assessed through the framework are around governance risks relating to 4 hour emergency access and 31 and 62 day cancer targets, the delivery of cash-releasing efficiency targets, and some areas of training compliance. In all instances, controls are in place to reduce the risks.

The governance and assurance specialist advisers from within the Trust have worked with the Chief Nurse and Director of Governance to ensure that the infrastructure is continually developed and fit for purpose, for example the electronic Risk Register. There has been continued work in 2009/2010 to ensure that Registers are up to date, reported to the appropriate groups and senior managers trained in their use. In addition, the Trust is also supported through the use of external advisers as necessary who are experienced in risk management as applied to the health service.

There is a comprehensive single incident reporting scheme for both clinical and non-clinical incidents, which has been highly commended by the NHS Litigation Authority in both its design and application. All incidents are assessed and those of a more serious nature are subject to a full investigation and root cause analysis and appropriate action plans are produced. This has included external review of incidents occurring in the Trust which have identified patient safety factors of national relevance.

The Trust places great emphasis on learning from good practice both from within and outside the Trust. This includes learning points identified through the investigation of incidents, complaints and claims, which are discussed at the relevant individual committees and the identification of trends and learning is undertaken in a joint review group which reports to the Governance and Risk Management Committee and the Clinical Divisions. In addition the Trust, through national groups such as the Association of Litigation and Risk Managers (ALARM), shares details of good practice in all areas of risk management. The Trust is a member of the regional Network of Governance and Risk Managers which shares details of good practice in all areas of risk management. The Trust is taking part in the South West Quality and Patient Safety Initiative This has been followed by the national 'Patient Safety 1st Campaign' which has five workstreams associated with patient safety hazards.

The Trust takes all complaints seriously and through the Senior Nurse for Complaints, under the direction of the Chief Nurse and Director of Governance, and in conjunction with Divisions, investigates and responds to all complaints in accordance

with the requirements of the NHS Complaints Procedure and works closely with Patient Advisory and Liaison Services. The Trust responds to all legal claims appropriately and in accordance with NHS Litigation Authority guidance. Risk management issues identified through the complaints and/or litigation process are addressed through the appropriate committee of the Trust.

c. Training:

Risk awareness training is conducted throughout the Trust on a regular basis. This training commences at induction and is continued through more detailed training in clinical and non-clinical areas. Where appropriate, risk assessment training including root cause analysis training is provided to key members of staff. There is a risk management training matrix for all staff.

4. The risk and control framework

a. Risk management strategy:

The risk management strategy, which is regularly updated and was approved by the Board on 30 June 2009, seeks to achieve a culture where everyone has a responsibility for risk management. Its objective is to ensure a pro-active approach to risk management involving staff at all levels. It is available to the public on the Trust web site at www.uhbristol.nhs.uk/keypublications.html.

b. Risk management system:

The risk management system is embedded throughout the organisation and seeks to ensure that risks are identified and managed through the Risk Register and the specialist advisory committees such as the Clinical Risk Assurance Committee, as well as the system of Board Committees. The Trust seeks to continually improve its performance in all areas and in terms of risk management this is achieved through relevant assessments, audits and inspections with detailed action plans produced to address areas where performance can be improved. The Risk Register is central to the overall system of risk management being applied to both 'high level' corporate risks as well as risks identified through the Divisions. It is regularly reviewed and updated. The 'live' data entry facility, to enable Divisions to adopt a pro-active approach to the review of identified risks, is enabling a new link to be made to the Assurance Framework. The System has been reviewed and developed during 2009/10 to make more explicit the links between risks and assurances.

c. Assurance framework:

The Assurance Framework approved by the Board is balanced and considers all the stated aims and objectives of the Trust together with the controls and assurances in place. Furthermore, it identifies any gaps in those controls and assurances, and action plans are formulated to address those gaps. Gaps relate to spreading information about new or improved practices throughout the Trust, verifying compliance, uncertainties and shortfalls in external funding, and in some instances, maintaining performance against targets. The framework is reviewed regularly by the Governance and Risk Management Committee and the Audit and Assurance Committee and reported to the Board on a full reporting basis.

The Audit and Assurance Committee selected Core Standards (chosen according to levels of compliance, the focus of wider discussion and emerging issues) for closer scrutiny at each of its meetings. The Board approved the Trust's submission at its January meeting to the Care Quality Commission in relation to the registration process. Registration of all the services provided by the Trust without conditions has been confirmed by the Care Quality Commission.

There has been extensive Board involvement in the process for maintaining assurance for the Core Healthcare Standards throughout 2009/10. The Trust ended the year fully compliant with the Core Healthcare Standards.

d. Involvement of public stakeholders:

The Trust has established its Membership Council of Governors and has developed systems to ensure interaction between the Board and Governors through recruitment and engagement of members. The Trust has built on previous public and patient involvement mechanisms and works actively with a number of groups involving patient and public representatives in the design and planning of its services. There has been significant engagement of the general public, voluntary organisations, staff and scrutiny committees as well as the involvement in the detailed planning of a number of services and

the Trust's redevelopment schemes. The Trust has a Board approved Membership Strategy and systems to involve the public and particularly seldom heard minority groups were strengthened as part of this process.

e. Information governance:

The Trust recognises that the information it holds, including personal data of patients, employees and others, as well as corporate information is a valuable asset and it has made great efforts to ensure the security and integrity of that information throughout 2009/10.

The Trust has maintained its focus on the risks associated with loss of data and is implementing software to manage and monitor use of removable devices. The Trust has made improvements in the area of Corporate Information Assurance and has performed audits of its corporate records. Other audits have been performed to validate the scores within the Information Governance Toolkit and to make year on year continuous improvements to its information governance arrangements.

For 2009/10, the Trust was able to declare an overall score for the 62 elements of the Toolkit of 82%.

The Information Governance Steering Group, chaired by the Medical Director / Senior Information Risk Owner, meets monthly to review and action plans for improvement. A structure has been developed to support risk ownership within the Trust, in line with the requirements of the Information Governance Toolkit.

During 2009/2010, there have been two Serious Untoward Incidents reported within the Trust in relation to information governance.

f. Climate Change:

The Foundation 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. A five year Carbon Management Programme, approved by the Board is in place.

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

The Trust has continued to work to develop and expand an improvement programme to streamline working practices using 'lean' methodology. This brings together multi-disciplinary teams to review their ways of working and agree how they can improve services for patients. The focus is placed on identifying and removing unnecessary activities that do not add to the quality of the care patients receive. An Audit Commission report and action plan on ward staffing was considered by the Audit & Assurance Committee on 3 March 2010. A report on consultant productivity was considered in June 2009 and is now being taken forward through the "Making our Hospitals Better" transformation programme. The Audit & Assurance Committee will be considering a report on this at its 8 June 2010 meeting.

Divisional Review meetings were held six-monthly and monthly financial and operational reviews are undertaken with Divisions. These review meetings focus on issues relating to performance targets, human resources and finance such as cash releasing efficiency savings.

Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Audit and Assurance Committee. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Audit Standards. Individual audits have raised issues relating to economy, efficiency and effectiveness and, where scope for improvement was identified during an internal audit review, appropriate recommendations were made and action plans were agreed with management for implementation. The internal audit reviews of the Trust's Estate's service has provided limited assurance, particularly as to the system for procuring services and therefore uncertainty as to whether the Trust is getting best value from all its contracts.

Measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Implementation of the Single Equality Scheme and Action Plan is monitored on a six monthly basis by the Trust Board, on the basis of a report from the Chair of the Equality and Diversity Strategy Group.

6. Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts Regulations 2010) to prepare Quality Accounts for each financial year.

In preparing these accounts, directors are required to take steps to satisfy themselves that:

- the Quality Accounts present a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Accounts is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Accounts, 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 Accounts is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Accounts have been prepared in accordance with relevant requirements and guidance issued by Monitor.

The following steps have been put in place to give assurance in respect of the Quality Account.

Governance & Leadership

- There is clear leadership by the Board on development and progress of the Quality Account
- Clear accountability at all levels in the Trust is in place
- The Trust has given delegated responsibility to the Medical Director for delivering the improvements described in the Quality Account
- The Trust's Governance & Risk Management and the Audit & Assurance Committee led by the Chief Executive and Deputy chair of the Trust respectively exercise an assurance role

Policies

- Through the NHS Litigation Authority standard level 3 in maternity services and level 1 in acute/general services, there is assurance that the Trust's policies reflect the standard required to support the delivery of the Quality Account
- The Trust's information governance policy supports and ensures the reliability of the data used in the Quality Account

Systems & Processes

- The Trust Board provides clear leadership for Quality and the Quality Account
- Clinical Quality data is considered throughout the year by the Governance & Risk Management Committee and the Audit & Assurance Committees and within the Trust's divisional board structures
- Systematic reviews of data take place through internal audit reviews

People & Skills

- The Trust's Medical Director as the owner of the Quality Account has the appropriate skills to discharge the responsibilities of the role
- There is robust appraisal, training and performance management of staff to ensure capability exists across the organisation

Data Issues

- There is monthly reporting to the Board on quality metrics, including clinical benchmarking data, reports from the South West Quality Improvement Programme, results of external inspections and alert data
- Key clinical data is submitted to national database agencies for peer review
- Quality metrics are also used at Divisional Boards and in divisional performance reviews with the Executive Team, led by the Chief Executive

Review of effectiveness

The Trust's assurance arrangements include monthly Board-level monitoring of progress against national and local quality targets. The Trust will act upon the findings of an internal audit which will be carried out during June 2010.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Accounts.

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 and the executive managers within the University Hospitals Bristol NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Assurance Committee and the Governance and Risk Management Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by assurances received from internal sources including clinical audit reports and reports of the Head of Internal Audit as well as activities such as the extensive staff survey carried out in 2007. The Heads of Division and Executive Directors meet on a monthly basis under the auspices of the Trust Executive Group and advise me accordingly.

Following review by the Governance and Risk Management Committee and Audit and Assurance Committee, the Trust Board met on 30th November 2009 and agreed a mid-year declaration of 'Compliant' in relation to all those Standards for which a declaration was required. The Trust had previously declared non-compliance with Core Standard 4c Decontamination for the year 2008/9: key aspects of the associated action plan were completed during the first quarter of the year as planned, and the Trust was not required to make a declaration on this Standard for 2009/10 as this was deemed by the Care Quality Commission to be covered by the Trust's successful registration under the Hygiene Code. The Trust continued to monitor compliance with the Core Standards - by exception - for the remainder of the year 2009/10, in parallel with preparation for Registration with the Care Quality Commission, subsequent to which the Trust has been registered without compliance conditions.

The Head of Internal Audit's overall opinion for 2009/10 is that 'significant assurance can be given that there is a generally sound system of internal control, designed to meet the Trust's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk'.

I have also received assurances as a result of inspections, audits and reviews by a number of national and professional bodies. The Trust participates in nationally organised bench marking programmes. Importantly the Trust achieved Level III compliance with the maternity risk management standards under the National Health Service Litigation Authority in 2010. The Trust was reassessed under the National Health Service Litigation Authority acute general standards and attained the Level I standard. The Trust is working diligently to achieve Level II compliance. The Trust continues to enjoy the highest level Practice Plus status under the Improving Working Lives scheme.

The overall effectiveness of the Assurance Framework is assessed by the Governance and Risk Management Committee and the Audit and Assurance Committee who report to the Board. The other Board Committees assess specific areas of the Assurance Framework and through the Executive Directors approve improvement plans. The overall effectiveness of the Assurance Framework and its ability to support the system of internal control is reviewed as part of the work of internal audit.

Conclusion

During 2009/10 no significant control issues were identified.

Signed…….
Robert Woolley, Acting Chief Executive Date: 4 June 2010

Independent auditor's report to the Board of Governors of University Hospitals Bristol NHS Foundation Trust

I have audited the financial statements of University Hospitals Bristol NHS Foundation Trust for the year ended 31 March 2010 under the National Health Service Act 2006. The financial statements 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. These financial statements have been prepared under the accounting policies set out within them.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers on page 25 and
- the table of pension benefits of senior managers on pages 26 and 27

This report is made solely to the Board of Governors of University Hospitals Bristol NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My work was undertaken so that I might state to the Board of Governors those matters I am required to state to it in an auditor's report and for no other purpose. In those circumstances, to the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for the audit report or for the opinions I form.

Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions made by the Independent Regulator of NHS Foundation Trusts (Monitor) are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements in accordance with statute, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether, in my opinion, the information which comprises the commentary on the financial performance included within the Directors' Report and 'Our financial performance' included in the Annual Report, is consistent with the financial statements.

I review whether the Accounting Officer's Statement on Internal Control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Financial Reporting Manual 2009/10. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I are aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises the Chair's Statement, the Chief Executive's Statement, Directors' Report, the sections on quality accounts, staffing, community, consultation and the environment, teaching and research, Board of Governors, the Board of Directors, membership, audit and counter fraud and the un-audited part of the Remuneration Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (United Kingdom and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report subject to audit. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report subject to audit have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report subject to audit.

Opinion

In my opinion:

- the financial statements give a true and fair view of the state of affairs of University Hospitals Bristol Foundation Trust as at 31 March 2010 and of its income and expenditure for the year then ended in accordance with the accounting policies adopted by the Trust;
- the financial statements and the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and

- information which comprises the commentary on the financial performance included within the Directors' Report and 'Our financial performance', included in the annual report, is consistent with the financial statements.

Certificate

I certify that I have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Lee Budge
Engagement Lead

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