University Hospitals Bristol NHS Foundation Trust
Trust Headquarters
Marlborough Street
Bristol BS1 3NU

Tel: 0117 923 0000
www.uhbristol.nhs.uk

ANNUAL REPORT 2008/09

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Annual Report 2008/09

University Hospitals Bristol NHS Foundation Trust

Annual Report 2008/09

This annual report and annual accounts cover the period from authorisation as a Foundation Trust on 1 June 2008 up to and including 31 March 2009.

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

Chairman's statement

I am delighted to welcome you to the Annual Report for University Hospitals Bristol NHS Foundation Trust for the period 1 June 2008 to 31 March 2009.

This period, starting with the award of Foundation Trust status and ending with the completion of the new Bristol Heart Institute, was a watershed in the progress of our ambitious plans to transform the way we provide healthcare for Bristol and beyond. Foundation Trust status constitutes recognition of the clinical, governance and financial strengths of the Trust and of the excellent work delivered by over 7,500 staff across our eight hospitals and the Central Health Clinic.

Achieving Foundation status is not an end in itself, however, but a means to help us offer patient care, teaching and research of the highest quality. For instance, the freedom to set our own investment priorities means that this year we will be investing £3.2m in a refurbishment of the Bristol Royal Infirmary, as the first step in our plans to move all inpatient services out of the 18th century Old Building.

Other highlights of the year included the following:

- Dr Jonathan Sheffield, our Medical Director, was awarded an OBE in the New Year's Honours list recognising the contribution he has made to healthcare across the region, especially in relation to Lord Darzi's healthcare review.
- The opening of a major new service for sexual health in Bristol, bringing together all services under one roof, following the £2.2 million refurbishment of the Central Health Clinic in July 2008.
- Dr Jacqueline Cornish OBE, Consultant in Paediatric Bone Marrow Transplant, performed the 500th non related Bone Marrow Transplant at the Bristol Royal Hospital for Children, one of the largest units in Europe. The unit receives referrals for transplants from right across the UK and overseas and specialises in the field of unrelated donor bone marrow transplant.
- West Country actor Charles Dance officially opened a new £750,000 state-of-the art SPECT/CT (single photon emission computed tomography) scanner, replacing a 22 year old gamma camera. This camera is the first in the UK with such high specifications and gives doctors and patients vital information that can help to diagnose specific cancers, the cause and severity of benign conditions such as endocrine, renal disorders and brain function.
- The Bristol Royal Infirmary became the first hospital in the region to offer patients a new, virtually pain-free procedure for treating varicose veins. The keyhole surgery procedure is an effective clinically proven alternative to vein stripping. The technique is also quicker and more efficient because it can be performed in outpatients using a local anaesthetic.
- Patients at the Eye Hospital were also the first in the region to benefit from a new sutureless eye surgery technique. The new surgery does away with the need for stitches in the eye, considerably reducing patient discomfort and improving post-operative recovery times. Trialled earlier this year, around 100 operations for conditions such as retinal detachments have now been carried out using the new technique, in which minute instruments are inserted into the patient's eye through a cannula.

The Trust Board saw two Executive Directors leave during the year to take career opportunities elsewhere in the public sector: Anne Coutts, after eight years' service with the Trust as Director of Human Resources and latterly Director of Workforce and Organisational Development, and Lindsey Scott, after 11 years as Chief Nurse and Director of Governance. The Board also welcomed two new Non-Executive Directors, Kelvin Blake and Paul May. Kelvin brings experience from the private sector, particularly in the area of government relations and engagement with stakeholders, while Paul has over 45 years of public sector experience, heading up some of the largest public sector bodies in the region.

I believe the Trust ends this year in a confident, secure place and is looking forward to a challenging and exciting year ahead. I would like to offer my personal thanks to all members of staff who work so very hard every day of the year to deliver care to patients, and finally to my fellow board 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

Chief Executive's report

I am pleased to report on progress in my first full year as Chief Executive.

Business review

Authorisation as a Foundation Trust occurred in June 2008, representing the culmination of significant effort to develop robust, affordable plans for our long-term development.

By the end of March 2009 we had delivered our entire planned £13 million revenue surplus for the financial year and cleared the remainder of our £20 million loan from the Department of Health, meaning that the Trust is now debt-free and in excellent financial health to face the economic challenges ahead.

In February 2009 the commissioning phase for the new Bristol Heart Institute (BHI) started. The BHI is a flagship building which will bring together the best in ground-breaking research, innovative treatment, skilled staff and 21st century facilities for the diagnosis and treatment of heart conditions. This is a major milestone in the Trust's strategic development plans and consolidates our position as a specialist provider of cardiac services. It also creates space for the transfer of a number of inpatient wards from the 18th century Old Building into more suitable accommodation in the Bristol Royal Infirmary, which remains a key strategic objective of the Board.

Other strategic developments include a successful planning application for the construction of an elevated helipad on the roof of the Bristol Royal Infirmary, which will allow emergency air ambulance access for patients needing specialist services.

In the first year as a Foundation Trust, we have devoted significant effort to growing our patient and public membership, which now stands at over 10,000 people, and developing the role of the elected Governors through induction and training activities and direct involvement in the planning processes of the Trust.

With the support of Monitor, the Trust commissioned a Patient Experience and Satisfaction pilot project in the Bristol Haematology and Oncology Centre. The resulting analysis of patient feedback about all aspects of their care has resulted in the development of a major service improvement programme. We will extend this approach to other hospitals in the Trust in 2009/10.

Limiting the harm done to patients through healthcare-acquired infections is a major objective of the Board. The Trust has successfully delivered a significant year-on-year reduction in the number of cases of Clostridium Difficile last year and we kept numbers of post-48 hour cases of Methicillin-resistant Staphyloccus Aureus below our target agreed with NHS Bristol.

Performance against key priorities

The Trust successfully delivered the waiting time standards last year for elective admissions, new outpatient referrals and heart procedures, and for prompt access to chest pain and genito-urinary medicine clinics.

We also made significant strides in reducing the number of patients waiting more than 6 weeks for diagnostic tests and we plan to reduce these further in line with local ambitions in 2009/10.

However, we under-achieved on other patient access standards in 2008/09, which will be a major focus of attention going forward:

- Accident and Emergency waiting times – the level of emergency admissions via the Accident and Emergency Department grew by 10% last year, affecting our ability to manage patient flow effectively.
- Cancer treatment times – as a tertiary centre, the Trust receives high numbers of referrals for patients with suspected cancer. Pathways of care for cancer patients will continue to be monitored closely and actions are in place to support those specialties where challenges have been identified.
- Cancelled operations – despite improvements in the last quarter of the year, we did not meet national standards for minimising the number of operations cancelled at 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 delivery of the emergency access 4 hour standard.

The Trust did not meet required turnaround times for issuing discharge summaries and clinic letters to General Practitioners and patients but has invested in new systems and software for implementation in 2009/10.

Our internal assurance systems identified a weakness in the monitoring processes for decontamination of re-usable instruments during 2008/09. The Trust clinical incident processes give confidence that this has not resulted in any serious risk to patients. However, we have taken urgent steps to revise the governance framework for managing and monitoring decontamination activities throughout the Trust. We have declared this lapse to the Care Quality Commission and expect this to be reflected in our healthcare performance rating for 2008/09.

In all these areas, we have robust action plans in place to address the causes of under-achievement and to deliver to the required standards in 2009/10.

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 and seven Executive Directors, including the Chief Executive.

The Board of Directors considers that it was fully compliant with the provisions of the Code of Governance, except in the following areas, where we have alternative arrangements in place: appraisal of the Chair, Nominations Committees, Chief Executive and Executive Director Terms of Appointment, Information about elected Governors standing for re-election, Independent professional advice for Non-Executive Directors, external professional advice on remuneration for the Chairman and Non-Executive Directors.

The Board has approved a full compliance statement which can be found on the Trust's website.

Looking ahead

In 2009/10, the Trust will start to move inpatient services out of the Old Building into more suitable accommodation in the Bristol Royal Infirmary. We also aim to finalise plans to move all inpatient services from the Old Building by 2013/14.

The Bristol Heart Institute opened to patients in May 2009 and over the next twelve months the Board will be looking forward to the official opening of this facility and to hosting an academic conference there in the autumn, with the aim of forging ever stronger links between clinical services and academic research.

The Trust will look to develop its relationships with the Greater Bristol community, including the Universities, business and community partners, general practitioners and wider stakeholders, particularly working through the Foundation Trust membership.

The Board looks forward to welcoming two new Executive Directors in July 2009 – Steve Aumayer as Director of Workforce and Organisational Development and Alison Moon as Chief Nurse and Director of Governance – and Sarah Blackburn as a Non-Executive Director in June 2009.

Our ambitious plans are only possible because of those people who remain dedicated to supporting and working for the Trust, over 7,500 staff and 11,000 patient and public members, our committed Board, the Trust's many charitable partners, especially Above & Beyond Charities and the Wallace and Gromit Grand Appeal, and our wider stakeholders, including our health community colleagues across Bristol and the South West.

Quality

As may be expected of the organisation which was the subject of the Kennedy Enquiry, the Board takes issues of clinical quality very seriously and operates strong and open clinical governance systems. This report contains an account of our quality objectives and performance which should assure staff, patients and the public of our continued organisational commitment to the highest quality of clinical services. Below is my formal statement on behalf of the Trust about that commitment.

Statement of the Chief Executive

During 2008/09, this Trust focused considerable effort to improve quality in the day to day business of the organisation. The Board paid particular attention to the reduction of Healthcare Acquired Infections, where in July 2008 we noted continuing difficulties in the delivery of the agreed reductions of Clostridium Difficile infections within the main precinct buildings of the Bristol Royal Infirmary. As a result an action team was formed to direct a broad programme of work covering deep cleaning, hygiene, antibiotic policy and isolation practice. This resulted in achievement of the target and continued reductions in infection within the organisation. Post 48 hour Methicillin Resistant Staphylococcus Aureus infections were also successfully tackled. The Trust Board continues to receive the Infection Control report on a monthly basis. The Board also receives monthly Hospital Standardised Mortality Ratio reports demonstrating continued annual improvement since 2003-4. The Trust was one of four organisations in the South West which participated in the Health Foundation's second wave Patient Safety Initiative with focused activity for improvement in Leadership, Peri-operative care, Adult intensive care, Anticoagulation drugs, and General Ward Monitoring of sick patients. At the conclusion of that initiative, the organisation signed up to continue the work under the auspices of the Patient Safety First Campaign. Major improvements in the year included the introduction of the Bristol Observation Chart for all adult patients.

The Trust continues to advance improvements in Patient Experience with a strong track record of complaints resolution and high recorded levels of patient satisfaction. The Trust participated in a Monitor-sponsored patient experience pilot at the Bristol Haematology and Oncology Centre: this work will be rolled out to all Clinical Divisions over the next two years.

The Trust performed its 500th non-related donor Bone Marrow Transplant last year, producing the largest series in Europe. Clinical excellence in Adult and Paediatric Cardiac Surgery continues to be recognised and published in national audits. The Trust is also recognised for its open approach to clinical audit: information about clinical audit activity is published on the internet. In 2008/09, the Trust has headed up a partnership to develop clinical audit policy and strategy guidance tools for NHS-wide use.

The Membership and public can be assured of our continued organisational focus on clinical quality for the future.

Graham Rich
Chief Executive

Our financial performance

University Hospitals Bristol NHS Foundation Trust was authorised with effect from 1 June 2008. This commentary therefore covers the results for the 10 month period to March 2009.

The Trust has achieved a surplus of £9.506m for this period. This position represents a satisfactory out-turn. The following items are worthy of note:

- The Trust's historic debt has now been cleared and the related long term loan fully repaid.
- The Trust cash flow statement shows an increase in cash of £22.113m
- The final year end surplus of £9.506m compares to the planned out-turn, of £9.301m.

The Trust has scored a 4 for its financial risk rating (the range is 1 to 5). The actual score has been calculated at 4.75 but is limited to 4 in the Trust's first year of operation as a Foundation Trust.

Income and expenditure

The Trust achieved a surplus of £9.506 million which is £0.205 million higher than planned. The Trust exceeded planned income for this period by £30.8 million. The increase in actual income was primarily a result of the Trust undertaking additional activity for a number of Primary Care Trusts, over and above original contracted levels together with higher than planned income for services provided by Skills for Health. This also resulted in additional expenditure associated with delivering this increased activity. The table to the right compares the 2008/09 outturn to the 2008/09 plan.

Income and expenditure

	2008/09 (10 months)		
	Plan £millions	**Actual £millions**	**Variance £millions**
Total income	349.9	380.7	30.8
Expenses	(318.4)	(347.4)	(29.0)
EBITDA*	**31.5**	**33.3**	**1.8**
Depreciation	(14.7)	(14.7)	0.0
Trust Debt Remuneration	(9.2)	(9.2)	0.0
Profit/(loss) on disposal	1.8	(0.1)	(1.9)
Interest receivable	0.7	0.9	0.2
Interest payable	(0.7)	(0.7)	0.0
Retained Surplus	**9.3**	**9.5**	**0.2**

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

Cash Releasing Efficiency Saving Plans

The Trust has a good track record of delivering Cash Releasing Efficiency Savings Plans for reducing expenditure, generating income and delivering efficiencies. For 2008/09, the Trust set a Cash Releasing Efficiency Savings target of £10.536 million and delivered savings of £10.591 million for the reporting period.

Balance sheet

The Trust has a healthy balance sheet which shows working capital of £9.110 million which has been generated by current assets of £60.648 million less current liabilities of £51.538 million.

The Trust completed an internal review of the market value for land, buildings and dwellings at 31 March 2009. Following discussions with the District Valuer, the Trust revised its valuations for these areas to reflect current market conditions, using the following indices:

	Original	Revised
Buildings	271	245
Land	122	110

There was a resulting impairment of £26.982m which has been charged directly to the revaluation/donated asset reserve. An external valuation of these assets will be completed in the year ended 31 March 2010. The District Valuer completed a revaluation of the Milne Centre at 31 March 2009 resulting in an impairment of £1.208m, which has been charged to the revaluation reserve.

The Trust took out a working capital loan with the Department of Health to a value of £20.3m in March 2007. In 2007/08 the Trust repaid £12.8m of the loan principal from the income and expenditure surplus in that year. In March 2009, the Trust completed repayment of the loan.

The other notable movements are debtors reducing by £3.453m. This is the result of a substantial push to clear NHS debts on service level agreements. Creditors falling due within one year increased by £10.508m mainly owing to the restoration of the Tax/National Insurance/Pension creditor in March 2009.

Cash flow

The Trust ended the period with £33.321 million cash in the bank. The cash flow in the annual accounts show a £22.113 million increase in cash. This is largely owing to the following factors:

- The Trust having a net cash flow from operating activities of £47.218 million.
- Realisation of cash investments of £7.0 million held on deposit at the 31 May.
- The Trust received Public Dividend Capital of £17.027 million.

The above is offset by:

- Capital expenditure of £28.213 million.
- Repayment of Department of Health loan of £7.5 million.
- A Trust debt remuneration payment of £11.061 million.
- Repayment of public dividend capital of £2.084 million.

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 to the right.

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 seeking to pay invoices for small businesses within 10 days.

Capital

The Trust incurred capital expenditure of £28.141 million. The table to the right shows a breakdown of capital expenditure on major schemes.

The Department of Heath set the Trust's Public Dividend Capital (PDC) limit to £24.07 million. The Trust drew down £17.027 million to finance specific capital schemes.

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 while the body was an NHS trust in 2002/03, which was 1.1%. The table to the right set our performance against this requirement.

The Trust operated within the Private Patient Cap in 2008/09.

Better Payment Practice Code

Items	By number	10 months to 31/03/09 by value
Total non NHS trade invoices paid in the period	164,295	£153.269m
Total non NHS trade invoices paid within target	145,624	£138.608m
Percentage of non NHS trade invoices paid within target	88.6%	90.4%
Total NHS trade invoices paid in the period	3,135	£38.536m
Total NHS trade invoices paid within target	2,484	£32.948m
Percentage of NHS trade invoices paid within target	79.2%	85.5%

Capital

Items	Actual spend 2008/09 (10 month period) £million
Strategic Schemes including £14.073m for the Bristol Heart Institute.	£19.496m
Medical Equipment	£2.410m
Other	£6.235m
Total	**£28.141m**

Private Patient Cap

Items	10 months to 31/03/09	2002/03
Private patient income – £m	1.710	2.341
Total patient income – £m	293.632	209.031
Proportion	0.6%	1.1%

Prudential Borrowing Limit

The Trust is also required to comply and remain within the Prudential Borrowing Limit (PBL). This is set by Monitor and for 2008/09 the Trust s PBL was £56.9 million. This is additional to the approved working capital facility of £31.75m. The Trust had no borrowings against the PBL during reporting period, which is in line with its plan.

The Trust's performance against the key ratios on which the Prudential Borrowing Code is shown in the table to the right.

At 31 March 2009, the Trust performed within all of the approved Prudential Borrowing Limit ratios (see Note 22 of the Annual Accounts).

Prudential Borrowing Limit

Financial ratios	Actual ratios 10 months to 31/03/09	Approved PBL ratios 10 months to 31/03/09
Maximum debt/capital ratio	2%	25%
Minimum dividend cover	3.9x	1x
Minimum interest cover	51.1x	3x
Minimum debt service cover	5.1x	2x
Maximum debt service to revenue	1.9%	3%

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 system looks at four criteria:

1. Achievement of plan.
2. Underlying performance.
3. Financial efficiency.
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 following table sets out the Trust performance against the criteria.

The table to the right shows the Trust's overall financial risk score is 4.75 and the overall rating remains at 4, the highest rating that an organisation can secure in its first year as a Foundation Trust.

Financial risk rating

		31 March 2009	
Financial criteria	**Metric to be scored**	**Actual**	**Rating**
Achievement of plan	EBITDA* margin	9.3%	4
Underlying performance	EBITDA* achieved	112%	5
Financial efficiency	Return on assets	7.1%	5
Financial efficiency	I&E surplus margin	3.1 %	5
Liquidity	Liquid ratio	41 days	5
	Overall rating		**4 (actual weighted score = 4.75)**

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

4.75

The Trust's overall financial risk score. The highest rating that an organisation can secure in its first year as a Foundation Trust

The Trust's activities are provided under legally binding contracts with Primary Care Trusts (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

After making enquiries, the Directors have a reasonable expectation that the 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.

The Trust has achieved financial break-even or better in each of the last 6 years. The Trust delivered a £13.2m surplus in 2008/09, building on the surplus of £12.8m achieved in 2007/08. The proceeds of these surpluses were primarily used to fully repay the Trust's historic debt and its related £20.3m loan from the Department of Health.

The Trust ended the year with a cash balance of £33.321m, an increase of £22.113m on the balance held on 31 May 2008.

The Trust moved to the new standard contract for acute services for 2009/10 for both its contracts with its local PCTs of Bristol, North Somerset and South Gloucester (BNSSG), and those with the ten Associate Commissioners from across the wider South West health economy. The South West Specialist Commissioning Group was included in both the BNSSG and Associate contracts. These contracts are variations of those previously agreed in 2008/09, amended to re-align the contract with the provisions of the NHS Operating Framework for 2009/10. The contract with BNSSG commissioners was agreed and signed on 31 March 2009 and with the Associates on 22 April 2009. This secures the Trust's customer base and income streams for its prime business activities.

The Trust is planning to achieve the following for 2009/10:

- A net surplus of £1.0m on the Income and Expenditure Account which represents an EBITDA rate of 7.8%.
- A planned surplus (excluding impairments) of £7.5 million.
- A planned cash balance at the year-end of £27.175 million.
- A savings programme of £14.9 million.
- A capital programme of £39.4 million.
- A Financial Risk Rating of 4.

This position will be challenging but is deliverable. The planned cash surplus 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 ongoing 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 2009/10.
- Conversion of non-recurring savings from 2008/09 into recurring savings.
- Maintenance of strict cost control.
- Delivery of National Performance targets and in particular the avoidance of Service Level Agreement fines.
- 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 Clinical Quality Indicator targets agreed with Commissioners.

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

- PCTs are experiencing financial difficulties owing 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 PCTs in future.
- Pressures on spending and delivery of efficiency savings are intensifying and firm control is required to avoid the Trust's current financial position and its medium term plans being undermined.
- Risk from the operation of the new national tariff using HRG version 4.

Countering 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 know 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 that 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.

External Audit services

The Trust's External Auditors are the Audit Commission. Audit fees in relation to the statutory audit of the Trust accounts for the 10 month period ending 31 March 2009 were £56,000 (+ VAT). The Trust also asked the Audit Commission to undertake reviews of consultant productivity and ward staffing during the reporting period. This work will be concluded in 2009/10, at which point the Trust will be invoiced for the work.

Where the Trust is planning to appoint external management consultants, the auditors may be considered if they have expertise in the area in which the work is to be undertaken. Factors to be taken into consideration include the likely fees, and whether undertaking the work would potentially compromise their independence as auditors. The auditors have their own procedures for concluding whether possible non-audit work could compromise their independence, or be perceived to compromise it. In line with the Auditing Practice Board's ethical standards, if they cannot put in place appropriate safeguards, they will not propose for the work.

Paul Mapson
Director of Finance

Our operational performance

Quality of Services assessment by the Care Quality Commission (formerly Healthcare Commission)

The annual 'health check' by the Healthcare Commission (now the Care Quality Commission) is the most comprehensive assessment of organisational performance in the NHS, providing a detailed picture of the state of public healthcare in England. The annual health check comprises two main elements: 'Quality of Services' and 'Use of Resources'.

University Hospitals Bristol NHS Foundation Trust achieved a score of 'Good' for Quality of Services and 'Good' for Use of Resources in the most recent health check published in October 2008, which assessed performance in the financial year 2007/08.

There were three elements of the Quality of Services assessment for 2008/2009:

1. Existing Commitments (formerly Existing National Targets).
2. National Priorities (formerly New National Targets).
3. Core Standards.

Based upon the thresholds that have been published, the Trust expects to be scored as Fully Met ('Excellent') for the Existing Commitments, achieving 8 out of the 10 standards. Fewer of the thresholds for achieving the required standard have been published for the National Priorities, including the level required for achieving the new Cancer Standards, but it is expected the Trust will achieve 'Good' against the new National Priorities.

Performance against national and local targets

In 2008/09, the Trust continued to perform well against most of the national targets, which were exceeded in the following areas:

- 93.3% of admitted patients received any treatment they needed within 18 weeks of referral (against a target of 90% for December 2008 onwards).
- 97.6% of non-admitted patients received any treatment they needed within 18 weeks of referral (against a target of 95% for December 2008 onwards).
- 300 Clostridium Difficile infections during the year against a target of 305, which is an 18% improvement on the 367 cases in the previous year.
- Every patient referred to a rapid access chest pain clinic was seen within two weeks of referral.
- Every patient requiring a heart revascularisation procedure was admitted within 13 weeks of the decision to treat.
- Over 99.9% of patients were admitted within 26 weeks of the decision to admit, and 99.9% of patients referred by their GP were seen in an outpatient clinic within 13 weeks of referral (target 99.7%).
- 77% of patients received thrombolytic drugs within 60 minutes of the call for professional help – significantly above the 68% national standard.
- 99.7% of patients referred by their GP with an urgent suspected cancer were seen within two weeks of referral (target 98%).
- Over 99.9% of patients were offered an appointment within 48 hours of contacting the Genito-Urinary Medicine service.
- 0.84% of patients experienced a reportable delay in discharge, as a percentage of the occupied beds (target 3.5%).
- 88% of patients had a valid ethnic group category recorded against their admission (target 85%), which is an improvement of 2% over last year.
- 88% of mothers were not smokers at the time of delivery, which is higher than the 2007/08 national average.
- 76% of mothers started breast-feeding, which is again higher than the 2007/08 national average.

The Trust also made progress towards achieving the local maximum waiting time of 13 weeks from referral to treatment. Since the end of November 2008, an average of 85% of admitted patients and 95% of non-admitted patients received any treatment they needed within 13 weeks of referral. The targets were for 90% of admitted and 95% of non-admitted patients to receive treatment within 13 weeks by March 2009.

Challenges remain in consistently achieving some of the national patient access standards, where the Trust will be redoubling its efforts to improve performance. The areas in which national targets not achieved were as follows:

- 97.6% of patients were discharged, admitted or transferred within four hours of arrival in one of the Trust's Emergency Departments (against a target of 98.0%).
- 97.7% of patients diagnosed with cancer were treated within 62 days of referral by their GP with an urgent suspected cancer (target 98%).
- 93.4% of cancer patients were treated within 31 days of the decision to treat (target 95%).

- 1.2% of operations were cancelled on the day of admission for non-clinical reasons (target 0.8%).
- 90% of patients whose operations were cancelled on the day were re-admitted within 28 days (target 95%).
- 31 MRSA bacteraemias (both community- and hospital-acquired) were identified in the year, against a target of 29, although this is an improvement of 31% on 2007/2008 levels.

In 2009/10, the Trust's plans focus on meeting the 10% increase in emergency admissions via the Accident and Emergency department seen last year. Improving bed availability will be essential for ensuring we achieve a maximum accident and emergency waiting time of four hours. This will also help to avoid unnecessary cancellations of surgery and improve our ability to re-admit patients within 28 days if we do have to cancel surgery owing to unforeseen circumstances. One of the primary aims of this year's programme of work will be to reduce length of stay for inpatients through improvements in the management of discharge and removal of non-clinical obstacles to early discharge.

Achievement of the existing Cancer Standards proved challenging in 2008/09. Further work will be undertaken in 2009/10 to increase capacity in key services and ensure as many patients as possible are seen within a week of first referral, as well as for any diagnostic tests they need. This will improve performance against the existing Cancer Standards. It will also support the achievement of the new standards, which bring patients referred from screening programmes, other types of urgent referrals and patients requiring surgery or chemotherapy for subsequent treatments/ cancers within the scope of the 62 and 31-day treatment time targets.

Hospital acquired infections are unacceptable to the Trust and we are working hard to minimise Clostridium Difficile and MRSA in our hospitals. We have already taken a number of steps to reduce infections and improve cleanliness and will build on these in 2009/10. These steps include:

- Recruiting additional cleaning teams to carry out intensified cleaning of single rooms and whole wards together with carrying out a further deep clean of many wards at Bristol Royal Infirmary.
- Introducing hydrogen peroxide vapour decontamination, which is the latest technology in deep cleaning. This process allows the cleaning of previously hard to reach areas and electronic equipment.
- Putting in place a team of specialist nurses and doctors to make sure that the small number of patients who get Clostridium Difficile receive the best management and care.
- Opening a specialist ward for patients with active Clostridium Difficile disease to reduce the risk of the infection spreading.
- Tightening up on the prescription of antibiotics by stopping the use of those antibiotics most likely to increase the risk of Clostridium Difficile and making sure they are not given for no longer than is essential.

In 2009/10, the Trust will continue to implement its wide-ranging programme of work on healthcare associated infections, including ongoing developments in the use of hydrogen peroxide misting in deep cleaning, and further focus on hand hygiene for staff and visitors to help the Trust prevent further cases of infection.

Core Standards Declaration

The Trust is required to make an annual declaration in respect of 42 separate Core Healthcare Standards covering seven 'Domains' of practice. Each Standard has designated Executive and Operational leads. Compliance with the Standards is monitored via detailed quarterly review of the Trust's Assurance Framework.

For 2008/09, the Trust has declared Core Standard 4c (Decontamination) as 'Not Met'. Following a review at the end of March 2009, the Executive Directors were made aware of areas of non-compliance with this Standard and an urgent review and action was put in place to address these issues. The action plan, produced at the end of March 2009, has target dates set within the first quarter of 2009/2010. At its meeting on 29 April 2009, the Board received and considered a range of evidence which included the standard statement and the related requirements within the Code of Practice for the NHS on the Prevention and Control of Healthcare Associated Infections. It presented the current position against the seven elements of the Healthcare Commission inspection guide for each of the areas in the Trust undertaking decontamination activities. The Board considered that the evidence demonstrated that there were some aspects of the responsibility and reporting structure which needed to be improved, and that implementation of appropriate testing schedules was not in place in some areas. There were no significant lapses or evidence of failure of decontamination or of patient harm.

All other Core Standards were declared as 'Compliant'.

Monitor's Compliance Framework

At the end of each quarter the Trust made the required self-certification to Monitor on current and forecast risks to achievement of the national targets. For each quarter, the Trust rated itself as 'Amber'. The targets not met, or forecast not to be met during the year were as follows:

- A & E four hour maximum wait (declared risk in quarter 2, not met in quarters 3 and 4).
- Clostridium Difficile (not met in quarters 1 to 3; declaration not required in quarter 4 owing to revised thresholds not having been published).
- 31-day diagnosis to treatment for all cancers (not met quarters 1 to 3; declaration not required in quarter 4 owing to revised thresholds not being published).
- 62-day referral to treatment (not met quarters 1 to 3; declaration not required in quarter 4 owing to revised thresholds not being published).
- Core standards (one standard not met in quarter 4).

For a summary of the actions being taken to improve performance in these areas, please see the earlier section on *'Performance against national and local targets'*.

Contractual Key Performance Indicators

As part of the 2008/09 contract with the lead commissioner, NHS Bristol, the Trust committed to achieve the key national standards and some additional stretch targets. Financial rewards and penalties were attached to the achievement of some of these standards.

The Trust received financial rewards for exceeding the standard of 90% of patients being able to book their appointment via Choose & Book at first attempt between November 2008 and March 2009. The Trust was also financially rewarded for achieving local stretch targets on the percentage of mothers who were breast-feeding and not being smokers at the time of their baby's birth.

Penalties were incurred for failing to achieve the national standards for 4-hour emergency access, last-minute cancelled operations and the 31 and 62-day cancer treatment time standards. Financial penalties were also incurred for exceeding maximum waiting times for GP referred outpatients (13-week wait) and for revascularisation procedures (11-week wait); although in both cases the national standards were exceeded for the year.

At the end of the year, the Trust received a net total of £450,000 from commissioners. £510,000 was received for achievement of key national and local stretch targets. This was offset by £60,000 of financial penalties.

Social responsibility

The Trust is engaged in many social and community activities, including involvement with its Foundation Trust members, with GWE Business West and with the Bristol Council of Mosques.

'Making a Difference in the Community' – the Trust's Corporate Social Responsibility Report for 2007/2008 – was sent to all Foundation Trust members, GP surgeries served by the Trust and key stakeholders across Bristol and beyond. The report provided an overview of the Trust's key partnership with the University of Bristol Medical School and the Mbarara University of Science and Technology in Uganda and community involvement of staff through the Territorial Army and Scouts. It also highlighted new and exciting projects such as the design philosophy and art projects for the new Bristol Heart Institute which opened in 2009.

Information risks

There were no Serious Untoward Incidents involving data loss or confidentiality breach during the period from 1 June 2008 up to and including 31 March 2009.

Quality report

Introduction

The Board has a strong commitment to improving clinical quality. Over the past year, the Trust has focused firmly on achievement of major reductions in Healthcare Acquired Infections, particularly Clostridium Difficile, where continual reduction in rates has been the result of meticulous attention to detail by the Infection Control Team and all clinical staff. New isolation facilities were introduced in November 2008 with dedicated trained staff to manage infected patients. The Facilities Cleaning Teams have had further resources to improve routine deep cleaning throughout the organisation and for the introduction of Hydrogen Peroxide deep cleaning systems. Executive leadership ward rounds have also focused on infection control, briefing staff on the importance of isolation of infected patients and adherence to antibiotic policies.

While great emphasis has been applied to infection control, the Trust has also worked hard on the broader issues of patient quality. The Board recognises that its patient safety campaign has to be integrated with the overall aim of service transformation and improvement within the organisation and, for this reason, patient safety work will be integrated with the Lean Programme in 2009/10. Achievements of the Patient Safety Initiative are highlighted below.

Since becoming a Foundation Trust, Trust Governors have been consulted about programme priorities and design for our work on improving the patient experience. The Board is particularly proud of the achievements of the Bristol Haematology and Oncology Centre in the Monitor-sponsored Patient Experience pilot last year. While satisfaction from patients was high, the use of real-time patient surveys has brought new insights into how to improve the experience of patients even further.

The Trust was also pleased to see high and improving satisfaction from national patient surveys in both the Emergency Department and the General Patient Survey.

The remainder of this section gives highlights of the Board priorities over the last year. Over coming months, the Board will seek to develop an outcome report that will provide greater background data for the Quality Account for 2009/10.

Patient Safety

A. Patient Safety Initiative Key Achievements

Overall Aims

- Mortality: 15% reduction achieved.
- 30% reduction in Adverse Events and Crash Calls not achieved. These measures may improve following the introduction of the Bristol Observation Chart in February 2009. Monitoring is continuing.
- MRSA Bloodstream Infection: 50% reduction achieved.
- Harm from Anti-coagulation: 50% reduction in Adverse Drug Events not achieved. This measure may improve following the introduction of new protocols in January 2009. Monitoring is continuing.

Critical Care

Intensive Care Unit (ITU)

Most of the recommended measures were already in place but data stored on the ITU system could not be extracted in the required format. A data analyst has been appointed to address this.

- Data on ventilator associated pneumonia and central line infections could not be collated.
- Blood sugars within range: 80% or greater than within range achieved.

50%

MRSA reduction achieved

Neonatal Intensive Care Unit
The Neonatal Intensive Care Team developed its own set of outcome and process measures aligned to the Safer Patient Initiative. Achievements include:

- 'Tilt to Teddy' to raise bed heads to 15 degrees implemented.
- 'Nesting' to support babies in incubators implemented.
- Noise meter installed along with silent bins.
- Multi-disciplinary ward rounds introduced.
- SBAR (Situation, Background, Assessment, Recommendation) communication tool introduced.

General Ward

The Deteriorating Patient
An Early Warning Observation Chart for adult patients with an escalation protocol was implemented in February 2009. Similar charts were already in place for paediatric and maternity patients.

The SBAR communication tool was implemented to support the escalation protocol.

Infection Control
The following measures have been implemented:

- Weekly hand hygiene audits in all clinical areas Trust-wide.
- Infection Control Risk Assessment on admission.
- Clostridium Difficile checklist with Bristol Stool Chart.
- Isolation cubicles and/or cohort wards.
- Deep cleaning and use of hydrogen peroxide.

Leadership

- Patient Safety data is reported to Trust Board monthly.
- There is a corporate Patient Safety Team with a designated Manager, and Patient Safety Advisors in each division reporting to the Clinical Risk Assurance Committee.
- Patient Safety is included at induction for all staff.
- Leadership walk rounds conducted by all Trust Executives occasionally accompanied by Non-Executives. All clinical areas have been visited and action notes are recorded and monitored.

Medicines Management

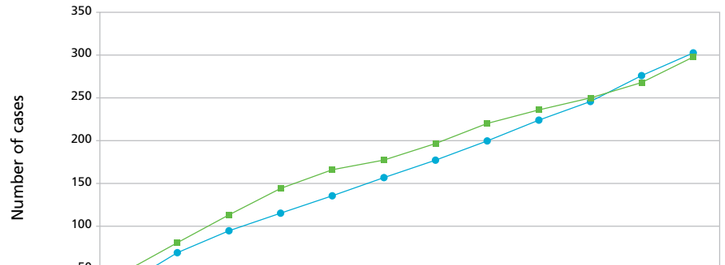
- Guidelines for the management of oral coagulation developed and a new oral coagulation chart introduced in January 2009.
- Thromboprophylaxis guidelines incorporated into surgical and medical admissions forms.
- Testing is continuing for reconciliation of medicines. The admissions form has been altered to include space to record patients' medicines.

Perioperative Care

- Appropriate timely administration of antibiotic prophylaxis achieved.
- Deep Vein Thrombosis prophylaxis guidelines for surgical admissions developed and implemented.
- Work is continuing on maintaining patients' normothermia. A standard monitoring procedure has been implemented in theatres. Ways of maintaining patients' temperature during transfer to theatre are being assessed.
- Perioperative surgical briefings are being implemented.

B. Trend Graphs

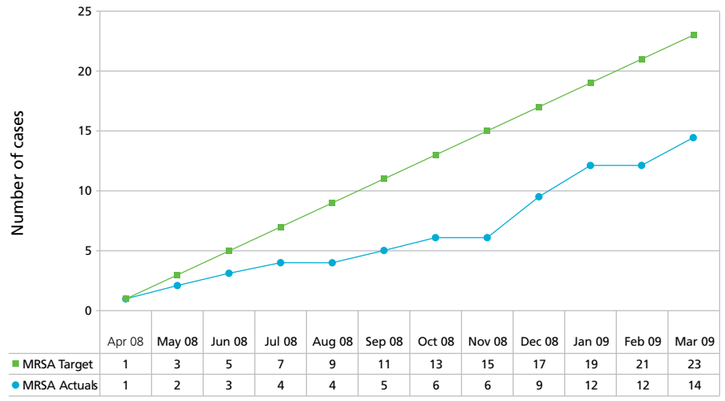
Clostridium Difficile (post) UH Bristol April 2008 – March 2009



	Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09
Cdiff Target	35	70	95	116	137	158	179	201	225	249	277	305
Cdiff Actuals	46	79	112	143	165	177	195	219	235	250	268	300

The target for Clostridium Difficile is based on the number of positive samples from inpatients, excluding those positive on day of admission or day following day of admission. Specimens from the same patient that are positive 28 days after the previous positive are counted as a new cases.

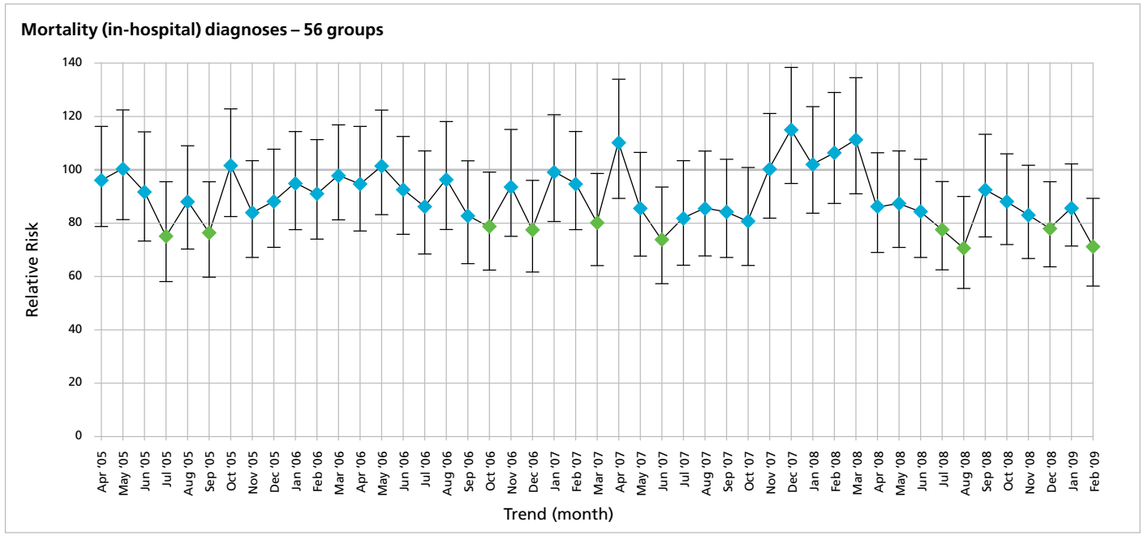
MRSA UH Bristol April 2008 – March 2009



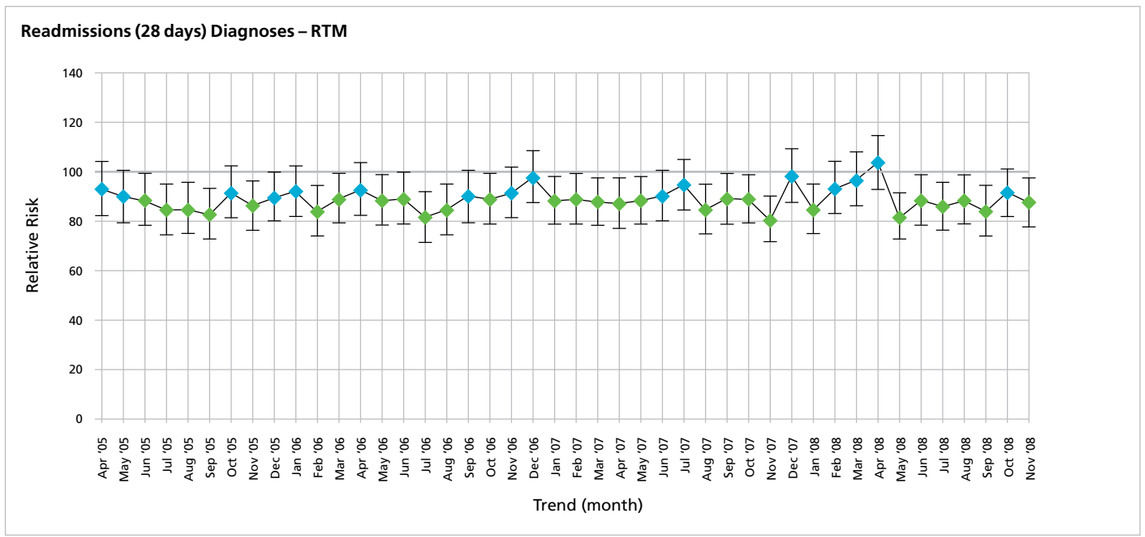
	Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09
MRSA Target	1	3	5	7	9	11	13	15	17	19	21	23
MRSA Actuals	1	2	3	4	4	5	6	6	9	12	12	14

The MRSA bacteraemia target agreed with NHS Bristol Primary Care Trust includes post-48 hour cases only.

Data Analysis from Real Time Monitoring (RTM) application within Dr Foster



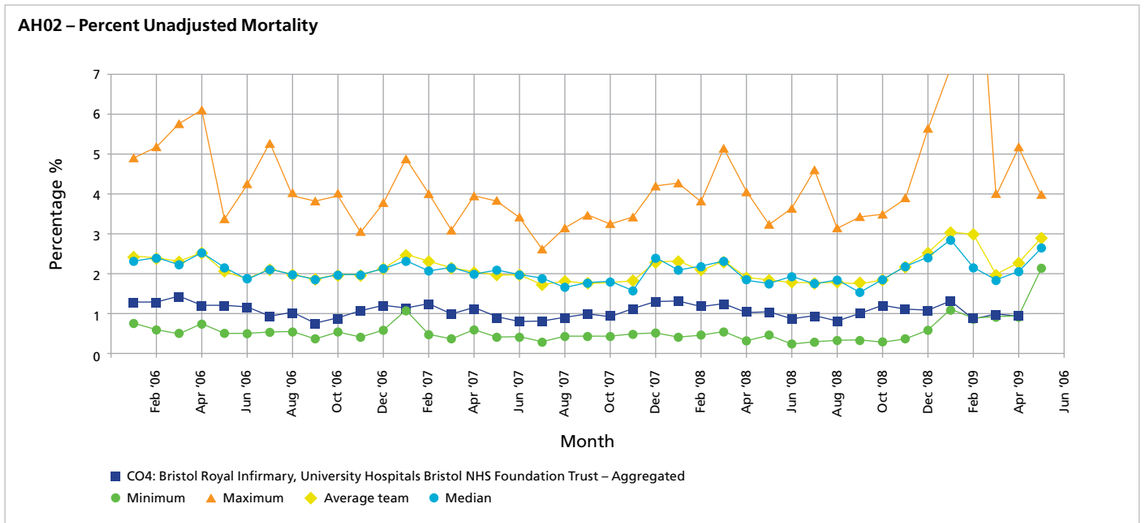
HSMR is the Hospital Standardised Mortality Ratio and covers the diagnoses that account for 80% of in-hospital deaths and is a recognised measure of both safety and clinical outcomes in Acute Trusts. A Relative Risk below 100 demonstrates better than average performance.



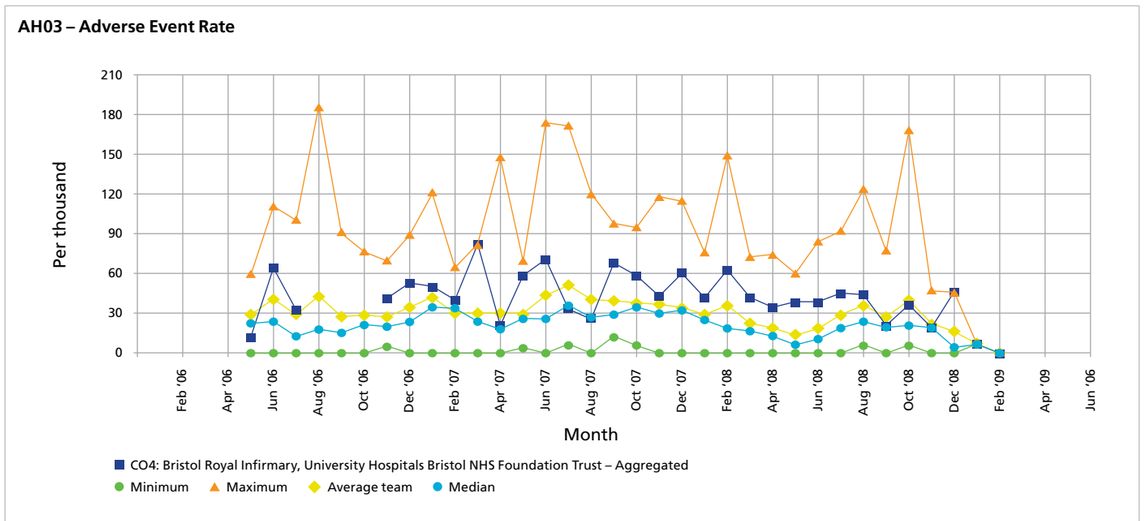
Readmissions relate to emergency readmissions (at any hospital) within 28 days of discharge from the Trust. The vertical bars on each data point are the 95% confidence intervals. This graph is standardised against all Acute Trusts in England from the Doctor Foster Tool. A Relative Risk below 100 demonstrates better than average performance and is a marker of effectiveness at the initial admission.

Data from the Health Foundation's Safer Patient Initiative (continued post-conclusion of the initiative)

The Patient Safety Initiative was sponsored by the Healthcare Foundation charity in collaboration with the Institute for Healthcare Improvement (Boston, USA). All participating Trusts submit data which the Foundation then compiles to enable comparisons.



'Unadjusted Mortality' is the number of deaths as a percentage of all discharges. This report benchmarks the Trust against other included organisations.



Adverse events are identified by applying a standardised tool ('UK Global Trigger Tool') to the clinical notes of randomly selected adult patients discharged from the Bristol Royal Infirmary, and then factored up to get number of adverse events per thousand case notes.



Clinical Effectiveness

A. The National Chronic Obstructive Pulmonary Disease Audit 2008: clinical audit of COPD exacerbations admitted to acute NHS units across the UK

Chronic Obstructive Pulmonary Disease (COPD) is the fifth biggest cause of death in the UK, the second most common cause of emergency admission to hospital and one of the most costly in-patient conditions treated by the NHS. Results from the 2008 national audit of COPD demonstrated that all patients at the Trust underwent a chest radiograph on admission in line with best practice for patients referred to hospital with an exacerbation of COPD. 89% of patients admitted to us with an exacerbation of COPD were treated with systemic corticosteroids as outlined in the guidance: higher than the national level of 86%. 81% of Trust patients were seen by a respiratory specialist during their admission, compared to a national average of 78%. Inpatient mortality for this group of patients was reported as 6% compared to 7.7% nationally. 24% of our patients were accepted onto an Early Discharge Scheme (as advocated by the National Institute for Clinical Excellence), compared to 18% nationally.

B. Comparative audit of red cell use in the hospitals in the South West and West Midlands Regions

This audit represented collaboration between the South West and West Midlands Regional Transfusion Committees to help understand current red cell use in England and identify where practice could be improved. The results showed that the overall rate of appropriate usage at the Trust was 95%, compared to the 79.3% of transfusion episodes for the overall study, and approximately 80% in an earlier audit involving all hospitals across Northern Ireland.

C. Annual Cataract Outcomes Benchmarking Audit

The Bristol Eye Hospital introduced a Cataract Electronic Patient Record in 2003, allowing patient data to be recorded at every stage of the cataract pathway. This has allowed us to contribute a substantial proportion of the data to a study that sets current national and international benchmark standards for cataract surgery (Jaycock et al. 2009*, using data up to July 2006). It also forms the basis for our own annual review of surgical outcomes. Our overall visual acuity outcomes and surgical complication rates are consistently comparable to those standards. One key measure of success is the percentage of patients achieving a post-operative visual acuity of 6/12 or better: the Trust achieved 87% for 2008, which is broadly in line with results of the Jaycock study (92% across all participating sites). Operative complication rates were noted to be better this year, in part owing to purchase of a new microscope for Theatre 1. Post-operatively, complication rates compared favourably to the benchmarks, although the rate of Cystoid Macular Odema has been relatively high for the past two years and requires further monitoring. A recommendation to encourage more patients towards local anaesthetic has shown success, with a drop in General Anaesthetics from 7% in 2005 to 3.6% in the past two years.

*Jaycock P, Johnston RL, Taylor H, Adams M, Tole DM, Galloway P et al. The Cataract National Dataset electronic multi-centre audit of 55 567 operations: updating benchmark standards of care in the United Kingdom and internationally. Eye (2009) 23, 10–16.

D. National Sentinel Stroke Audit 2008

The National Sentinel Audit of Stroke has been running for 10 years, leading to dramatic improvements in the services provided to stroke patients in England, Wales and Northern Ireland. The disease has moved from being a condition that many professionals considered largely untreatable to one where there is recognition that specialist care at all stages of the illness confers significant benefits in reducing mortality and morbidity. The 2008 figures show that 75% of our patients spent at least 90% of their stay on a stroke unit, comparing well to the national average of 58%. 78% of our patients receive a brain scan within 24 hours of their stroke; this is above the national level of 59%. The results also show that 78% of our patients were screened for swallowing disorders within 24 hours of admission compared to 72% nationally. 81% of patients were assessed by an Occupational Therapist within four days of admission, exceeding the national figure of 66%. In terms of rehabilitation, 92% of our patients had goals agreed by the multidisciplinary team, slightly above the national level of 91.8%.

E. Local clinical audit activity

Trust staff took part in several hundred clinical audit projects during 2008/09. The following are examples of changes in practice which resulted from this activity and will hopefully result in improved services and outcomes for patients:

Prescribed oral nutritional supplements at Bristol General Hospital

The care plan for oral nutritional supplements and education leaflet has been updated and re-launched. An information campaign has raised awareness of the implications of giving patients the wrong supplements.

The introduction of a Radiographer's Image Interpretation Form as an addendum to the Red Dot

This will provide more in depth communication of the radiographer's opinion, helping to inform patient diagnosis and assist the Emergency Department in deciding the most appropriate treatment and management.

Completion of treatment in Tuberculosis

A need was identified for a Tuberculosis Specialist Nurse and the position has now been filled.

Head & Neck Cancer – Dental Assessment

A treatment-specific referral form has been introduced at the Bristol Haematology & Oncology Centre for patients referred to the Bristol Dental Hospital to ensure correct dental assessment pre-radiotherapy.

Improving hand hygiene at the Bristol Royal Infirmary

Shelving units have been introduced outside of trauma wards after this audit identified poor compliance with the Trust's hand hygiene policy amongst staff carrying notes and other objects. A subsequent re-audit has shown that compliance has increased following this action.

An audit of Gentamicin prescribing & monitoring

Gentamicin is an antibiotic introduced by the Trust to help reduce cases of Clostridium Difficile. As a result of this audit, an online Gentamicin dosage calculator is being developed to aid junior doctors. Teaching about Gentamicin prescribing has been added to the Trust induction programme for junior doctors, and sections of the existing Gentamicin chart have been redesigned to allow for easier monitoring of dosage levels.

Child Protection documentation in infants presenting to the Emergency Department with head injuries

A tick box system of red flags to identify infants at risk of non accidental injury coupled with an improved programme of education has resulted in a statistically significant increase in clinicians completing child protection documentation.

Patient Experience

A. National Inpatient Survey 2008

The Trust participated in the annual National Inpatient Survey, the results of which were published in late Spring of 2009. The Trust's scores (note that these are not percentages, but a score calculated by the Care Quality Commission) for two key questions are shown in the table to the right, benchmarked against previous years' performance.

The Trust performed particularly well in relation to the following questions:

Do you think the hospital staff did everything they could to help control your pain?

Were you told how to take your medication in a way you could understand?

Were you given clear written or printed information about your medicines?

B. Food survey

In 2008/09, the Bristol Royal Infirmary conducted a quarterly food survey where patients were asked to comment on various aspects of the food they had received. The table to the right is based on cumulative data for the year.

81% of patients felt that they had had enough food, and 92% of patients said that the people who served them had been friendly and helpful.

National Inpatient Survey

Year	'Overall, how would you rate the care you received?'	'Did you feel you were treated with respect and dignity while you were in the hospital?'
2008	90	80
2007	89	78
2006	89	81
2005	88	79

Food survey

	'How would you rate your overall satisfaction with the catering service?'	'How would you rate the taste of meals?'	'How would you rate the temperature of the food?'
Excellent or Good	57%	47%	51%
Acceptable	24%	32%	30%
Poor or Very Poor	9%	13%	10%

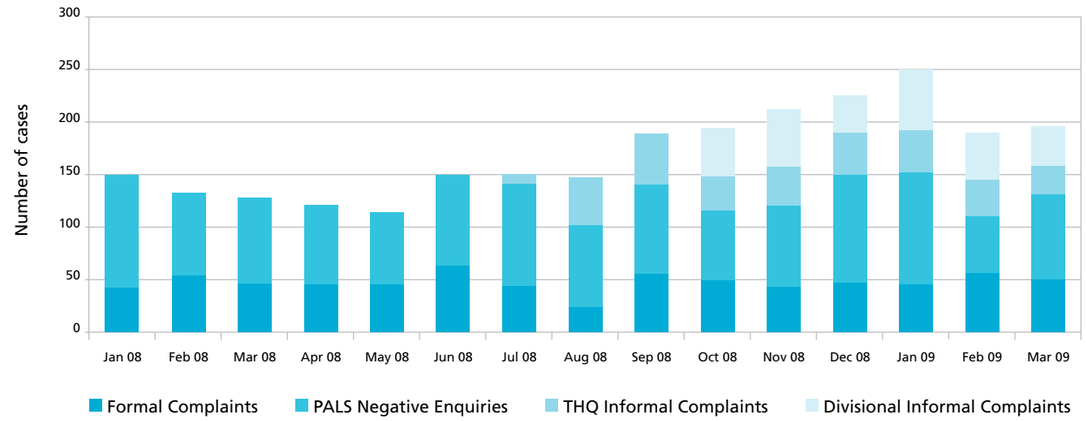
92%

Patients said that the people who served them had been friendly and helpful

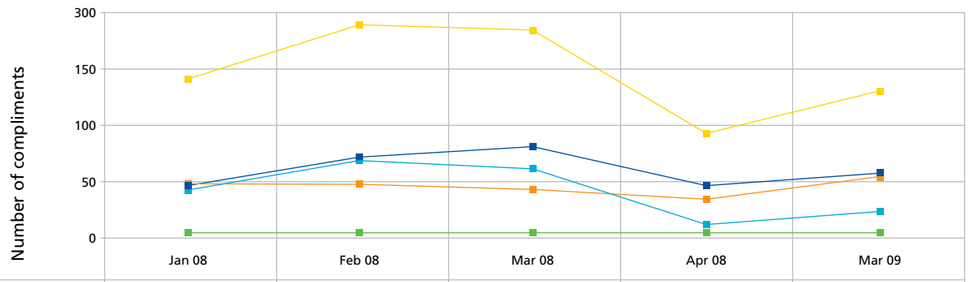
C. Complaints

The number of formal complaints remained within expected levels at 562, averaging 48 per month. To place these figures in context, the average number of recorded compliments was approximately 600 per month (based on the second half of year, when recording of this data commenced). Data from the Complaints Department has been linked with information from the Patient Advice and Liaison Service (PALS) and negative client contacts sent directly to the divisions, providing a clearer picture of activity across the Trust. A small number of complainants who remained dissatisfied with the Trust's response were able to seek a review of the complaint by the Healthcare Commission.

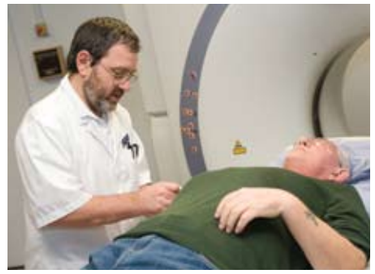
Formal complaints, informal complaints, and negative PALS enquiries



Compliments received via the division



	Jan 08	Feb 08	Mar 08	Apr 08	Mar 09
Diagnostics & Therapies	13	7	4	10	3
Women's & Children's	166	275	242	41	89
Surgey, Head & Neck	195	200	175	146	218
Medicine	191	279	317	174	212
Total	565	761	738	371	522



D. Bristol Haematology and Oncology Centre Patient Experience Survey

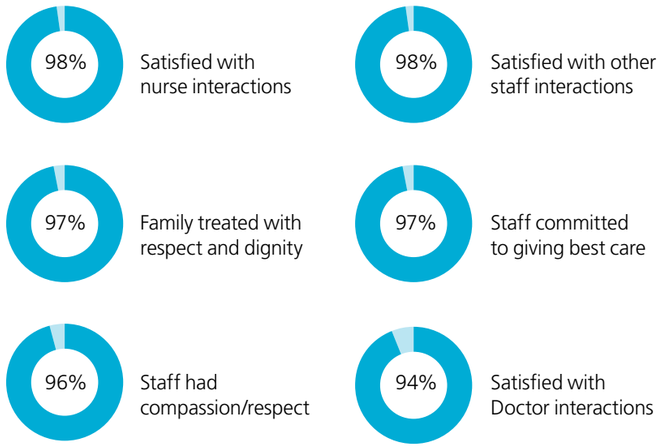
Quality of Services assessment by the Care Quality Commission (formerly Healthcare Commission)

An account of the Trust's performance against core national standards is given in the Operating Review section of this report. Here we describe performance against specific quality-related standards not covered elsewhere.

In May 2009, the Trust completed the self assessment exercise on Engagement in Clinical Audits. In declaring itself compliant with five of the six criteria set-out by the Care Quality Commission, the Trust confirmed it met the required national standards for undertaking clinical audits. As in previous years, the Trust took part in the Myocardial Ischaemia National Audit Project and the British Cardiovascular Intervention Society National Audit, achieving the data quality standards set by the Commission. An audit of stroke care was also conducted during the year, in the form of the National Sentinel Stroke Audit (2008). The results of this audit showed the Trust to be above the national average for the combined score of nine key indicators of stroke care.

Two key national surveys were undertaken during 2008 which also form part of the Quality of Services assessment carried out by the Care Quality Commission, one on patient experience, the other on staff satisfaction. The results of the National Patient Survey showed a general improvement in how patients rated their experience of our services, relative to 2007. Similarly, the responses of staff captured in the recent NHS Staff Survey showed an overall improvement in how staff rated the NHS and the Trust, compared with the previous year. The Commission's formal analysis of the Trust's performance in both these areas will be published in October 2009, as part of the announcement of the rating of our quality of services.

BHOC Survey across Care Settings, Nov 2008
Percentage of patients who moderately/strongly agree



Summary

The overall assessment of Quality of Services for 2008/2009, based upon year-end performance and published/estimated thresholds is:

- Existing Commitments – Fully Met
- National Priorities – Good
- Core Standards – Almost Met

It is expected therefore that the Trust will achieve a rating of 'Good' for its Quality of Services for 2008/09.

Priorities for Quality Improvement 2009-2010

A. Healthcare Acquired Infection Rates

The Trust will continue to drive down Clostridium Difficile and Methicillin Resistant Staphlococcal Aureus Infection rates and will seek to go beyond the national reduction targets and achieve the stretch targets agreed with the NHS Bristol.

Metric to be used: standard monthly incident charts within the Board Infection Control Report.

B. Patient Safety First Campaign

The Trust will continue with this campaign using the metrics and focus areas agreed in the previous Patient Safety Initiative.

Executive Leadership Walk-rounds

These are led by Executive Directors and are weekly events with Non-Executives Directors partnering on some of the visits. These will continue to be a priority for Board members to reassure staff of the commitment to safety from the Board. During 2009 the Medical Director has also agreed to pilot Governors participation in the walk-rounds.

General Ward Observation Chart

The Bristol Observation Chart was introduced to all wards in February 2009. Work will continue to cascade clear training in the development of the Medical Early Warning System, with audit and further training to ensure appropriate management of the declining patient.

Medicines Management

The focus for the coming year will be further emphasis on the management of high risk drugs, with a continuing priority in anticoagulation management and expanding the work to include better control of insulin in diabetic inpatients. Increased investment will also see the development of robust medicines reconciliation plans.

Peri-operative Care

The next year will see the robust implementation of the World Health Organisation Surgical Safety Checklist, with roll-out to all theatres.

Metrics to be used are at Board level, continuing with routine monthly reporting of the Hospital Standardised Mortality Ratio (as per Dr Foster Real Time Monitoring Tool), Crude Mortality Index and mapping of Global Trigger Tool (as per Institute for Health Improvement Methodology).

Outcomes from the Patient Safety First Campaign will be reported in the Quarterly Clinical Risk Assurance Committee Report. The depth of these reports will be increased through the performance reporting structure.

C. Human Factors Training in High Risk Procedures

The Trust is investing in Human Factors training for high risk procedures using the Bristol Simulation Centre. The emphasis in 2009/10 will be in the development of team understanding in error prevention during paediatric and adult cardiac surgery using the High Fidelity Theatre Simulation Suite and the Orpheus Perfusion Simulator. However, the Trust's goal is to give such training to all clinical areas, developing staff to gain insight into when a clinical scenario can create a harmful environment for the patient.

Metrics to be used: number of team members receiving training as percentage by staff group.

D. Patient Experience

Work carried out by the Bristol Haematology and Oncology Centre in partnership with McKinsey and Monitor demonstrated the powerful effect of concentrated focus on patient experience and has laid a template for rapid review and improvement in other areas of the Trust. The Board's principles for improvement are embedded in Lean methodology and any work to improve patient experience should embed Continuous Quality Improvement techniques. The Trust is working closely with NHS Bristol to achieve the latter's Health Experience Ambitions for 2009/10.

The Trust will commence the roll-out of the Patient Experience improvement programme in the Maternity and Obstetric Services in June 2009 and develop a roll-out programme for the whole Trust over a two year period.

The Trust will continue to develop plans for an effective real-time patient experience survey encompassing inpatient and outpatient attendance throughout the organisation. This survey will provide rapid feedback to the areas of patient attendance and will be embedded into ward performance data and help to provide Key Performance Indicators for Clinical Teams.

Metrics to be used: number of teams trained in methodology; monthly patient experience outcomes as per each Productive Ward Report.

Clinical Outcome
The Clinical Effectiveness Committee has previously focussed on the safe deployment of new procedures within the clinical environment and also the establishment and monitoring of National Institute for Health & Clinical Excellence guidance and guidelines within the Trust. The Trust will review the Clinical Effectiveness Committee Terms of Reference to establish a role with the Clinical Audit Committee to monitor outcome data. The data will be provided from both divisional and corporate reporting structures. The Medical Director will work with divisions and the Clinical Effectiveness Committee to develop robust outcome measures across the Trust. The Trust already has an established reputation for outcome measurement in many of our key specialist areas: Cardiac, Vascular, Ophthalmology, Obstetrics and Specialist Paediatric Services, however, as with many other NHS organisations, the Trust's data collection systems are bespoke, often managed by enthusiastic clinicians with no managerial back-up. In 2009/10 the Trust will resource the help of analysts to develop:

- Broad sets of clinical outcome data at a corporate, divisional and clinical service line level by stepwise development throughout the clinical areas of the Trust, focusing initially on priority areas as per clinical strategy.
- Assurance of outcome quality through the Clinical Effectiveness Committee and the Clinical Audit Programme.
- Robust benchmarking of outcome through links with Regional Quality Observatories and national specialist bodies.
- Metric: a consolidated annual outcome report for the board.

Conclusion
This is the first year the Trust has attempted to consolidate the efforts of staff to deliver high quality care for all patients into a single report. This can only be a snapshot of all the activity performed within the Trust. Over the next year, the report will be refined and expanded to deliver a broader perspective of all the services delivered. The Trust will back future reports with linked data to the Trust public website. University Hospitals Bristol Foundation NHS Trust is committed to high quality care for all and to openness in reporting that quality.

The Trust places great value on the involvement of patients, the public and Trust members in reviewing and developing its services. The continuing development of patient and public involvement activities has been an integral part of the Trust's Membership Development Plan for 2008/09. Patient and public involvement activity takes place throughout the Trust in a variety of ways, some of which are briefly described here.

In 2008/09, the corporate Patient & Public Involvement Team has continued to provide expert support, advice and facilitation for staff wishing to undertake patient surveys, focus group and community engagement activities. Like all NHS Trusts, we take part in National Patient Surveys. The results of the 2008 National Inpatient Survey showed an overall improvement in performance compared to 2007. As well as participating in the national surveys, the Trust undertakes a large number of local patient surveys, interviews and focus groups. These activities are overseen by a Patient Involvement Facilitator and the Questionnaire Interview & Survey Group. In 2008/09, the Trust has also continued to work to engage 'seldom heard' community groups through the work of its Public Involvement Project Lead.

Patient and public involvement continues to be at the heart of major redevelopment activity within the Trust, for example, the opening of the new Bristol Heart Institute, the redevelopment of the Bristol Royal Infirmary and the planned closure of the Bristol General Hospital when Bristol Primary Care Trust completes the new South Bristol Community Hospital.

2008/09 has been the first year of working with Local Involvement Networks. The Trust has high hopes for this developing relationship in light of its successful relationship with the previous Patient & Public Involvement Forum.

Patient and public involvement is also at the heart of service improvement work led by Clinical Divisions and the Innovation Team, for example, through the Productive Ward initiative and the concept of 'Experience-Based Design'. A major initiative this year has been the Trust's involvement in the Monitor-sponsored Patient Experience Project at the Bristol Haematology and Oncology Centre. The model used involves patient surveys, interviews and focus groups, with data collected in real time, focusing on developing rapid and effective solutions to identified issues. The project was a great success and the model will be rolled out across the Trust from 2009/10.

The second half of the year saw the formation of the Involvement sub-group of the Board of Governors. This group, consisting of Governors who have identified an interest in involvement, will maintain a strategic overview of the continuing development of patient and public involvement in the year ahead.

Listening to our patients

Patient Information
Good information helps patients to understand the risks and benefits of treatment and to make informed decisions about their care. Over recent years, the Trust has developed a comprehensive resource of over 1,500 patient information leaflets, many of which are available to the public online via the Trust's Document Management Service. 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. Leaflets can also be produced upon request in large type, Braille and audio formats.

The Trust continues to provide a comprehensive translating and interpreting service for patients and visitors. We employ a 'bank' of interpreters, supported by the 'Languageline' telephone interpreting service. Translation of written documents is arranged by divisions upon request. In 2008/09, the Trust has developed a positive dialogue with the Bristol British Sign Language (BSL) Forum, with whom it is actively seeking ways of improving access to BSL interpreting for the deaf.

Complaints
The Trust recognises the value of feedback in evaluating services, which helps to improve existing services and to develop new ones. Comments and complaints, where the needs and expectations of patients have not been met, form an important tool for learning lessons from these experiences. The Trust aims to achieve a culture where complaints are viewed by all staff as positive opportunities to make a difference.

During 2008/09, work has been undertaken to improve the accessibility of the complaints system by installing text-phones in the Complaints and Patient Advice and Liaison Service (PALS) offices and making the complaints leaflet readily available in audio format, as well as working closely with specific community groups.

The appointment of a Senior Nurse to work in the Complaints Department and PALS has also helped to bring clinical insight into the issues raised by complainants.

Responsiveness to complaints has been reviewed and the Trust have worked towards an individually-tailored, proactive response to complaints in preparation for the new Complaints Regulations, which came into effect on 1 April 2009.

In December 2008 a random selection of people were surveyed who had recently made a complaint as part of an evaluation of the complaints service and the feedback will be used to improve the complaints service during 2009/10.

Working in partnership

University Hospitals Bristol NHS Foundation Trust works in close partnership with its charitable partners, including our official charity Above & Beyond Charities and Wallace & Gromit's Grand Appeal and many Leagues of Friends often set up by patients who have experienced lifesaving, or life changing treatment at our hospitals.

Over the last year, the Trust Board has ratified a new Fundraising Strategy which describes how the Trust will take a more proactive fundraising stance in support of its charitable partners and ensure that charitable activities undertaken on behalf of the Trust are appropriately aligned with its strategic plans.

This year saw two main fundraising appeals, the Heart of Bristol Appeal launched by Above & Beyond Charities and the Cots for Tots Appeal launched by Wallace and Gromit's Grand Appeal. The Cots for Tots Appeal aims to provide facilities and equipment to enable the Neonatal Intensive Care Unit at St Michael's Hospital, a regional specialist centre for neonatal intensive care, to provide more facilities for the number of babies it receives from across the South West. The Unit cares for over 600 babies a year from all over the region, particularly babies who require surgery or those who need highly specialist care following complex pregnancies and deliveries. There are 23 cots, nine of which are intensive care. In its first year, the Appeal has raised £150,000.

The Heart of Bristol Appeal aims to enhance the Bristol Heart Institute facility by raising £800,000 to add value to the £61 million NHS investment. The Appeal has focused on two key areas of support, creating a positive healing environment and enhancing medical equipment and technology. The Appeal has already raised more than £750,000 towards its target, which it hopes to reach by 2009. The artwork in the new Institute, funded by the Appeal, has already brought many compliments and comments from patients and visitors to the new building.

In addition, the Trust hosted a three day radiothon, Bristol's Big Give, broadcast live on Bristol GWR radio from the Bristol Children's Hospital in December. The appeal raised over £75,000 which is currently being spent across the Children's Hospital including in oncology, cardiac theatres, physiotherapy and the play department. The producers of the live three day programme recently won a highly coveted Sony Radio Academy Award.

£75,000

Raised by the Heart of Bristol Appeal

Valuing our staff

At University Hospitals Bristol NHS Foundation Trust we recognise the unique contribution our staff make to the life and work of the Trust, delivering excellent patient care, through front-line clinical and non-clinical roles, as well as through support roles that enable the Trust to care for over 100,000 inpatients and over 400,000 outpatients each year. Our 7,500 staff are based at the Trust's estate in central Bristol, working in six divisions (Medicine; Surgery, Head and Neck; Women's and Children's; Diagnostics and Therapies; Specialised Services and Trust Services which itself includes Estates and Facilities, Finance, Human Resources, Corporate Development and Information Management and Technology.)

Equality and diversity

The Trust has developed a Single Equality Scheme which is designed to incorporate all the equality strands including disability. The Scheme includes a detailed action plan with a number of objectives relating to disability, including an Equality of Access Project which enables Trust staff to flag any particular patient requirements relating to for example, services, communication etc on the Patient Administration System.

The Trust also has a Valuing Diversity Strategy and a Code of Expectations of Employees which highlight the importance and organisational benefit of a diverse workforce, demonstrate the Trust's commitment to equality of opportunity and outline the expectations from staff in terms of equality.

As well as the actions contained in the Single Equality Scheme, the Trust is recognised as being 'Positive About Disabled People', and meets the five commitments of the Double Tick initiative. Those applicants who wish to be considered under the Double Tick initiative and who meet the minimum criteria of a post will be guaranteed an interview and considered on their abilities. The Trust works with local Disability Employment Advisors from JobCentre Plus to support applicants and new employees. The Trust was delighted to receive an award from Remploy as Branch Employer of the Year award for 'displaying dedication and determination to overcoming barriers to employment'.

The Trust is committed to supporting staff who may become disabled during their continuing employment with the Trust. The Trust's Occupational Health Service is used to access support in overcoming any practical obstacles to employment; providing advice and assessment for disabled employees wishing to continue work and providing advice in becoming a disability symbol user. Staff can also access a confidential counselling service.

The Trust's Redeployment Policy may also be used for staff who become disabled during their employment or who experience any changes in their disability or impairment. Advice is always sought from the Occupational Health Department to ensure reasonable adjustments are undertaken appropriately.

The Trust has an Equal Opportunities in Employment Statement detailing its commitment to equality of access both to recruitment and selection and to training and development. All staff must undertake an annual appraisal where objectives are agreed and training and development needs and opportunities are discussed.

Staff Involvement

The Trust participates in the Annual Staff Attitude Survey and subsequently develops a detailed action plan intended to improve the experience of staff. The Trust works closely with its staff side representatives, using formal groups such as the Joint Union Committee, the Industrial Relations Group, the Local Negotiating Committee (medical and dental staff) and the Trust Consultative Committee, to understand staff views and consult on change, service provision and policy developments. Strategic issues are discussed monthly with representatives at the Trust Consultative Committee, with operational matters discussed at the monthly Industrial Relations Group. All Trust employment policies are considered and agreed by the Trust Policy Group.

Communicating with staff

The Trust uses a variety of mechanisms to communicate with staff including a weekly electronic bulletin – 'Newsbeat', which is also available in hard copy for those without easy access to a computer. Information is also sent out with payslips and communicated via divisions through team briefs. The Trust publishes a bi-monthly staff magazine, 'The Pulse', focusing on the life and work of staff right across the Trust. Regular features include staff news, team focus and an update from the Chief Executive.

The Trust has undertaken an extensive piece of staff research under the heading 'Loud and Clear'; over 500 staff were interviewed via a questionnaire with an additional 50 staff taking part in focus groups. The research sought to ascertain whether current communication mechanisms are effective for all staff groups and how communication methods can be improved. It also looked at staff attitudes to health and wellbeing and their knowledge of our main linked charity, Above & Beyond. This is the first time the Trust has undertaken such a detailed, bespoke piece of research into staff communications and attitudes. Each division will devise its own action plan to meet their specific needs. Some changes are already being implemented, including at the time of writing a newly designed staff email bulletin. The Trust is grateful to Above & Beyond Charities for funding this research.

The Chief Executive gives quarterly briefings for all staff, providing an opportunity for staff to hear directly about the issues currently affecting the Trust and future plans. In addition, all staff were invited to attend a staff engagement event to contribute their views on what would make the Trust an even better place to work.

Information from key Trust meetings directly related to financial, economic and performance matters are available on the Trust's intranet site and information is also cascaded across divisional teams.

All clinical and non-clinical policies are available for staff on the Trust's intranet site, 'Connect'.

A safe working environment

The overall strategy for Health & 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 & Safety systems, practices and processes ensure that all key risks to compliance with the legislation have been identified and addressed.

Health & 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 & 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 and absence

All sickness absence is recorded centrally via ESR and published monthly in the Board report. Staff are supported during periods of absence by line managers, HR and Occupational Health.

Teaching and research

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 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. In addition, there are many other partnerships which support the teaching and learning culture we wish to foster. These include partnerships with other NHS organisations, Bristol City Council, the Severn Institute, 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.

A key partnership is with Skills for Health (the Sector Skills Council for health), for whom the Trust acts as host employer, with representation on the Board through the Director of Workforce and Organisational Development and we will work positively to support the Strategic Plan for Skills for Health.

In September, the Trust was the first in the country to see Orthodontic Therapists graduate. Six students piloted the year long course which started in October 2007 and involved a four-week taught programme led by consultant orthodontists, combined with a hands-on work placement treating patients under the guidance of a registered specialist Orthodontic Trainer. Thanks to the success of the first round of graduates, with one individual receiving a gold medal for distinction, the course is taking on an additional two applicants for the next year of study.

This arrival of this additional qualification follows current government incentives to improve both the quality and speed by which Orthodontic care may be administered. Qualified Orthodontic Therapists will have the additional responsibility of carrying out a number of both routine and emergency procedures, with the hope of reducing waiting lists for more specialised treatment. Currently any qualified dental care professional is eligible to apply for the course.

Research

University Hospitals NHS Foundation Trust is the most research active NHS Trust in the South West of England. The Trust continues to lead, host and support research across all clinical areas, with over 700 members of staff involved in some kind of research at any given moment. This research allows the Trust to develop treatments and procedures which will improve patient care and services. In addition, through collaboration with industry partners we are able to access novel approaches to development, or to glean understanding of innovative approaches to issues at their outset.

Two major research programmes are in Cardiac Surgery and in Clinical Genetics.

Research grants were awarded to the Trust in March 2008 by the UK National Institute of Health Research in the form of a Biomedical Research Unit and an Applied Programme of Research for our Cardiac Surgery group. A second Applied Programme of Research was awarded for work in head and neck cancer and cleft palate.

The Bristol Heart Institute (BHI) is a research partnership between the Trust and the University of Bristol, now centred around a brand new hospital building. Research activity is focused on understanding and treating heart disease more successfully. The BHI is a centre of international excellence and has attracted over £50 million of research funding since 1995.

In the past, BHI researchers have concentrated on laboratory research or on finding out whether new treatments improve the health of patients in everyday clinical practice. The new funding for a Biomedical Research Unit in Cardiovascular Disease (£5m over four years) is specifically for translational research, that is research to turn the most promising findings from the laboratory into new treatments to benefit patients. The new unit will carry out research on five themes:

- Protecting the heart and patients during cardiac surgery.
- Preventing blockages in vein grafts.
- The role of stem cells in heart failure progression and for treatment.
- Long term blood pressure changes in children having cardiac surgery.
- Vulnerable atherosclerotic plaques.

The Clinical Genetics research team are based at St Michael's Hospital and includes a team of consultants, specialist registrars and genetic counsellors who are involved in a wide range of research projects. Their work falls into broad themes:

- Identifying genes that cause congenital malformations or diseases in children.
- The genetic basis and outcome of neuromuscular disorders.
- Understanding how genes influence types of cancer in adults.

Running single and multi-centre studies allows patients from Bristol and the South West to participate in research studies. Examples of the current multi-centre studies are:

- Looking at learning outcomes for children who have an extra X or Y chromosome (with Oxford University).
- A study of genes involved in balancing growth in children (with Southampton University).
- Identifying genes that cause learning difficulties in boys (with Cambridge University).

Of the local studies, one defined a new skeletal disorder leading to early arthritis caused by an error in the gene for collagen type 2 which makes the cartilage inside our joints. This gene causes a wide range of other problems with the skeleton but all of them share the problem of early onset arthritis.

Another project being carried out involves researchers looking at differences between patients with genetic and environmental obesity and identifying genes which cause severe childhood obesity. The study, funded by Above & Beyond Charities, has identified a gene in the brain pathway controlling appetite not previously studied in humans.

Our organisation

Our Membership Council

The Membership Council (equivalent to a Board of Governors) is responsible for advising the Trust strategically on how services can best meet the needs of the local population, patients and their carers. The Membership Council has statutory powers to bring its influence to bear by appointing key members of the Trust Board, the Chair and Non-Executive Directors and approving the appointment of the Chief Executive. The Membership Council independently monitors the Trust's performance and helps ensure its compliance with its Terms of Authorisation as a Foundation Trust.

The Membership Council's three working groups were set up during 2008/09 to enable the Governors to focus in more detail on strategy development, patient, public and staff involvement and quality of patient care.

Initial elections to the 27 elected Governor's places on the Membership Council ensured all elected seats were filled, with an additional 10 out of 11 appointed Governors in place ready for Foundation Trust authorisation on 1 June 2008. There have been some Governor changes during 2008/09 but by-elections have been avoided since Governor candidates were available to step into place as a result of successful elections in early 2008.

Who's who

Constituency	Name	Length of appointment	Status
Public Governors			
Public South Gloucestershire	Patricia Robinson	2 years (end May 2010)	Elected
	David Clark	2 years (end May 2010)	Elected
Public North Somerset	Elizabeth Corrigan	3 years (end May 2011)	Elected
	Anne Ford	3 years (end May 2011)	Elected
Public Bristol	Heather England	3 years (end May 2011)	Elected
	Mo Schiller	3 years (end May 2011)	Elected
	Jason Edgar	3 years (end May 2011)	Elected
	George Wynne Willson	2 years (end May 2010)	Elected
	Elizabeth Obileye	2 years (end May 2010)	Elected
	Violet Stephens	Oct to Nov 08	Elected
	John Alcock	June to Sept 08	Elected
Patient Governors			
Patient Governors from tertiary areas (who live in rest of England & Wales)	Rosemary Chalmers	2 years (end May 2010)	Elected
	Des Osborne	3 years (end May 2011)	Elected
Local patient Governors who live in Bristol, N. Somerset & S. Glos.	Christine Webb	3 years (end May 2011)	Elected
	Pam Yabsley	3 years (end May 2011)	Elected
	Anne Skinner	3 years (end May 2011)	Elected
	Allan Attwood	3 years (end May 2011)	Elected
	Clive Hamilton	3 years(end May 2011)	Elected
	Vacancy	3 years (end May 2011)	Elected
Carers of patients 16 years and over	Wendy Gregory	2 years (end May 2010)	Elected
	Sylvia Smith	2 years (end May 2010)	Elected
Carers of patients under 16 years	Philip Mackie	3 years (end May 2011)	Elected
	Lorna Watson	3 years (end May 2011)	Elected
Patient Governors from tertiary areas (who live in rest of England & Wales)	Anne Jordan	June to July 08	Elected
Local patient Governors who live in Bristol, N. Somerset & S. Glos.	Heather Saunders	June 08 to March 09	Elected
Staff Governors			
Non-clinical Healthcare Professional	Martin Long	3 years (end May 2011)	Elected
	Jan Dykes	3 years (end May 2011)	Elected
Other Clinical Healthcare Professional	Phil Quirk	2 years (end May 2010)	Elected
Medical and Dental	James Catterall	3 years (end May 2011)	Elected
Nursing and Midwifery	Wendy Hurn	2 years (end May 2010)	Elected
	Belinda Cox	2 years (end May 2010)	Elected

John Savage, as Chair of the Board, is also the Chair of the Membership Council and is therefore in a unique position to understand the views of Governors and members and to reflect these back to the Board. Governors have access to all the Directors, including the Senior Independent Non-Executive Director, who also attends the Membership Council meetings where there is an opportunity for Governors to raise issues directly. All members received a personal invitation to the annual public meeting in September 2008, which resulted in record attendance and an opportunity for dialogue with the Directors. Members have also had the opportunity to make their views known to the Directors through Trust involvement events. The Governor sub-groups of the Membership Council each have an Executive Director lead.

Who's who

Constituency	Name	Length of appointment	Status
Appointed Governors			
Bristol City Council	Cllr Bill Payne – Councillor	3 years (end May 2011)	Appointed
Bristol Primary Care Trust	Deborah Lee – Director of Commissioning	3 years (end May 2011)	Appointed
North Somerset Primary Care Trust	James White – Non-Executive Director	3 years (end May 2011)	Appointed
South Gloucestershire Primary Care Trust	Chris Payne – Director of Public Health and Children's commissioning lead	3 years (end May 2011)	Appointed
University of Bristol	Prof Massimo Pignatelli – Head of Clinical Science	3 years (end 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	3 years (end May 2011)	Appointed
North Somerset Primary Care Trust	Tina Lewis	June to Sept 08	Appointed
Partnership Organisations			
Avon and Wiltshire Mental Health Trust	Jane Britton – Deputy Director of Integrated Governance	3 years (end May 2011)	Partnership
Great Western Ambulance Trust	John Newman – Non Executive Director	3 years (end May 2011)	Partnership
Joint Union Committee	Jeanette Jones – Representative	3 years (end May 2011)	Partnership
Voluntary Groups	Frank Palma	3 years (end May 2011)	Partnership
Community Groups	Andrew Yerbury	3 years (end May 2011)	Partnership

Attendance at meetings

June 2008 to March 2009: 3 meetings

To view the register of interests for our Membership Council, please contact the Membership Office by telephone on 0117 342 3764 or by email foundationtrust@uhbristol.nhs.uk.

Constituency	Name	Actual/possible attendance
Public Governors		
Public South Gloucestershire	Patricia Robinson	2/3
	David Clark	3/3
Public North Somerset	Elizabeth Corrigan	3/3
	Anne Ford	2/3
Public Bristol	Heather England	3/3
	Mo Schiller	3/3
	Jason Edgar (joined Dec 08)	1/1
	George Wynne Willson	3/3
	Elizabeth Obileye	1/3
	John Alcock (left Sept 08)	1/1
	Violet Stephens (joined Oct & left Nov 08)	1/1
Patient Governors		
Patient Governors from tertiary areas	Rosemary Chalmers	3/3
	Des Osborne (joined Aug 08)	2/2
Local patient Governors who live in Bristol, N. Somerset & S. Glos.	Prof Christine Webb	3/3
	Pam Yabsley	2/3
	Anne Skinner	2/3
	Allan Attwood	3/3
	Clive Hamilton	3/3
	Heather Saunders (left Mar 09, vacancy to be filled)	3/3
Carers of patients 16 years and over	Wendy Gregory	3/3
	Sylvia Smith	3/3
Carers of patients under 16 years	Philip Mackie	3/3
	Lorna Watson	3/3
Patient Governors from tertiary areas	Anne Jordan (left Jul 08)	0/1
Staff Governors		
Non-clinical Healthcare Professional	Martin Long	3/3
	Jan Dykes	3/3
Other Clinical Healthcare Professional	Phil Quirk	3/3
Medical and Dental	James Catterall	3/3
Nursing and Midwifery	Wendy Hurn	1/3
	Belinda Cox	3/3

Constituency	Name	Actual/possible attendance
Appointed Governors		
Bristol City Council	Cllr Bill Payne – Councillor	3/3
North Somerset Primary Care Trust	James White – Non-Executive Director (Dec 08)	1/1
University of Bristol	Prof Massimo Pignatelli – Head of Clinical Science	1/3
University of the West of England	Prof John Duffield – Pro Vice-Chancellor and Executive Dean	1/3
Bristol Primary Care Trust	Deborah Lee – Director of Commissioning	0/3
South Gloucestershire Primary Care Trust	Chris Payne – Director of Public Health and Children's commissioning lead	1/3
North Somerset Primary Care Trust	Tina Lewis (left Sept 08)	0/1
Partnership Organisations		
Joint Union Committee	Jeanette Jones – Representative	3/3
Great Western Ambulance Service NHS Trust	John Newman – Non-Executive Director	2/3
Avon and Wiltshire Mental Health Partnership NHS Trust	Jane Britton – Deputy Director of Integrated Governance	0/3
Community Groups	Andrew Yerbury (joined July 08)	1/2
Voluntary Groups	Frank Palma (joined June 08)	3/3
Chairman		
John Savage	Chair	3/3
Directors in attendance		
Irene Scott	Chief Operating Officer	3/3
Graham Rich	Chief Executive	2/3
Lindsey Scott	Director of Nursing	1/3
Jonathan Sheffield	Medical Director	1/3
Robert Woolley	Director of Corporate Development	1/3
Anne Coutts	Director of Human Resources	0/3
Paul Mapson	Director of Finance	0/3
Emma Woollett	Vice Chair	3/3
Iain Fairbairn	Senior Independent	2/3
Patsy Hudson	Chair of Audit Committee	2/3
Paul May (started Sept 08)	Non-Executive Director	1/2
Kelvin Blake (started Sept 08)	Non-Executive Director	1/2
Lisa Gardner	Chair of Finance Committee	0/3
Selby Knox	Non-Executive Director	0/3

Nominations Committee

The Nominations Committee is a formal committee of the Membership Council. Its role is to make recommendations to the full Council regarding the appointment of the Chair 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 Chair and Non-Executive Directors.

At a general meeting in October 2008, the Membership Council approved the recommendation of the Nominations Committee to appoint Paul May and Kelvin Blake as Non-Executive Directors, and to appoint Sarah Blackburn a further Non-Executive Director. She will take up her position in June 2009.

Membership and attendance at Nominations Committee Meetings

Name	Attendance
John Savage (Chair)	4/4
Jeanette Jones	4/4
Clive Hamilton	4/4
Phil Mackie	2/4
Phil Quirk	4/4
David Clark	2/4
Liz Corrigan	3/3
Bill Payne	0/1

Our Membership

University Hospitals Bristol NHS Foundation 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 constituency, and are four years of age and above. Public membership is opt-in by application.

By the end of 2008/09, the Trust had 4,643 public members, an increase of 41%. This has been achieved by recruitment campaigns, transfer of ineligible patient members to the public membership, inviting staff who have left the Trust to join as public members and inviting young people on the Trusts' work experience scheme to join. Members have also joined through the Trust's involvement activities with young people and community groups.

Patient Constituency

Eligibility for the patient constituency is open to all those who are recorded on the Patient Administration System as having attended the Trust as a patient within the preceding three years, who are not eligible to become a member of the staff constituency and are of four years of age and above. 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 three years as a patient has expired, patient's membership can be switched to the public constituency, if eligible. Patient membership is also by application.

By the end of 2008/09, the Trust had 5,760 members in its patient and carer constituency, an increase of 10%. This was mainly achieved through recruitment campaigns and use of the Trust's routine communication systems, including forms with patient appointment letters and through our Outpatient Call Centre.

Staff Constituency

The staff constituency is made up of people who are permanently employed by the Trust or hold fixed-term or honorary contracts for at least 12 months, are registered volunteers or qualifying contracted staff and in all cases are at least 16 years of age. The staff constituency has four groups: Medical and Dental staff, Nursing and Midwifery staff, Other Clinical Healthcare Professionals and Non-Clinical Healthcare Professionals.

Staff membership is opt-out, that is to say, staff are automatically made members on appointment unless they choose otherwise. Information on opting out of the scheme is included in induction packs and on the intranet. Volunteers must apply to become a member. Staff membership remains at nearly 100% with only two staff opting out.

Governors

The Governors received an extensive induction and training development programme. The Membership Council has set up a Nominations and Appointments Committee and three subgroups to assist the Governors in the discharge of their duties. These three subgroups focus on quality, strategy and involvement.

Communicating with and engaging with our members

The Trust has 10,403 public and patient members and 8,707 staff members. A key objective of the Trust's Membership Development Plan is to communicate regularly with its members and the Board of Directors and the Membership Council are committed to involving public, patient and staff members and the local community in improving the Trusts services and commenting on the Trust's strategic direction. Communication includes regular newsletters and invitations to be involved in services that members are interested in, as well as the Membership Council and the Trust's Annual Members Meeting.

The Membership Council has set up the Governor's Involvement Sub-Group which will assist in developing the Patient & Public Involvement Plan and the Membership Development Plan for 2009/10. This sub-group will monitor the membership and advise on the acceptability of the Trust's plans to service users, members and the general public.

Membership size and movements

Public constituency	2008/09	2009/10 (estimated)
At year start (April 1)	2,894	4,643
New members	1,834	514
Members leaving	85	85
At year end (31 March)	4,643	5,072

Staff constituency	2008/09	2009/10 (estimated)
At year start (April 1)	8,609	8,707
New members	1,853	1,853
Members leaving	1,755	1,755
At year end (31 March)	8,707	8,805

Patient constituency	2008/09	2009/10 (estimated)
At year start (April 1)	5,680	5,760
New members	327	818
Members leaving	247	247
At year end (31 March)	5,760	6,331

Throughout 2008/09, we have communicated with our members through regular newsletters and have invited members interested in specific areas of the Trust to become involved in a range of work-streams. These include divisional strategic reviews, evaluating the previous annual report, a review of the patient safety strategy and patient environment assessment team visits. General members' events and the first young persons' event for 10 to 21 year olds have also been held.

The main work streams of our Membership Development Plan 2009/10 are focused on a representative membership, particularly of children and young people and those from black and minority ethnic communities. The Trust is proud of the newly formed Youth Council which represents the views of young members. Members will continue to be involved through newsletters, members' events and strategic development projects.

Members wishing to communicate with Directors and elected members of the Membership Council or 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

Analysis of membership at 31 March 2009

	Number of members	Eligible membership
Age (years)		
0-16	250	143,200
17-21	167	
22+	4,226	691,800
Total		**835,000**
Ethnicity		
White	4,066	782000
Mixed	40	12,000
Asian or Asian British	105	19,000
Black or Black British	88	13,000
Other	344	9,000
Socio-economic groupings		
ABC1	3,452	463,421
C2	691	121,343
D	132	132,156
E	368	118,080
Gender		
Male	2,096	411,000
Female	2,547	424,000
Patient Constituency		
Age (years)		
0-16	144	91,507
17-21	102	23,772
22+	5,514	305,850

Board of Directors

The Board of Directors is legally accountable for the overall performance of the Trust. It is made up of the Trust's Chair John Savage, seven Non-Executive Directors 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 are evidence-based, safe, underpinned by quality and are delivered in a cost-effective way, in order that they meet the needs of patients, carers and the wider community and partner organisations. In doing so, the Board of Directors ensures that the Trust complies with its Terms of Authorisation and all statutory obligations.

The Board is balanced and complete having been joined by two new Non-Executive Directors during the year, selected to bring additional skills and experience in the areas of investment appraisal, governance, strategic transformation and public relations. During the year, Anne Coutts, Director of Workforce and Organisational Development, and Lindsey Scott, Chief Nurse and Director of Governance, both left the Trust after many years of service. Acting up arrangements remain in place until new appointments take up post in July 2009.

During assessment for authorisation as a Foundation Trust in April and May 2008, a thorough evaluation of the performance of the Board, its Committees and Directors was undertaken by Monitor, the independent regulator of Foundation Trusts. Towards the end of 2008/09, the Governor Nominations Committee considered the process for the annual performance evaluation of the Chair and Non-Executive Directors and has commissioned independent external assistance for this task, to include the performance of the whole Board, which will take place in early 2009/10.

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.

Board meetings are held monthly in public and the papers and dates of future meetings are made freely available on the Trust's website. Governors are actively encouraged to attend Board meetings.

On authorisation of University Hospitals Bristol as a Foundation Trust, all existing Non-Executive Directors chose to remain in post and serve out their terms of office. 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.

Non-Executive Directors

John Savage CBE
Chair
(appointed December 2006)

16 years general management experience followed by five years running an international distribution company. Specialist Consultant for the Associated Newspaper Group and Managing Director for six wide ranging Associated Newspaper businesses.

– 1989 Chief Executive of the Bristol Initiative.
– 1993 Chief Executive of the Bristol Chamber of Commerce and Initiative.
– 2002/3 High Sheriff of Bristol.
– 2004 Chairman of Business West.

Currently, also:

– Vice Chair of West of England Partnership.
– Chairman of South West Learning and Skills Council Board and West of England Learning and Skills Council.
– Board member of South West Regional Development Agency and Regional Assembly.
– Chair, Financial Director, Vice President or Chair of 12 other organisations based in Bristol or the South West.

Emma Woollett
Non-Executive Director and Vice-Chair (appointed January 2006)

Marketing Director for both Somerfield Convenience Stores and Kwik Save Stores.

Business Development Executive, with responsibility for developing, implementing and marketing strategic projects.

Strategy and Policy Consultant for Coopers and Lybrand.

Various roles in Logistics and Finance within Mobil Oil.

Freelance Management Consultant, including work within the NHS in England and Wales and Northern Ireland.

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

Qualified as a nurse in the 1960s and worked for the Family Planning Association in a variety of roles.

Lecturer in Government and Politics at St Alban's College of Further Education 1979–1985.

Appointed as District Manager for Oxfam in 1986 and selected as one of Oxfam's first Equal Opportunities Trainers in late 1980s. Oxfam's Regional Retail Manager for South West and South Wales 1996–2000.

Board Member, Avon and Somerset Probation Board 2001-07. Chair of Victim Support Avonvale 2004-08.

Currently Chair of Audit and Assurance Committee at the Trust. Judicial Appointments Committee Panel Chair for appointment of judges from January 2008: management coach and mentor.

Lisa Gardner
Non-Executive Director and Finance Committee Chair (appointed June 2007)

Qualified Accountant, joined Aardman Animations Ltd as Finance Director, responsible for the whole Aardman group.

Subsequently employed by Business West at Director level, as well as freelance work.

Previously Company Accountant – Stokes plc – retailer of fruit and vegetables.

Director of Watershed Arts Trust Limited, a local media centre/hub.

Iain Fairbairn
Senior Independent Non-Executive Director (appointed December 2007)

Former commercial solicitor, in City of London and Bristol legal practices, with more than 20 years experience of property, commercial, planning and construction advice to the NHS, including establishment of NHS Trusts, PFI projects and various forms of joint working between the NHS and other public and private bodies.

Business background as a Director of a private manufacturing company; Director of a nursing home; and as the developer of a care village for the elderly, incorporating nursing home and primary care facilities.

Director of elderly care consultancy.

Professor Selby Knox
Non-Executive Director (appointed February 2008)

35 years experience within the University of Bristol, including 15 in senior management positions. Experience of leadership, operational management and strategic planning in an organisation that has complex interactions with a wide variety of stakeholders and a turnover of £350m.

Academic chemist (1972–1992).

Head of School of Chemistry (1992–2001).

Head of Inorganic & Materials Chemistry (2001–2003).

2004 Appointed to the post of Pro Vice-Chancellor (Resources: Finance and Estates), University of Bristol. Senior Pro Vice-Chancellor from 2007.

Member of the Senior Management Team and Council of the University.

Chair of University Planning & Resource Committee; Standing Committee of Senate; Budget Committee; Capital Prioritisation Committee.

Paul May
Non-Executive Director
(appointed November 2008)

Over 45 years public sector experience including being a Local Government Chief Executive for 20 years, responsible for £350m pa budgets and 6,500 staff. Executive Director of the West of England Learning and Skills Council(LSC) which included significant local capital investment in colleges and schools within the Bristol area. National Chief Executive of the Further Education Bureaucracy Reduction Group and strategic adviser to Government Departments on education and skills. Now a public sector strategic consultant advising Government and agencies on issues including Core Cities, procurement, reorganisations and the creation of the Bristol Sexual Assault Referral Centre; member of the Bristol University Estates Committee and a Fellow of the Institution of Civil Engineers.

Kelvin Blake
Non-Executive Director
(appointed November 2008)

Currently a Programme Director responsible for technology based transformational programmes for BT Global Services UK. Formerly Head of Public Sector Relations responsible for the development of good relations between BT Global Services and UK Government. 2006-2007: Defence Sector Transformation Director responsible for the delivery of the new BT Defence and Security Strategy and 24 major contracts worth £1.5bn. 2005-2006: Defence Fixed Telecom Service Programme Director, responsible for the redesign of the contract with the MOD worth in excess of £340m per annum. Non-Executive Director of the Spinal Injuries Association, Non-Executive Director of the Vassal Centre Trust, Bristol and a former Bristol City Councillor (1997–2003).

Executive Directors

Graham Rich
Chief Executive
(appointed October 2007)

Qualified in medicine and undertook variety of hospital clinical roles as part of GP training. Worked in the Department of Health in performance management. Has undertaken roles at both Chief Executive and Director level within the primary care and commissioning sector. 12 years at Board level within the NHS. 24 years in healthcare. Previously a member of Department of Health Board on long term conditions. Member of the Foundation Trust Network Board.

Senior Medical Officer at the Department of Health in performance management. Worked in the USA with Jackson Hole Group on managed care and system reform, and in strategy consultancy with Boston Consulting Group. Director of Commissioning and Primary Care, Newcastle and North Tyneside Health Authority; Chief Executive, West Hull Primary Care Trust; Chief Operating Officer, United Bristol Healthcare NHS Trust.

Irene Scott
Chief Operating Officer
(appointed March 2008)

23 years of Board level experience in a range of healthcare organisations. Highly experienced and nationally recognised healthcare leader. Extensive experience of management of change, major projects, organisation redesign and turnaround. Strong track record of achieving sustainable change and improving efficiency and effectiveness in a business environment. Qualified Registered Nurse (1975, Withington Hospital, Manchester).

Previous roles include Director of Nursing and Deputy Chief Executive at Surrey and Sussex Healthcare NHS Trust, Chief Executive, Nurse Directors Association UK; Director of Nursing, Guy's and St. Thomas' NHS Trust; Director of Nursing and Workforce Development, NHS Executive, West Midlands Region; Director of Nursing, Leicester Royal Infirmary NHS Trust; Nurse Executive Director/Deputy Chief Executive, Christie Hospital NHS Trust and honorary Professor of Nursing at three UK universities.

Robert Woolley
Director of Corporate Development
(appointed January 2001)

Significant acute sector NHS experience in both strategic planning and operational roles. Seven years' of Board level experience in the NHS. Successful design and delivery of major service reconfiguration projects. Several successful business cases for major service developments. Extensive partnership working associated with commissioning and service planning.

Previous roles include Head of Strategic Planning and Assistant Director of Private Finance Initiative project at Barts and the London Trust; General Manager roles in Children's Services and Anaesthetics, Radiology and Physics and variety of small private company positions, including Trade Sales Manager at MacLine Computers. Appointed as Director of Performance Management, United Bristol Healthcare NHS Trust in 2001 and Director of Corporate Development in 2004.

Anne Coutts
Director of Workforce and Organisational Development (appointed 2004 – left 2 November 2008)

30 years experience within human resources, predominantly in the NHS, but also in education, security industry and consultancy. 13 years experience at Board level in NHS including operational management, information technology and management of clinical support services. Strong experience in employment law. BA Honours in Geography and Anthropology, University of Durham, Masters in Strategic Human Resource Management, University of East Anglia and Fellow of the Chartered Institute of Personnel and Development. Appointed Director of Human Resources at United Bristol Healthcare Trust in 2000.

Previously held a range of roles in human resources, including Unit Personnel Manager for Westminster Hospitals and Assistant Director, Riverside Hospitals, Personnel Research Project Director (national project in Further Education), Consultancy within the security industry and with Training and Enterprise Council and Director of Human Resources at Chelsea and Westminster Hospital.

Alex Nestor
Acting Director of Workforce and Organisational Development (appointed 3 November 2008)

Joined the NHS in 1988 as a workforce information officer, becoming qualified in Human Resources at the University of the West of England in 1993. In 2000 completed Masters in International Strategic HRM. Member of the Chartered Institute of Personnel and Development and in 2003 completed the NHS Excellence in Leadership programme at the University of Manchester.

Previously held a range of human resource roles within the South West region, including Human Resources Manager at North Bristol NHS Trust and the Royal United Hospital, Bath.

Appointed to the University Hospitals Bristol NHS Foundation Trust in 2003 as Assistant Director of Human Resources, and became Head of Human Resources/Deputy Director of Workforce Development in 2004. Became Acting Director of Workforce and Organisational Development in November 2008.

Lindsey Scott
Chief Nurse and Director of Governance (appointed 1998 – left 20 March 2009)

Qualified in both nursing and midwifery. Worked clinically in cancer nursing before entering a general management role in the NHS. Corporate responsibilities included strategic leadership for nursing, midwifery, allied healthcare professionals and healthcare scientists and technicians. Lead Director for Governance and patient and public involvement and founder member of the University Teaching Trusts UK Director of Nursing Forum and the Trust Nursing Association.

Previously held a variety of roles in cancer care, followed by general management role in medicine and elderly care services at Bolton Hospitals, Director of Nursing at Luton and Dunstable Hospitals.

Jonathan Sheffield OBE
Medical Director (appointed 2004)

Qualified as a doctor and worked in a variety of medical roles in Scotland, Nottingham and London, before being appointed as a Consultant Histopathologist with a special interest in gastrointestinal disease. Six years of working as a Medical Director. Led clinical networks and chaired both Regional Modernisation Taskforces and Department of Health Advisory Groups for cancer services.

Previous roles include Registrar, Nottingham Hospitals; Clinical Research Fellow at the Imperial Cancer Research Fund and Honorary Senior Registrar at St. Mark's Hospital, London; Consultant Histopathologist, Yeovil Hospital; Medical Director, Yeovil Hospital and undertook role of Lead Clinician, Avon, Somerset and Wiltshire Cancer Services.

Appointed Medical Director in 2004, Chair of Chairs South West Darzi Review 'Our NHS, Our Future' (2007), Chair of Acute Care Clinical Pathway South West Darzi Review (2007) and NHS Medical Director representative on the National Institute for Health Research Advisory Board (2007).

Paul Mapson
Director of Finance (appointed 2004)

Substantial experience in finance roles within the NHS, originally joined as a National Finance Trainee. Six years' experience at Board level. Significant experience in management of capital projects, specialist commissioning, information technology and procurement.

Joined the NHS as a National Finance Trainee, following full qualification as an accountant, undertaken a variety of finance roles in the NHS, before becoming Deputy Finance Director at United Bristol Healthcare NHS Trust, appointed as substantive Director following a period of acting at Director level.

Pat Fields
Acting Chief Nurse (appointed 23 March 2009)

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

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. Other roles have included Associate General Manager covering trauma and orthopaedics and General Manager for anaesthetics and intensive care. Throughout this period continued in her role as Professional Advisor to the Director of Nursing.

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

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

Register of interests held by Directors

Blake, Kelvin
Non-Executive Director
Relevant business interests
Full time employee of BT PLC
Other interests
Trustee Director of Vassall Centre Trust Charity (no remuneration), Trustee Director of the Spinal Injuries Association Charity (no remuneration), Trustee Director of the Bristol Development Cultural Partnership (no remuneration). Member of CONNECT Trade Union, Member of UNITE Trade Union, Member of the Labour Party

Fields, Pat
Interim Chief Nurse
Relevant business interests
None
Other interests
None

Nestor, Alex
Acting Director of Workforce and Organisational Development
Relevant business interests
Board Member of Skills for Health (hosted by the Trust)
Other interests
Provision of HR Advice to Abbott Burke Associates, provision of HR Advice to Devon Local Medical Committee

Coutts, Anne
Director of Workforce and Organisational Development
Relevant business interests
Board Member of Skills for Health (hosted by the Trust)
Other interests
None

Fairbairn, Iain
Non-Executive Director
Relevant business interests
H&I Partnership Limited – owned jointly with wife – consultancy operating in the field of care and accommodation of the elderly.
Other interests
Very minor shareholding of 192 shares in Tribal Group Ltd.

Gardner, Lisa
Non-Executive Director
Relevant business interests
None
Other interests
Parent Governor – Westbury Park Primary School
Director Watershed Arts Trust
Partner in an Internet business mainly selling children's goggles, beach and outdoor wear – www.chillicrush.co.uk

Hudson, Patsy
Non-Executive Director
Relevant business interests
None
Other interests
Panel Chair, Judicial Appointments Committee

Knox, Selby
Non-Executive Director
Relevant business interests
Paid executive role at the University of Bristol as Pro Vice-Chancellor (Resources and Estates) and have oversight (non-operational) responsibility for the Faculties of Medicine & Dentistry and Medical & Veterinary Sciences, both of which have teaching and research interactions with the Trust. The University and the Trust are co-employers of clinical academic staff. Retired from the University on 31 August but is occasionally employed by it on a consultancy basis.
Other interests
None

May, Paul
Independent Member
Relevant business interests
Managing Director of Skihls Ltd. Consultancy company mainly involved in education. Independent Chief Executive of the FE Bureaucracy Reduction Group
Other interests
None

Mapson, Paul
Director of Finance
Relevant business interests
None
Other interests
None

Rich, Graham
Chief Executive
Relevant business interests
Spouse, Sarah Purdy is a Senior Lecturer in Primary Health Care at University of Bristol. Member, Advisory Group for Common Purpose, Bristol and sub region
Other interests
Vice Chair, Governors, Henleaze Junior School

Savage, John
Chairman
Relevant business interests
Business West, Executive Chairman. 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. South West Regional Assembly, Member. Broadmead Board Limited, Joint Chairman. 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.
Other interests
Enuresis Resource and Information Centre (ERIC) – Treasurer. The Grand Appeal, Trustee. Young Bristol, Vice President. Bristol Society, Secretary and Treasurer. Bristol Choral Society, Patron and Vice-President.

Scott, Irene
Chief Operating Officer
Relevant business interests
None
Other interests
Honorary Positions: Professor of Nursing, Wolverhampton University; Professor of Nursing, South Bank University; Professor of Nursing, Kings College London. Trustee: Florence Nightingale Foundation

Scott, Lindsey
Chief Nurse and Director of Governance
Relevant business interests
None
Other interests
Trustee of Abbeyfield Society Weston-Super-Mare, Chair of Mary Elton Primary School Home School Association Clevedon

Sheffield, Jonathan
Medical Director
Relevant business interests
None
Other interests
None

Woollett, Emma
Non-Executive Director
Relevant business interests
Undertakes management consultancy activities for NHS organisations outside AGW (e.g. DSU in Wales, SDU in Northern Ireland). Consultancy is undertaken on a freelance basis as Woollett Consulting.
Other interests
None

Woolley, Robert
Director of Corporate Development
Relevant business interests
None
Other interests
None

Audit and Assurance Committee

The Audit and Assurance Committee has the following duties and responsibilities:

- To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical).
- To ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee.
- To review the work and findings of the External Auditor and consider the implications and management's response to their work.
- To review the Annual Report and financial statements before submission to the Board.
- To review the findings of other significant assurances, both internal and external to the organisation, and consider the implications to the governance of the organisation.
- To review arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.

The Committee is a non-executive Sub-Committee of the Board and has no executive powers, other than those specifically delegated in its terms of reference. The Committee is authorised by the Board to investigate any activity within its terms of reference and has unrestricted access to the Trust's records and documentation. It is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Directors' attendance at Trust Board meetings

	2008							2009			
Name	**Jun**	**Jun**	**Jul**	**Jul**	**Sep**	**Oct**	**Oct**	**Dec**	**Jan**	**Feb**	**Mar**
Blake, Kelvin	–	–	–	–	–	–	–	✓	✓	✓	✓
Coutts, Anne	✗	✗	✓	✗	✓	✗	✓	–	–	–	–
Fairbairn, Iain	✗	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Fields, Pat	–	–	–	–	–	–	–	–	–	–	✓
Gardner, Lisa	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hudson, Patsy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Knox , Selby	✗	✓	✓	✗	✗	✓	✗	✗	✗	✓	✗
Mapson, Paul	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
May, Paul	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nestor, Alex	–	–	–	–	–	–	–	✓	✓	✓	✓
Rich, Graham	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗
Savage, John	✓	✗	✓	✓	✗	✓	✓	✗	✓	✓	✓
Scott, Irene	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓
Scott, Lindsey	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	
Sheffield, Jonathan	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓
Woollett, Emma	3	✓	✓	✗	✓	✓	✓	✓	✓	✓	✗
Woolley, Robert	3	✓	✓	✗	✓	✓	✗	✓	✗	✓	✓

Attendance at audit committee meetings

	2008				2009	
Name	**June**	**June (Accounts)**	**Sep**	**Dec**	**Jan**	**Mar**
Edmunds, Sue	✗	✗	✓	Brian Mann	✗	✓
Fairbairn, Iain	✗	✓	✓	✓	✓	✓
Gardner, Lisa	✗	✓	✓	✓	✗	✓
Henderson, Kevin	✓	✓	✓	✓	✓	✓
Hudson, Patsy	✓	✓	✓	✓	✓	✓
Lott, Richard	✓	✓	✓	✓	✗	✓
Mapson, Paul	✗	✓	✓	✓	✓	✓
McCall, Jenny	✓	✓	✓	✓	✓	✓
Rich, Graham	✗	✓	✗	✓	✓	✓
Scott, Lindsey	✓	✓	✓	✓	✗	–
Swonnell, Chris	✓	✗	✗	✓	✗	✓
Woollett, Emma	✓	✓	✓	✓	✓	✓

In 2008/09 the Committee met on the following occasions:

10 June 2008, 16 June 2008 (for Annual Accounts 2007/2008), 15 September 2008, 9 December 2008, 28 January (for 2-month Accounts to 31st May 2008) and 10 March 2009.

The minutes of the Committee are formally submitted to the Board and the Chair of the Committee draws to the attention of the Board any issues that require disclosure to the full Board, or require Executive action.

At the general meeting of the Membership Council in October 2008, the Governors approved the extension of the Audit Commission as external auditors until 31 March 2010.

Audit and Assurance Membership

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust. Its members are currently as follows:

- Patsy Hudson (chair) (Non-Executive Director)
- Emma Woollett (Non-Executive Director)
- Lisa Gardner (Non-Executive Director)
- Iain Fairbairn (Non-Executive Director)

Appropriate internal and external audit representatives normally attend Committee meetings. The Chief Executive, Director of Finance and the Executive Director with responsibility for governance are invited to attend. A nominated representative from the Local Counter Fraud Service will normally attend meetings. Those routinely invited to attend are as follows:

- Jennifer McCall (Head of Internal Audit)
- Richard Lott (Audit Commission)
- Kevin Henderson (Audit Commission)
- Paul Mapson (Director of Finance)
- Lindsey Scott (Chief Nurse and Director of Governance)
- Chris Swonnell (Assistant Director for Audit and Assurance)
- Graham Rich (Chief Executive – to discuss with the Committee the process for assurance that supports the Statement on Internal Control)

Remuneration Committee

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.

All contracts for Directors are permanent contracts with six months notice on either side. Termination payments would be in accordance with normal rules on notice and redundancy payments, there are no special provisions.

There are no special service contracts for any Directors. Notice periods are six months on either side. The Trust has the ability to withhold remuneration if insufficient notice is given by a Director.

The Committee comprises the Chair (Chairman of Remuneration Committee), a committee chair and the Non-Executive Directors of the Trust.

The remuneration of senior managers is determined annually by the Remuneration Committee using guidance issued by the Department of Health. In 2008/09 the uplift applied was 2.2 per cent of salary from April 2008. Remuneration was based on national guidance, not on performance.

All contracts for Directors are permanent contracts, with a period of six months' notice on either side. Termination payments would be in accordance with normal rules on notice and redundancy payments, with no special provisions.

Remuneration Committee Membership: Chairman and Non-Executive Directors (5 Non-Executives 1 April – 31 October 2008, 7 Non-Executives 1 November 2008 – 31 March 2009)

Remuneration Committee Advisors: Chief Executive and Director of Workforce and Organisational Development give advice to the Committee

Attendance at meetings 2008/2009

One meeting: 2 September 2008

Attendance:
Emma Woollett
Lisa Gardner
Patsy Hudson
Iain Fairbairn

Apologies:
John Savage and Selby Knox

Remuneration Report

The remuneration of Directors is determined annually by the Remuneration Committee using guidance issued by the Department of Health. The Remuneration Committee comprises the Chair of the Trust and Non-Executive Directors of the Trust.

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

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 these years values with last year's. This difference is owing 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 CETVs (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 owing 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.

Graham Rich
Chief Executive

Salaries and allowances of Directors (for the 10 month period to 31st March 2009)

Name and title	Salary (bands of £5000) £000	Other remuneration (bands of £5000 £000	Benefits in kind rounded to the nearest £000
Chair			
John Savage	40-44	Nil	Nil
Executive Directors			
Graham Rich, Chief Executive	140-144	Nil	Nil
Jonathan Sheffield, Medical Director	145-149	Nil	Nil
Anne Coutts, Director of Workforce and Organisational Development (until 2 Nov 2008)	50-54	Nil	Nil
Lindsey Scott, Chief Nurse and Director of Governance (until 22 March 2009)	95-99	Nil	Nil
Paul Mapson, Director of Finance	105-109	Nil	Nil
Irene Scott, Chief Operating Officer (from 11/03/08)	95-99	Nil	Nil
Robert Woolley, Director of Corporate Development	95-99	Nil	Nil
Alex Nestor, Acting Director of Workforce and Organisational Development (from 3 November 2008)	35-39	Nil	Nil
Patricia Fields, Acting Chief Nurse (from 23 March 2009)	0-4	Nil	Nil
Non-executive Directors			
Iain Fairbairn	10-14	Nil	Nil
Lisa Gardner	10-14	Nil	Nil
Patsy Hudson	10-14	Nil	Nil
Selby Knox	10-14	Nil	Nil
Emma Woollett	10-14	Nil	Nil
Kelvin Blake (from 1 November 2008)	5-9	Nil	Nil
Paul May (from 1 November 2008)	5-9	Nil	Nil

Pensions Disclosures of Directors

Name and title	Real increase in pension at age 60 at 31 March 2009 (bands of £2,500)	Real increase in lump sum at age 60 at 31 March 2009 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2009 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2009 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2009 £000	Cash Equivalent Transfer Value at 31 May 2008 £000	Real increase in Cash Equivalent Transfer Value £000	Employer funded contribution to growth in CETV £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 Nov 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

University Hospitals Bristol NHS Foundation Trust

Accounts for the 10 months ended 31 March 2009

FOREWORD TO THE ACCOUNTS

These accounts for the 10 months ended 31st March 2009 have been prepared by University Hospitals Bristol NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Services Act 2006.

Graham Rich
Chief Executive

Income and Expenditure Account for the 10 months ended 31 March 2009

	Note	10 months ended 31 March £'000
Income from activities	3	293,632
Other operating income	4	87,018
Operating expenses	5-7	(362,065)
Operating surplus		**18,585**
Loss on disposal of fixed assets	8	(58)
Surplus before interest		**18,527**
Finance income	9.1	901
Finance costs	9.2	(705)
Surplus for the period		**18,723**
Public Dividend Capital dividends payable		(9,217)
Retained surplus for the period		**9,506**

All income and expenditure is derived from continuing operations.
The notes on pages 60 to 75 form part of these Accounts.

Balance sheet as at 31 March 2009

	Note	31 March 2009 £'000	1 June 2008 £'000
Fixed assets			
Intangible assets	10	2,565	2,834
Tangible assets	11	353,158	366,971
Investments	14.1	–	–
		355,723	**369,805**
Current assets			
Stock and work in progress	12	5,624	5,463
Debtors	13	21,703	25,156
Investments	14.2	–	7,555
Cash at bank and in hand	18.3	33,321	11,246
Total current assets		**60,648**	**49,420**
Creditors: amounts falling due within one year	**15.1**	**(51,538)**	**(41,030)**
Net current assets		9,110	8,390
Total assets less current liabilities		364,833	378,195
Creditors: Amounts falling due after more than one year	15.1	(6,446)	(13,648)
Provisions for liabilities and charges	16	(622)	(1,887)
Total assets employed		**357,765**	**362,660**
Financed by: taxpayers' equity			
Public dividend capital	17.2	183,958	169,015
Revaluation reserve	17.3	121,971	149,156
Government grant reserve	17.3	–	480
Donated asset reserve	17.3	13,302	14,811
Other reserves	17.3	85	85
Income and expenditure reserve	17.3	38,449	29,113
Total taxpayers' equity		**357,765**	**362,660**

The financial statements on pages 58 to 75 were approved by the Board on 5 June 2009 and signed on its behalf by:

Graham Rich
Chief Executive

Statement of Total Recognised Gains and Losses 10 months ended 31 March 2009

	10 months ended 31 March 2009 £'000
Surplus for the period before dividend payments	18,723
Fixed asset impairment losses	(28,190)
Unrealised deficit on fixed asset revaluations	(191)
Increases in the donated assets reserve due to receipt of donated assets	532
Reduction in the donated asset reserve due to the depreciation, impairment and disposal of donated assets	(1,036)
Other recognised gains and losses	21
Total recognised gains and losses recognised in the 10 month period	**(10,141)**

Cash Flow Statement for the 10 months ended 31 March 2009

	Note	10 months ended 31 March 2009 £'000
Operating activities		
Net cash inflow from operating activities	**18.1**	**47,218**
Returns on investments and servicing of finance		
Interest received		613
Interest paid		(374)
Interest element of finance leases		(483)
Net cash outflow from returns on investments and servicing of finance		**(244)**
Capital expenditure		
Payments to acquire tangible fixed assets		(28,213)
Receipts from sale of tangible fixed assets		62
Net cash outflow from capital expenditure		**(28,151)**
Dividends paid		(11,061)
Net cash inflow before management of liquid resources and financing		**7,762**
Management of liquid resources		
Realisation of current asset investments		7,000
Net cash inflow from management of liquid resources		**7,000**
Net cash inflow before financing		**14,762**
Financing		
New public dividend capital received		17,027
Public dividend capital repaid		(2,084)
Other loans repaid		(7,500)
Capital element of finance lease rental payments		(92)
Net cash inflow from financing		7,351
Increase in cash		**22,113**

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 2008/09 NHS Foundation Trust Financial Reporting Manual issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) 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.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS foundation trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report 'earnings per share' or historical profits and losses.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector. Activities are considered to be 'discontinued' where they meet all of the following conditions:

a. the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;

b. if a termination, the former activities have ceased permanently;

c. the sale or termination has a material effect on the nature and focus of the reporting NHS foundation trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the NHS foundation trust's continuing operations; and

d. the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes. Operations not satisfying all these conditions are classified as continuing.

1.3 Income recognition

Income is accounted for applying the accruals convention. The main source of income for the trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income for partially completed spells is calculated on a pro-rata basis based on expected length of stay.

1.4 Pooled Budgets

The Trust has entered into a Pooled Budget arrangement with Bristol PCT, North Bristol NHS Trust and Bristol City Council, for the management and prevention of delayed discharges from hospital. Under the arrangement funds are pooled under Section 31 of the Health Act 1999. The Pool is hosted by Bristol City Council.

The Trust makes no contributions to the Pool Fund but receives income in the form of reimbursement payments which are paid where the level of delayed discharges exceeds an agreed threshold.

A Memorandum Note of Accounts, detailing the joint income and expenditure of the Pooled Budget, is prepared by Bristol City Council and included in the Council's Statutory Annual Accounts.

1.5 Expenditure

Expenditure is accounted for by applying the accruals convention.

1.6 Tangible fixed assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs, such as installation, directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

Land and buildings

All land and buildings are revalued using professional valuations in accordance with Financial Reporting Standard 15 every five years. 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 2004 as at the prospective valuation date of 1 April 2005. The revaluation undertaken at that date was accounted for on 31 March 2005.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non–specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Additional alternative open market value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Assets in the course of construction are valued at cost and are 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 balance sheet 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 values are updated annually using appropriate indices to reflect current value (net current replacement cost).

Equipment surplus to requirements is valued at the net recoverable amount.

Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land, and assets surplus to requirements.

Assets in the course of construction and residual interests in off-balance sheet 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 life of the asset as assessed by the NHS foundation trust's professional valuers. Leaseholds are depreciated over the primary lease term.

Assets are depreciated on a straight line basis over their estimated useful lives as follows:

Engineering plant and equipment	15
Medium and long life medical equipment	10
Set up costs in new buildings	10
Mainframe information technology installations	8
Vehicles	7
Furniture	7
Soft furnishings	7
Short life medical and other equipment	5
Office and information technology equipment	5

Fixed asset impairments resulting from losses of economic benefits are charged to the income and expenditure account. All other impairments are taken to the revaluation reserve and reported in the statement of total recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset. Any remaining impairment is recognised in the income and expenditure account, except where the carrying value is lower than the recoverable amount (higher of net realisable value and value in use), in which case the remaining impairment is also taken to the revaluation reserve (this could leave a negative reserve for a particular asset).

1.7 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use (except for emissions allowances – see note below) are valued at historical cost and are amortised over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the licence and their useful economic lives.

Allowances granted under the EU greenhouse gas emissions scheme are held at market value. Changes to market value are recognised directly within reserves, except for impairments which are recognised in the income and expenditure account. Allowances are used to extinguish emission liabilities arising under the scheme and are therefore not amortised.

1.8 Donated fixed 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.

1.9 Liquid Resources

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cashflow statement. The Trust does not hold any investments with maturity dates exceeding one year from the date of purchase.

1.10 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 Income and Expenditure account to match that expenditure. Where the grant is used to

fund capital expenditure the grant is held as deferred income and released to the income and expenditure account over the life of the asset on a basis consistent with the depreciation charge for that asset.

1.11 Private Finance Initiative (PFI) transactions

The NHS follows HM Treasury's Technical Note 1 (Revised) 'How to Account for PFI transactions' which provides definitive guidance for the application of application note F to FRS 5.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI payments are recorded as an operating expense. Where the trust has contributed land and buildings, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the income and expenditure account. Where, at the end of the PFI contract, a property reverts to the trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset. Where the balance of risks and rewards of ownership of the PFI property are borne by the trust, it is recognised as a fixed asset along with the liability to pay for it which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

1.12 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. Work-in-progress comprises goods and services in intermediate stages of production. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks.

1.13 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the NHS foundation trust's cash book. These balances exclude monies held in the NHS foundation trust's bank account belonging to patients (see 'third party assets' below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, 'interest receivable' and 'interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.14 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to its technical feasibility and its resulting in a product or services that will eventually be brought into use; and
- adequate resources exist, or are reasonably expected to be available, to enable the project to becompleted and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, NHS foundation trusts disclose the total amount of research and development expenditure charged in the Income and Expenditure account separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed. Fixed assets acquired for use in research and development are amortised over the life of the associated project.

1.15 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet 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.

1.16 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 21 where an inflow of economic benefits is probable. Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in note 21 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.

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 16.

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.

1.17 Pension costs

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 on the NHS Pensions website at 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 the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme under FRS 17: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

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 income and expenditure account at the time the trust commits itself to the retirement, regardless of the method of payment.

1.18 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.

1.19 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 conjunction with the HMR&C website. As a result of this review the Trust has concluded that there is no corporation tax liability for the period ended 31 March 2009.

1.20 Foreign exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the income and expenditure account.

1.21 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 a separate note to the accounts in accordance with the requirements of the HM Treasury Financial Reporting Manual.

1.22 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 a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. 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 interest element of the finance lease payment is charged to the income and expenditure account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the income and expenditure account on a straight-line basis over the term of the lease.

1.23 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 original NHS trust. 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 real 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 mean of opening and closing relevant net assets.

1.24 Losses and Special Payments

Losses and Special Payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and Special Payments are charged to the relevant functional headings in the Income and Expenditure Account on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, note 29 is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.25 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows 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 income and expenditure account.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: cash at bank and in hand, 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 income and expenditure account.

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 balance sheet 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. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised in reserves are included in the income and expenditure account.

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 the income and expenditure account.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from reference to 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 prices obtained in actual market transaction, the Trust should use that technique.

Impairment of financial assets
At the balance sheet date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' is 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 cashflows of the asset.

It is the Trust's policy to make provision for potential bad debts. An assessment is made by using estimation techniques based on previous experience and prevailing economic conditions. Such techniques involve an aged analysis of the Trust's outstanding debtors. In addition, individual assessments are made on long outstanding significant debts.

2. SEGMENTAL ANALYSIS

University Hospitals Bristol NHS Foundation Trust only operates within the Healthcare segment and is therefore not required to complete Note 2 to the Accounts.

3. INCOME

3.1 Income from activities

	10 months ended 31 March 2009 £'000
NHS Trusts	23
Primary Care Trusts	263,328
Department of Health – other	21,615
NHS injury scheme	567
NHS Other	70
Non-NHS:	
– Private patients	1,710
– Overseas patients (non-reciprocal)	53
– Other	*6,266
Total	**293,632**

*Material items comprise: income from Non NHS Territorial Bodies £6.25m.

The NHS injury scheme is subject to a provision for doubtful debts of 7.8% to reflect expected rates of collection.

3.2 Mandatory and non mandatory split of income from activities

Of the total income from activities, £288.348m is mandatory and £5.284m is non-mandatory.

3.3 Private Patient Cap

	10 months ended 31 March 2009 £'000	2002/03 £'000
Private patient income	1,710	2,341
Total patient income	293,632	209,031
Proportion	0.6%	1.1%

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 Trust's Private Patient Cap has not been exceeded in the 10 months ended 31 March 2009.

4. OTHER OPERATING INCOME

	10 months ended 31 March 2009 £'000
Research and development	6,057
Education training and research	31,505
Charitable and other contributions to expenditure	518
Transfers from the donated asset reserve	1,036
Non-patient care services to other bodies	39,822
Other	8,080
Total	**87,018**

5. OPERATING EXPENSES

5.1 Operating expenses comprise:

	10 months ended 31 March 2009 £'000
Services from other NHS Foundation Trusts	197
Services from NHS Trusts	4,064
Services from other NHS bodies	3,547
Purchase of healthcare from non NHS bodies	2,571
Executive Directors costs	970
Non-Executive Directors costs	127
Staff costs	232,193
Drug costs	26,189
Supplies and services:	
– Clinical	34,015
– General	5,369
Establishment	6,732
Research and development	–
Transport	301
Premises	13,104
Bad debts	(234)
Depreciation and amortisation	14,672
Fixed asset impairments	61
Auditor's remuneration:	
– Audit services – statutory audit	67
– Other services	18
Clinical negligence	2,769
Other	15,333
Total	**362,065**

There is no limitation of liability in respect of audit services.

5.2 Operating Leases

Operating expenses include:	10 months ended 31 March 2009 £'000
Hire of plant & machinery	121
Other operating lease rentals	211
Total	**332**

There are no non-cancellable operating leases for land and buildings. Annual commitments under non-cancellable operating leases are as follows:

Operating leases which expire:	Other Leases 31 March 2009 £'000
Within 1 year	12
Between 1 and 5 years	221
After 5 years	–
Total	**233**

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:

	10 months ended 31 March 2009 £'000
Salaries & wages	179,360
Social security costs	19,056
Employer contributions to NHSPA	25,633
Agency contract staff	9,359
Total	**233,408**

6.2 Average Number of Employees

	10 months ended 31 March 2009 No
Medical and dental staff	873
Ambulance staff	–
Administration and estate staff	1,520
Healthcare assistant & other support staff	705
Nursing, midwifery & health visiting staff	2,477
Nursing, midwifery & health visiting learners	4
Scientific, therapeutic and technical staff	1,096
Social care staff	–
Bank and agency staff	449
Total	**7,124**

Numbers are expressed as average whole time equivalents for the period. The total employer pension contribution for the 10 month period was £ 25.633m.

6.3 Employee Benefits

There were no non-pay benefits that were not attributable to individual employees.

6.4 Management Costs

	10 months ended 31 March 2009 £'000
Management costs	13,737
Income	380,650
Percentage of Income	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 10 months ended 31 March 2009 there were 14 early retirements from the Trust on the grounds of ill health The estimated additional pension liabilities of these ill-health retirements will be £0.646m . The cost of these ill health retirements will be borne by the NHS Business Services Authority – Pensions Division.

7. BETTER PAYMENT PRACTICE CODE

7.1 Measure of Compliance

	Number	10 months ended 31 March 2009 £'000
Total Non NHS trade invoices paid in the period	164,295	153,269
Total Non NHS trade invoices paid within target	145,624	138,608
Percentage of Non NHS trade invoices paid within target	88.6%	90.4%
Total NHS trade invoices paid in the period	3,135	38,536
Total NHS trade invoices paid within target	2,484	32,948
Percentage of NHS trade invoices paid within target	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 £0.002m arising from claims made under this legislation in the period ended 31 March 2009. No other compensation was paid to cover debt recovery cost under this legislation for this period.

8. LOSS ON DISPOSAL OF FIXED ASSETS

The loss on the disposal of fixed assets 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

	10 months ended 31 March 2009 £'000
Interest on loans and receivables	473
Other	428
Total	**901**

9.2. Finance costs

	10 months ended 31 March 2009 £'000
Department of Health loan	300
Finance leases	403
Other	2
Total	**705**

10. INTANGIBLE FIXED ASSETS

	Software licences £000	Other £000	Total £000
Cost at 1 June 2008			
Opening balance adjustment	3,016	–	3,016
	–	555	555
Revised opening balance	3,016	555	3,571
Disposals	–	(76)	(76)
Fair value adjustment	–	(191)	(191)
Cost at 31 March 2009	**3,016**	**288**	**3,304**
Accumulated amortisation at 1 June 2008	182	–	182
Impairments	–	61	61
Charged during the year	496	–	496
Disposals	–	–	–
Accumulated amortisation at 31 March 2009	**678**	**61**	**739**
Net book value at 31 March 2009			
Purchased	2,338	227	2,565
Total net book value at 31 March 2009	**2,338**	**227**	**2,565**

At 1 June 2008 emission allowances granted under the EU Emissions Trading Scheme were reclassified from current asset investments to intangible assets 'other'. These allowances are held at market value.

11. TANGIBLE FIXED ASSETS

	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 June 08	**42,577**	**234,971**	**6,983**	**47,404**	**79,434**	**696**	**15,303**	**1,924**	**429,292**
Additions – purchased	–	1,137	–	24,539	1,800	73	592	–	28,141
Additions – donated	–	–	–	–	532	–	–	–	532
Impairments	(4,116)	(23,071)	(1,003)	–	–	–	–	–	(28,190)
Reclassifications	–	4,664	30	(4,927)	203	–	30	–	–
Other in year revaluation	–	–	–	–	–	–	–	–	–
Disposals	(120)	–	–	–	(561)	–	–	–	(681)
At 31 March 2009	**38,341**	**217,701**	**6,010**	**67,016**	**81,408**	**769**	**15,925**	**1,924**	**429,094**
Accumulated depreciation at 1 June 08	**–**	**–**	**–**	**–**	**51,855**	**476**	**8,942**	**1,048**	**62,321**
Charged during the year	–	8,119	298	–	4,516	35	1,187	21	14,176
Impairments	–	–	–	–	–	–	–	–	–
Reversal of Impairments	–	–	–	–	–	–	–	–	–
Reclassifications	–	–	–	–	–	–	–	–	–
Other in year revaluation	–	–	–	–	–	–	–	–	–
Disposals	–	–	–	–	(561)	–	–	–	(561)
At 31 March 2009	**–**	**8,119**	**298**	**–**	**55,810**	**511**	**10,129**	**1,069**	**75,936**
Net book value at 31 March 2009									
– Purchased	38,341	200,117	5,712	67,016	22,057	258	5,758	598	339,857
– Donated	–	9,465	–	–	3,541	–	38	257	13,301
Total at 31 March 2009	**38,341**	**209,582**	**5,712**	**67,016**	**25,598**	**258**	**5,796**	**855**	**353,158**

11. TANGIBLE FIXED ASSETS CONTINUED

The Trust completed an internal review of the market value for land, buildings and dwellings at 31 March 2009. Following discussions with the District Valuer, the Trust revised its valuations for these areas to reflect current market conditions, using the following indices:

	Original	Revised
Buildings	271	245
Land	122	110

There was a resulting impairment of £26.982m which has been charged directly to the revaluation/donated asset reserve. An external valuation of these assets will be completed in the year ended 31 March 2010. The District Valuer completed a revaluation of the Milne Centre at 31 March 2009 resulting in an impairment of £1.208m, which has been charged to the revaluation reserve.

Of the totals at 31 March 2009, £0.610m related to land valued at open market value and £1.258m related to buildings, installations and fittings valued at open market value. There were no dwellings valued at open market value.

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.

The net book value of assets held under finance leases and hire purchase contracts at 31 March 2009 was:

Net book value	Buildings excluding dwellings £'000	Total £'000
At 31 March 2009	6,499	6,499

The total amount of depreciation charged to the income and expenditure in respect of assets held under finance lease and hire purchase contracts at 31 March 2009 was:

Depreciation	Buildings excluding dwellings £'000	Total £'000
Depreciation 31 March 2009	303	303

The net book value of land, buildings and dwellings at 31 March 2009 comprises:

	31 March 2009 £'000
Freehold	247,136
Long leasehold	6,499
Total	**253,635**

	£'000
Protected assets	96,554
Non-protected assets	157,081
Total	**253,635**

12. STOCKS AND WORK IN PROGRESS

	31 March 2009 £'000
Raw materials and consumables	5,624
Total	**5,624**

13. DEBTORS

Amount falling due within one year:	31 March 2009 £'000
NHS debtors	8,868
Other debtors	6,669
Provision for irrecoverable debts	(1,314)
Prepayments and accrued income	6,740
Total falling due within one year	20,963
Amounts falling due after more than one year:	
Other debtors	790
Provision for irrecoverable debts	(50)
Total falling due after more than one year	740
Total	**21,703**

Provision for irrecoverable debts (impairment of receivables):	31 March 2009 £'000
Balance at 1 June 2008	1,216
New provisions	389
Utilised in period	(70)
Reversed in period	(171)
Balance at 31 March 2009	1,364

Ageing of impaired debtors:	31 March 2009 £'000
By up to three months	153
By three to six months	231
By more than six months	980
Total	**1,364**

Ageing of non-impaired debtors past their due date:	31 March 2009 £'000
By up to three months	3,999
By three to six months	187
By more than six months	497
Total	**4,683**

14. INVESTMENTS

14.1 Fixed Asset Investments

The Trust held no fixed assets investments during the period.

14.2 Current Asset Investments

	EU Emissions £'000	Dept of Health £'000	Total £'000
Balance at 1 June 2008	555	7,000	7,555
Opening balance reclassification	(555)	–	(555)
Disposals	–	(7,000)	(7,000)
Balance at 31 March 2009	**–**	**–**	**–**

Allowances issued under the European Union Emissions Trading Scheme were reclassified as intangible assets at 1 June 2008. Short term investments are arranged through the Department of Health within its National Loans Fund.

15. CREDITORS

15.1 Creditors at the 31 March 2009:

	31 March 2009 £'000
Amounts falling due within one year:	
NHS creditors	11,596
Capital creditors	1,609
Other tax and social security costs	6,223
Obligations under finance leases and hire purchase contracts	116
Other creditors	9,899
Accruals and deferred income	22,095
Total falling due within one year	**51,538**
Amounts falling due after more than one year:	
Obligations under finance leases and hire purchase contracts	6,446
Total falling due after more than one year	**6,446**
Total	**57,984**

Other creditors include £3.374m relating to outstanding pension contributions.

15.2 Long-term Loans

The Trust's Department of Health working capital loan was repaid in full during the period (balance at 1 June 2008 £7.5m). The loan was originally taken out over a 20 year period commencing on 22 March 2007. There were no charges for early repayment.

15.3 Finance Lease Obligations

Payable:	31 March 2009 £'000
Within one year	575
Between one and two years	575
Between two and five years	1,725
After five years	8,294
Sub-Total	11,169
Less finance charges allocated to future periods	(4,607)
Net Obligation	**6,562**

15.4 Finance Lease Commitment

There are no finance lease commitments at 31 March 2009.

16. PROVISIONS FOR LIABILITIES AND CHARGES

	Legal Claims £'000	Other £'000	Total 31 March 2009 £'000
At 1 June 2008	500	1,387	1,887
Arising during the period	157	115	272
Utilised during the period	(110)	(456)	(566)
Reversed unused	(28)	(922)	(950)
Market value adjustment	–	(21)	(21)
At 31 March 2009	**519**	**103**	**622**
Expected timing of cashflows:			
Within 1 year	223	103	326
1 – 5 years	96	–	96
Over 5 years	200	–	200
Total	**519**	**103**	**622**

16.1 Legal Claims

The provision at 31 March 2009 comprises:

a) Provision for Staff Injuries
A staff injuries provision of £0.321m 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 £0.198m representing the excess payable by the Trust, under the NHS Litigation Authority (NHSLA) Liabilities to Third Parties Scheme.

16.2 Other Provisions

Other provisions at 31 March 2009 of £0.103m relate to the charge for carbon emissions under the EU Emissions Scheme.
This provision is stated at market value.

16.3 Clinical Negligence

Included in the provisions of the NHS Litigation Authority is £31.284m at 31 March 2009 in respect of Clinical Negligence liabilities of the Trust.

17. TAXPAYERS' EQUITY

17.1 Movements in taxpayers' equity

	31 March 2009 £'000
Taxpayers' equity 01 June 2008	362,660
Opening balance adjustment	(480)
Revised opening balance	362,180
Surplus for the period	18,723
Public Dividend Capital dividend paid	(9,217)
Fixed asset impairments	(28,190)
Surplus on revaluation of fixed assets	(170)
New Public Dividend Capital received	17,027
Public Dividend Capital repaid	(2,084)
Reduction on donated asset reserve	(504)
Taxpayers' equity at 31 March 2009	**357,765**

The opening balance adjustment relates to the reclassification of the Government Grant reserve to deferred income, following conversion to a Foundation Trust.

17.2 Movements in Public Dividend Capital

	31 March 2009 £'000
Public Dividend Capital at 01 June 2008	169,015
New Public Dividend Capital received	17,027
Public Capital Dividend repaid	(2,084)
Public Dividend Capital at 31 March 2009	**183,958**

17.3 Movements on Reserves

	Revaluation Reserve £'000	Donated Asset Reserve £'000	Government Grant Reserve £'000	Other Reserves £'000	Income & Expenditure Reserve £'000	Total £'000
At 01 June 2008	149,156	14,811	480	85	29,113	193,645
Opening balance adjustment on conversion to Foundation Trust	–	–	(480)			(480)
Restated opening balance	149,156	14,811	–	85	29,113	193,165
Transfer from the income and expenditure account	–	–	–	–	9,506	9,506
Fixed asset impairments	(27,185)	(1,005)	–	–	–	(28,190)
Deficit on revaluation of intangible assets	(191)	–	–	–	–	(191)
Transfer of realised profits to income & expenditure reserve	–	–	–	–	21	21
Receipt of donated assets	–	532	–	–	–	532
Transfer to income & expenditure account for depreciation of donated assets	–	(1,036)	–	–	–	(1,036)
Other transfers between reserves	191	–	–	–	(191)	–
At 31 March 2009	**121,971**	**13,302**	**–**	**85**	**38,449**	**173,807**

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.
- A miscellaneous reserve to accommodate rounding differences which arise during the production of the Trust's Accounts.

18. NOTES TO THE CASH FLOW STATEMENT

18.1 Reconciliation of operating surplus to net cash flow from operating activities

	10 months ended 31 March 2009 £'000
Total operating surplus	18,585
Depreciation & amortisation	14,672
Fixed asset impairments	61
Transfer from donated asset reserve	(1,036)
Increase in stocks	(161)
Decrease in debtors	3,368
Increase in creditors	12,994
Decrease in provisions	(1,265)
Net cash inflow from operating activities	**47,218**

18.2 Reconciliation of net cash flow to movement in net debt

	10 months ended 31 March 2009 £'000
Increase in cash in the period	22,113
Cash outflow from debt repaid & finance lease capital payments	7,576
Cash inflow from decrease in liquid resources	(7,000)
Change in net funds resulting from cash flows	22,689
Non-cash changes in debt	–
Change in net funds	22,689
Net funds at 1 June 2008	4,070
Net funds at 31 March 2009	**26,759**

18.3 Analysis of changes in net funds

	1 June 2008 £'000	Cash Flows £'000	Non Cash Changes £'000	31 March 2009 £'000
OPG cash at bank	11,189	22,012	–	33,201
Commercial cash at bank & in hand	57	63	–	120
Bank overdrafts	(38)	38	–	–
Loan from DH due within 1 year	(394)	394	–	–
Loan from DH due after 1 year	(7,106)	7,106	–	–
Finance leases	(6,638)	76	–	(6,562)
Current asset investments	7,000	(7,000)	–	–
Totals	**4,070**	**22,689**	**–**	**26,759**

The Trust's Department of Health Working Capital loan was repaid in full during the period.
The loan was originally taken out over a 20 year period commencing on 22 March 2007. There were no charges for early repayment.

19. CAPITAL COMMITMENTS

Commitments under capital expenditure contracts at 31 March 2009 were £5.560m, comprising:

– The Bristol Heart Institute £4.550m, to be financed from Public Dividend Capital

– Information Management and Technology Hub relocation £1.010m, to be financed from Trust capital

20. POST-BALANCE SHEET EVENTS

There are no post-balance sheet events that have a material impact on the Trust's Accounts necessitating disclosure or adjustment to the Accounts.

21. CONTINGENCIES

21.1 Contingent Assets

The Trust has no contingent assets at 31 March 2009.

21.2 Contingent Liabilities

Contingent liabilities at 31 March 2009 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 relating 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.

22. PRUDENTIAL BORROWING CODE

The Trust is required to comply and remain within the Prudential Borrowing Limit (PBL). This is made up of two elements:

– the maximum cumulative amount of long-term borrowing. This is set by reference to the five 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.

– 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.

The Trust has a prudential borrowing limit of £88.65m at 31 March 2009 (maximum long term borrowing of £56.9m and an approved working capital facility of £31.75m). The Trust repaid its long term loan with the Department of Health during the period and at 31 March 2009 had £NIL outstanding long term borrowings. At 31 March 2009 the Trust had utilised £NIL funds from its working capital facility.

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

Financial ratio	Actual ratios 10 months ended 31 March 2009	Approved PBL ratios 10 months ended 31 March 2009
Maximum debt/capital ratio	2%	25%
Minimum dividend cover	3.9x	1x
Minimum interest cover	51.1x	3x
Minimum Debt service cover	5.1x	2x
Maximum debt service to revenue	1.9%	3%

At 31 March 2009 the Trust is performing within all of the approved PBL ratios.

23. RELATED PARTY TRANSACTIONS

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. These entities are listed below, the figures unless otherwise stated relates to income.

Avon and Wiltshire Mental Health Partnership NHS Trust (£0.94m)
Bath and North East Somerset PCT (£11.41m)
Cornwall and the Isles of Scilly (£2.45m)
Devon PCT (£4.75m)
Dorset PCT (£0.99m)
East of England SHA (Expenditure £0.51m)
Gloucestershire PCT (£8.54m)
Gloucestershire Hospital NHS Foundation Trust (£0.59m expenditure)
Great Western Ambulance Service NHS Trust (£1.56m expenditure)
Hampshire PCT (£0.71m)
Health Protection Agency (£2.1m expenditure)
Health Commission Wales (£4.35m)
London SHA (£0.48m)
NHS Blood and Transplant (£4.47m expenditure)
NHS Bristol PCT (£135.22m and £9.09m expenditure)
NHS Bristol SWSCG (£19.82m)
NHS Litigation Authority (£2.77m expenditure)
NHS Supply Chain (£6.12m expenditure)
North Bristol NHS Trust (£5.17m and £4.78m expenditure)
NHS Business Service Authority Pension Division (£25.63m expenditure)
North Somerset PCT (£35.46m)
North West SHA (£7.25m)
Pennine Acute Hospitals NHS Trust (£0.44m expenditure)
Plymouth Teaching PCT (£0.78m)
Royal United Hospitals Bath Trust (£0.45m and £0.52m expenditure)
Somerset PCT (£17.02m)
South Gloucestershire PCT (£27.71m)
South West SHA (£28.19m)
Southeast Essex PCT (£0.46m)
Swindon PCT (£2.67m)
Taunton and Somerset NHS Foundation Trust (£0.58m expenditure)
Torbay Care Trust (£0.71m)
Weston Area Health NHS Trust (£1.51m and £0.61m expenditure)
Wiltshire PCT (£6.62m)
Yorkshire and the Humber SHA (£1.88m)

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:

HM Revenue and Customs (£60.16m)
University of Bristol (£2.2m and £5.61m expenditure)

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

24. PRIVATE FINANCE TRANSACTIONS

At 31 March 2009 the Trust has no PFI schemes.

25. POOLED BUDGET PROJECTS

The Trust is party to a Pooled Budget arrangement with NHS Bristol, 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 31 of the Health Act 1999. 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 10 months ended 31 March 2009 the total income amounted to £0.009m.

A Memorandum Note of Accounts for the Pooled Fund is prepared by Bristol City Council and included in the Council's Statutory Annual Accounts.

26. 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 Trust's 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. 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 March 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 22.

26.1 Financial Instruments by currency

Financial Assets Currency	Total £000
At 31 March 2009	
Denominated in Sterling	53,147
Total	**53,147**

Financial Liabilities Currency	Total £000
At 31 March 2009	
Denominated in Sterling	37,722
Total	**37,722**

The Trust has negligible foreign currency income or expenditure.

26.2 Financial instruments by category

Financial assets per balance sheet	Total 31 March 2009 £'000	Loans and receivables £'000
NHS debtors	8,868	8,868
Other debtors	7,459	7,459
Accrued income	4,863	4,863
Provision for irrecoverable debts	(1,364)	(1,364)
Cash at bank and in hand	33,321	33,321
Total at 31 March 2009	**53,147**	**53,147**

Loans and receivables are held at amortised cost.

Financial liabilities per balance sheet	Total 31 March 2009 £'000	Other Financial Liabilities £'000
NHS creditors	11,596	11,596
Capital creditors	1,609	1,609
Other creditors	9,899	9,899
Accruals	8,056	8,056
Finance lease obligations	6,562	6,562
Total at 31 March 2009	**37,722**	**37,722**

Other financial liabilities are held at amortised cost.

26.3 Fair Values

As at 31 March 2009 there is no significant difference between the fair value and the carrying value of any of the Trust's financial instruments.

26.4 Maturity of financial assets

	31 March 2009 £'000
Less than one year	52,407
In more than one year but not more than two years	740
Total	**53,147**

Financial assets due after one year of £0.740m relate to amounts due in respect of the NHS injury scheme.

26.5 Maturity of financial liabilities

	31 March 2009 £'000
Less than one year	31,276
In more than one year but not more than two years	140
In more than two years but not more than five years	564
In more than five years	5,742
Total	**37,722**

27 THIRD PARTY ASSETS

At 31 March 2009 the Trust held £NIL cash at bank and in hand which relates to monies held by the Trust on behalf of patients.

28 Intra-Government Balances

	Debtors: amounts falling due within one year £'000	Debtors: amounts falling due after more than one year £'000	Creditors: amounts falling due within one year £'000	Creditors: 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 CGA bodies	7	–	227	–
NHS WGA bodies	7	–	207	–
TOTAL NHS	**8,868**	**–**	**11,596**	**–**
Other WGA bodies	1,131	–	6,399	–
TOTAL at 31 March 2009	**9,999**	**–**	**17,995**	**–**

29 Losses and Special Payments

There were 487 cases of losses and special payments totalling £0.096m paid during the period ended 31 March 2009.

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 I met on a weekly basis with the Chairman and reported on a monthly basis to the Board. In addition I met regularly at Chief Executive Officer level with the lead commissioning Primary Care Trust for 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 2008 and monthly financial and operational reviews have been undertaken with all divisions.

The Board approved the Trust's income and expenditure budget in April 2008. The reported surplus for the ten months to 31st March 2009 is £9.506 m. This surplus together with the surplus achieved for the two months to 31st May 2008 (as an NHS Trust) is greater than the planned surplus underpinning the Trust's Integrated Business Plan.

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 2008/09 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 in excess of £15m. For 2009/10 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 reviewed its liquidity position throughout 2008/09 and has repaid £7.5m being the balance of the Department of Health loan. The availability of cash resources and the movement during the latter part of the year to a situation where there was an adverse position on relative rates of interest payable and receivable made it commercially appropriate to bring forward the repayment of the loan principal. This is one year earlier than had been planned in the Integrated Business Plan.

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 10-months ended 31 March 2009 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 in public session and to the Audit and 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 and 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. There are prepared monthly Integrated Performance Reports on the Trust's governance and assurance activities and these are considered by the Board.

B. Risk management:
During the ten months ending 31 March 2009 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 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 2008/2009 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 has completed a 2-year project with North Bristol Trust (Safer Patient 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. During 2008/2009 the Board members consolidated their learning on method and process of monitoring and managing risk. 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 approved by the Board, 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. During the 10-months ending 31 March 2009 further training of managers in the use of the Risk Register and Assurance Framework was undertaken and this work is ongoing in 2009/2010.

The Trust considered in detail the 2008/2009 Standards for Better Health and assessed critically the Trust's position against the standards for its declaration on compliance. The Assurance Framework for 2008/2009 was structured around these Standards and other key risks such as finance, information management and technology, planning and targets. The Risk Register uses categories linking risks to the Assurance Framework.

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. 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 routinely selects two Core Standards (chosen according to the focus of wider discussion and emerging issues) for closer scrutiny at each of its meetings. There has been extensive Board involvement in the process for gaining assurance leading to a final declaration at the Trust Board meeting held on 29 April 2009 for the Core Healthcare Standards throughout 2008/2009. This process for Board involvement will be continued in 2009/2010.

D. Involvement of public stakeholders:
During 2008/2009 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. Work continues to be undertaken in 2009/2010 to further strengthen involvement of public stakeholders.

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 2008/2009. Particular focus this year has been on encryption of laptops and other portable media thus ensuring the security of data held on these devices.

The Trust has used the Information Governance Toolkit to make year on year continuous improvements to its information governance arrangements. For 2008/9 the Trust was able to declare an overall score for the 62 elements of the Toolkit of 79%. The Trust recognises further improvements are necessary particularly in the area of Corporate Information Assurance and an action plan has been developed by the Information Governance Steering Group to address outstanding issues in 2009/2010. This group which is chaired by the Medical Director – who is the Senior Information Risk Officer (SIRO) for the Trust – meets regularly to review progress with improvement plans.

During 2008/2009, there have been no Serious Untoward Incidents within the Trust in relation to information governance; therefore there were no significant control issues.

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. Divisional Review meetings are 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.

During 2007/2008, the Trust benefited from the Healthcare Commission's Maternity Services Review, the aim of which was to inform the Trust about its performance compared with other comparable providers and to make recommendations where there is scope for quality or value for money improvements to be made. The Trust has also positively benefited from a review by the Department of Health's MRSA intensive support team in relation to the prevention and control of infection as a result of this visit.

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. In 2008/2009 the Audit Commission began work to undertake reviews on consultant productivity and ward staffing. These reviews would be concluded in 2009/2010.

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

6. 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 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.

There was extensive Board involvement in the process for gaining assurance on the Healthcare Standards for 2008/2009. Following review by the Governance and Risk Management Committee and Audit and Assurance Committee, the Trust Board met on 29 April 2009 and agreed a declaration for the Core Healthcare Standards throughout 2008/2009. The Trust Board agreed a declaration of 'compliance' for all Core Healthcare Standards, with the exception of Standard 4c Decontamination where a declaration of 'not met' was made.

The Core Standard Statement for Standard 4c Decontamination states that 'Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.'

Following review at the end of March 2009, the Executive Directors were made aware of areas of non-compliance with the Core Healthcare Standard 4c (Decontamination) and an urgent review and action was put in place to address these issues. The action plan, produced at the end of March 2009, has target dates set within the first quarter of 2009/2010.

At its meeting on 29 April 2009, the Board received and considered a range of evidence which included the standard statement, the related requirements within the Code of Practice for the NHS on the Prevention and Control of Healthcare Associated Infections and presented the current position against the seven elements of the Healthcare Commission inspection guide for 2007/2008 for each of the areas in the Trust undertaking decontamination activities. The Board considered that the evidence demonstrated some aspects of the responsibility and reporting structure which needed to be improved and implementation of appropriate testing schedules was not in place in some areas. Although action had been taken in March 2009 (in-year), completion of these actions could not be evidenced to state compliance in 2008/2009. There were no significant lapses or evidence of failure of decontamination or of patient harm. Therefore a declaration of 'not-met' was agreed for Standard 4c Decontamination.

The Head of Internal Audit's overall opinion for the ten months ending 31 March 2009 is that significant assurance can be given and that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

I have also received assurances as a result of inspections, audits and reviews by a number of national and professional bodies including the Audit Commission who have conducted a number of reviews, the medical Royal Colleges who have considered clinical areas specifically, as well as external audits conducted in accordance with ISO 9000 accreditation of, for example, security services and the Medicines and Healthcare Products Regulatory Agency with respect to the manufacture and supply of medicines. The Trust participates in nationally organised benchmarking programmes. Importantly the Trust achieved Level III compliance with the maternity risk management standards under the National Health Service Litigation Authority in 2007/2008. The Trust can apply for re-assessment for Level III compliance with the maternity risk management standards in December 2009. 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 the ten months ending 31 March 2009 no significant control issues were identified other than in respect of Core Healthcare Standard 4c Decontamination as outlined in section 6 of this Statement.

Graham Rich
Chief Executive

Statement of the chief executive's responsibilities as the accounting officer of University Hospitals Bristol NHS Foundation Trust

The National Health Service 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 National Health Service Act 2006, Monitor has directed 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.
- 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.

Graham Rich
Chief Executive