University Hospitals Bristol NHS
NHS Foundation Trust

Annual Report and Accounts 2012-2013

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

1. Chairman's Statement

Welcome to the Annual Report and Accounts, including the Quality Report, for University Hospitals Bristol NHS Foundation Trust for the year from 1 April 2012 to 31 March 2013.

1.1 The National Perspective

It has been a momentous and challenging year for the whole of the NHS as we have all been preparing for, and implementing the changes brought in by the Health and Social Care Act 2012 (the Act), which have, and are being, commenced in stages. We have worked to ensure that we were ready for the main commencement on 1 April 2013, for example agreeing a revised Trust Constitution for adoption by the Trust Board of Directors (the Board) and the Council of Governors.

There has also been a necessary spotlight on quality of care as a result of the publication of two reports: the Department of Health's report on events at Winterbourne View and the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC (the 'Francis Report'). The Board will be reviewing all of Francis's recommendations to see what further improvements we can make to ensure that the interest of the patient is at the centre of all we do, and that our existing values, one of which promotes the theme 'Respecting Everyone', translate into compassionate care at all times.

1.2 Our Values

As an organisation we embrace the Nolan principles and public service values, as well as having our own. We rolled out our 'Living the values' training during the year to ensure that as well as setting out our values we are also doing all we can to embed them throughout the Trust. Results of a survey which reported in December 2012 confirmed that 94% of respondents were aware of our values, 80% were clear how they related to their role and 29% had changed the way they or their teams work as a result: an increase from 16% in the previous year. We want to do what we can to improve these figures so that the values become a code by which more and more staff consciously behave towards patients and each other.

1.3 Strategy and Risk

We continue with our strategy under the Transforming Care programme into the next financial year. Within this programme, the 'Delivering Best Care' work stream helps us to involve our patients and public more meaningfully, whilst 'Improving Patient Flow' includes vital improvements to the administration of outpatient services. These, and a host of other measures, will help to improve the quality and responsiveness of the Trust to the challenges that lie ahead whilst creating the best conditions for delivering value for the cost of our services. The Trust's departure point for strategic planning and objective setting is the NHS Constitution which was updated at the end of March 2013, so we will be reviewing the main changes to it (which include improved focus on candour with patients and integration of patient pathways) as part of our strategic discussions in the year ahead.

When we reviewed the Board's 'risk appetite', and its relevance to the fulfilment of our strategy, at the start of the financial year, the Board confirmed that it has zero tolerance for harm to patients and staff through any actions or omissions of the Trust[1]. The full Board Statement of Risk Appetite can

[1] Where clinical risks are known to be associated with treatment, these risks will be professionally assessed, understood, and discussed in full with patients and/or carers prior to commencement of any such treatment or procedure.

be found along with our principal risks set out in the Annual Governance Statement published in the Annual Accounts.

1.4 Governance – the Trust Board of Directors and the Council of Governors

The expanded role of the Council of Governors under the Health and Social Care Act 2012 has been one which we have been preparing for throughout the year, to ensure that from April 2013 we are ready not only to fulfil our duty of equipping our governors with the skills and knowledge they need, but also enabling them to fulfil their new statutory duties to hold the non-executive directors to account for the performance of the Board, and to represent the interests of the members, and the interests of the public.

As well as ensuring we comply with statutory requirements, it is the Board's stated intention to work as closely as possible with the Council of Governors on all matters of joint interest. To this end, after careful discussions with our governors, we have revised our annual cycle of business to include new formal mechanisms to support and enable our working together more frequently, and on a broader range of topics. New 'Project Focus Groups' have been designed to ensure the formal engagement of governors by the Board on matters of constitution (including membership), strategy and planning (including significant transactions - these are major transactions, as defined in our Trust Constitution from 1 April 2013, and require the prior approval of the Council of Governors) and reporting (including quality and performance monitoring and metrics). More details about our evolving ways of working, and changes to induction and development plans, can be found in the section on the Council of Governors on page 72.

The Board and the Council of Governors have also agreed a new code of conduct ('Governors Responsibilities and Code of Conduct') for adoption by the Council of Governors from 1 April 2013. The Board also signed up to the Professional Standards Authority's 'Standards for members of NHS Boards and Clinical Commissioning Group Governing Bodies in England'. This means that each member of the Board has committed to the highest standards of personal behaviour, and to seeking the highest standards in respect of both technical competence across the Trust and the Trust's business practices.

The requirement under the Act to hold Board meetings in public from April 2013 will not mark a departure for the Trust, as this is something we have been doing voluntarily since authorisation as a Foundation Trust. We hold as much of our business as we can in public, and during 2012/13 we have regularly had governors in attendance, and asking questions, at Board meetings. We have further reinforced this public accountability through the introduction of governors' questions for the Board as a standing agenda item at meetings of the Council of Governors.

The Board undertook its own development programme using eight Board development workshops during the year to cover a wide selection of topics, including: quality in the new NHS architecture, safeguarding, the Board performance assessment, integration of health services in Bristol, ethical fundraising, environmental sustainability, regulation and governance of NHS charities, procurement, staff appraisal and the new Monitor Compliance Framework and Risk Assessment Framework.

The Board and Council of Governors were pleased to welcome a new non-executive director during the year, Professor Anthony (Guy) Orpen. He brings with him exceptional expertise, and local understanding as can be seen from his biography on page 90. He replaces Professor Selby Knox whom, on behalf of the Board, Council of Governors, and wider Trust, I would like to thank for his hard work and contribution over the years.

I would also like to express my thanks, on behalf of the Trust, to two executive directors who left during the year, for their significant services to the Trust: Steve Aumayer as Director of Workforce and Organisational Development and Alison Moon, our Chief Nurse. We have two acting directors covering their roles at the time of writing; formal appointments will be made in respect of these directorships in the coming months.

It is generally accepted, as Lord Davies states in his 2011 report on 'Women on Boards', that 'boards perform better when they include the best people who come from a range of perspectives and backgrounds'. Lord Davies goes on to cite evidence that positively associates gender-diverse boards with improved performance. We want to ensure that our Board is of a composition that not only has the correct balance of executive to non-executive directors, but also delivers diversity of personal attributes, background and gender. Including the acting directors, at the close of the year, we can confirm that our Board was one third female. This can be viewed against Lord Davies's recommendation to FTSE 100 companies to aim for a minimum of 25% by 2015. Other aspects of diversity are subject to on-going review and full details are provided in our equality and diversity report on page 44.

We would also like to welcome our new external auditors, PwC, who were appointed by the Council of Governors during the year. Changing auditor is a healthy part of good governance practice and we look forward to their contribution. Further details can be found in our Audit Committee report on page 66.

1.5 The Local Perspective

From 1 April 2013 Clinical Commissioning Groups (CCGs) replace Primary Care trusts as the lead commissioner for services such as ours. The CCGs will be principally focused on a clinical view of the decisions that underpin the commissioning process. We look forward to this new era and the change in emphasis in the debate that we will have with those responsible for commissioning and funding the Trust.

The Trust participated in the South West Pay Terms and Conditions Consortium which was made up of 20 trusts across the South West. These trusts agreed to work together to explore different ways of rewarding and incentivising staff, while making better use of public money. The Trust's pay bill is more than 60% of our annual budget and it has therefore been essential to look at the money we spend on staff as part of our work to improve efficiency. Discussion of pay and conditions has also taken place at national level, but the Consortium has explored changes that could be made locally. Our approach has, and continues to be, to protect jobs whilst achieving the savings required in the current economic climate. As a result, there will be closer scrutiny of pay, terms and conditions in the months ahead in close consultation with trade unions and staff representatives.

The review of acute services in Bristol has been well documented in the press. A joint project group from North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust met several times in the year, surveying the landscape in some detail and considering all the options, but in the end it was clear that formal integration was unlikely to be achieved quickly inside the present competition framework. However, consideration of a wide range of issues has amplified the intention of both hospitals to work closely together and in partnership to improve clinical pathways where we can. Bristol needs and deserves seamless care for its patients and both Trust Boards are committed to this as a common aim.

On the redevelopment of our hospitals I would like to congratulate all those involved in the strategic development projects which we have seen progress this year, in particular construction of the new

ward block at the Bristol Royal Infirmary and the extension of Bristol Royal Hospital for Children to provide a specialist facility for the treatment of teenagers with cancer.

More on our performance in the year and the progress made against Transforming Care can be found in the Chief Executive's foreword on page 10 and our business review on page 17.

The coming year will present particular challenges both in terms of adapting to the new commissioning arrangements and dealing with continuing financial pressure to make further savings, but we are confident that good progress can be made in the year ahead.

As Chairman of the Trust I would like to offer my sincere thanks to all the charities that have contributed to our funding in the year, most particularly Above and Beyond and the Grand Appeal. I thank my fellow Board members, the Council of Governors and all staff for their contribution to achieving our overarching mission to provide patient care, education and research of the highest quality.

John Savage CBE

Chairman, 29 May 2013

2. Chief Executive's Foreword

2.1 Transforming Care

In 2011 we launched a major strategic programme called Transforming Care and as I reported last year the programme is based on the belief that redesigning services to give the best care to patients is the route to making taxpayers' resources go further, and that clinical teams across the Trust are best placed to identify opportunities for improvement and to lead the changes. The structure of the programme, with its six themes, pre-dates the recent recommendations made by Robert Francis QC in his final report about the failings at Mid Staffordshire NHS Foundation Trust. Whilst we need to carefully consider the detail of these recommendations, we are confident that they resonate with our current programme structure and this supports our view that Transforming Care remains appropriate for 2013/14.

In this report you will see how our services have evolved this year as a result of Transforming Care to improve the experience of patients and staff. I have provided highlights of our progress under the six themes below.

2.2 Delivering Best Care

The safety of our patients and the quality of our patient care is of paramount importance to us. On the headline indicator of patient safety, the Hospital Standardised Mortality Ratio, the Trust continued to score exceptionally well last year.

We also received various accolades for the quality of care experienced by our patients, and for clinical innovation. However, we held an 'amber-red' governance risk rating during each Quarter of the year, with a 'red' rating over-ride applied by Monitor for Quarter 3 arising from the failure to achieve the Accident and Emergency 4-hour standard and the annual target reduction in Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia cases. Following Monitor's review of the Trust's plans for recovery and its robust governance of the performance issues throughout the year, this over-ride was lifted.

Additionally, in Quarter 2, the Trust received a warning notice from the Care Quality Commission (CQC) relating to concerns about the adequacy of staffing within children's cardiac services (CQC Outcome 13), which resulted in a 'red' governance risk rating applied by Monitor. This was subsequently de-escalated to 'amber-red' by Monitor following confirmation that actions had been taken to address the issues identified through the CQC review and a subsequent re-inspection which confirmed that the Trust was compliant with Outcome 13 on the ward in question. We are not by any measure complacent, but I would like to reassure patients that despite these issues, we have among the best clinical outcomes for paediatric heart surgery in the country.

We have worked hard to increase the ratio of midwives and consultant obstetricians to births since maternity and midwifery was another area where levels of staffing were considered to be having an impact, albeit minor, on people using the service. We have also been working with neighbouring trusts to ensure that joint polices and protocols are in place to increase flexibility across the city. Again I can assure you that we have provided a safe service to mothers and babies and that the clinical indicators for our service are good.

The CQC inspections over the year have highlighted many areas of good practice of which we can be justly proud. We were particularly pleased that one report highlighted that our patients' privacy, dignity and independence were respected; their views taken into account in the way services were

provided and delivered, and that people's treatment and care were provided with best practice in mind.

More details about our CQC registration status can be found in the Quality Report and Annual Governance Statement.

While recognising the challenge we have faced with Accident and Emergency waiting times, in common with many other hospitals in England, it was nevertheless heartening to learn that the Bristol Royal Infirmary Emergency Department was rated as one of the top five of 147 trusts in the CQC's Accident and Emergency Patient Survey Report for 2012. This highlighted that the department was among the best nationally in ratings from patients for their care and treatment, for the doctors and nurses and their communication and listening skills, and for levels of information about aftercare.

I am also proud to report that 5 of the Trust's paediatric experts have been honoured in a list of 'Britain's Top 100 Children's Doctors' published by The Times. The doctors have been credited for their outstanding skills and contribution in the fields of cardiac surgery; neonatal medicine; oncology; rheumatology and chronic pain; and orthopaedics.

Best care is reliant on research and innovation. Collaboration between clinicians and scientists at the Bristol Heart Institute has enabled us to pioneer new techniques in treatment this year. In May 2012, as part of a clinical trial designed to discover a further treatment option for heart failure patients, our thoracic surgery team successfully implanted the first two patients in the UK with a vagal nerve stimulator – over a million adults in the UK suffer from heart failure so new treatments like this are needed to improve patients' symptoms and improve life expectancy. In December 2012, a team of cardiologists at the Institute were the first doctors in the South West of England to use neat alcohol to induce a controlled heart attack, allowing them to perform a procedure called ethanol ablation to treat a life threatening heart rhythm.

2.3 Improving Patient Flow

Enhancing patient flow through hospital brings benefits to patients in terms of more expeditious care while also helping the Trust improve efficiency. No matter how careful we are, hospitals can never be risk-free environments, and prolonged hospital stays can themselves lead to further complications for patients. The ultimate aim is that patients always receive the right care, in the right place, at the right time.

We have put significant effort into designing and implementing models of care which promote rapid diagnosis and assessment followed by admission when necessary into the appropriate specialist inpatient unit and well-planned discharge when ready, supported by optimal staffing at every stage and proactive management of clinical information and facilities. Further rollout of the patient flow programme will continue in 2013/14, including a new operating theatre schedule across the Trust.

I mentioned last year how an enhanced surgical recovery programme had delivered spectacular benefits for thoracic (chest) surgery patients and had improved the recovery times for patients undergoing lung cancer surgery. I am delighted that our Thoracic Surgery team at University Hospital Bristol won best in category for their work developing this programme at the first National Enhanced Recovery Summit in London. The enhanced surgical recovery programme is a key quality initiative as well as part of improving patient flow and now covers most surgical specialties in the Trust, with notable success in gynaecological oncology surgery at St Michael's Hospital.

Another major initiative is the productive outpatients programme, designed to improve the booking process for patients, improve communications and reduce the rate of hospital cancellation of clinic

appointments. We also aim to reduce the number of patients who do not attend their appointments, which can waste as much as 10% of all the clinic capacity across the Trust. While a lot of the work is about improving administrative processes at a local level, we have also started the centralisation of our booking arrangements so that patients can increasingly expect to receive a uniformly high standard of communication about their appointments.

We have implemented our new patient administration and electronic patient record system, Medway. The system brings together patient information from different clinical computer systems across the Trust into one place. This allows clinicians and managers quick and easy access to information that relates to the patient in one place (known as the clinical 'portal'). The system's reporting tools help clinical staff make more timely and better informed decisions which ultimately improves clinical outcomes and the quality of care provided to patients.

2.4 Delivering Best Value

The Transforming Care programme aims to achieve improvements in quality, efficiency and effectiveness, and sustainability of patient care, while also supporting a programme of financial savings. I review our use of resources in terms of economy, efficiency and effectiveness in more detail in the Annual Governance Statement published in the Annual Accounts.

I am pleased to report, however, that the Trust maintained a healthy financial position and a strong balance sheet for the Financial Year ended 31 March 2013. We were particularly pleased to achieve an income and expenditure surplus of £6.635m, cash releasing efficiency savings of £22.6m, a healthy cash position of £35.1m and a strong balance sheet resulting in a financial risk rating of three. The surplus we have made allowed us to continue our significant investment in the future of health care in Bristol with expenditure on capital schemes totalling £57.865m.

The financial results for 2012/13 confirm we have delivered the fifth year of our financial strategy as a Foundation Trust. In summary, a good result for 2012/13 but with a lot of work to be done in 2013/14 particularly on the delivery of managing service level agreement activity and cash releasing efficiency savings to ensure the Trust's strategic objectives are progressed.

The Chairman has mentioned our work with the South West Pay, Terms and Conditions Consortium in his Statement. The Trust Board has considered its findings and recommendations and in March 2013 confirmed that it broadly supported the recommended approach in the final report. As part of this we understand the importance of recognising high-performing staff and ensuring staff are appropriately rewarded. Appropriate incentives are an important factor in workforce productivity and service quality. We will be looking at how we can adopt a flexible and progressive use of pay, terms and conditions to incentivise the provision of uniformly high quality and responsive patient services.

We have been operating our 'Big Green Scheme' for a number of years now. Our aim is for the Trust to embed the concept of sustainability in all our activities, and achievements have been made in the year which are described in our Business Review on page 17 and the Annual Governance Statement. By working to reduce our energy consumption across the estate, improving the efficiency and control of heating, lighting and cooling, we are already seeing efficiencies realised.

2.5 Renewing our Hospitals

The investment the Trust has made this year, and is committed to making in the year ahead, in buildings and equipment will serve us for many years to come and help us to continue to transform the ways in which services are delivered to patients.

The start of the year saw the closure of Bristol General Hospital, but the opening of the new £45m South Bristol Community Hospital. We recognised that the opening was a momentous development in the history of our Trust and I am pleased to report that there has been a smooth transfer of services from both the Bristol General Hospital and the Bristol Royal Infirmary. The Trust is delighted that the opening has allowed more people in South Bristol to access diagnostic tests, therapy services and surgical procedures closer to home.

Visible progress has been made on our major capital schemes. The construction of the new ward block at the Bristol Royal Infirmary literally reached its highest point in January 2013 and this milestone was marked with a topping out ceremony where the last 'golden bolt' was tightened at the top of the new structure. The new ward block, which is due to open in 2014, will see all clinical services move out of the Trust's oldest estate, the 1735 Old Building.

We have also progressed our creation of a Welcome Centre at the main entrance of the Bristol Royal Infirmary with a new retailer section which should be finished next year. This will offer clearer routes and better patient orientation and I am delighted that we will finally have a welcoming entrance for the many hundreds of thousands of patients and visitors we care for each year.

We are investing £32m in bringing together all specialist children's services in Bristol under one roof at the Bristol Royal Hospital for Children. This will position the hospital as one of the largest children's hospitals in England. The first phase of this project included the opening of a new hospital ward, uniquely designed for 11 to 16 year olds with a variety of complex health issues including cancer. The 'home-from-home' themed ward is unlike any other ward in the hospital thanks to design expertise from Teenage Cancer Trust with the enhancements funded jointly by this charity and by Wallace & Gromit's Grand Appeal. The age-sensitive design is in response to the growing understanding that children recover more quickly and achieve better overall outcomes when the care and environment provided is sensitive to their age.

Recognising the continued importance of developing our facilities and infrastructure to optimise the delivery our transformation plans, I am excited to report that work is underway on the £16m expansion to the Bristol Haematology and Oncology Centre, and in September 2012 we announced that we would be working in partnership with the Helicopter Emergency Landing Pads Appeal to develop an onsite helipad at the Bristol Royal Infirmary, which will open in 2014.

I would like to emphasise the enormous contribution our charitable partners make to these projects, in particular Above and Beyond, the Grand Appeal, the Teenage Cancer Trust and the Friends of Bristol Haematology and Oncology Centre.

2.6 Building Capability

Only by developing leadership skills and improvement at every level of the organisation can we give ourselves the best chance of delivering the ambition to transform the care we provide. Engagement with our staff is a constant priority, and we recognise that there is always more that can be done in this regard to embed the programme in a meaningful way. There has been a great deal of focus on leadership development and each division now has its own Transforming Care programme to help integrate the approach.

I have changed our divisional leadership arrangements with the intention that new Clinical Chair appointees will lead divisions jointly with new Divisional Directors to strengthen the fundamental partnership between clinicians and managers in delivering the best care possible while providing the best value to the taxpayer. This will increase clinical engagement in the Transforming Care programme (see the Annual Governance Statement included in the Annual Accounts for more

details of the review). These plans chime with changes in the external environment, where strong emphasis has now been given to the clinical perspective in local commissioning.

We rolled out our Living the values scheme during the year across all staff groups, and by the end of the financial year 3,800 members of staff had received the training. The Chairman reported in his Statement on the promising results of a survey testing the understanding and application of our values throughout the Trust.

We have also launched a Staff Recognition Scheme and held our first Recognising Success staff award ceremony in November 2012. There were various categories including 'Unsung Hero Award' and 'Clinical Team of the Year', and I would like to congratulate all our winners.

Finally we have responded positively to the new requirements of the General Medical Council (GMC) regarding medical revalidation. This is a process by which all doctors with a licence to practise in the UK need to satisfy the GMC at regular intervals that they are fit to practise and should retain that licence. We have a new programme led by the Medical Director and as part of this we have enhanced the appraisal process of medical practitioners to enable us to make the right assessments. Patient feedback is taken into account as part of the process.

2.7 Leading in Partnership

We continue to recognise the important role we have to play, as a major teaching, research and tertiary service provider, working in partnership with other institutions locally and further afield, to design and operate the most effective health system for greater Bristol.

Bristol Health Partners is a dynamic collaboration between ourselves, the two universities in Bristol, Bristol City Council, North Bristol NHS Trust, Avon and Wiltshire Mental Health Partnership NHS Trust and primary care. Its aim is to share ideas and find ways to transform the understanding of, and approach to, key health problems in Bristol and beyond. Much work has been done in the year to establish the partnership and I am delighted to report that our launch took place in April 2013, where we spent a day discussing a number of important topics such as the role of the patient, dementia care, innovation, and prevention.

We have also been engaged in efforts to establish an Academic Health Science Network for the West of England. There has been much enthusiasm for this among our partners across the West of England and we have spent recent months working together to identify our strengths, challenges and common interests. A proposal was submitted to the Department of Health in February 2013.

The Chairman has already described our important partnering with the North Bristol Trust on the Bristol Acute Services Review.

Smaller scale partnerships have also been producing great outcomes. In February 2013 the Bristol Surgical Trials Centre was opened, based at the University of Bristol. Led by Jane Blazeby, Professor of Surgery at the University, and Honorary Consultant Surgeon at the Trust, this new centre will enable surgeons to learn more about how to deal with a range of conditions, assess new surgical techniques, and discover surgical breakthroughs to help deliver better care to thousands of patients in Bristol.

We took steps this year to embrace social media and web developments for our patients. In September 2012, we launched a new social network for teenagers and young people with cancer in the South West. We partnered with the Young Cancer Trust and Teenage Cancer Trust, and, with the help of the University of Bath, created a virtual platform where young people with cancer could interact with each other and share their experiences in real-time. We also launched a child-friendly

interactive website to communicate directly with young patients at the Bristol Royal Hospital for Children. We recognise that utilising technology enables us to optimise our ability to communicate with everyone in our community, and fully intend to further our digital endeavours in the year to come.

As we plan to take Transforming Care into 2013/14 we recognise the risks associated with the major restructuring of the NHS and commissioning landscape and that is why this programme and the Bristol Acute Services review seek to refine the provision of care, and the ways of providing the best care, as efficiently as possible. My Annual Governance Statement sets out the key risks that we face, together with steps we are taking to mitigate them.

In summary, it has been an exciting and demanding year of progress for the Trust. In the course of the year ahead I will be seeking even greater engagement with our patients and staff, and by looking for every opportunity to collaborate and share our knowledge, resources and strengths. It is my hope that the people of Avon, Somerset, Wiltshire, and, indeed, beyond, will receive care that is the best it possibly can be.

As ever, I thank my Board colleagues, our governors, staff, volunteers, members, charitable partners and our health community colleagues for their unswerving support.

Robert Woolley

Chief Executive, 29 May 2013

3. Director's Report

This report is presented in accordance with the Monitor NHS Foundation Trust Annual Reporting Manual 2012/13 published on 5 March 2013 which includes guidance and regulations for the Directors' Report, Quality Report and Annual Accounts. For the purpose of the Accounts, the directors are responsible for preparing the accounts on a true and fair basis 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 Annual Reporting Manual have been followed and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

3.1 Principal Activities of the Trust

University Hospitals Bristol NHS Foundation Trust is a Public Benefit Corporation authorised by Monitor, the Independent Regulator of NHS Foundation Trusts on 1 June 2008. The Trust provides services in the three principal domains of clinical service provision, teaching and learning, and research and innovation. The most significant of these with respect to income and workforce is the clinical service portfolio consisting of local, general and specialised services.

For local provision, services are directed to the population of central and south Bristol and the north of North Somerset, serving a population of about 350,000 patients. A comprehensive range of services, including all typical diagnostic, medical and surgical specialties provided through outpatient, day care and inpatient models. These are largely delivered from the Trust's own city centre campus with the exception of a small number of services delivered in community settings such as those recently introduced with the opening of the South Bristol Community Hospital in March 2012.

In contrast, the portfolio of specialist services is delivered locally, throughout the South West and beyond, serving populations typically between one and five million people. The main components of this portfolio are children's services, cardiac services and cancer services as well as a number of smaller, but highly specialised services, some of which are nationally commissioned.

Whilst not significant income generators in contrast to clinical service provision, the Trust places great importance on its role as a teaching hospital and research centre recognising the value of these in their own right but equally importantly, the value they add to the clinical services we provide. The Trust has strong links with both of the city's universities and teaches students from medicine, nursing and other professions allied to health. Research plays an increasingly important role in the Trust's business, with plans to significantly increase research activities in the next three years through the development of our academic health sciences collaboration, Bristol Health Partners.

3.2 Directors of the Trust

As a public benefit corporation, the Trust has a Board of Directors which exercises all of the powers of the corporation.

The Trust Board of Directors consists, at the time of drafting this report, of the Chairman, Chief Executive, seven Non-executive Directors and six Executive Directors as follows:

Non-executive Directors	Executive Directors
John Savage – Chairman	Robert Woolley – Chief Executive
Emma Woollett – Vice Chair	Paul Mapson – Director of Finance and Information
Iain Fairbairn – Senior Independent Director	Helen Morgan – Acting Chief Nurse
Kelvin Blake – Non-executive Director	Claire Buchanan – Acting Director of Workforce and Organisational Development
Paul May – Non-executive Director	Deborah Lee – Director of Strategic Development and Deputy Chief Executive
Lisa Gardner – Non-executive Director	Sean O'Kelly – Medical Director
Anthony (Guy) Orpen – Non-executive Director	James Rimmer – Chief Operating Officer
John Moore – Non-executive Director	

Biographies of the members of the Board are provided on page 88 of this report.

3.3 Independence of the Non-executive Directors

The Trust Board of Directors has formally assessed the independence[2] of the Non-executive Directors and considers all of its current Non-executive Directors to be independent in that there are no relationships or circumstances that are likely to affect their judgement that cannot be addressed through the provisions of the Foundation Trust Code of Governance as evidenced through their declarations of interest.

3.4 Statement as to Disclosure to Auditors

The Trust Board of Directors confirms that each individual who was a Director at the time that this report was approved has certified that:

- so far as the director is aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware, and;
- the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

3.5 Business Review

The following is a summary review of our business activities for the year ended 31 March 2013.

(a) Our performance in 2012/13 (an overview of regulatory risk ratings)

Disappointingly, during 2012/13 the Trust held an amber-red governance risk rating during each Quarter of the year, with a red rating over-ride applied by Monitor for Quarter 3 arising from the failure to achieve the Accident and Emergency 4-hour standard and the annual target reduction in MRSA bacteraemia cases. This was

[2] As defined in the Foundation Trust Code of Governance provisions at A.3.1

against a back-drop of a forecast amber-green rating in the annual plan, relating to risks to compliance with the Accident and Emergency 4-hour standard.

Additionally, in Quarter 2, the Trust received a warning notice from the Care Quality Commission (CQC) relating to concerns about the adequacy of staffing within children's cardiac services (CQC Outcome 13), which resulted in a red governance risk rating. This was subsequently de-escalated to amber-red by Monitor following confirmation that actions had been taken to address these issues identified through the CQC review and a subsequent re-inspection which confirmed that the Trust was now compliant with Outcome 13.

The table below sets out our Monitor risk ratings for finance and for governance (which equates to performance):

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial Risk Rating	3	3	3	4	4
Governance Risk Rating	AMBER-RED	AMBER-RED	AMBER-GREEN	GREEN	AMBER-GREEN

	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	AMBER-GREEN	AMBER-RED	AMBER-RED	Red (over-ride)	AMBER-RED
Standards declared at risk/not met	A&E 4-hour maximum wait	A&E 4-hour maximum wait and *Clostridium difficile*	*Clostridium difficile and CQC enforcement notice*	A&E 4-hour maximum wait, 62-day Cancer screening and *MRSA*	A&E 4-hour maximum wait, 62-day Cancer screening and *MRSA*

(b) Review of quarterly performance

As part of the 2012/13 Annual Plan the Trust declared the Accident & Emergency 4-hour maximum wait 95% standard to be at risk of not being achieved, with specific risks to the winter period identified following a failure to achieve the standard in Quarter 4 of 2011/12. The significant increase in the length of stay for emergency medical patients within the Bristol Royal Infirmary continued from Quarter 4 into the first half of Quarter 1 of 2012/13. This was associated with a significant increase in the number of over 75 and over 90 year olds, attending the Bristol Royal Infirmary (BRI) Emergency Department and with an increase in delayed discharges (i.e. patients medically fit for discharge but needing support services, such as a care package, or placement in a residential home).

In Quarter 3 performance against the 4-hour standard was unexpectedly lower than in previous years due to a significant influx of paediatric patients with respiratory problems. In the local community the levels of bronchiolitis were unusually high in November and December 2013. This mirrored the national peak in respiratory conditions during the same period. Although the numbers of children admitted via

the Bristol Royal Hospital for Children Emergency Department was not higher than in previous seasons the children needing admission were particularly unwell and required intensive management in the Emergency Department along with longer stays in hospital.

Levels of Norovirus within the community remained a challenge for the Trust, especially in Quarter 4, with a number of wards having to be closed during a two-week period in the last Quarter of the year in the Bristol Royal Infirmary and Bristol Heart Institute. This coincided with higher levels of emergency admissions, which put additional pressure on bed availability and led to a state of 'black escalation' being declared. During a 'black escalation', the first priority is towards the safety of patients, and resources are diverted from other parts of the hospital to ensure the Emergency Department remains a safe environment for patients.

Performance against six of the eight key national cancer waiting times standards remained strong, with full achievement in every Quarter of the year. The 62-day wait from GP referral with a suspected cancer to treatment failed to be achieved in Quarter 4. This was due to a combination of high volumes of late referrals from other providers, clinical complexity, patient choice, but also higher levels of cancellations of non-emergency surgery during exceptional levels of emergency pressures and the Norovirus outbreak which led to the state of 'black escalation' being declared.

The 62-day standard for screening referred patients was not achieved in Quarters 3 and 4. The delays occurred within the bowel screening service, with longer waiting times for specialist screening practitioner appointments (SSP), and colonoscopy diagnostic procedures, during October and November 2012. Waiting times for SSP appointments increased due to the departure of a number of members of staff at the same time, which severely limited capacity.

Waiting times for colonoscopies increased as a result of a general increase in demand for the procedure which could not be responded to quickly due to delays in the opening of additional service capacity at South Bristol Community Hospital. However, both issues that contributed to delays in 62-day screening pathways were addressed at the end of Quarter 3 and performance improved significantly towards the latter half of Quarter 4.

Both 62-day cancer standards are expected to be met again in 2013/14.

In every month of 2012/2013, the Trust achieved an 18-week Referral to Treatment Time (RTT) for over 90% of admitted patients, and 95% of patients not requiring an admission as part of their treatment. In addition, the Trust achieved the target for incomplete pathways, which came into effect from April 2012, with over 92% of patients waiting less than 18 weeks at each month-end. In so doing, the Trust met all the 18-week RTT standards in Monitor's 2012/13 Compliance Framework. In 2013/14 there will be further focus on achievement of these standards at a specialty level.

The Trust reported 48 cases of Clostridium difficile (C. diff) infections in 2012/13, which was six fewer than the maximum permissible of 54 for the year. Historically, the number of C. diff cases shows a strong seasonal profile, with around 60% of cases being reported in the first half of each year. In the first two Quarters of the year the Trust reported a higher number of cases than Monitor's flat phasing of the annual

target. However, significant reductions in cases were seen in Quarters 3 and 4 to bring the Trust back within target at year-end.

The annual target of MRSA bacteraemia cases proved very challenging in 2012/13. The Trust reported 9 MRSA bacteraemias against a target for the year of 2. The Root Cause Analysis identified an emerging theme of intravenous lines (IV) being the route of infection in a majority of cases. An action plan was implemented in the latter half of the year which focused on improvements in IV line care management. Since the implementation of the plan a further two bacteraemias have been reported. The most recent bacteraemia was in an immuno-compromised patient and was not related to IV line care. The Trust is using the learning from this case, and from one of the highest performing trusts in the country, to further enhance its recovery plan, with the aim of meeting the Department of Health's target of having no MRSA bacteraemias in 2013/14.

The Trust will continue to analyse the reasons for failures to achieve the national cancer waiting times standards for individual patients on a Quarterly basis, and use this to inform its on-going cancer improvement plan. Achievement of the 4-hour Accident and Emergency standard was considered to be at risk in the 2012/13 Annual Plan due to the historical difficulties encountered in achieving the 4-hour standard in the fourth Quarter of each year.

The Trust has recently launched a wide-ranging programme of work on patient flow with the aim of reducing any unnecessary emergency admissions and reducing lengths of stay in hospital. This should help to improve bed availability and the Trust's responsiveness to meet fluctuations in levels of emergency demand.

(c) Annual performance against national access standards

During 2012/13 the Trust cancelled 1.1% of operations on the day of the procedure for non-clinical reasons. Disappointingly, this was higher than the cancellation rate in the previous year. The primary cause of the higher levels of cancellations this year was a bed not being available to admit a patient to. This reflected the significant emergency pressures seen in the latter half of the year. The programme of work that has been launched which is focusing on patient flow should improve bed availability in 2013/14 and reduce the last-minute cancellation rate. We expect this to help the Trust readmit patients within 28 days of their operation being cancelled, as achievement of this standard is very dependent upon the level of cancellation of operations at any point in time.

During the year the Trust failed to meet the standard of 99% of diagnostic tests being carried-out within six weeks. This was due to a significant rise in demand for the gastrointestinal endoscopic procedures, which is a pattern that has been seen both regionally and nationally. The rise in demand could not be responded to quickly due to delays in the opening of the additional facility at South Bristol Community Hospital. However an action plan was implemented which included a range of options for increasing capacity, including putting on additional weekend sessions and using other capacity across the community.

At the end of March 2013 the Trust was one month ahead of its target trajectory to achieve the 99% standard by the end June 2013.

In 2012/13 the Trust reported a significant improvement in the percentage of mothers initiating breast feeding. Improvements were also reported in the Door to Balloon 90-minute reperfusion standard. The Door to Balloon time measures the time from the arrival of the patient in the Trust through to the time when the reperfusion treatment commences (i.e. balloon inflation in the blood vessel). The Call to Balloon time 150-minute standard measures the time from the call for professional help through to the commencement of reperfusion treatment.

The Trust met the target of 75% but did not meet the 90% local 'stretch target'. This mainly reflected the time it took for patients to get to the hospital (Call to Door time), rather than the time from arrival to treatment, as the Door to Treatment times showed.

The table below sets out annual performance against key national standards in 2011/12 and 2012/13. Requirements are shown as per the Monitor Compliance Framework and 2012/13 NHS Operating Frameworks.

National Standard	Target	2011/12	2012/13
A&E maximum wait of 4 hours	95%	Achieved	Not achieved
MRSA bloodstream cases against trajectory	Trajectory	Achieved	Not achieved
Clostridium Difficile infections against trajectory	Trajectory	Achieved	Achieved
Cancer – 2-week wait (urgent GP referral)	93%	Achieved	Achieved
Cancer – 2-week wait (symptomatic breast cancer not initially suspected)	93%	Achieved	Achieved
Cancer – 31-day diagnosis to treatment (First treatment)	96%	Achieved	Achieved
Cancer – 31-day diagnosis to treatment (subsequent surgery)	94%	Achieved	Achieved
Cancer – 31-day diagnosis to treatment (subsequent drug therapy)	98%	Achieved	Achieved
Cancer – 31-day diagnosis to treatment (subsequent radiotherapy)	94%	Achieved	Achieved
Cancer – 62-day referral to treatment (urgent GP referral)	85%	Achieved	Not achieved
Cancer – 62-day referral to treatment (screenings)	90%	Achieved	Not achieved
18 weeks referral to treatment - admitted pathways	90%	Achieved	Achieved
18 weeks referral to treatment - non admitted pathways	95%	Achieved	Achieved
18 weeks referral to treatment – incomplete pathways	92%	Target not in effect	Achieved
GUM offer of appointment within 48 Hours	98%	Achieved	Achieved
Number of last minute cancelled operations	0.80%	Not achieved	Not achieved
28 day readmissions	95%	Not achieved	Not achieved
Primary PCI – 90 minutes door to balloon time	90%	Achieved	Achieved
Diagnostic waits of 6 weeks	99%	Achieved	Not achieved

(d) An overview of quality

The safety of our patients, the quality of their experience of care, and the success of their clinical outcomes are at the heart of everything we want to achieve as a provider of healthcare services. We want all our patients to receive harm-free care. We want them to be treated with kindness, understanding, dignity and respect, and for them to be fully involved in decisions affecting their treatment, care and support. We are also determined that each patient should receive the right care for them, according to scientific knowledge and evidence-based assessment.

The Trust's commitment to providing the highest quality of patient care can be summed up in the following highlights from the 2012/13 Quality Report, which is included in full at Appendix C. The Quality Report includes a review of progress against quality objectives for 2012/13 and details of agreed quality objectives for 2013/14. The structure of the Quality Report addresses each of the three core dimensions of quality in turn, and incorporates guidance issued by the Department of Health and Monitor.

(i) Patient safety

In 2012/13, 91.3% of patients received harm-free care as measured by the NHS Safety Thermometer, and 95.7% of patients did not acquire any new 'harms', i.e. pressure ulcers, falls, urinary tract infections or venous thrombo-embolisms (VTEs), following admission to hospital. 96.7% of UH Bristol inpatients received a VTE risk assessment upon admission to hospital, which compares favourably with the national average of 93.8%.

We continue to encourage proactive reporting of patient safety incidents and are very encouraged to have achieved our goal of reducing the proportion of medication errors which result in moderate or greater harm to patients – less than 1% in 2012/13.

We have continued to focus on providing excellent nutritional care: in 2012/13, over 90% of adult patients received a fully completed nutritional assessment within 24 hours of admission to hospital.

We are pleased that numbers of Clostridium difficile cases fell for the sixth consecutive year (48 cases in 2012/13), but we're disappointed not to have achieved our challenging national target for MRSA (there were nine bacteraemia in 2012/13). Our focus on infection prevention and control training continues, with a strong emphasis on IV line care management.

In 2013/14, we will seek to increase harm-free care; to further reduce medication errors and hospital-acquired infections; to continue our improvements in nutritional care; and to focus on the early identification and escalation of deteriorating patients.

(ii) Patient experience

In 2012/13, we implemented a new three year Patient Experience and Involvement Strategy confirming our commitment to ensuring a first class experience of care for our patients. This year we focussed in particular on the

experience of care of emergency patients, children, carers and patients with a learning disability.

96% of inpatients said that based on their experience of the care they received in our hospitals, they would recommend us. 71% of staff said that they would recommend us, compared to a national average of 62% (note that the staff and patient surveys quoted here use different methodologies, which means that the two results are not directly comparable). Furthermore, 96% of patients rated their inpatient care as either excellent, very good or good.

We were pleased to achieve a target agreed with our commissioners for increasing the number of maternity patients who felt that they had been treated with kindness and understanding.

We received around ten percent more complaints in 2012/13 compared to the previous year. This was at least partly attributable to the introduction of the Trust's new patient administration system (Medway) early in the year, and to cancelled and delayed outpatient appointments. However, by the final Quarter of the year, our rate of complaints as a proportion of patient activity was consistently lower than in 2011/12.

In 2013/14, we will embed the NHS Friends and Family Test, and ensure that patients across the Trust are treated with kindness and understanding. We will also focus on explaining medication side effects to patients when they are discharged from hospital, and on continuing to improve the experience of maternity patients.

(iii) Clinical effectiveness

The Trust continues to have a low overall Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) score. In other words, we prevent deaths in hospital that would be considered likely based on the national statistical 'norm'.

Provisional adult cardiac surgery data for 2012/13 shows the Trust's mortality rate to be better than the national average.

In 2012/13, we continued our commitment to improving the care of patients with a dementia, in accordance with the NICE Quality Standard for Dementia and the South West Standards.

We applied the principles of enhanced recovery to cardiac, thoracic, colorectal, and gynaecological surgery with the goal of improving recovery times and reducing readmissions (data is currently being analysed).

In 2013/14, we will re-double our efforts to ensure that at least 90% of stroke patients spend at least 90% of their time on a dedicated stroke ward (79.3% in 2012/13 against the national standard of 80%). We will continue to focus on dementia care and timely risk assessment of patients with a learning disability. We will also improve access to specialist diabetic support and seek to achieve the best practice tariff for hip fractures.

(e) Contractual performance

As part of the 2012/13 contract with lead commissioners, NHS Bristol and the South West Specialised Commissioning Group, the Trust committed to the achievement of a number of 'stretch targets' under the Commissioning for Quality and Innovation scheme (CQUIN). Financial rewards were attached to achievement of targets and there were a number of national penalties for non-achievement of key national standards such as Clostridium Difficile, 18-week Referral to Treatment Time standards, Accident and Emergency 4-hour maximum wait and Cancer standards.

The CQUIN targets included quality improvement indicators, ranging from the national safety thermometer and dementia measures; to system-wide CQUINs for reducing emergency admissions and end of life measures; local goals on high impact innovations, the enhanced recovery programme, diabetes care for surgical patients; and specialised goals including quality dashboards and neonatology measures. For 2012/13 the Trust expects to achieve 16 of the CQUIN standards in full and five in part, as follows:

- VTE prevention (part);
- Patient experience (part);
- Dementia (part);
- NHS safety thermometer;
- High Impact Innovations (part);
- End of life care - increasing the number of people dying at home;
- Enhanced Recovery Programme (Surgery, Head & Neck and Cardiac Surgery);
- Nutrition (part);
- Medication errors;
- Emergency theatre waiting times;
- Diabetes care for surgical patients;
- Paediatric disability;
- Improvement in spontaneous vaginal deliveries;
- Quality dashboards;
- Neonatal coagulase negative staphylococcal (CONS) infections;
- Neonatology - increasing the number of babies receiving timely total parenteral nutrition (TPN);
- Paediatric intensive care unit (PICU) - unplanned extubation;
- Paediatric intensive care unit (PICU) – reduction of acquired line sepsis (potentially);

– Cardiac - improving inpatient access to catheter laboratory procedures, and;

– Cystic Fibrosis – improving intravenous line insertion access times.

Alongside the quality incentive scheme, the Trust was exposed to a series of financial sanctions where performance fell short of the contracted standards. In 2012/13 the Trust incurred financial penalties of £0.674m due to the non-achievement of certain national quality standards, including cancer 62-day referral to treatment (screenings), diagnostic six-week wait, emergency department 4-hour wait, and specialty level referral to treatment times. Recovery plans to address these areas of poor performance are in place with the aim of delivering care to the contracted standards throughout 2013/14.

(f) Financial performance

The key highlights for University Hospitals Bristol NHS Foundation Trust's financial performance during 2012/13 include:

– Delivery of an income and expenditure surplus of £5.768m before the technical adjustment of the asset revaluation impairment loss of £1.068m to give a reported income and expenditure surplus of £4.684m for the year;

– A Monitor financial risk rating of '3';

– An EBITDA (earnings before interest, tax and depreciation/impairments) of £34.5m;

– Achievement of cash releasing efficiency savings of £22.6m;

– Expenditure on capital schemes of £57.865m;

– A healthy cash position of £35.1m and a strong Balance Sheet.

The results for 2012/13 confirm we have delivered the fifth year of our financial strategy as a Foundation Trust. In accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) our income from the provision of goods and services for the purposes of the health service in England continues to exceed our income from the provision of goods and services for other reasons.

In summary, a good result for 2012/13 but with a lot of work to be done in 2013/14, particularly on the delivery of managing service level agreement activity and cash releasing efficiency savings to ensure the Trust's strategic objectives are still progressed.

(i) Statement of going concern

We have a reasonable expectation that the University Hospitals Bristol NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, we continue to adopt the going concern basis in preparing the Accounts.

(ii) Statement of comprehensive income (formerly income and expenditure)

The out-turn position is £1.016m below the Annual Plan surplus for the year.

Items	Plan for Year	Actual Year ended 31 March 2013	Variance Favourable / (Adverse)
	£ 'm	£ 'm	£ 'm
Operating Income	520.917	527.747	6.830
Operating Expenses	(485.321)	(493.264)	(7.943)
EBITDA	35.596	34.483	(1.113)
Depreciation	(19.457)	(18.729)	0.728
Trust Debt Remuneration	(9.551)	(9.672)	(0.121)
Profit/(loss) on disposal	0.350	(0.097)	(0.447)
Interest receivable	0.173	0.222	0.049
Interest payable	(1.411)	(0.437)	0.974
Net Surplus before technical adjustments	5.700	5.770	0.070
Impairment (Losses) / Reversals	-	(1.086)	(1.086)
Net Surplus for Year	**5.700**	**4.684**	**(1.016)**

(iii) Cash releasing efficiency saving (CRES) plans

The Trust achieved cash releasing efficiency savings of £22.581m in 2012/13. Income generation schemes contributed £6.547m. Reductions in pay costs of £8.410m were achieved and a further £7.624m was saved on supplies and services.

(iv) Statement of financial position (formerly balance sheet)

The Trust has a healthy statement of financial position which shows net working capital of £5.1m. The reduction over the year reflects the income and expenditure surplus (before exceptional items) achieved by the Trust offset by the use of Trust cash balances to fund the Capital Programme.

(v) Cash flow

The Trust ended the year with a cash balance of £35.12m. The cash flow statement in the Annual Accounts shows a £6.36m decrease in cash over the year. This is due to the following factors:

	£ 'm
Net cash flow from operating activities	35.92
Net cash flows from investing and other financing activities	3.23
Capital expenditure	(60.90)
Loans received from the Foundation Trust Financing Facility	24.95
Public Dividend Capital dividend payment	(9.56)
Decrease in cash balance 2012/13	**(6.36)**

(vi) Better payment practice code

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

	Year ended 31 March 2013	
Items	**Number**	**Value £ 'm**
Total non-NHS trade invoices paid in the period	159,332	195.884
Total non-NHS trade invoices paid within target	138,690	175.413
Percentage of non-NHS trade invoices paid within target	87.0%	89.5%
Total NHS trade invoices paid in the period	4,561	60.075
Total NHS trade invoices paid within target	3,735	54.828
Percentage of NHS trade invoices paid within target	81.9%	91.3%

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

No payments were made from claims made under the Late Payment of Commercial Debts (Interest) Act 1998 in 2012/13 (2011/12: £nil). No other compensation was paid to cover debt recovery cost under this legislation.

(vii) Capital

The Trust incurred capital expenditure of £57.865m. The table that follows shows a breakdown of funding and expenditure on major schemes.

	Year Ended 31 March 2013		
	Plan	**Actual**	**Variance** Favourable/ (Adverse)
	£ '000	£ '000	£ '000
Sources of Funding			
Donations	453	376	(77)
Capital Grants	577	577	-
Retained Depreciation	17,685	17,627	(58)
Sale of Property	8,395	7,720	(675)
Prudential Borrowing	24,950	24,950	-
Cash balances	7,067	6,615	(452)
Total Funding	**59,127**	**57,865**	**(1,262)**
Expenditure			
Strategic Schemes	(41,966)	(41,808)	158
Medical Equipment	(4,496)	(4,109)	387
Information Technology	(4,607)	(4,501)	106
Roll Over Schemes	(2,035)	(1,792)	243
Refurbishments	(1,103)	(1,020)	83
Operational / Other	(4,920)	(4,635)	285
Total Expenditure	**(59,127)**	**(57,865)**	**1,262**

The Trust has secured a loan in the sum of £70m from the Foundation Trust Financing Facility to partially fund the capital costs of the scheme to facilitate the centralisation of specialist paediatric services and the Redevelopment of the BRI. The first tranche of the loan (£20m) was drawn down in March 2013 and the balance of £50m will be drawn down in 2013/14.

The Trust has taken up a long-term loan in the sum of £4.95m from the Foundation Trust Financing Facility to fund the capital costs of the Welcome Centre scheme. The scheme provides for the replacement of essential hospital accommodation such as main reception, waiting areas and Patient Advice and Liaison Services coupled with a retail provision to meet the needs of patients, visitors and staff.

(viii) Prudential borrowing limit (PBL)

The Trust is also required to comply and remain within the Prudential Borrowing Limit which is set by Monitor. For 2012/13 this was set at

£189.9m. This represents maximum long term borrowing of £152.4m and an approved working capital facility of up to £37.5m. A Working Capital Facility of £37.5m agreed for two years from 1st September 2010 was extended by a further 12 months from September 2012.

The Trust uses the Education Resource Centre under a Finance Lease arrangement. The liability of £5.953m is a first call against the Prudential Borrowing Limit of the Trust.

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

Financial ratio	Actual ratios Year ended 31 March 2013	Approved PBL Tier 1 ratios
Minimum dividend cover	3.4x	>1x
Minimum interest cover	77x	>3x
Minimum debt service cover	52x	>2x
Maximum debt service to revenue	0.1%	<2.5%

At 31 March 2013, the Trust is performing within all of the approved Prudential Borrowing Limit ratios (see Note 23 of the Annual Accounts).

(ix) Financial risk rating

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

Achievement of plan	Underlying performance
Financial efficiency	Liquidity

The risk rating is forward looking and is intended to reflect the likelihood of an actual or potential financial breach of the foundation trust's terms of authorisation.

The table below sets out the Trust's performance against the criteria. The overall rating of three is a good result and reflects the sound financial position of the organisation.

Financial Criteria	Metric to be scored		31 March 2013
Actual			**Rating**
Achievement of plan	EBITDA[3] Margin	6.33%	3
Underlying performance	EBITDA Achieved	93.94%	4
Financial efficiency	Net Return after Financing	1.10%	3
Financial efficiency	I&E Surplus Margin	1.11%	3
Liquidity	Liquid Ratio	24.1 days	3
Overall rating	Actual weighted score = 3.10		3

The above table shows the Trust's weighted financial risk score is 3.10 and the overall financial risk rating is 3.

The Trust's activities are undertaken under legally binding contracts with commissioners which are financed from resources voted annually by Parliament. The Trust also has the potential to finance 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 we face.

(x) Financial outlook

We are planning to achieve the following for 2013/14:

- A surplus on the Statement of Comprehensive Income which represents an EBITDA rate of 6.8%;
- A planned surplus of £6.164m;
- A planned cash balance at the year-end of £35.3m;
- A savings programme of £21.0m;
- A capital programme of £76.3m;
- A Financial Risk Rating weighted score of 3.20 leading to an overall rating of 3.

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

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

[3] Earnings before interest, tax, depreciation and amortisation

To achieve the planned surplus the following are required:

- Delivery of the planned savings for 2013/14;
- Conversion of non-recurring savings from 2012/13, into recurring savings;
- Continued maintenance of strict cost control;
- Delivery of National Performance targets and in particular the avoidance of Service Level Agreement fines;
- Delivery of clinical performance within agreed Contract Limiters to avoid non-payment of activity by commissioners;
- Proper recording and coding of activity leading to full income recovery;
- Achievement of significant clinical service improvement in a planned and effective manner using lean methodology to enable the delivery of savings;
- Delivery of CQUIN targets agreed with commissioners.

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

- Commissioners are experiencing financial difficulties due to large planned savings from QIPP (Quality, Innovation, Productivity and Prevention) schemes not being particularly successful. Attempts to restrict/cap payment to trusts are becoming common. Over-performance on Service Level Agreements cannot be automatically assumed to be funded from commissioners in future, and;
- Pressures on spending and delivery of CRES are intensifying and firm control is required to avoid the Trust's current financial position and its medium term plans being undermined.

(xi) Management Costs[4]

	Year ended 31 March 2013 £ '000	Year ended 31 March 2012 £ '000
Management costs	17,480	18,281
Income	528,209	533,739
Percentage of Income	3.3%	3.4%

Analysis by Segment	Year ended 31 March 2013	Year ended 31 March 2012 (restated)
	£ '000	£ '000

[4] 'Management costs' are as defined as those on the Management Costs Website: www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en

Segment	University Hospitals Bristol NHS Foundation Trust	Skills for Health	Totals	University Hospitals Bristol NHS Foundation Trust	Skills for Health	Totals
Management costs	16,830	650	17,480	17,009	1,272	18,281
Income	514,832	13,377	528,209	506,827	26,912	533,739
Percentage of Income	3.3%	4.9%	3.4%	3.4%	4.7%	3.4%

(xii) Retirements due to ill health

During the year ended 31 March 2013 there were 5 (2011/12: 11) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill-health retirements will be £0.147m (2011/12: £0.890m). The cost of these ill health retirements will be borne by the NHS Business Services Authority – Pensions Division.

(xiii) Policies on counter-fraud and corruption

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

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

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

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

The Trust works closely with local counter-fraud specialists to implement the NHS Counter Fraud and Security Management Service's national strategy on countering fraud in the NHS and to ensure the Trust is working with the local counter fraud specialist in fully complying with Secretary of State's directions.

Work is carried out across the seven areas of counter fraud activity of creating an anti-fraud culture, deterrence, preventing fraud, detecting fraud, investigation, sanctions, and redress.

(xiv) External audit

University Hospitals Bristol NHS Foundation Trust's External Auditors are PricewaterhouseCoopers (PwC). The audit fee in relation to the statutory audit of the Trust for the year ended 31 March 2013 was £50,050 (excluding VAT). The audit fee in relation to the quality accounts was £8,100 (excluding VAT).

(g) Research and innovation

Over the last year we have further strengthened our collaborative working with the Universities of Bristol and The West of England and our NHS partners. This has been underpinned by our research collaborations, largely driven by the National Institute for Health Research Biomedical Research Unit (NIHR BRU) and other funding we receive, through the joint directorship of our R&I department with North Bristol Trust, as a core member of Bristol Health Partners and as a partner within the West of England Academic Health Sciences Network.

In 2012/13 the Trust recruited 4,340 patients into NIHR portfolio studies, representing an 18% increase in weighted recruitment on the previous year. University Hospitals Bristol NHS Foundation Trust is the highest recruiting trust in the Western Comprehensive Local Research Network. Recognising that our research staff are key to delivering our research, we welcomed Paula Tacchi as our new Research Matron, responsible for professional line management and development of our research nurses and allied health professionals and performance management through our research unit structures.

Our two NIHR Biomedical Research Units opened on 1 April 2012, and programmes of work are well under way. These prestigious units are in Cardiovascular Disease, led by Professor Gianni Angelini, and Nutrition, Diet and Lifestyle, led by Professor Andy Ness. Projects in the Nutrition BRU include investigations of nutrition in cancer, in long term childhood conditions and in surgery. In the Cardiovascular BRU we are continuing thematic work around improving the outcomes in cardiac surgery and translating laboratory research into clinical trials. The total value of National Institute for Health Research grant income increased from £14,509 million (2011/12) to £21,590 million. This includes our new BRUs and five other new grants totalling £1.3 million: four Research for Patient Benefit grants (led by Dr Shane Clarke, Professor Rob Tulloh, Professor Margaret Fletcher & Dr Jacqui Clinch, and Dr Richard Brindle), and one Health Services and Delivery Organisation grant (led by Professor Peter Fleming).

Also awarded and due to start later in 2013 are two large research grants in Ophthalmology (led by Professor John Sparrow) and rheumatoid arthritis (led by Professor Sarah Hewlett), which will bring in over £3.2 million.

Commercial and non-commercial research activity in our Bristol Eye Hospital Research Unit increased over the year as our collaboration through Professor Andrew Dick as one of three theme leaders for Moorfields Biomedical Research Centre has developed. As part of this we have been working with the National Eye Institute, part of the US National Institutes for Health, to deliver their research here in Bristol. We look forward to strengthening that relationship over the next year to expand our portfolio of retinal and other ophthalmology research.

Activity in collaborative and contract commercial trials substantially increased during 2012/13. Commercially sponsored trials generated an income of £1.7 million, an increase of 11% over the previous year. The number of trials brought in through our preferred provider status with large multinational contract research organisations went up and they continue to increase while also expanding into new research areas. Alongside this we attracted large commercial grants to support investigator led research, particularly in rheumatology and cancer.

We have maintained good performance in opening new trials this year, and our focus has been on recruiting patients into research to time and target. Professor Wynick, as Director of Research, has led nationally on initiatives around the new research performance benchmarks with other major teaching trusts and the Department of Health, and within the Trust we are working with our research teams to identify and address barriers to optimal recruitment into trials.

During 2012/13 we have invested in research estate, and there are plans for further development. We are delighted to have welcomed into a Joint Research Facility in the Education and Research Centre in September 2012 the NIHR BRU in Nutrition, Diet and Lifestyle and our Chair of Nursing, Professor Margaret Fletcher, and her team. This brings together researchers from the Trust, the University of Bristol and the University of the West of England into a shared space alongside the core R&I team and the Medicines for Children Research Network. In the Bristol Heart Institute, plans to develop a joint research space adjacent to our Cardiac MR facilities have been approved. This facility will support our increasing volume of cardiology research and will provide space for staff to discuss research with patients near to where they are seen in outpatient clinics, supporting our strategy that clinical research is embedded alongside clinical care.

As part of the Bristol Royal Infirmary redevelopment, plans for the physical integration and co-location of the research units of the Divisions of Medicine and Surgery, Head and Neck, have progressed. Detailed drawings have been finalised and the new joint facility in the King Edward's Building will open in 2014.

Looking more broadly across the city and the region, as a trust we are one of the core Bristol Health Partners and have contributed significantly to the development of the West of England Academic Health Sciences Network proposal, seconding Dr Mary Perkins to develop the model. Led by Professor Peter Mathieson, and formally launched in May 2012, Bristol Health Partners is a pan-Bristol strategic partnership, with common goals and operational activities, including University Hospitals Bristol NHS Foundation Trust, North Bristol NHS Trust, Bristol, North Somerset and South Gloucester CCGs and the Avon & Wiltshire Mental Health Partnership NHS Trust), the two Universities (University of Bristol and University of the West of England) and the city council.

The Partnership aims to integrate clinical service, research and teaching and has formed nine Health Integration Teams (HITs) which are focused on optimal research into practice, service transformation and pathway redesign. The two newest HITs are both led by the Trust; these are RENOIR – Retinal Outreach, Integration and Research and CIPIC – Child Injury Prevention and Injury Care. Dr Elizabeth Dymond, our innovation manager, holds a joint post across University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust. She has also contributed

to the West of England Academic Health Sciences Network (WEAHSN) bid and supports the 'Wealth Creation' work stream in particular.

Within the Trust we continue to support innovators in product commercialisation and management of intellectual property assets particularly in research.

Adoption and diffusion of research findings, innovations and service improvements within and outside the Trust will be a priority for the WEAHSN as it moves forward, and our innovation manager will hold a key role for the Trust in this.

(h) Teaching and learning

Our commitment is to continue to improve the care we provide to our patients with a workforce that has the right skills, in the right place at the right time. As a teaching hospital, we support the teaching of all staff groups including undergraduates, postgraduates, medical and non-medical to aid their lifelong learning.

When a member of staff joins us they attend a comprehensive induction programme and during orientation agree a development plan with their manager. This covers essential training requirements as well as personal and professional development needs. A talent matrix has been developed to support our current and future leaders in the organisation as this is central to our strategic aims going forward.

As one of the UK's leading teaching hospital trusts, closely linked to academic institutions locally, nationally and worldwide, we have an extremely successful history of developing clinical skills and careers. The Trust positively encourages under and post graduate study and research with active continuous professional development programmes that include workshops, seminars and e-Learning to keep professionals up to date with the latest clinical developments. Through the Qualifications Credit Framework, the Trust offers a wide range of training and learning opportunities for non-clinical members of staff, along with extensive continuous professional development to encourage internal succession for staff across all disciplines.

Strong partnerships exist with the Severn Deanery, University of Bristol, University of West of England, City of Bristol College, North Bristol NHS Trust and other NHS organisations. Further education partnerships are being strengthened, including collaborative working with the new clinical commissioning groups and with the newly formed Bristol Health Partners. We value these partnerships highly and will continue to develop them as part of our governance structure and partnership working arrangements.

In order to ensure we deliver excellent standards of Teaching and Learning the Trust has a five year strategic framework which aims to:

> 'Develop a culture of lifelong learning across all staff groups within the Trust where Teaching and Learning is aligned with the Trust values and Strategies and synonymous with quality, cost, performance, and the delivery of excellent patient care.'

The Teaching and Learning Strategy is reviewed annually by the Trust Board of Directors and an annual report of Teaching and Learning activity is produced in

order to ensure a continuous improvement culture is central to the Teaching and Learning services the Trust provides for the benefit of the staff and patients we serve.

(i) About our staff

Regular consultation with staff takes place through both informal and formal groups, including the Trust Consultative Committee, a Policy Group, the Industrial Relations Group and the Local Negotiating Committee (medical and dental staff). Staff and management representatives consult on change programmes, terms and conditions of employment, policy development, pay assurance and strategic issues.

Over the past year, the Trust has consulted with staff on a number of key changes, including two major projects: Transforming the Nursing Workforce and, the Allied Health Professionals Review.

The Trust also consulted on changes to terms and conditions of employment for staff covered by the national employment contracts. Financial pressures faced by this trust, alongside every other trust, mean it is likely that there will be further staff consultation on changes in the coming year.

The Trust takes part in the Annual Staff Attitude Survey and subsequently develops an action plan to improve staff experience.

(i) Summary of performance – NHS staff survey

Questionnaires were sent to a random sample of 821 staff across the Trust. This included only staff employed directly by the Trust, and excluded staff working for external contractors and Bank only staff.

455 staff at the Trust took part in this survey. This is a response rate of 55%, which is above average for acute trusts in England, and compares with a response rate of 60% in this trust in the 2011 survey. The average response rate for acute trusts was 49%.

(ii) The Trust's 5 top-ranking scores

	2011/12		2012/13		
Top 4 Ranking Scores	**Trust**	**National average for acute trusts**	**Trust**	**National average for acute trusts**	**Improvement/ deterioration**
Staff motivation at work	3.87	3.82	3.92	3.84	Improvement by 0.05
Effective team working	3.74	3.72	3.80	3.72	Improvement by 0.06
Percentage of staff agreeing their role makes a difference to patients	92%	90%	92%	89%	Identical score

	2011/12		2012/13		
Top 4 Ranking Scores	**Trust**	**National average for acute trusts**	**Trust**	**National average for acute trusts**	**Improvement/ deterioration**
Percentage of staff experiencing harassment, bullying or abuse from patients.	15%	15%	26%	30%	Deterioration by 11%
Percentage of staff feeling pressure in last three months to attend work when feeling unwell	20%	26%	24%	29%	Deterioration by 4%

(iii) The Trust's 5 bottom-ranking scores

	2011/12		2012/13		
Top 4 Ranking Scores	**Trust**	**National average for acute trusts**	**Trust**	**National average for acute trusts**	**Improvement/ Deterioration**
Percentage of staff saying hand-washing materials are always available	52%	66%	52%	60%	Identical score
Staff witnessing potentially harmful errors, near misses or incidents in the last month	39%	34%	39%	34%	Identical score
Percentage of staff receiving health and safety training in the last 12 months	75%	81%	63%	74%	Deterioration by 12%
Percentage of staff experiencing harassment bullying or abuse from staff in past 12 months.	15%	16%	27%	24%	Deterioration by 12%
Percentage of staff experiencing discrimination at work in past 12 months.	14%	13%	12%	11%	Improvement by 2%

The Trust scored in the **best 20%** of acute trusts in:

- % agreeing that their role makes a difference to patients;
- % staff able to contribute towards improvements at work;
- Staff motivation at work;
- Effective team working;
- % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months, and;
- % feeling pressure in last 3 months to attend work when feeling unwell

The Trust scored **better than average** in:

- % suffering work-related stress in last 12 months;
- % receiving job-relevant training, learning or development in last 12 months;
- % having well-structured appraisals in last 12 months;
- % reporting errors, near misses or incidents witnessed in the last month;
- Fairness and effectiveness of incident reporting procedures;
- Staff job satisfaction;
- Staff recommendation of the Trust as a place to work or receive treatment;
- % believing the Trust provides equal opportunities for career progression or promotion, and;
- Overall staff engagement.

The Trust scores were **average** in:

- % feeling satisfied with the quality of work and patient care they are able to deliver;
- % working extra hours;
- % appraised in last 12 months;
- Support from immediate managers;
- % experiencing physical violence from patients, relatives or the public in last 12 months;
- % experiencing physical violence from staff in last 12 months, and;
- % reporting good communication between senior management and staff.

Trust scores were **worse than average** in:

- Work pressure felt by staff;

- % saying hand washing materials are always available;
- % experiencing harassment, bullying or abuse from staff in last 12 months;
- % experiencing discrimination at work in last 12 months, and;
- % having equality and diversity training in last 12 months

Trust scores were in the **worst 20%** in:

- % receiving health and safety training in last 12 months, and;
- % witnessing potentially harmful errors, near misses or incidents in last month

(iv) Key areas of improvement

Key areas in supporting staff include robust performance management, development and training, effective steps to tackle bullying and harassment and improved communications. Therefore, it is positive that the 2012 staff survey results showed improvements against the previous year's survey results and/or better than average scores in the following:

- % feeling satisfied with the quality of work and patient care they are able to deliver – at 79% this was a 5% improvement on the 2011 scores;
- % agreeing their role makes a difference to patients - 92% - in the highest (best) 20% nationally;
- Effective team working - at 3.80 this was an improvement on the previous year's score and in the highest (best) 20% nationally;
- % receiving job-relevant training, learning or development in last 12 months – at 82% this was above (better than) the national average;
- % having well-structured appraisal in last 12 months – at 38% this was above (better than) average. 83% of respondents stated that they had had an appraisal in the past 12 months;
- Fairness & effectiveness of incident reporting procedures – at 3.56 this was above (better than) average of 3.50;
- % able to contribute towards improvements at work – 70% - a 5% increase on the previous year and in the highest (best) 20% nationally;
- Staff job satisfaction – at 3.60 this was an improvement on the previous year's score and above (better than) the national average of 3.58;
- Staff recommendation of the Trust as a place to work or receive treatment – at 3.66 this was a slight improvement on the 2011 scores and above (better than) the national average of 3.57;
- Staff motivation at work – 3.92 - a 0.5 increase on the 2011 score and in the highest (best) 20% nationally, and;

- Overall staff engagement score - 3.76 was above (better than) average for acute trusts and also showed an improvement against the previous year's score.

(v) Key priority areas for improvement

The Trust intends to build on the positive movement detailed above, and will focus on the areas where a deterioration has been indicated. This plan will be fully integrated with the Trust values.

The proposed key priority areas for improvement, which at the time of authoring this report were being consulted on, are:

- Work pressure felt by staff - the Trust score was 3.17 - (this is a decrease of 0.6 from the 2011 score, but is worse than the acute Trust average of 3.12;
- % suffering work-related stress in the past 12 months The response rate of 34% is 7% higher than the 2011 score of 27% this is below (better than) the national average for acute trusts of 37%. However, the percentage is still high and has increased since the previous year;
- % of staff saying hand washing materials are always available. – 52% which is an identical score to the 2011 survey findings and below (worse than) the national average of 60%;
- % receiving health & safety training in last 12 months – 63% respondents stated that they had received this training in the past 12 month - a 12% decrease from the 2011 score of 75% and in the worst 20% of acute trusts. The National average was 74%;
- % witnessing potentially harmful errors, near misses or incidents to other staff or to patients in the last month – 39% which an identical score to that of the 2011 survey and in the highest (worst) 20% nationally;
- % experiencing harassment, bullying or abuse from staff or from patients/service users/ relatives/ public in last 12 months - 26% - an increase of 11% on the previous year's score and in the lowest (best) 20% nationally - however this is unacceptably high and a significant increase on the previous year;
- % experiencing harassment, bullying or abuse from managers/team leaders/colleagues in last 12 months – 27% - an increase of 12% on the previous year's scores, and above (worse than) the national average of 24%;
- % experiencing physical violence from staff or from patients/service users/relatives/public in last 12 months – 14% - an increase of 6% on the 2011 8% response. This is average for acute trusts;
- % having equality and diversity training in last 12 months – 50% - this is slightly below the 2011 survey result of 51% and below (worse than) average of 55%. It is noted, however, that 88% of respondents said that they had received this training either in the past 12 months or more than 12 months ago – which is 2% above the national average;

- % experiencing discrimination at work in last 12 months - 12% - this is a 2% decrease on the 2011 score, but is above (worse than) average of 11%, and;
- In addition, work will be carried out with focus groups and via further specific surveys to identify and address areas of concern expressed by nursing staff.

It is anticipated that further actions will be added following full communication with staff. This feedback and the finalised action plans will support the Trust's staff engagement activities for 2014/15.

(vi) Communication with staff

The Chief Executive holds Quarterly open staff meetings which all staff are encouraged to attend. These provide an opportunity for staff to hear about issues affecting the Trust and a chance to contribute their views. This year we introduced the Leadership Forum, a place for senior managers to come together to hear from the directors and leaders of the Trust in a more informal setting and to in turn engage with their own staff groups. In addition, the weekly Trust email bulletin 'Newsbeat' provides a mix of staff and Trust news and information, including an update on performance and a message from the Chief Executive.

With respect to actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the NHS foundation trust, in addition to the channels of communication mentioned, the Director of Finance and Information has addressed meetings with consultant staff. His deputy, the Head of Finance speaks on these matters at the Joint Consultative Committee, and there are other briefings made by divisional management staff through Divisional Management Board, team briefings, operational planning and of information available to the Finance Committee and Trust Board of Directors.

(vii) Key trust meetings – information

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

(viii) Staff magazine

The bi-monthly staff magazine 'Voices' recognises success amongst staff and is a well-recognised and well-received publication, featuring teams, individuals, updates from our charities and news relating to the Trust in an informal and interesting way.

(ix) Values training

Our key priority is to ensure that our patients not only receive excellent clinical treatment but are treated respectfully and with dignity and compassion at every stage of their care. It is also vital for us to ensure that our

staff are treated, and treat each other with, the same level of dignity and respect that we expect for our patients.

The Trust values act as an invaluable guide to the principles of how we expect each other to behave to patients, relatives, carers, visitors and each other. The values reflect the undertaking set out in our mission to provide *Expertise with Compassion* through the delivery of high quality care which is sensitive to individual need. The values are embedded at recruitment and induction stages and are clearly and regularly communicated. Commencing in May 2012, Living the values training for all staff has been rolled out with approximately 3,800 staff receiving training so far.

The values training provides opportunities for reflection for all staff about how their behaviour at work impacts on patient experience and on their colleagues. The emphasis of the training is that living the values means respecting everyone, communicating effectively, embracing change which results in improved patient care, working together and demonstrating a positive and proactive attitude in everything we do. These values are then linked directly to the experience of patients, carers, relatives and other members of staff. Through the examination of complaints and compliments we can understand where values have been demonstrated effectively, resulting in improved care and experience for our service users and staff, and where improvements can be made. The sessions are also used as an opportunity to engage staff in suggesting improvements to services for patients.

(x) NHS change day

National NHS Change Day was on 13 March 2013. The Trust asked staff from all areas including executives, managers, clinical leaders and people from clinical and non-clinical teams to move around the Trust asking staff to commit to making a change to improve care for patients, their families and their carers. This could be done by writing a pledge or suggestion either on a postcard or via a website. The Trust received 434 contributions – through pledges/ suggestions/ideas on the national website, our bulletin board or by completion of Change Day postcards. The majority of pledges were for more training, improved engagement with patients and taking opportunities to share learning with colleagues. Other popular ideas focused on improving communication and improving our facilities. These ideas are being reviewed and will be shared with relevant senior managers to see what can be taken forward.

(xi) Acknowledging excellence and recognising success

The Trust has a variety of schemes to reward excellence and to recognise and celebrate service and success by individuals and teams. These include:

- Recognising Success Awards – An annual awards ceremony and celebration dinner which recognises exceptional performance and achievements of staff in support of the Trust's vision, values and goals;
- Divisional Schemes – Some Divisions have implemented their own awards for excellence. These encourage nominations and give awards to teams or individual members of staff in recognition and appreciation of teamwork and commitment which improve services for patients and staff;
- The facilities and estates service has a recognition award for Excellence scheme, encouraging nominations for people in the Division who have achieved something special in terms of their service delivery towards patients, Trust staff and/or visitors or have overcome adversity or pressures/demands within the Division, which is believed to deserve being recognised as being out of the ordinary;
- Celebration of Service Awards – each year the Trust celebrates the service of staff who have reached 30 years' service with the Trust – in recent years this ceremony has been part of the Annual Members' Meeting and most recently was part of the recognising success awards evening, and;
- Each year the Trust celebrates International Nurses Day on 12 May by holding an event for the Trust's nurses.

(xii) Additional surveys

In addition to the National NHS Staff Survey, other work is carried out to seek the views of staff across the Trust. In 2012, the Loud and Clear survey team conducted 513 short, quantitative interviews with staff across the Trust. Qualitative research was then undertaken in the form of seven focus groups during October 2012 across all staff groups. Similar surveys had also been carried out in 2009 and 2011. Feedback from both surveys is communicated to senior managers and executives of the Trust for onward communication to staff.

(xiii) Tackling harassment and bullying

A task and finish group has been working in a number of areas around tackling harassment and bullying in the Trust. In addition to strengthening the existing policy and procedure, the group has focused on:

- Developing questions for an additional survey on people's experience and perception of harassment and bullying in the Trust;
- Carrying out a small scale initial survey on harassment and bullying, via the Trust values training, which measures what people believe

bullying to be and the methods by which people would like further surveys to be carried out;

- Creating a diagnostic toolkit to address concerns in areas where bullying/ harassment/ inappropriate behaviour is known/strongly suspected but no formal complaint has been made. This toolkit is now included in policy directions;
- Communications for all staff around raising concerns about harassment and bullying and sources of support; and'
- Specifically targeted information for junior doctors on how to raise concerns and sources of support available.

(xiv) Statement of approach to equality and diversity

The Trust is committed to eliminating discrimination, promoting equality of opportunity, and providing an environment which is inclusive for patients, carers, visitors and staff. We aim to provide equality of access to services and to deliver healthcare, teaching, and research which are sensitive to the needs of the individual and communities, and we are committed to providing equal access to employment opportunities and an excellent employment experience for all.

The Trust Board of Directors is responsible for ensuring that the Trust's commitment to equality and diversity is implemented at all levels of the organisation and that all business is carried out in accordance with the values of the organisation. The Board monitors the implementation of its equality and diversity work as part of its annual cycle of Board reporting and the Board Assurance Framework.

The Director of Workforce and Organisational Development is the nominated lead director for equality and diversity on the Trust Board and is the chair of the Trust's Equality and Diversity/Health and Wellbeing Group.

Implementation of the Equality Act 2010 and the Public Sector Equality Duty associated with the Act, form the foundation of equality and diversity activities in the Trust.

The Public Sector Equality Duty requires the Trust to have due regard to the need to:

- eliminate discrimination, harassment and victimisation;
- advance equality of opportunity between people who share a characteristic and those who do not, and;
- foster good relations between people who share a characteristic and those who do not.

The Trust uses the NHS Equality Delivery System as the principal means of fulfilling the Public Sector Equality Duty. The Trust's Equality and Diversity Report profiling our staff and patients has been revised to reflect information as at January 2013; the publication of the Trust's Equality Objectives as required for statutory compliance with the Act. Whilst further information is

available on the Trust's website, some of the key findings in the 2013 report on Trust staff are identified in this report as follows:

- Only 9% of Trust staff are aged under 25 compared to 11% in 2011/12 with 23.5% over 50 years old;
- Just over 3% of staff reported a disability;
- 22% of Trust staff are from a black or minority ethnic background;
- Black or minority ethnic staff are under-represented in higher pay bands, and;
- Just 1.3 % of staff identify as lesbian, gay or bisexual, although the national average is around 5%.

(xv) Protected characteristics

The Duty covers nine protected characteristics as defined in the Equality Act. These are: age, disability, gender, gender re-assignment (transgender), pregnancy and maternity, race, religion or belief, sexual orientation and marriage and civil partnership. The Trust has reported on our data and monitoring of patients and staff and identified where there are gaps in our knowledge.

(xvi) Training on the Equality Act

Training for managers on the Equality Act took place during 2011/12 and with further training planned in 2013 for all new managers.

Information about the Equality Act and wider principles of equality and diversity are being included in the revised Trust values training sessions.

(xvii) The NHS equality delivery system

The Trust continues to implement the NHS Equality Delivery System. Evidence of the organisation's performance across the 18 outcomes of the Equality Delivery System has been collected from a range of sources. Evidence collated to support the Trust's declarations of compliance with the Care Quality Commissions Outcomes—has been useful in demonstrating compliance elements of the Equality Delivery System, as has the Trust's Quality Report. Commitments made by the Trust to the principles of the NHS Constitution are also relevant and have been cited where appropriate.

The Trust has continued previous engagement work with five other local NHS trusts to ensure a co-ordinated and effective use of time and support from a range of individuals and stakeholders, including local involvement networks, the overview and scrutiny committees of local authorities covering the Trust's membership areas and voluntary sector organisations representing people from protected groups.

The Patient and Public Involvement (PPI) officer has run various engagement events including groups on patient access, maternity services, and working with our specialist nurses on dementia care and learning disabilities.

There were no formal consultations conducted 2012/13. A formal consultation will take place where the relevant Health Overview and Scrutiny Committee (HOSC) determines there to be a substantial variation of service. The Bristol Homeopathic Hospital (BHH) move to South Bristol Community Hospital was submitted to HOSC and determined as not a substantial variation. BHH patient representatives were involved in PPI activities about the geographic move of this service.

(xviii) Action plans and timeframes to address any shortfalls

A review of the outcomes from the Trust's Equality Delivery System is being conducted as at the time of this report. Any outcomes requiring specific objectives will be presented to the Equality and Diversity/Health and Wellbeing Group for approval and future monitoring.

(xix) Priorities, monitoring arrangements and targets

Equality impact assessments are used for new services and service re-designs and demonstrates the changing needs of the local community.

The management of Trust staff is supported by key performance indicators that are reported to the Board every month. Key indicators include vacancy and turnover rates, sickness absence rates, appraisal compliance rates, mandatory and statutory training rates and bank and agency usage. Indicators are analysed and the results are used to ensure compliance with national targets and local action plans.

All new staff undertake online equality and diversity training as part of the induction programme and the aim is to increase coverage year-on-year and to develop further training programmes for managers. The Trust has developed a task and finish group which has been working in a number of areas around tackling harassment and bullying.

The Trust understands its obligations to ensure that people with disabilities are given equal opportunity to enter into employment and progress wherever possible. Recruitment procedures have been aligned with the Equality Act's requirements for good practice for pre-application health checks permitted in the Equality Act.

The Trust complies with the "Positive about Disabled People" scheme. This scheme commits the Trust to interview all applicants with a disability who meet the minimum criteria for a job vacancy and consider them on their skills, experience and knowledge. All staff must adhere to the Trust Equal Opportunities in Employment policy and Recruitment policy.

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

The Trust has established three staff forums: for black and minority ethnic staff; staff with disabilities and lesbian, gay, bisexual and transgender staff,

enabling staff from these groups to raise issues among peers and to contribute to Trust policy.

The Trust is developing its career pathways and succession planning processes as part of the Teaching and Learning strategy to ensure transparency and equity of opportunity for all. It is a requirement that all staff are appraised annually.

A range of communication channels are used to keep employees informed on current developments. This includes regularly updated information on the intranet, a weekly e-bulletin and information in the staff magazine, as well as information included with monthly payslips.

The Trust works in partnership with its Trades Union colleagues and staff side representatives. Equality and diversity issues can be raised at any point but notably the Industrial Relations Group regularly reviews equality data and all Trust employment policies are agreed in partnership and are equality impact-assessed.

(xx) Equality objectives and statement of compliance with publication duties

The Equality Act requires the Trust to publish its equality objectives by 6 April 2013. The following two draft objectives for the Trust are set out below and have been published on the Trust's website.

- We become an acknowledged regional leader in equality and diversity outcomes both for our patients and staff. (This includes specific commitments to staff training, to patient satisfaction levels and to mitigating differential experiences reported in healthcare), and;
- We become a national exemplar for the NHS Equality Delivery System. (This is a commitment to make the Scheme work for the benefit of all the Trust's patients and staff in 2012/13).

(xxi) Summary of performance – workforce statistics:

(A) Staff in post diversity profile (data point January 2013)

	January 2013	
Gender	Total	%
Male	1,916	23.95%
Female	6,085	76.05%
TOTAL	8,001	100.00%

	January 2013	
Ethnicity	Total	%
A - White - British	6,231	77.88%
B - White - Irish	96	1.20%

	January 2013	
C - White - Any other White background	415	5.19%
D - Mixed - White & Black Caribbean	27	0.34%
E - Mixed - White & Black African	15	0.19%
F - Mixed - White & Asian	26	0.32%
G - Mixed - Any other mixed background	54	0.67%
H - Asian or Asian British - Indian	353	4.41%
J - Asian or Asian British - Pakistani	37	0.46%
K - Asian or Asian British - Bangladeshi	6	0.07%
L - Asian or Asian British - Any other Asian background	100	1.25%
M - Black or Black British - Caribbean	125	1.56%
N - Black or Black British - African	225	2.81%
P - Black or Black British - Any other Black background	58	0.72%
R - Chinese	51	0.64%
S - Any Other Ethnic Group	173	2.16%
Z - Not Stated	9	0.11%
TOTAL	8,001	100.00%

	January 2013	
Disability	Total	%
No	7,527	94.08%
Not Declared	220	2.75%
Yes	254	3.17%
Total	8,001	100.00%

	January 2013	
Age Profile	Total	%
16 – 20	58	0.72%
21 – 25	661	8.26%
26 – 30	1,099	13.74%
31 – 35	1,222	15.27%
36 – 40	1,073	13.41%
46 – 50	990	12.37%
51 – 55	1,021	12.76%
56 – 60	890	11.12%

	January 2013	
Age Profile	Total	%
61 – 65	663	8.29%
Age over 65	265	3.31%
Total	59	0.74%

	January 2013	
Religious Belief	Total	%
Atheism	785	9.81%
Buddhism	38	0.47%
Christianity	3,332	41.64%
Hinduism	82	1.02%
Islam	130	1.62%
Jainism	3	0.04%
Judaism	8	0.10%
Sikhism	13	0.16%
Other	437	5.46%
I do not wish to disclose my religion/belief	3,173	39.66%
Total	8,001	100.00%

	January 2013	
Sexual Orientation	Total	%
Bisexual	30	0.37%
Gay	42	0.52%
Heterosexual	4,793	59.91%
I do not wish to disclose my sexual orientation	3,103	38.78%
Lesbian	33	0.41%
TOTAL	8,001	100.00%

(xxii) Analysis of staff diversity profile

As at January 2013, the split between male and female staff is 24% and 76% respectively. This figure has not changed from last year.

The number of black and minority ethnic staff working in the Trust is 22% (this figure includes ‘white Irish’ and ‘white other’ backgrounds).

254 staff declared themselves as having a disability as at January 2013, compared to 234 in the previous year. This figure has increased significantly through the Trust encouraging staff to declare any disability or impairment. This equates to 3.2% of the workforce compared to 2.9% in the previous year.

The number of staff employed in the age group of 16-25 is 719, an increase of 17 from the previous year. This group of staff represents 9% of the workforce. The number of staff aged 56 years or above has increased very slightly from 981 to 987.

(xxiii) Occupational health service

The Trust works with Avon Partnership NHS Occupational Health Service to provide an integrated occupational health service with the objective of making a positive impact on sickness absence through both healthy working environments and healthy management styles. The service works proactively, through consensus and evidence based practice, to enable staff to achieve and maintain their full employment potential within a safe working environment, thus enhancing the quality of their working lives.

Avon Partnership NHS Occupational Health Service was formed in October 2001, bringing together a wealth of experience from within the occupational health departments of the Trust (then United Bristol Healthcare NHS Trust), North Bristol NHS Trust and Weston Area Health NHS Trust. Avon Partnership is now one of the largest fully integrated NHS Occupational Health services within the NHS in England and Wales, and provides comprehensive occupational health care to partner trusts and other organisations. It has been recognised as an exemplar service for its innovation and efficiency and was mentioned in the recent 'Boorman' review of Occupational Health services in the NHS for its 'Physio-direct' service. This service supports staff by telephone with early intervention for musculoskeletal issues. It is also piloting a service to support Trust staff while away from work by signposting appropriate support.

(xxiv) A safe working environment

The overall strategy for health and safety in the Trust complies with the Health and Safety (Guidance) 65: Successful Health and Safety Management, which is implemented in full as the healthcare model for safety management systems. Health and safety risk assessments, safe systems of work, practices and processes ensure that all key risks to compliance with the legislation have been identified and addressed.

Health and safety is integral to the Trust's Risk Management Strategy, from which the three-year Risk Management Training Plan April 2010 - June 2013 has been developed. In January 2012 the Risk Management Training Needs Analysis was replaced by the Essential Training matrix which is currently under review. In addition there is the annually reviewed Risk Management matrix which identifies needs beyond the essential requirements for all staff based on the employee's role e.g. Health & Safety for Executives/ Senior Managers or mandatory departmental needs e.g. Manual Handling Risk Assessors. The annually reviewed Risk Management Training Prospectus and

Training Delivery Plan includes all statutory and mandatory, patient safety and risk management training.

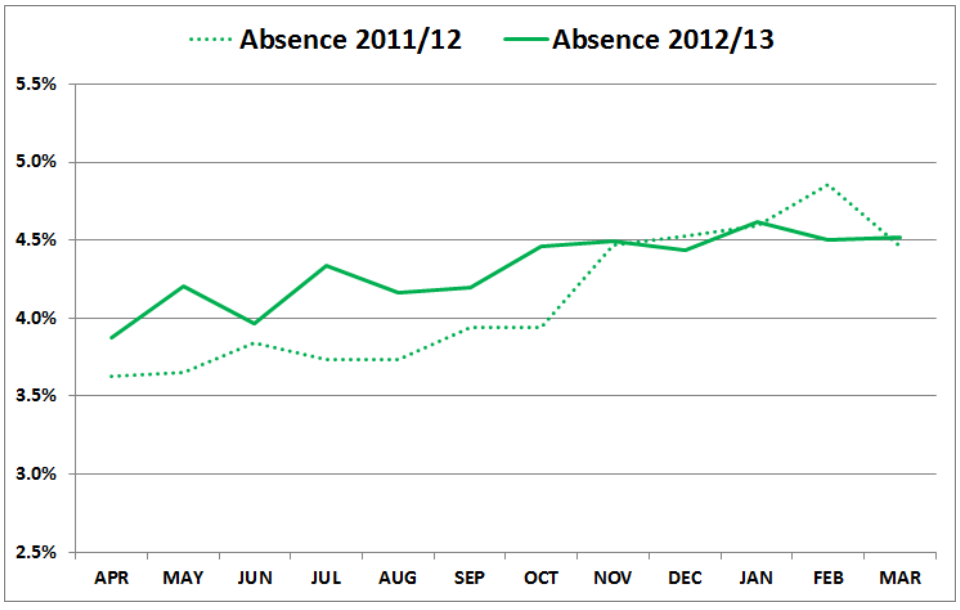
Issues and concerns raised by external audit, external enforcement and assessment agencies (including the Health and Safety Executive, the Healthcare Commission, Willis Ltd and the NHS Litigation Authority) are addressed and where possible resolved. There is a trust key performance indicator to achieve 5% improvement annually with the overall compliance of the Willis Risk Management audit. This assists with the Trust objective in the Assurance framework to comply as far as is reasonably practicable with all Health & Safety Regulations and as such each Divisional Operating Plan includes a section which covers their Health & Safety concerns and an action plan for improving compliance. This is monitored at the Quarterly divisional reviews to assure of progress against each divisions top five Health & Safety priorities.

Where any issues or concerns are outstanding, these matters are taken to the Board with appropriate action plans in place to address the issues. A formal log is kept on the Risk Register in each Division, or depending on impact, the Corporate Risk Register.

(xxv) Sickness absence

There was a Trust-wide increase in sickness absence in the year ended 31 March 2013. Length of sickness increased with more employees taking 1-3 days absence in 2012/13 compared to 1 day absence in 2011/12.

In 2012/13 within the top five reasons for sickness, there has been a 30% increase in calendar days lost due to anxiety/stress, with gastrointestinal problems showing a 16% increase compared with 2011/12.The Trust-wide sickness absence rate was 4.3% for 2012/13 compared with 4.1% for 2011/12 as shown in the graph below.



The average number of days lost to sickness per full time equivalent (FTE) was 9.6 for 2012/13 compared to 9.1 for 2011/12.

2011/12		2012/13		
Sickness Rate	Days lost per FTE	Sickness Rate	Days lost per FTE	Improvement/ Deterioration
4.1%	9.1	4.3%	9.6	5% Deterioration

Whilst there was an overall increase in absence, the rate reduced in Medicine, Women's and Children's and Trust Services. Divisions have robust measures in place to reduce absence in 2013/14, including panels to review and challenge areas of high absence, production of percentage attendance reports and the provision of detailed information to managers through the Qlikview application.

(j) Our wider role and future developments

We remain committed to involving and consulting patients and the public in the planning of our services with the aim of ensuring that our services continue to meet, and wherever possible, exceed the expectations of patients. The Trust does so in accordance with Section 242 of the NHS Act 2006. Patient involvement activities during 2012/13 are summarised in the 'Patient Experience' section of the Quality Report.

The Trust's core patient experience strategy ensures that we gather feedback from patients in a wide variety of ways which includes the use of comments cards made available on wards and in clinics; a monthly post discharge inpatient survey; an annual outpatient survey and bi-monthly ward-based interviews. In addition, in 2012/13 the Trust undertook a further 80 patient surveys seeking to understand patients' experience of the quality of, and access, to services. We believe this comprehensive approach to understanding how patients experience our services will ensure that the wide variety of views held by patients are captured and positively influence the development of our services.

With changes to the national landscape in relation to the commissioning of our services, we continue our efforts to build relationships with these new stakeholders both locally, with respect to GP commissioners, and in relation to nationally commissioned services through the local presence of the National Commissioning Board. Whilst 2012/13 has been a year of transition, relationships are starting to flourish and the commitment to work together for the benefit of patients is stronger than ever.

The Trust's Transforming Care Programme signals the importance of Leading in Partnership with a wide range of stakeholders and we take this responsibility very seriously. Beyond our commissioning partners, we recognise the value of other key relationships including our academic partners, charitable partners, community and social care providers, the voluntary sector and individual volunteers who partner us in delivering care every day throughout the Trust.

Despite the challenging financial climate, the Trust is committed to a number of developments in the coming years, made possible through strong financial stewardship in previous years and the support of our commissioners to ensure we are able to offer services appropriate to the needs of our patients.

Service developments planned for the period 2013/14 include:

- The establishment of a dedicated Cardiac High Dependency Unit (HDU) in Ward 32 of the Bristol Royal Hospital for Children (BRHC) which will provide care for children who have undergone cardiac surgery and for any other children with cardiology conditions who have higher than usual needs and for whom HDU care may be appropriate for part of their stay;

- The development of a six bedded medical High Dependency Unit within Ward 30 of the BRHC to provide higher levels of care to children with complex medical conditions and specifically those children supported through long term mechanical ventilation who often spend long periods of time in hospital and who require a greater degree of care and supervision to ensure their needs are met;

- The expansion of the Bristol Haematology and Oncology Centre which will conclude in 2013/14 and will enable the creation of a single, integrated haematology and bone marrow transplant unit, alongside the development of dedicated facilities for teenagers and young adults with cancer. The scheme will also enable the upgrade of radiotherapy equipment to ensure the Trust is able to deliver the most up to date, and comprehensive range of cancer treatments, and;

- Alongside improvements in clinical services, the Trust will open the doors to its new Welcome Centre during 2013/14 which will provide a new and inviting main entrance to the BRI. This facility will not only create a bright and welcoming first impression for patients and visitors to the Trust but will respond to the different needs of patients, visitors and staff whilst they are in our hospitals through the provision of a range of patients' services alongside five major retailers. The Welcome Centre is being funded through an innovative public private partnership and as well as providing a valuable range of facilities, it will provide a future income stream to support the delivery of patient care.

Finally, 2013/14 sees the count-down to our two major capital schemes which have been in the planning and construction phase for many years.

- An £92 million capital scheme to support the redevelopment of the Bristol Royal Infirmary to enable the delivery of new, progressive models of care from a fit-for-purpose estate. Benefits will include the retirement of all existing nightingale wards, the creation of a 60-bed integrated assessment unit and a significant increase in the proportion of single rooms. The scheme includes the creation of a helipad and much needed improvements to the façade of the Queens Building, and;

- A £32 million scheme to extend the Bristol Royal Hospital for Children to accommodate the transfer of specialist children's burns and neurosciences services from Frenchay Hospital, operated by North Bristol NHS Trust. This will provide a single, co-located service for children serving the South West and beyond.

(k) Environmental impact and sustainability

The Trust has reviewed its environmental campaign and carbon reduction plans and is developing a single sustainability action plan to draw all of the activities of the Trust under the Big Green Scheme, including the development of sustainable models of care, procurement and travel. We are working in partnership with the University of Bristol to pilot the Green Impact awards scheme in the NHS.

We have increased our spend-to-save investment programme to reduce our energy consumption across the estate focussing on improving the efficiency and control of heating, lighting and cooling.

As well as implementing climate-change mitigation measures we continue to work with our partners in the Avon Health Executive Resilience Group to ensure our obligations with regards to emergency preparedness and adaptation under the Climate Change Act are being complied with. Regular exercises to test a range of scenarios have been undertaken and the lessons learned have been incorporated into our reviews and updates.

(i) Cost of energy

The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal. Although we reduced our overall consumption, due to increasing energy costs our expenditure has increased by 2% in 2012/13, the equivalent of 12 hip operations.

We have put plans in place to reduce carbon emissions and improve our environmental sustainability. Over the next five years we expect to save £2,855,000 as a result of these measures.

(ii) Waste

We recycle 272 tonnes of our waste each year, which is 16% of the total waste we produce. We plan to continue increasing the amount we recycle.

(iii) Energy consumption

Our total energy consumption has fallen during the year, from 89,246 MWh to 88,978 MWh. 21% of our electricity is generated by our on-site combined heat and power generation. 25% of the electricity we purchase is generated from renewable sources.

(iv) Carbon emissions

Greenhouse gas emissions from energy used have reduced by 1,096 tonnes this year.

(v) Water consumption

Our water consumption has decreased by 14,654 cubic meters in the recent financial year.

Our organisation has an up to date Sustainable Development Management Plan. Having an up to date Sustainable Development Management plan is a good way to ensure that an NHS organisation fulfils its commitment to conducting all aspects of its activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to approve such a plan.

Through our business continuity planning we have started to identify the risks we need to consider in adapting the organisation's activities and its buildings to cope with the results of climate change.

Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future.

NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations. Sustainability issues are included in our analysis of risks facing our organisation.

In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This is set out within our policies on sustainable procurement.

A Board-level lead for sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation. All our staff have sustainability issues, such as carbon reduction, included in their job descriptions.

Staff awareness campaigns have been shown to deliver cost savings and associated reductions in carbon emissions. Our Green Impact staff energy awareness campaign is on-going and the efforts of our green champions continue to improve the Trust's sustainability through, for example, our sustainable transport programme.

3.6 Remuneration Report

Details of the remuneration, salaries, allowances and pensions for senior managers of the Trust are set out in full starting at note 6.8 on page 26 of the Annual Accounts attached at "Appendix D – Annual Accounts 2012/13". Accounting policies for pensions and other retirement benefits (which apply to all employees) are also contained in the Annual Accounts at note 1.3 to the accounts.

(a) Remuneration of Executive Directors[5]

The remuneration and allowances, and the other terms and conditions of office of the Executive Directors are determined by the Remuneration Committee which is established by the Board in accordance with Schedule 7 of the NHS Act 2006 (paragraph 18(2)), Schedule 1 of the University Hospitals Bristol NHS Foundation Trust Constitution (paragraph 30.2), and the Monitor NHS Foundation Trust Code of Governance Provision E.2.13. The Committee also reviews the suitability of structures of remuneration for senior management which includes the first layer of

[5] Information not subject to audit

management below Board level (in accordance with the Foundation Trust Code of Governance E.2.2.).

The Remuneration Committee consists of not less than three independent Non-executive Directors and the Chairman of the Trust Board of Directors. The Committee is chaired by the Vice Chair of the Trust. Details of membership and attendance are included on page 70.

The Committee is attended by the Director of Workforce and Organisational Development in an advisory capacity when appropriate, and is supported by the Trust Secretary to ensure it undertakes its duties in accordance with applicable regulation, policy and guidance.

In reviewing the suitability of pay and conditions of employment for senior managers, the Committee takes account of the principles and provisions of the Foundation Trust Code of Governance, national pay awards, comparable employers, national economic factors and the remuneration of other members of the Trust's staff. Levels of remuneration are set to be sufficient to attract, retain and motivate directors of the quality and with the skills and experience required to lead the NHS foundation trust successfully, but the Trust also avoids paying more than is necessary for this purpose.

The Committee takes into account the ratio relationship between the remuneration of the highest-paid director in the organisation and the median remuneration of the organisation's workforce. This ratio is disclosed in the 'Hutton Review of Fair Pay' set out at note 6.7 on page 26 of the Annual Accounts attached at "Appendix D – Annual Accounts 2012/13".

(b) Remuneration of Non-executive Directors[6]

The remuneration of the Chairman and Non-executive Directors is determined by the Governors' Nominations and Appointments Committee. The Committee is a formal Committee of the Council of Governors established in accordance with the NHS Act 2006, the University Hospitals Bristol NHS Foundation Trust Constitution, and the Monitor Foundation Trust Code of Governance for the purpose of carrying out the duties of governors with respect to the appointment, re-appointment removal, remuneration and other terms of service of the Chairman and Non-executive Directors.

Members of the Committee are appointed by the Council of Governors as set out in paragraph 10 of Annex 7 of the Trust's Constitution (Standing Orders of the Council of Governors). The membership includes:

– four elected public, patient or carer governors;

– two appointed governors, and;

– one elected staff governor.

The Committee is Chaired by the Chairman of the Trust (pursuant to Provision C.1.3 of the NHS Foundation Trust Code of Governance, and in his absence, or when the Committee is to consider matters in relation to the appraisal, appointment, re-

[6] Information not subject to audit

appointment, suspension or removal of the Chairman, the Senior Independent Non-executive Director).

The principal functions of the Committee with regard to remuneration are: to consider and make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Chairman and other Non-executive Directors, and; on a regular and systematic basis to monitor the performance of the Chairman and other Non-executive Directors and make reports thereon to the Council of Governors from time to time.

The decisions of the Governors' Nominations and Appointments Committee are reported to the Council of Governors. In determining the remuneration for the Chairman and Non-executive Directors, the Committee takes account of the guidance provided by the Foundation Trust Network.

The Chairman and Non-executive Directors declined any increase in their remuneration in 2012/13 as they did in the previous two years.

(c) Assessment of performance[7]

All Executive and Non-executive Directors are subject to individual performance review. This involves the setting and agreeing of objectives for a 12 month period running from 1 April to the following 31 March. During the year, regular reviews take place to discuss progress, and there is an end-of-year review to assess achievements and performance.

Executive Directors are assessed by the Chief Executive. The Chairman undertakes the performance review of the Chief Executive and Non-executive Directors. The Chairman is appraised by the Governors' Nominations and Appointments Committee chaired for this purpose by the Senior Independent Director and advised by the Trust Secretary.

No element of the Executive and Non-executive Directors' remuneration was performance-related in this accounting period.

(d) Expenses

The Trust may pay travelling and other actual expenses to members of the Council of Governors and the Trust Board of Directors at rates determined by the Trust. Directors expenses are published on the Trust's website. Governors' expenses may be viewed on request to the Trust Secretariat.

(e) Duration of contracts[8]

All Executive Directors have standard substantive contracts of employment with a six-month notice provision in respect of termination. This does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the Executive Director.

[7] Information not subject to audit
[8] Information not subject to audit

(f) Early termination liability[9]

Depending on the circumstances of the early termination, the Trust would, if the termination were due to redundancy, apply the terms under Section 16 of the Agenda for Change Terms and Conditions of Service; there are no established special provisions. All other Trust employees (other than Non-executive Directors) are subject to national terms and conditions of employment and pay.

(g) Review of tax arrangements of public sector appointees[10,11]

(i) Off payroll engagements

This section lists any off-payroll engagements entered into at a cost of more than £58,200 per annum in place as of 31 January 2012.

As at the 31 January 2012, one contractor was engaged to undertake a specialist project for the Trust. Subsequent to this, the Trust has introduced a renegotiated contract to include contractual clauses allowing the Trust to seek assurance as to the contractor's tax obligations. There have been no unsuccessful re-negotiated contracts, no engagements have come on to the payroll and none has been terminated.

All new off-payroll engagements between 23 August 2012 and 31 March 2013, at a cost of more than £220 per day and longer than six months are as follows:

Number of new engagements	3
Number of which include contractual clauses giving University Hospitals Bristol NHS Foundation Trust the right to request assurance in relation to income tax and National Insurance obligations of the contractor	0
No. for whom assurance has been accepted and evidence received	2
No. for whom assurance has been accepted and evidence not received	1
No. that have been terminated as a result of assurance or evidence not being received	0

(h) Sundry[12]

Please also refer to the notes in the 2012/13 Annual Report at note 6.8 on page 27 of the Annual Accounts attached at Appendix D to this report in respect of the following:

– Salaries and allowances;

– Benefits in kind;

– Pension benefits for the year ended 31 March 2013;

[9] Information not subject to audit

[10] In accordance with new reporting requirements published by HM Treasury in PES(2012)17 'Annual Reporting Guidance 2012-13' December 2012.

[11] Information not subject to audit

[12] Information subject to audit

- Pension benefits for the year ended 31 March 2012, and;
- Value of the cash equivalent transfer value at the beginning of the year.

4. NHS Foundation Trust Code of Governance

University Hospitals Bristol NHS Foundation Trust NHS Foundation Trust is a 'public benefit corporation' and is required either to comply with the practices set out in the NHS Foundation Trust Code of Governance or to explain what suitable alternative arrangements it has in place for the governance of the Trust.

The NHS Foundation Trust Code of Governance (the Code), maintained by Monitor and last published in 2010, sets out an overarching framework for the governance of Foundation Trusts which aims to bring together best practice from a number of recognised governance references, including the UK Corporate Governance Code (formerly the Combined Code) that sets out standards of good practice in relation to board leadership and effectiveness, remuneration, accountability and relations with shareholders for the private sector.

The Code requires Foundation Trusts to disclose how they have applied the main and supporting principles of the Code and to provide an explanation of any alternative arrangements, should they not be complying with the more detailed provisions of the Code. The Board is committed to the highest standards of good corporate governance and follows an approach that complies with the main and supporting principles of the Code.

This section (4), the Directors' Report on page 16 (in particular sections 3.2 and 3.3: composition of the Board and the independence of the non-executive directors, and section 3.6: the Remuneration Report), the directors' biographies on page 88 and the Annual Governance Statement on contained in the Annual Accounts, together describe how the Trust applied the principles of the Code during the year.

4.1 Compliance with the Code

It is recognised by Monitor that departure from the provisions of the Code can be justified where an alternative approach better suits the particular circumstances of the Trust. The Board has considered the extent to which the Trust satisfied the provisions of the Code and for the year ending 31 March 2013 the Board considers that it was fully compliant with the provisions of the Code.

4.2 Trust Board of Directors

In accordance with the Foundation Trust Code of Governance Main Principle A.1. the Trust is headed by a Board of Directors with collective responsibility for the exercise of the powers and the performance of the Trust. The Trust Board of Directors of an NHS Foundation Trust is accountable for the stewardship of the Trust, its services, resources, staff, and assets. The arrangements established by a Board must be compliant with the legal and regulatory framework, protect and serve the interests of stakeholders, specify standards of quality and performance, support the achievement of organisational objectives, monitor performance, and ensure an appropriate system of internal control. Directors are jointly and severally responsible for all of the decisions of the Board.

The University Hospitals Bristol NHS Foundation Trust Foundation Trust Constitution specifies that the Board of Directors shall comprise:

- a non-executive Chair;
- up to seven other Non-executive Directors (one of which may be nominated as the Senior Independent Director), and;

- up to seven Executive Directors.

To ensure the balance and effectiveness of the Board, the Foundation Trust Constitution further requires that:

- one of the Executive Directors shall be the Chief Executive;
- the Chief Executive shall be the Accounting Officer;
- one of the Executive Directors shall be the Finance Director;
- one of the Executive Directors shall be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984);
- one of the Executive Directors shall be a registered nurse or a registered midwife, and;
- the Board of Directors shall at all times be constituted so that the number of Non-executive Directors (excluding the Chair) equals or exceeds the number of Executive Directors.

Appointments to the Board both of Executive and Non-executive Directors in the reporting period meant that the Board was fully constituted whilst utilising the services of two 'acting' Executive directors. The Board does not consider that its performance or balance as a whole was significantly impacted during the period of 'acting' arrangements, and the Nominations and Appointments Committee has considered succession plans for both posts.

The Board is accountable to stakeholders for the achievement of sustainable performance and the creation of stakeholder value. It is responsible for organising and directing the affairs of the Trust and its services in a manner that will promote success and is consistent with good corporate governance practice, and, for ensuring that in carrying out its duties, the Trust meets its legal and regulatory requirements. In doing so, the Board of Directors ensures that the Trust maintains compliance with its terms of authorisation and other statutory obligations.

The Board reserves some responsibilities to itself, delegating others to the Chief Executive and other Executive Directors. Those matters reserved to the Board are set out as a formal schedule which includes approval of:

- the Trust's long-term objectives and financial strategy;
- annual operating and capital budgets;
- changes to the Trust's senior management structure;
- the Board's overall 'risk appetite';
- the Trust's financial results and any significant changes to accounting practices or policies;
- changes to the Trust's capital and estate structure, and;
- conducting an annual review of the effectiveness of internal control arrangements.

The Trust Board of Directors delegates responsibility to the Chief Executive to:

- enact the strategic direction of the Trust Board of Directors;
- manage risk;
- achieve organisational compliance with the legal and regulatory framework;
- achieve organisational objectives;

- achieve specified standards of quality and performance, and;
- operate within, generate and capture evidence of the system of internal control.

(a) Board of Directors – disqualification

The following may not become or continue as a member of the Trust Board of Directors:

– A person who has been adjudged bankrupt or whose estate has been sequestrated and who (in either case) has not been discharged;

– A person who has made a composition or arrangement with, or granted a Trust deed for his creditors and who has not been discharged in respect of it;

– A person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him, and;

– A person who falls within the further grounds for disqualification.

(b) Members of the Trust Board of Directors

The table below sets out the names, appointment dates and tenure over two terms of three years each of the Chairman, Vice Chair, Senior Independent Director and Non-executive Directors of the University Hospitals NHS Foundation Trust Board of Directors.

All of the Non-executive Directors serving on the Trust Board of Directors were considered to be 'independent' as defined in the Foundation Trust Code of Governance when assessed at a formal meeting of the Board on 29 May 2013.

Non-executive Directors	Appointment	End of 1st Term of Office	End of 2nd Term of Office
John Savage, CBE – Chairman	01 June 2008[13]	31 May 2011	31 May 2014
Emma Woollett – Vice Chair	01 June 2008	31 May 2011	31 May 2014
Iain Fairbairn – Senior Independent Director	01 June 2008	31 May 2011	31 May 2014
Lisa Gardner – Non-executive Director	01 June 2008	31 May 2011	31 May 2014
Selby Knox – Non-executive Director	01 June 2008	31 May 2011	31 May 2012[14]
Anthony (Guy) Orpen – Non-executive Director	02 May 2012	02 May 2015	02 May 2018
Paul May – Non-executive Director	01 November 2008	31 October 2011	31 October 2014
Kelvin Blake – Non-executive Director	01 November 2008	31 October 2011	31 October 2014

[13] John Savage, Emma Woollett, Iain Fairbairn, Lisa Gardner and Selby Knox previously served on the Board of United Bristol Healthcare NHS Trust as Non-executive Directors. Their terms of office on the Board of University Hospitals Bristol NHS Foundation Trust are calculated from the date of authorisation in accordance with Monitor guidance that: "The time a non-executive director has been appointed is taken from when that trust became an NHS foundation trust".

[14] Selby Knox retired from the Board at the end of May 2012.

Non-executive Directors	Appointment	End of 1st Term of Office	End of 2nd Term of Office
John Moore – Non-executive Director	01 January 2011	31 December 2014	31 December 2017

The table below sets out the names, offices, appointment dates and tenure of the Executive Directors of the University Hospitals NHS Foundation Trust Board of Directors:

Executive Directors	Appointment	End of Term of Office	Notice Period
Robert Woolley, Chief Executive	08 September 2010	Not applicable	6 months
Paul Mapson, Director of Finance and Information	01 June 2008[15]	Not applicable	6 months
Deborah Lee, Director of Strategic Development	4 February 2011	Not applicable	6 months
Sean O'Kelly, Medical Director	18 April 2011	Not applicable	6 months
Alison Moon, Chief Nurse	13 July 2009	30 March 2013	6 months
Steve Aumayer, Director of Workforce & Organisational Development	25 June 2009	30 April 2012	6 months
James Rimmer, Chief Operating Officer	04 July 2011	Not applicable	6 months
Claire Buchanan, Acting Director of Workforce & Organisational Development	01 May 2012	Not applicable	6 months
Helen Morgan, Acting Chief Nurse	18 March 2013	Not applicable	6 months

Biographies of the Chairman, Chief Executive and Directors are set out on page 88 of this report.

(c) Directors' interests

Members of the Board of Directors are required to disclose details of company directorships or other material interests in companies held which may conflict with their role and management responsibilities at the Trust. The register also contains any significant commitments of the Chairman and any changes to these during the year. The Trust Secretariat maintains a register of interests, which is available to members of the public by contacting the Trust Secretariat, contact details are shown on page 96.

(d) Meetings of the Board

The Board met on 23 occasions both in public and in private to discharge the duties described above, and to consider a comprehensive annual cycle of reports and business to be transacted. The Chairman of the Board submitted a report to the

[15] Paul Mapson and Robert Woolley previously served on the Board of United Bristol Healthcare NHS Trust as Executive Directors. Their dates of appointment to the Board of University Hospitals Bristol NHS Foundation Trust are shown as the date of authorisation or subsequent date of appointment, whichever is the later office.

Council of Governors at each meeting, highlighting any issues requiring disclosure to the Council of Governors. Attendance at meetings of the Board is set out in the table at Membership and attendance at Board and Committee meetings" on page 70 of this report.

4.3 Committees of the Trust Board of Directors

The Board has established the three 'statutory' committees required by the NHS Act 2006 and the Foundation Trust Constitution. The Directors Nominations and Appointments Committee, the Remuneration Committee and the Audit Committee each discharge the duties set out in the Foundation Trust Constitution and their Terms of Reference as set out below.

The Board has chosen to deploy two additional 'designated' committees to augment its monitoring, scrutiny, and oversight functions, particularly with respect to quality and financial risk management. These are the Quality and Outcomes Committee and the Finance Committee.

The role, functions and summary activities of the Board's committees are described below. Membership and attendance at Board and Committee meetings is set out on page 69 of this report.

(a) Directors Nominations and Appointments Committee

The purpose of the Directors Nominations and Appointments Committee is to conduct the formal appointment to, and removal from office, of Executive Directors of the Trust, other than the Chief Executive (who is appointed or removed by the Non-executive Directors subject to approval by the Council of Governors). The committee also gives consideration to succession planning for Executive Directors, taking into account the challenges and opportunities facing the Trust, and the skills and expertise that will be needed on the Board of Directors in the future.

As there were no appointments to the office of Executive Director on the Board in the reporting period, the committee's remaining function was to consider Executive succession planning. When meeting for this purpose, on two occasions, the committee took into account the potential for churn amongst Executive Directors, as well as contingency planning for unexpected circumstances. The Committee's approach to these circumstances was agreed, and the Chief Executive was briefed on preferred procedures. Two 'acting' directors were appointed to the Executive team in the course of the year by the Chief Executive. Neither appointment constituted an appointment to the Trust Board of Directors in a voting capacity. These were the Acting Director of Human Resources and Organisational Development and the Acting Chief Nurse.

Additionally, the committee considered and approved an application by the Chief Executive to establish the role of Deputy Chief Executive as an addition to the portfolio of an existing Executive Director. The principal purpose of the role, as approved by the committee is to fulfil the responsibilities of the Chief Executive role adequately with regard to the continuing strategic development of the organisation while ensuring that key standards of performance and quality are maintained. The committee agreed that it is important that the Chief Executive has the ability to delegate effectively while maintaining clarity of senior leadership inside the

organisation. Deborah Lee, the Director of Strategic Development was subsequently appointed to the new role of Deputy Chief Executive.

(b) Remuneration Committee

The Trust is required to appoint a Remuneration Committee in accordance with Schedule 7 of the NHS Act 2006 (paragraph 18(2)), Schedule 1 of the University Hospitals Bristol NHS Foundation Trust Constitution (paragraph 30.2), and the Monitor NHS Foundation Trust Code of Governance Provision E.2.1.

The purpose of the Remuneration Committee is to decide the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors, and to review the suitability of structures of remuneration for senior management.

The committee met on two occasions in the reporting period to consider the remuneration of Executive Directors. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure.

(c) Audit Committee

The Trust's new Audit Committee was formed in 2011 following a review of Board governance arrangements by the Trust Secretary. The Committee, which replaced the 'Audit and Assurance Committee', works in parallel with the Quality and Outcomes Committee. Three non-Executive Directors serve on both committees. This provides the Non-executive Directors with two different perspectives, allowing for comparison or 'triangulation' of similar or related intelligence when considering processes and outcomes.

Terms of Reference for both committees are published in the public domain. The Audit Committee consists of four Non-executive Directors and reviews the effectiveness of systems of governance, risk management and internal control across the whole of the Trust's activities. By comparison, the Quality and Outcomes Committee reviews the actions being taken by the Trust to ensure the on-going maintenance of standards of quality of care, and recommends to the patient experience which it may deem necessary.

The committee met on five occasions in the reporting period. The Chair of the committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

In particular during 2012-13, the Audit Committee reviewed the adequacy of:

- all risk- and control-related disclosure statements, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the controls in place and the appropriateness of the disclosure statements;
- policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and;

– policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

The committee sought reports and assurances from Directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. Notably, the committee oversaw improvements to the Board Assurance Framework and enhancements to the Risk Register undertaken by the executive Risk Management Group.

Additionally, the Audit Committee assessed the effectiveness and value provided by the Trust's procurement partner (South West Purchasing Consortium). The committee also initiated a strategic review of the Trust's Clinical Audit function. Finally, following the independent study in 2011 of the Trust's Estates Department, the committee sought assurances that the service improvement plan was being implemented.

(i) Independence and objectivity of the external auditor

In circumstances where the Trust's external auditor provides services which are not related to audit, i.e. 'non-audit services', the Foundation Trust Code of Governance recommends that the Trust provides "an explanation of how auditor objectivity and independence is safeguarded" (Foundation Trust Code of Governance F.3.8).

The Audit Committee is aware that the auditor, PwC, provides non-audit services to the Trust. The auditor has declared that they have made enquiries of all PwC teams providing services to the Trust and of those responsible in the UK Firm for compliance matters.

PwC have provided a statement of the perceived threats to independence and a description of the safeguards in place.

At the date of presenting the audit plan, PwC confirmed that in their professional judgement, they are independent accountants with respect to the Trust, within the meaning of UK regulatory and professional requirements and that the objectivity of the audit team is not impaired. Together with the safeguards provided by PwC, the Audit Committee accepts these as reasonable assurances of continued independence and objectivity in the audit services provided by PwC within the meaning of the UK regulatory and professional requirements.

(ii) Audit Committee Chair's opinion and report

In support of the Chief Executive's responsibilities as Accountable Officer for the Trust, the Audit Committee has examined the adequacy of systems of governance, risk management and internal control within the Trust. From information supplied, we have formed the opinion:

– There is a generally adequate framework of control in place to provide reasonable assurance of the achievement of objectives and management of risk;

- Assurances received are sufficiently accurate, reliable and comprehensive to meet the Accountable Officer's needs and to provide reasonable assurance;
- Governance, risk management and internal control arrangements within the Trust include aspects of excellence and there is on-going attention to control improvement where these are considered suitable;
- Financial controls are adequate to provide reasonable assurance against material misstatement or loss, and;
- The quality of both Internal Audit and External Audit over the past year has been satisfactory.

The Committee discharged its role through the year as follows:

- We reviewed the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical);
- We accepted valid evidence that there was an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee. The committee reviewed and approved the internal audit strategy, ensuring that it was consistent with the audit needs of the organisation as identified in the Assurance Framework. We considered the major findings of internal audit's work (and management's response). The Internal Auditor had unrestricted access to the chair of the committee for confidential discussion;
- We reviewed the work and findings of the external auditor and considered the implications and management's response to their work. The External Auditor had unrestricted access to the chair of the committee for confidential discussion;
- We reviewed the Annual Report and financial statements before submission to the Board;
- We ensured the Standing Financial Instructions and Standing Orders were maintained and kept up to date, with an annual review of instances where exceptions to the rules were made (this was not applicable in the reported year 2012/13);
- We reviewed the findings of other significant assurance functions, both internal and external to the organisation, and considered the implications to the governance of the Trust. This included a regular report from the NHS Counter Fraud Service, and;
- Additionally we specifically reviewed the Trust's Information Governance procedures, its Whistle Blowing Policy, and sought assurances regarding the control of data used in the Quality Report.

A new External Auditor was appointed in 2012, and a thorough handover was made prior to the closure of the Audit Commission. The Audit Committee welcomes the fresh approach being provided by PricewaterhouseCoopers and looks forward to the

Trust benefiting from their significant expertise. In the forthcoming year, the Audit Committee will review the following in detail:

- Clinical audit;
- External auditor's assurance of internal audit function and processes;
- Information governance;
- Procurement effectiveness;
- Exception reports (to trust standing orders and standing financial instructions);
- E-rostering, and;
- Emergency planning & business continuity.

(d) Quality and Outcomes Committee

The Quality and Outcomes Committee was established by the Trust Board of Directors to support the Board in discharging its responsibilities for monitoring the quality and performance of the Trust's clinical services and patient experience. This includes the essential standards of quality (as determined by Care Quality Commission's registration requirements), and national targets and indicators (as determined by the Monitor Compliance Framework).

The committee reviews the outcomes associated with clinical services and patient experience and, the suitability and implementation of risk mitigation plans with regard to their potential impact on patient outcomes. The committee is also required, as directed by the Board from time to time, to consider issues relating to performance where the Board requires this additional level of scrutiny. One example of this role in the year is the committee's monitoring the progress of the actions set out in the 'histopathology action plan'.

During the course of the year, the committee has considered a set of standard reports as follows:

- The compliance framework monitoring & declaration report;
- The quality and performance report;
- The corporate risk register;
- The histopathology action plan progress report, and;
- The clinical quality group meeting report (including clinical audit).

Additional targeted reviews have included:

- Complaints;
- National and local inpatient & outpatient surveys;
- Results of the annual programme of clinical audit;

- Quality objectives as set out in the annual plan and quality strategy;
- Draft quality report;
- Progress report on annual corporate quality objectives;
- Maternity services, including midwifery;
- Frail/elderly care, including dementia;
- Safeguarding adults and children;
- Communications with patients and carers;
- Diabetes (adults and children);
- Complex health needs (adults and children);
- Staff engagement (health and wellbeing);
- Update on the recommendations of the toft report;
- Induction of nurses and doctors;
- Productive outpatients;
- Accident and emergency 4-hour performance;
- Patient experience - discharge arrangements at strategic level;
- Serious and catastrophic incidents (including key actions arising from root cause analyses);
- External review of tissue viability & tissue viability escalation protocols;
- Draft corporate quality objectives, and;
- Strategy for care of the elderly.

The Committee met 10 times in the course of this reporting period. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

(e) Finance Committee

The Finance Committee has delegated authority from the Trust Board of Directors, subject to any limitations imposed by the Schedule of Matters Reserved to the Board, to review and make such arrangements as it considers appropriate on matters relating to:

- Control and management of the finances of the Trust;
- Target level of cash releasing efficiency savings and actions to ensure these are achieved;
- Budget setting principles;

– Year-end forecasting;

– Commissioning, and;

– Capital planning.

The Finance Committee met on twelve occasions in the course of this reporting period. The Chair of the committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

(f) Membership and attendance at Board and Committee meetings

The Trust Board of Directors discharged its duties during 2012/13 in twenty-three private and public meetings, and through the work of its committees. The table below shows the membership and attendance of Directors at meetings of the Trust Board of Directors and Board committees.

Figures in brackets (3) indicate the number of meetings the individual could be expected to attend by virtue of their membership of the Board or Committee. A figure of zero (0) indicates that the individual was not a member. 'C' denotes the Chair of the Board or committee.

	Trust Board of Directors	Directors Nominations & Appointments Committee	Remuneration Committee	Audit Committee	Quality & Outcomes Committee	Finance Committee
Number of meetings	25	2	2	5	10	12
Chairman						
John Savage	C23(25)	0(2)	1(0)	0(0)	2(0)	9(0)
Chief Executive						
Robert Woolley	25(25)	2(0)	2(0)	4(0)	0(0)	9(12)
Non-executive Directors						
Emma Woollett	21(25) (C2)	C2(2)	2(2) (C2)	0(0)	9(10) (C2)	10(12)
Iain Fairbairn	18(25)	2(2)	1(2)	4(5) (C1)	6(10)	0(0)
Lisa Gardner	25(25)	2(2)	2(2)	5(5)	0(0)	C12(12)
Selby Knox	4(5)	0(0)	1(1)	0(0)	0(0)	3(3)
Paul May	25(25)	2(2)	2(2)	5(5)	C8(10)	7(8)
Kelvin Blake	14(25)	1(2)	2(2)	0(0)	0(0)	8(12)
John Moore	23(25)	1(2)	2(2)	4(5)	10(10)	0(0)
Anthony (Guy) Orpen	16(20)	2(2)	1(2)	0(0)	0(0)	0(0)
Executive Directors						
Paul Mapson	25(25)	0(0)	0(0)	4(0)	0(0)	12(12)

	Trust Board of Directors	Directors Nominations & Appointments Committee	Remuneration Committee	Audit Committee	Quality & Outcomes Committee	Finance Committee
Deborah Lee	21(25)	0(0)	0(0)	0(0)	0(0)	0(0)
Sean O'Kelly	25(25)	0(0)	0(0)	0(0)	09(10)	0(0)
Alison Moon	21(23)	0(0)	0(0)	0(0)	7(9)	0(0)
Steve Aumayer	0(0)	0(0)	0(0)	0(0)	0(2)	0(0)
James Rimmer	21(25)	0(0)	0(0)	0(0)	9(10)	11(12)
Acting Directors						
Helen Morgan	2(2)	0(0)	0(0)	0(0)	1(0)	0(0)
Claire Buchanan	20(25)	0(0)	0(0)	0(0)	0(0)	0(0)

(g) Performance of the Board and Board Committees

Members of the Board are subject to on-going and regular individual performance appraisal in accordance with the Trust's appraisal policy and the Foundation Trust Code of Governance. Individual Executive Directors are appraised by the Chief Executive; Non-executive Directors and the Chief Executive are appraised by the Chairman, who is appraised by the Senior Independent Director in conjunction with the governors' Nominations and Appointments Committee.

The Trust Board of Directors undertakes an assessment of its performance each year to establish whether it has adequately and effectively discharged its role, functions and duties during the preceding year.

For this year's assessment, an online survey was used to capture directors' responses to a range of questions addressing standards drawn from relevant best practice reference sources. Results of the survey were combined with the findings of the Internal Audit report on the functioning of the Board's Committees to provide a picture of whether the revised governance format introduced by the Board at the beginning of 2011/12 continued to operate to requisite standards. The assessment, facilitated by the Trust Secretary also provided a view on elements such as Boardroom dynamics, behavioural governance, and the balance between the Board's strategic and operational focus.

The Board's performance, taking into account the role, function and work of the Board Committees, was considered to be of a suitable standard evidenced by a thorough programme of work supporting the system of internal control. However, vacancies in two of the five substantive Executive director portfolios were filled by 'acting' directors in the reporting period, and this was identified as a priority to be addressed by the Nominations and Appointments Committee and the Chief Executive.

Throughout the year, the Board adhered to a comprehensive cycle of reporting, maintained a robust Board Assurance Framework and Risk Register, and undertook the development established during the previous performance assessment.

The findings of Internal Audit, combined with the Head of Internal Audit Opinion set out in the Annual Governance Statement, support the Board's conclusions as to the efficacy of their performance. Some additional areas for development were identified, including reviewing the role and function of the Quality and Outcomes Committee and Audit Committee in the light of the Final Report of the Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust (the 'Francis Report').

Similar assessment exercises were undertaken for each of the Committees of the Board, all of which were considered to have discharged the duties set out in their Terms of Reference to the extent required to provide the functions set out in their Terms of Reference.

4.4 Council of Governors

NHS Foundation Trusts are 'public benefit corporations' and are required by the National Health Service Act 2006 to have a 'board of governors' and a 'board of directors'. Board of governors have recently been renamed 'council of governors' through amendments brought by the Health and Social Care Act 2012.

The general duties of a council of governors (as amended by the Health and Social Care Act 2012) are to:

- hold the non-executive directors individually and collectively to account for the performance of the board of directors, and,
- represent the interests of the members of the corporation as a whole and the interests of the public.

The Foundation Trust Constitution provides for all the powers of the corporation to be exercisable by the board of directors on its behalf.

It is the responsibility of the Board of Directors to:

- set the strategic direction of the organisation within the overall policies and priorities of the government and NHS;
- define its annual and longer term objectives and agree plans to achieve these objectives;
- oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;
- ensure effective financial stewardship through financial planning and control;
- ensure that high standards of health service governance and personal behaviour are maintained in the conduct of the business as a whole;
- appoint, appraise and remunerate senior managers, and;
- ensure effective dialogue between the organisation and local community on its plans and performance, and that these are responsive to the communities' needs.

Governors are responsible for regularly feeding back information about the Trust's vision and performance to their constituencies and the stakeholder organisations that either elected or appointed them. The Council of Governors discharges a further set of statutory duties which include appointing and removing the Non-executive Directors, and approving the appointment and removal of the Trust's auditor.

The Council of Governors and Trust Board of Directors communicate principally through the Chairman who is the formal conduit between the two corporate entities. This relationship is formally extended and augmented by governors and directors participation in Working Groups for Strategy, Quality and Membership to ensure constant and clear communication between the Board and the Council of Governors. Additionally, directors regularly attend meetings of the council of governors and governors regularly attend meetings of the Board.

The Board of Directors may request the Chair to seek the views of the Council of Governors on any matters it may determine. Communications and consultations between the Council of Governors and the Board include, but are not limited to the following topics:

- The Monitor Annual Plan;
- The Board's strategic proposals;
- Clinical and service priorities;
- Proposals for new capital developments;
- Engagement of the Trust's membership;
- Performance monitoring, and;
- Reviews of the quality of the Trust's services.

The Board of Directors presents the Annual Accounts, Annual Report and Auditor's Report to the Council of Governors at the Annual Members' Meeting.

This year, the Council of Governors worked closely with the Chairman, Directors and Trust Secretary to develop a mature, challenging and constructive relationship with the Trust Board of Directors. Governors began the year with a survey of governors' priorities and a self-assessment of the council's efficacy. Short-life groups were established to develop new ways of engaging with governors' duties and responsibilities, particularly in the context of the important changes required to enable governors to undertake the new role and functions brought by the Health and Social Care Act 2012.

This work lead to the restructure of the governor's formal meetings including working groups transitioning into focus groups in early 2013. Public meetings are now held directly after the Quarterly meetings of the Trust Board of Directors at which the Board makes its declarations to Monitor. This allows governors to work closely with the Board on current matters of importance, with the most up to date data and intelligence available at the time. Governors are encouraged to ask challenging questions and gain immediate responses from the Board.

Governors spent considerable time working with the Trust Board to increase their own understanding of the process for the potential integration of services across Bristol. In this context, governors put forward a motion to change the Trust's Constitution to allow elected governors to serve for up to nine years (three terms of office, if re-elected) to allow for greater continuity during times of change for the NHS. The Board supported this motion and the Foundation Trust Constitution was duly amended.

(a) Meetings of the Council of Governors

The Council of Governors met on a total of seven occasions during 2012/13. This included its four Council of Governors meetings, the joint meeting of the Council of Governors and Trust Board of Directors, an extraordinary Council of Governors

meeting and the Annual Members' Meeting at which the Annual Report is presented to the governors by the directors.

The Council of Governors receive the agenda and papers for each meeting of the Board of Directors. On average, approximately 15 governors regularly attend meetings of the Board.

Membership and attendance at Council of Governors and Committee meetings is set out in the table on page 75 of this report.

The three Governor Working Groups each met six times during the year. Attendance at meetings of the Governor Working Groups is set out in the table on page 77 of this report.

Further comment on the interaction of the Council of Governors and the Trust Board of Directors is provided in the Annual Governance Statement included in "Appendix D – Annual Accounts 2012/13".

(b) Governors' Nominations and Appointments Committee

The Governors' Nominations and Appointments Committee is a formal Committee of the Council of Governors established in accordance with the NHS Act 2006, the University Hospitals Bristol NHS Foundation Trust Constitution, and the Monitor Foundation Trust Code of Governance for the purpose of carrying out the duties of governors with respect to the appointment, re-appointment removal, remuneration and other terms of service of the Chairman and Non-executive Directors.

(i) Function and Duties

The Committee:

(A) Determines the criteria and process for the selection of the candidates for office as Chairman or other Non-executive Director of the Trust having first consulted with the Board of Directors as to those matters and having regard to such views as may be expressed by the Board of Directors;

(B) Seeks by way of open advertisement and other means candidates for office; assesses and selects for interview such candidates as are considered appropriate;

(C) Makes recommendation to the Council of Governors as to potential candidates for appointment as Chairman or other Non-executive Director;

(D) Considers and makes recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Chairman and other Non-executive Directors;

(E) Monitors the performance of the Chairman and other Non-executive Directors, and;

(F) Gives consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the

skills and expertise required within the Board of Directors to meet them.

(ii) Meetings

The Committee met on four occasions during the course of the year to consider the performance of the Chairman and those Non-executive Directors due for re-appointment in the period. The Committee was chaired by the Senior Independent Director for the purposes of performance evaluation and appraisal of the Chairman.

(c) Membership and attendance at Council of Governors and Committee meetings

Figures in brackets (7) indicate the number of meetings the individual would be expected to attend by virtue of their membership of the Council of Governors or the Governor Working Group.

A figure of zero (0) indicates that the individual was not a member. 'C' denotes the Chair of the Council of Governors or Committee.

	Council of Governors	Governors' Nominations and Appointments Committee
Number of meetings	7	4
Chairman		
John Savage	C7(7)	C4(4)
Governors		
Public South Gloucestershire		
Pauline Beddoes	5(7)	0(0)
Mary Hodges	4(7)	0(0)
Public North Somerset		
Clive Hamilton	7(7)	0(0)
Anne Ford	7(7)	0(0)
Public Bristol		
Mo Schiller	7(7)	4(4)
Sue Silvey	6(7)	4(4)
Heather England	4(7)	0(0)
Ken Booth	4(7)	0(0)
Jade Scott-Blagrove	2(7)	0(0)
Patient Governors from tertiary areas		
Neil Auty	4(7)	0(0)
Mani Chauhan	2(2)	0(0)
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire		
John Steeds	7(7)	2(4)

	Council of Governors	Governors' Nominations and Appointments Committee
Anne Skinner	6(7)	2(2)
Jacob Butterly	5(7)	0(0)
Peter Holt	5(7)	0(0)
Pam Yabsley	3(3)	2(2)
Kylie Murray	0(7)	0(0)
Carers of patients 16 years and over		
Wendy Gregory	7(7)	4(4)
Garry Williams	5(7)	0(0)
Carers of patients under 16 years		
Philip Mackie	6(7)	2(4)
Lorna Watson	4(7)	0(0)
Staff Non-clinical Healthcare Professional		
Jan Dykes	7(7)	0(0)
Alex Bunn	6(7)	0(0)
Staff Other Clinical Healthcare Professional		
Phil Quirk	4(7)	3(4)
Staff Medical and Dental		
Louise Newall	1(7)	0(0)
Staff Nursing and Midwifery		
Florene Jordan	5(7)	0(0)
Belinda Cox	4(7)	0(0)
Appointed Governors		
Sylvia Townsend	6(7)	2(4)
Helen Langton	4(7)	0(0)
Tim Peters	2(7)	0(0)
David Tappin	2(7)	0(0)
Partnership organisations		
Jeanette Jones	6(7)	2(4)
Joan Bayliss	4(7)	0(0)
Jessica Burston	4(7)	0(0)
Jane Britton	3(7)	0(0)
Maggie Mickshik	2(7)	0(0)
Non-executive Directors		
Emma Woollett	5(0)	0(0)

	Council of Governors	Governors' Nominations and Appointments Committee
Paul May	5(0)	0(0)
Lisa Gardner	3(0)	0(0)
John Moore	3(0)	0(0)
Guy Orpen	3(0)	0(0)
Iain Fairbairn	2(0)	1(0)
Kelvin Blake	2(0)	0(0)
Selby Knox	1(0)	0(0)
Executive Directors		
Robert Woolley	7(0)	0(0)
Deborah Lee	6(0)	0(0)
Alison Moon	5(0)	0(0)
James Rimmer	4(0)	0(0)
Claire Buchannan	4(0)	0(0)
Sean O'Kelly	4(0)	0(0)
Paul Mapson	3(0)	0(0)

(d) Attendance at meetings of the Governor Working Groups

	Strategy Working Group	Quality Working Group	Membership Working Group
Number of meetings	5	5	5
Chairs			
Anne Ford	(C)4(5)		
Clive Hamilton		(C)5(5)	
Sue Silvey			(C)5(5)
Other Governors			
Public Bristol			
Ken Booth	2(5)	3(5)	3(5)
Mo Schiller	1(5)	5(5)	5(5)
Heather England	0(0)	0(0)	1(5)
Jade Scott-Blagrove	0(0)	0(0)	1(5)
Public North Somerset			
Clive Hamilton	5(5)	5(5)	4(5)
Anne Ford	4(5)	1(0)	3(5)
Public South Gloucestershire			

	Strategy Working Group	Quality Working Group	Membership Working Group
Mary Hodges	0(0)	4(5)	0(0)
Pauline Beddoes	0(0)	0(0)	0(0)
Patient Governors from tertiary areas			
Neil Auty	1(5)	0(0)	0(0)
Mani Chauhan	0(0)	0(0)	0(0)
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire			
John Steeds	5(5)	3(5)	0(0)
Anne Skinner	3(5)	4(5)	3(5)
Jacob Butterly	0(0)	0(0)	0(5)
Pam Yabsley	0(0)	3(3)	0(0)
Peter Holt	0(0)	2(5)	3(5)
Kylie Murray	0(0)	0(0)	0(0)
Carers of patients 16 years and over			
Wendy Gregory	4(5)	5(5)	3(5)
Garry Williams	2(0)	3(0)	1(0)
Carers of patients under 16 years			
Philip Mackie	0(0)	0(0)	0(0)
Lorna Watson	0(0)	3(5)	0(0)
Staff Non-clinical Healthcare Professional			
Alex Bunn	0(0)	4(5)	0(0)
Jan Dykes	2(5)	1(0)	0(0)
Staff Medical and Dental			
Louise Newall	0(0)	1(5)	0(0)
Staff Nursing and Midwifery			
Florene Jordan	0(0)	3(5)	3(5)
Belinda Cox	0(0)	0(0)	0(0)
Phil Quirk	0(0)	0(0)	0(0)
Partnership organisations			
Joan Bayliss, Community Group	4(5)	0(0)	0(0)
Jeanette Jones, Joint Union Committee	1(0)	2(5)	0(0)
Jessica Burston, South Western Ambulance Service NHS Foundation Trust	0(0)	1(5)	0(0)
Jane Britton,	0(0)	0(0)	0(0)

	Strategy Working Group	Quality Working Group	Membership Working Group
Avon & Wiltshire Mental Health Trust			
Maggie Mickshik, Voluntary Group	0(0)	0(0)	0(0)
Appointed			
Sylvia Townsend, Bristol City Council	0(0)	0(0)	0(0)
David Tappin, NHS Bristol	0(0)	0(0)	0(0)
Tim Peters, University of Bristol	0(0)	0(0)	0(0)
Helen Langton, University of West of England	0(0)	0(0)	0(0)
Non-executive Directors			
Paul May	3(0)	4(0)	0(0)
Executive Directors			
Deborah Lee	5(0)	0(0)	0(0)
Claire Buchannan	2(0)	2(0)	1(0)
Paul Mapson	1(0)	0(0)	0(0)
Alison Moon	0(0)	2(0)	0(0)
Sean O'Kelly	0(0)	2(0)	0(0)
James Rimmer	0(0)	1(0)	0(0)

(e) Qualification, appointment and removal of Non-executive Directors

Non-executive Directors and the Chair of the Trust are appointed by the Governors at a general meeting of the Council of Governors. The recruitment, selection and interviewing of candidates is overseen by the Governors' Nominations and Appointments Committee which also makes recommendation to the Council of Governors for the appointment of successful candidates. The Foundation Trust Constitution requires that Non-executive Directors are members of the public or patient constituencies.

Removal of the Chair or any other Non-executive Director is subject to the approval of three-quarters of the members of the Council of Governors.

(f) Business interests

Governors are required to disclose details of company directorships or other material interests which may conflict with their role as Governors. The Trust Secretariat maintains a register of interests, which is available to members of the public by contacting the Secretariat at the address given on page 96 of this report.

(g) Performance of the Council of Governors

The Council of Governors undertook a self-assessment of its performance in 2012 to establish whether it has adequately and effectively discharged its role, functions and duties during the preceding year.

Results of the survey were assessed to identify areas of development for the Council of Governors as well as priorities to be addressed in the forthcoming year. Pertinently, these included preparation for the new role of Governors established by the Health and Social Care Act 2012, including revisions to the governance structures supporting Governors in discharging their duties. This begins to formally address the new requirement established by the Act that Foundation Trusts equip governors with the skills and knowledge they need to carry out their revised role.

(h) Revised duties of governors

The Health and Social Care Act 2012 introduces both new and changed duties for governors and directors of NHS Foundation Trusts, and makes a clear distinction between the duties and accountabilities of governors and directors.

The Trust Board of Directors' duty to take into account the views of the Council of Governors in its planning remains unchanged. It is the stated intention of the Chairman and Trust Board of Directors to work as closely as possible with the Council of Governors on all matters of joint interest to the Board and the Council of Governors.

The revised annual cycle of business for the Board and Council of Governors includes new formal mechanisms to support and enable their working together.

New Project Focus Groups have been established to ensure the formal engagement of governors on matters of constitution (including membership), strategy and planning (including significant transactions), and reporting (including quality and performance monitoring and metrics) as part of the annual cycle of business.

Project Focus Groups are chaired and facilitated by the appropriate Executive Director, and are open to attendance by any interested governor.

(i) Governor development

In addition to the provision of new Project Focus Groups, a governor development programme has been established in close consultation with governors. The programme is designed to begin to equip governors with the skills and knowledge they need to carry out the role and functions established by the Health and Social Care Act 2012. The programme will run throughout the year with sessions presented by a selection of expert speakers and leaders in the field of healthcare governance, law and finance.

The programme includes the following topics:

- Trust induction;
- Structure of the Trust and local health economy;
- Strategy, quality, performance & finance;

- External stakeholders and organisations;
- Foundation trust membership;
- Foundation trust network governor training and development programme;
- Media and reputation management, and;
- Integration, mergers and acquisitions.

4.5 Foundation Trust membership

The Trust maintains a representative membership of people from eligible constituencies in keeping with the NHS Foundation Trust governance model of local accountability through members and governors. We continue to work to ensure that our membership remains representative of our catchment communities and that members have suitable opportunities to be engaged with the Trust and the work of the Council of Governors.

(a) Membership size and variations

The Council of Governors agreed that membership numbers should be maintained during 2012/13, and that the minimum age for membership should be changed from four to seven years of age. Our public and patient membership totalled 11,739 and staff membership was maintained at nearly 100% with only one staff member opting out.

The combined public, patient and staff membership as of 31 March 2013 stands at 21,040. The number of members has been maintained by offering membership to patients and their carers in our hospital outpatient areas and members of the public at Trust open events. Membership of the staff constituency is managed on an opt-out basis.

A total of 356 members were removed from the database during routine data maintenance. These will have included members who have moved out of the catchment area or who were deceased. Patient members who were no longer eligible for the patient constituency were switched to the public constituency if they were eligible.

The changes in membership size throughout 2012/13 and estimated growth for 2013/14 are shown in the table below.

	2012/13 (actual)	2013/14 (estimated)
Public constituency		
At year start (1 Apr 2012)	5,884	5,857
New members	76	80
Members leaving	103	80
At year end (31 March 2013)	5,857	5,857
Patient constituency		
At year start (1 Apr 2012)	6,065	5,882

	2012/13 (actual)	2013/14 (estimated)
New members	70	100
Members leaving	253	100
At year end (31 March 2013)	5,882	5,882
Staff constituency		
At year start (1 Apr 2012)	8,658	9,278
New members	1,265	996
Members leaving	645	1,120
At year end (31 March 2013)	9,278	9,154

(b) Analysis of current membership

The profile of the Trust's membership at the end of March 2013 is shown in the table below.

Constituency	Number of members	Eligible membership
Public constituency		
Age (years)		
0-16	289	175,484
17-21	566	65,591
22+	4,755	705,188
Unknown	247	0
Ethnicity		
White	4,989	775,326
Mixed	83	10,894
Asian/Asian British	156	13,391
Black/Black British	143	9,971
Other	486	136,681
Socio-economic groupings		
ABC1	3,427	305,430
C2	1,007	90,842
D	1,088	96,270
E	333	24,441
Unknown	2	0
Gender		
Male	2,491	337,947
Female	3,266	608,316

Constituency	Number of members	Eligible membership
Public constituency		
Unknown	100	0
Patient constituency		
Age (years)		
0-16	415	46,611
17-21	275	22,909
22+	5,192	315,845

(c) Developing a representative and engaged membership

Our Membership Plan is regularly revised to reflect current opportunities for engaging members, maintaining membership numbers and supporting governors to discharge their duties with respect to communicating with members.

Our aim is to focus on developing new membership in under-represented groups such as carers, children and young people to ensure that our membership remains representative as the demographic changes.

Targeted recruitment of younger members continues through the Trust's work experience programme and school career events, and the Youth Council remains instrumental in attracting younger members.

The new Foundation Trust Constitution Project Focus Group reflects the developing approach to ensuring the Constitution is regularly reviewed and that the membership and governor profile matches the changing demographic of the Trust's catchment and reach.

This work will provide a framework for building a representative and engaged membership for the future which will be reflected in the Membership Plan and Strategy.

(d) Engagement

We proactively support the involvement of our Governors in a wide range of activities within the Trust to assist them in completing their statutory responsibilities, and in particular, for engaging with members.

The focus for engaging members continues through a number of channels, including the activities of the Youth Council which meets each month and provides reports to the Council of Governors. Members are offered opportunities to be involved in service improvements through our Patient and Public Involvement (PPI) programme, and our regular Governors' Medicine for Members events have proved very popular.

Our members have also been engaged through three additional activities:

– Elections: Inviting eligible members to nominate themselves for 15 public, patient and staff seats. Our methods of engagement included meetings and events, personally addressed letters, web marketing and a social media campaign;

- Events: Five events have been held. Two Medicine for Members events covering cancer and nutrition; and three election information events, and;
- Newsletter: Three editions of the newsletter have been posted or emailed to members.

(e) Elections

The nomination process for 15 governor seats started in March 2013 with information events for members. The Trust encourages early engagement of members to enable them to make an informed decision about standing for elections. The ballot will be held in May.

(f) Membership commentary and strategy

The Trust has five membership constituencies:

- Public Bristol;
- Public North Somerset;
- Public South Gloucestershire;
- 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, and;
- Staff constituency with four groups: Medical and Dental, Nursing and Midwifery, Other Clinical Healthcare Professionals and Non-Clinical Healthcare Professionals.

The Health and Social Care Act 2012 has given trusts and governors opportunities to amend their own Foundation Trust Constitution. The Constitution Project Focus Group has responsibility for reviewing the Constitution and to make recommendations to the Council of Governors with respect to any amendments that may be considered beneficial. These changes would require approval by the Council of Governors and the Trust Board of Directors.

Provisionally agreed priorities include:

- To review the Foundation Trust constituencies and governor ratio;
- To maintain the public and patient membership numbers;
- To maintain staff membership at 95% or higher;
- To continue to engage our members by providing a range of involvement opportunities, including medicine for member's events, Trust open days and service improvement opportunities linked with members' special interests and the youth council;
- To hold elections in 2013 for 15 seats, and;
- To support governors in completing their statutory duties by providing a programme of training and development opportunities.

(i) 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, are not members of any other constituency and are four years of age and above. Public membership is by opting in by application.

(ii) Patient constituency

The patient constituency is open to all those who are recorded on the Trust's administration as having attended as a patient within the preceding three years, and who are neither eligible to become a member of the staff constituency nor are less than seven years of age.

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

(iii) Staff constituency

The staff constituency is made up of people who are employed under a contract with the Trust for at least 12 months, or, are employed by the Trust and whose place of work is at the Trust, or are contractor's staff working full-time at the Trust, and are at least 16 years of age.

The staff constituency has four groups:

– Medical and dental;

– Nursing and midwifery;

– Other clinical healthcare professionals, and;

– Non-clinical healthcare professionals.

Staff are automatically registered as members on appointment and may opt out if they wish. Information on opting out of the scheme is included in induction packs and on the intranet.

(g) Governors communication with members

Governors communicate with members through regular newsletters, invitations to be involved in services that members are interested in, 'Medicine for Members' events, Council of Governors and Annual Members' Meetings.

Members wishing to communicate with Governors or Directors, or anyone interested in finding out more about membership, should contact the Trust Secretariat at the address given on page 96 of this report.

(h) Governors by constituency – 1 April 2011 to 31 March 2012

Constituency	Name	Tenure	Elected Appointed Partnership
Public Governors			
Public South Gloucestershire	Pauline Beddoes	June 2010 to May 2013	Elected
Public South Gloucestershire	Mary Hodges	June 2010 to May 2013	Elected
Public North Somerset	Clive Hamilton	June 2011 to May 2014	Elected
Public North Somerset	Anne Ford	June 2008 to May 2014	Elected
Public Bristol	Jade Scott-Blagrove	June 2010 to May 2013	Elected
Public Bristol	Heather England	November 2011 to May 2013	Elected
Public Bristol	Mo Schiller	June 2008 to May 2014	Elected
Public Bristol	Sue Silvey	June 2011 to May 2014	Elected
Public Bristol	Ken Booth	June 2011 to May 2014	Elected
Patient Governors			
Patient Governors from tertiary areas (who live in the rest of England and Wales)	Mani Chauhan	November 2012 to May 2013	Elected
Patient Governors from tertiary areas (who live in the rest of England and Wales)	Neil Auty	June 2010 to May 2013	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Kylie Murray	June 2011 to May 2014	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Anne Skinner	June 2008 to May 2014	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	John Steeds	June 2010 to May 2013	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Jacob Butterly	June 2010 to May 2013	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Peter Holt	June 2011 to May 2014	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Pam Yabsley	September 2012 to May 2013	Elected
Carers of patents 16 years and over	Wendy Gregory	June 2008 to May 2013	Elected
Carers of patents 16 years and over	Garry Williams	June 2010 to May 2013	Elected
Carers of patients under 16 years	Philip Mackie	June 2008 to May 2014	Elected
Carers of patients under 16 years	Lorna Watson	June 2008 to May 2014	Elected

Constituency	Name	Tenure	Elected Appointed Partnership
Staff Governors			
Medical and Dental	Louise Newall	June 2011 to May 2014	Elected
Nursing and Midwifery	Florene Jordan	June 2010 to May 2013	Elected
Nursing and Midwifery	Belinda Cox	June 2010 to May 2013	Elected
Non-clinical Healthcare Professional	Alex Bunn	June 2011 to May 2014	Elected
Non-clinical Healthcare Professional	Jan Dykes	June 2008 to May 2014	Elected
Other Clinical Healthcare Professional	Phil Quirk	June 2010 to May 2013	Elected
Appointed Governors			
University of Bristol	Tim Peters	March 2011 to May 2014	Appointed
University of the West of England	Helen Langton	Oct 2010 to May 2014	Appointed
Bristol City Council	Sylvia Townsend	June 2009 to May 2014	Appointed
NHS Bristol	David Tappin	June 2008 to May 2014	Appointed
Partnership organisations			
Avon and Wiltshire Mental Health Trust	Jane Britton	June 2008 to May 2014	Partnership
South Western Ambulance Trust	Jessica Burston	October 2011 to May 2014	Partnership
Joint Union Committee	Jeanette Jones	June 2008 to May 2014	Partnership
Community groups	Joan Bayliss	Jan 2011 to May 2014	Partnership
Voluntary groups	Maggie Mickshik	June 2011 to May 2014	Partnership

5. Appendix A – Biographies of Members of the Trust Board of Directors

5.1 John Savage – Chairman

John Savage was appointed Chairman of University Hospitals Bristol NHS Foundation Trust on 1 June 2008. From 1989, he was full-time Chief Executive of the Bristol Initiative and, from February 1993, Chief Executive of the Bristol Chamber of Commerce and Initiative, after the merger of these two bodies.

In September 1994 he became Chief Executive of Business West, the joint operating company of the Chamber and Business Link West. He was awarded the CBE for service to Business and Regeneration in the 2006 New Year Honours List. He is Chairman of the Churches Council for Social Responsibility, Chairman of the Bristol Chamber of Commerce and Initiative, Chairman of Learning Partnership West and Chairman of Destination Bristol.

He served as a board member of the Regional Development Agency and was Chairman of the South West Learning and Skills Council from inception until its closure. He has gained a broad range of business experience over a period of more than 40 years.

John is Chairman of the Trust Board of Directors, Council of Governors and the Nomination and Appointments Committee of the Board.

5.2 Robert Woolley – Chief Executive

Robert Woolley has been Chief Executive since 2010. He joined the Trust in 2002 as Director of Performance Management, responsible for service delivery and the achievement of key patient access targets. As Director of Corporate Development from 2004, he oversaw the £18 million expansion and refurbishment of the Bristol Dental Hospital, the construction of the £60 million Bristol Heart Institute and drew up the initial plans for the current redevelopment of the Bristol Royal Infirmary and the centralisation of specialist paediatrics.

He was project director for the Trust's successful application for Foundation status in 2008 and wrote the Trust's 10 year business plan.

Robert started his NHS career at the Royal London Hospital in 1992. He was appointed head of strategic planning in the merged Barts and the London NHS Trust and then assistant director for the redevelopment of the Royal London Hospital before becoming general manager for children's services across the City and East London in 1996 and later of clinical support services across St Bartholomew's, the Royal London and the London Chest Hospitals. Robert read English at Lincoln College, Oxford, and holds an MBA with distinction from the University of Bath.

5.3 Non-executive Directors

(a) Emma Woollett – Vice-Chair

Emma was appointed as a Non-executive Director on 01 June 2008, and is Vice-Chair of the Trust. She has worked in both the private and public sectors and has held senior management positions in marketing and business development. She was marketing director for Kwik Save Stores, following its merger with retailer Somerfield plc.

Emma left Somerfield in 2001 to set up a freelance management consultancy practice, providing analytical advice to NHS organisations on capacity planning and waiting list management. Prior to joining Somerfield, Emma spent a number of years as a management consultant for PricewaterhouseCoopers, working worldwide on projects for utility companies looking to develop more commercial approaches within a public sector environment. She started her career in the oil industry and has degrees in physics and international relations from Cambridge University. Emma is Chair of the Remuneration Committee, and member of the Finance and Quality and Outcomes Committees.

(b) Lisa Gardner – Non-executive Director

Lisa Gardner was appointed as a Non-executive Director on 1 June 2008. She has acquired a broad range of business experience over more than 20 years; the posts held during that time include finance director of both Aardman Animations Limited and Business West Bristol. She qualified as a chartered accountant in 1992 after gaining a BA Honours degree in accounting and finance at Kingston University. Her current role is as a freelance Finance Director after over two years working as an associate in a local chartered accountant's practice, building this up ready for merger.

Lisa is Chair of the Finance Committee at the Trust and sits on the Audit Committee. She is also a board member at the Watershed's Trust and Trading Companies. She has served as a Parent Governor at Westbury Park Primary School, where she was also Chair of the Finance Committee, was the financial director at Aardman Animations Limited for 11 years and since then has worked in the finance director role at Business West and in the retail industry before returning to practice and freelance work.

(c) Iain Fairbairn – Senior Independent Director

Iain Fairbairn was appointed as a Non-executive Director of University Hospitals Bristol NHS Foundation Trust on 1 June 2008. He is currently the Senior Independent Director and a member of the Audit Committee.

Iain gained an honours degree in law at University College London before qualifying as a solicitor in 1979. He was a commercial solicitor in legal practices in both the City of London and Bristol for more than 20 years. His legal experience included the provision of property, commercial, planning and construction advice to the NHS, covering 'private finance initiative' projects, the establishment of NHS trusts and joint working between the NHS and other public and private bodies.

Iain was the founder and developer of a care village for the elderly in Cornwall, which included a nursing home; and a director of a not-for-profit social enterprise to support women and their families through the menopause. He is currently managing director of an engineering technology company.

(d) Selby Knox – Non-executive Director

Professor Knox was appointed as a Non-executive Director of University Hospitals Bristol NHS Foundation Trust on 1 June 2008. Selby retired in August 2008 from the position of Pro Vice-Chancellor of the University of Bristol where he was a member of the University's senior management team, with responsibility for oversight of

finance and estates, and the Faculties of Medicine and Dentistry and Medical Sciences.

Selby was chair of the budget and capital prioritisation committees, and a member of the University Council and its finance, estates and audit committees. He obtained a BSc in 1966 and a PhD in 1969, both from the University of Bristol. He returned there as lecturer in 1972 after postdoctoral research at the University of California, Los Angeles, and was awarded a Doctor of Science degree by the University of Bristol in 1985. He was promoted to Reader in 1983 and to Professor in 1990 and from 1992 to 2001 was Head of the School of Chemistry.

From 1996 to 2004, Professor Knox held the Alfred Capper Pass Chair of Chemistry, which he relinquished on being appointed Pro Vice-Chancellor. Professor Knox's research in organometallic chemistry attracted several awards from the Royal Society of Chemistry and visiting professorships in North America and Europe.

Selby left the Trust at the end of May 2012.

(e) Guy Orpen – Non-executive Director

Guy Orpen was appointed as a Non-executive Director of University Hospitals Bristol NHS Foundation Trust on 2 May 2012.

Guy is a graduate of the Universities of Cape Town and Cambridge. He is Pro Vice-Chancellor for Research and Enterprise at the University of Bristol. In this role he chairs the University Research Committee, the Engaged University Steering Group and the Executive Committee of the National Composites Centre and serves on the Board of Bristol Health Partners (the city's academic health sciences partnership) and the board of the Bristol Partnership (the local strategic partnership for the city). He is Chair of the Board of Governors of the Cambridge Crystallographic Data Centre.

In the University of Bristol, Guy has served as Dean of the Faculty of Science (2006-09) and Head of the School of Chemistry (2001-06). He served as Chair of Heads of Chemistry UK in 2005-7. Since 1994 he has been Professor of Structural Chemistry in the School of Chemistry. His research has been recognised by a number of awards of the Royal Society of Chemistry: the Meldola and Corday-Morgan Medals, the Tilden Lectureship, the Structural Chemistry Award and then the Nyholm Lectureship.

His research includes structure determination using diffraction and spectroscopy methods, molecular modelling and chemoinformatics studies using structural databases. Major themes of his research are crystal engineering and ligand design. The former involves the use of supramolecular chemistry to direct the formation and exploitation of new crystal structures of metal complexes. In the latter he has explored development of knowledge bases to inform the use of ligands in coordination chemistry and homogeneous catalysis.

(f) Paul May – Non-executive Director

Paul May was appointed as a Non-executive Director of University Hospitals Bristol NHS Foundation Trust on 1 November 2008.

Paul is a public sector strategic consultant who brings 30 years' experience at the highest levels in local government and further education. He was the Chief Executive of Wansdyke District Council, and then North Somerset Council for nearly 20 years. He was also the Executive Director of the Learning and Skills Council in the West of England, and Chief Executive of the Further Education Bureaucracy Reduction Group for England.

Paul's projects as a consultant included working on the framework for excellence quality system for further education and re-shaping the structure of the South West's Learning and Skills Council. He also took a lead role for the Sexual Assault Referral Centre (SARC) for Avon and Somerset, helping agencies to work more closely together to improve the experience for victims of this crime. He then helped Devon and Cornwall and Dorset with their community approaches to the creation of their SARCs.

Paul is currently the Chair of the Quality and Outcomes Committee of the Board.

(g) Kelvin Blake – Non-executive Director

Kelvin Blake was appointed as a Non-executive Director of University Hospitals Bristol NHS Foundation Trust on 1 November 2008.

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

Kelvin is also a member of the BT South West Regional Board. The work of the board is to ensure BT is represented across the region in business and community activities. It is also responsible for delivering BT strategic goals including super-fast broadband and Digital Britain. Previously, he has worked for RTZ, Post Office Counters and Royal & Sun Alliance.

Kelvin is also a trustee of two charities. The Vassal Centre Trust is a local charity that manages barrier free workspace in Bristol primarily for the use of organisations that provide services to disabled people. Knowle West Media Centre, based in South Bristol supports individuals and communities to get the most out of digital technologies, music, media and the arts.

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

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

(h) John Moore – Non-executive Director

John Moore was appointed as a Non-executive Director of University Hospitals Bristol NHS Foundation Trust on 1 January 2011. He is an experienced managing director and Trustee, supporting strategic change throughout organisations. He has multi-sector industrial experience (aerospace, defence, automotive, utilities) together with the public and third sectors.

Following 12 years international corporate life, and having sold a medium sized business, John has taken a Non-executive Director role with University Hospitals

Bristol NHS Foundation Trust, and is a Trustee of various charities, including Education Towards a Future.

John is passionate about creating a service and quality culture in the organisations he serves as a board member, whether in an executive or non-executive capacity. A chartered director and chartered engineer, John has a Master's degree in Engineering and a Master of Business Administration from the International Institute for Management Development. He is married with three children and lives near Bristol.

John is currently Chair of the Audit Committee of the Board, and serves on the Quality and Outcomes Committee.

5.4 Executive Directors

(a) Deborah Lee – Director of Strategic Development & Deputy Chief Executive

Deborah Lee is an experienced NHS manager. She qualified originally as a registered nurse, before returning to university to read economics and subsequently gained a postgraduate qualification in health economics and an MBA, from Bristol Business School.

She started her NHS management career in 1990 and has worked in acute, primary and community sectors, holding board appointments in three different commissioning organisations before joining University Hospitals Bristol NHS Foundation Trust.

In 1996, she left the NHS and moved to industry and held positions in the areas of policy development and health economics before returning to her first board appointment in Wiltshire Health Authority with a renewed commitment to service in the NHS. From 2004 to 2005 Deborah was Joint Chief Executive of South Wiltshire Primary Care Trust prior to the creation of Wiltshire Primary Care Trust.

Deborah joined the Trust on secondment from NHS Bristol in May 2010 and was appointed to the substantive role of Director of Strategic Development in February 2011 and became Deputy Chief Executive in January 2013.

(b) Steve Aumayer – Director of Workforce and Organisational Development

Steve Aumayer joined University Hospitals Bristol NHS Foundation Trust in July 2009 and brought with him a wealth of senior human resources experience from a variety of sectors. Over the course of his career Steve worked extensively within consulting, retail banking and the telecommunications sectors.

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

Steve also held roles as a Director at Deloitte and Touche, at Hay Management Consultants and at Bristol and West. Steve's career started with a commission in the Royal Navy where he graduated from Britannia Royal Naval College in Dartmouth and then went on to be a navigation officer.

Steve left the Trust at the end of April 2012.

(c) Claire Buchanan – Acting Director of Workforce and Organisational Development

Claire Buchanan joined the NHS as management trainee and trained in the South West region at Gloucestershire Royal Hospital. She then held a number of positions initially in general management for Wakefield Area Health Authority and United Leeds Teaching hospitals. During her time in Leeds Claire undertook further qualifications and moved into Human Resources management.

She joined the Trust in 1995 and has held a number of roles within the Human Resources function. Claire was deputy director of Human Resources and Organisational Development for 4 years before she took on her current role in May 2012. She is a Fellow of the Institute of Personnel and Development and has a Master's degree in Strategic Human Resources management.

(d) Paul Mapson – Director of Finance and Information

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

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

Prior to joining the Trust in 1991 as Deputy Finance Director, Paul held posts in Somerset, Southmead and Frenchay hospitals. He was appointed Director of Finance in February 2005.

Paul serves on the Finance Committee of the Board.

(e) Alison Moon – Chief Nurse

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

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

Alison has a proven record and passion for ensuring the patient experience and voice is at the centre of all services and improving standards of care, delivering service improvements, influencing change and pioneering new roles both locally and nationally. Alison was awarded an MA in Management in 1999 from the Bristol Business School. Alison has also completed the Leading Strategic Change programme at INSEAD, France (2005).

In addition to her role at University Hospitals Bristol NHS Foundation Trust, Alison has also taken on the Regional Clinical Champion role for improving care for people with dementia in acute hospitals.

Alison left the Trust to join the Bristol Clinical Commissioning Group at the end of March 2013.

(f) Helen Morgan – Acting Chief Nurse

Helen Morgan Helen joined the NHS in 1980 and qualified as a Registered Nurse at St Thomas' Hospital, London in 1983.

She has many years' experience as a clinician, working in oncology and palliative care in a secondary care setting. She was awarded an MA in Death and Society in 2001.

Helen has worked in the Trust for the last 25 years and has held roles of Matron, Head of Nursing and Deputy Chief Nurse. She has a determined passion and track record for ensuring the patient experience and voice is at the heart of all services and improving standards of care and delivering service improvements.

Helen assumed her current role in March 2013.

(g) Sean O'Kelly – Medical Director

Following degrees in Medicine and Psychology at Bristol University Dr O'Kelly undertook postgraduate training in paediatrics and anaesthetics at Southampton University Hospitals. He then worked at the University of Michigan, Ann Arbor for six years as Associate Clinical Professor and Director of Paediatric Cardiac Anaesthesia.

Returning to the UK in 1998, Dr O'Kelly worked initially as a Consultant Anaesthetist in Swindon, where he took on the role of College Tutor and Lead for Paediatric Anaesthesia. Dr O'Kelly then undertook the year-long National Clinical Governance Development Programme, after which he worked with the Modernisation Agency as National Clinical Lead for the Agency Associate Scheme.

In 2002 Dr O'Kelly was appointed Associate Medical Director for Clinical Governance in Swindon and in 2004 was seconded to the Department of Health as Associate Medical Director to the Deputy Chief Medical Officer. In 2006 he was seconded to North Devon Healthcare Trust as Interim Medical Director during a period of performance turnaround and in 2008 was appointed Associate Medical Director for Women's and Children's Services at the Great Western Hospital, Swindon. In 2009 Dr O'Kelly was appointed Medical Director at Salisbury NHS Foundation Trust and was appointed to University Hospitals Bristol NHS Foundation Trust as Medical Director in January 2011.

Between 2005 and 2009 Dr O'Kelly also completed a Master of Science degree in Strategic Management at the University of Bristol, chaired the Department of Health National Steering Group on Cosmetic Surgery Regulation and acted as Honorary Treasurer to the Quality in Healthcare section of the Royal Society of Medicine.

(h) James Rimmer – Chief Operating Officer

James Rimmer James Rimmer is an experienced Healthcare Director and has worked in the NHS for over 15 years. James has a breadth of Director level experience having been a Board member in both the provider and commissioner sectors. James' qualifications include a BSc Honours in Psychology from the University of Bristol and a Masters in Evidence Based Health Care from the University of Oxford. James has also completed the European Health Leadership Programme at INSEAD.

James' achievements include both operational and strategic developments such as leading a Trust from lower quartile to upper quartile in the delivery of the emergency care 4 hour standard, through to successfully leading an early wave Foundation Trust application. James has also led major capital and IM&T programmes.

James started his health career in research at the University of Bristol and later had an honorary contract at the University of the West of England leading a Department of Health funded study across three organisations. James' research focused on user involvement in service development and on moving research into practice.

6. Appendix B – Contact Details

The Trust Secretariat can be contacted at the following address:

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

Telephone: 0117 342 3702

Email: Trust.Secretariat@UHBristol.nhs.uk

University Hospitals Bristol NHS
NHS Foundation Trust

Quality Report 2012/13

Contents

Note:

The requirements to report in line with the *2012/13 Detailed Guidance for External Assurance on Quality Reports* published by Monitor have been satisfied as follows:

Part 1 - Statement on quality from the Chief Executive	Page 3

Part 2 – Priorities for improvement and statements of assurance from the Board	
Priorities for improvement – plans for 2013/14	This information can be found at the end of the reports for the three domains of quality (patient safety, patient experience and clinical effectiveness). See pages 20, 35 and 47
Statements of assurance from the Board	Page 52

Part 3 – Other information	
Review of quality performance	This information can be found in the reports for the three domains of quality. See pages 7-47
Overview of the quality of care based on performance in 2012/13 against indicators mandated for inclusion in Quality Accounts/ Reports	Page 5
Performance against key national priorities	Page 48

Statement on quality from the Chief Executive

Welcome to this, our fifth annual report describing our quality achievements. The Quality Report provides an open and honest assessment of the quality of services for which the Trust Board is accountable.

Each year, our quality objectives reflect a mixture of national and local priorities – many of which reflect priorities expressed in the NHS Outcomes Framework. In the pages of this Quality Report, you will read about some notable success stories and also some of the challenges we have faced. I am proud of the fact that the University Hospitals Bristol continues to have a consistently low overall mortality rate: this means that more patients survive in our care than would normally be expected for the severity of their condition. I am also delighted that 96% of inpatients say that they would recommend our services to their friends and family. Despite many successes during the year, we have also faced considerable challenges. We are disappointed that in 2012/13 we exceeded the targets we had been set for MRSA infections: we have implemented a comprehensive plan to improve our performance. We also continue to work closely with our partner organisations to understand and respond to patterns of increasing demand on Emergency Department services, both in Bristol and beyond.

At the request of our governors, we have made this year's Quality Report a little shorter than last year's in order to make it more accessible. This means that a small number of the quality themes we reported last year have not been repeated for 2012/13 (for example, safeguarding and single sex accommodation), however each of the 17 corporate quality objectives we set ourselves has been reported comprehensively, along with a wider assessment of our progress in the areas of patient safety, patient experience and clinical effectiveness. We have also returned to a key theme that we last reported in 2009/2010 – mortality following paediatric cardiac surgery.

During the past year, we have continued to work closely with the Care Quality Commission (CQC), the official body that monitors whether the Trust meets essential quality and safety standards. In 2012/13 we received a total of six visits from the CQC, including a scheduled inspection of our main site in June 2012 and the opening of the new South Bristol Community Hospital. The CQC expressed concerns about our staffing levels in maternity services and on Ward 32 in the Bristol Royal Hospital for Children. We took prompt and appropriate action. The CQC has re-inspected both areas: a warning notice relating to Ward 32 has been lifted and we are also now compliant for maternity services. We continue to be vigilant with local monitoring of compliance with all of the CQC's standards.

Looking ahead to 2013/14, we recognise that there is still much work to do. These remain challenging times for the NHS: at UH Bristol, we will continue to transform care by maintaining a relentless focus on the quality of our services, whilst making necessary efficiency and productivity savings. Robert Francis QC's final report into failings in at Mid Staffordshire NHS Foundation Trust is painful reminder of the consequences of putting financial efficiencies before care and compassion: Dr Sean O'Kelly, our Medical Director is currently developing our Board's response to the detailed recommendations of the inquiry. In the context of the Francis Report, the importance we place on our core values of respecting everyone, embracing change, recognising success and working together, becomes ever more apparent.

I would like to thank everyone who has contributed to this year's report, including our governors, commissioners, local councils, and the outgoing Local Involvement Networks. To the best of my knowledge the information contained in this Quality Report is accurate. If you have any comments about how we might further improve the presentation of this report in future years, I would be pleased to hear from you.

Robert Woolley, Chief Executive

Overview of 2012/13

The University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of general and specialist hospitals, employing around 7000 staff and with a turnover of approximately £500m. We are also the major medical research centre in the South West of England. During 2012/13, The Trust provided treatment and care to around 68,000 inpatients, 57,500 day cases and 113,300 attenders at our emergency departments. We also provided half a million outpatient appointments. Our goal has been that each and every one of these patients should be safe in our care, have an excellent experience of being in our care, and the right clinical outcome. Ensuring that the Trust delivers high quality services is at the heart of the business of our Board, which every month receives a comprehensive report describing the quality of patient services. This report begins with a patient's story and the focus is always on organisational learning. The monthly Board quality report includes a detailed 'dashboard' of indicators, many of which are described in this Quality Report: if performance fails to meet agreed targets, the Board expects to receive exception reports describing the issues and the steps being taken to recover performance. The Board's responsibilities for monitoring quality continue to be supported by its Quality and Outcomes sub-committee. Appendix B of this report, taken from the Trust's Quality Strategy for 2011-2014, explains how the Trust assesses the quality of its services, seeks to make improvements where required, and provides assurance to the Board and its regulators.

Last year, we set ourselves 17 quality objectives: we fully achieved eight of these and partially achieved eight more. In the pages which follow, you will be able to read a detailed account of how we got on. Each objective has been assigned a 'traffic light' or 'RAG' rating (Red = not met; Amber = partially met; Green = fully met) to give the reader an idea of the progress we have made. The table below provides an overview. The table on page 6 – *Quality objectives at a glance* – summarises the quality improvement themes we have been focussing on in recent years, and introduces the ones we will be prioritising in 2013/14.

We wanted to…		**How did we get on?**
1	Meet our targets for participation in the NHS South West Quality and Safety Improvement Programme	Amber
2	Implement and develop use of NHS Patient Safety Thermometer	Green
3	Embed high quality nutritional care	Green
4	Implement a proactive clinical audit programme in Histopathology	Green
5	Reduce recorded complication, misadventure and re-admission rates in gynaecological surgery	Amber
6	Implement our Patient Experience and Involvement Strategy	Green
7	Reduce patient-reported noise at night	Amber
8	Ensure patients are treated with kindness and understanding	Green
9	Improve communication with patients: in particular about waiting times in clinic and making sure patients know who to speak to if they have worries or concerns	Amber
10	Reduce numbers of complaints and respond to complaints as quickly as possible	Amber
11	Reduce incidence of discrimination at work	Green
12	Ensure that at least 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke unit	Red
13	Develop the use of service-specific standardised mortality ratios	Amber
14	Implement our dementia action plan	Green
15	Ensure patients with an identified need, including those with a learning disability, have a risk assessment and patient-centred care plan in place	Amber
16	Develop the use of enhanced recovery for all surgical areas	Green
17	Re-focus on ensuring compliance with published NICE guidance including the targeted use of clinical audit	Amber

In February 2012, the Department of Health and Monitor announced a new set of mandatory quality indicators for all Quality Accounts and Quality Reports. The Trust's performance in 2012/13 is summarised in the table below. Where relevant, reference is also made to pages of our Quality Report where related information can be found. The Trust is confident that this data is accurately described in the Quality Report. A Data Quality Framework has been developed by the Trust which encompasses the data sets which underpin each of these indicators and addresses the following dimension of data quality: accuracy, validity, reliability, timeliness, relevance and completeness. The Framework describes the process by which the data is gathered, reported and scrutinised by the Trust. Further details are available upon request.

Mandatory indicator	**UHB 2012/13**	**National average 2012/13**	**National best 2012/13**	**National worst 2012/13**	**UHB 2011/12**	**Page ref.**
Venous thromboembolism risk assessment[1]	96.7%	93.8%	100%	85.5%	93.2%	11
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)	Comparative data for 2011/12: UH Bristol rate 19.6; England average 21.8; low zero; high 51.6. Comparative data is not currently available for 2012/13 from the Health & Social Care Information Centre. Our report, based on numbers of *C Diff* cases, can be found on page 15.					16
Rate of patient safety incidents per 100 admissions[2]	8.28	6.44	1.37 (lowest)[3]	24.88 (highest)	6.66	18
Percentage of patient safety incidents resulting in severe harm or death (see footnote 2)	0.8%	0.5%	0%	2.5%	1.2%	18
Responsiveness to inpatients' personal needs[4]	Comparative data for 2011/12: UH Bristol score 69.9; England median 66.9; low 56.5; high 85.0. Comparative data is not currently available for 2012/13 from the Health & Social Care Information Centre; UH Bristol's score for 2012/13 was 72.4					30
Percentage of staff who would recommend the provider	71%	62%	86%	35%	75%	34
Summary Hospital-level Mortality Indicator (SHMI) value[5] and banding	91.1 Band 2	100	68.5	121.1	96.4 Band 2	40
Percentage of patient deaths with specialty code of 'Palliative medicine' or diagnosis code of 'Palliative care'[6]	19.4%	18.9%	Min 0.2%	Max 43.3%	17.5%	N/A
Patient Reported Outcome Measures	Comparative groin hernia data for 2011/12: 55.8% of UH Bristol patients reported an improved EQ-5D score (national average 51.0%); 39.0% of UH Bristol patients reported an improved EQ-VAS score (national average 38.3%). Comparative data is not currently available for the full year 2012/13 from the Health & Social Care Information Centre.					45
Emergency readmissions within 28 days of discharge: • age 0-15 • aged 16 or over	Comparative data is not available for 2012/13. Latest comparative data available from the Health & Social Care Information Centre is for 2010/11: UH Bristol 0-15 rate = 8.26% (England average 10.15%; low 0%; high 25.8%). UH Bristol 16+ rate = 11.90% (England average 11.42%; low zero; high 53.3%).					46

[1] Latest nationally published data covers April-December 2012 only; UH Bristol score for full financial year is 94.6%
[2] Published (validated) data is for the first six months of the financial year only
[3] National data, i.e. not UH Bristol peer group; low reporting rate is not necessarily positive (i.e. not "best")
[4] This is the national patient experience CQUIN
[5] In-hospital deaths plus deaths within 30 days of discharge: October 2011 – September 2012 (latest 12 month data available); data quoted for '2011/12' covers the period October 2010 – September 2011
[6] Specialty 315, diagnosis Z515: October 2011 – September 2012 (latest 12 month data available)

Quality objectives at a glance

The table below summarises the themes which have underpinned our quality objectives over the past four years and our plans for 2013/14.

Quality domain	2009/10	2010/11	2011/12	2012/13	2013/14 plans
Patient Safety	Patient Safety First campaign	Antibiotic prescribing compliance	South West Quality and Patient Safety Programme	South West Quality and Patient Safety Programme, including inpatient falls, pressure ulcers, medication errors and hospital acquired thrombosis	Harm-free care (NHS Safety Thermometer – includes falls, ulcers, VTE, UTI)
	Healthcare acquired infections	Healthcare acquired infections	Inpatient falls	NHS Safety Thermometer	Healthcare acquired infections
	Human factors training in high risk procedures	High risk medication errors which cause actual harm	Medication errors	Nutritional care	Medication errors
		Hospital acquired thrombosis	Hospital acquired thrombosis	Gynaecological surgery	Medicines reconciliation
			Histopathology	Histopathology audit	Escalation of deteriorating patients
			Pressure ulcers		72 hour nutritional review
Patient Experience	Learning from McKinsey patient experience project	Patient feedback systems	Patient feedback systems	Patient Experience Strategy	Patient Experience Strategy (focus on maternity)
			Carer feedback	Kindness and understanding	Kindness and understanding
			Patient-reported noise at night	Patient-reported noise at night	Friends and Family Test
			Help at mealtimes	Communication with patients	Explaining medication side effects
			Ward-based information	Complaints	
			Customer care training	Discrimination against staff at work	
Clinical Effectiveness		NICE Quality Standard for dementia	Cancer survival rates	Service-specific mortality data	Clinical outcomes baseline
			Stroke	Stroke	Stroke
			Dementia	Dementia	Dementia
			Spontaneous vaginal births	Risk assessment for learning disabilities	Risk assessment for learning disabilities
				Enhanced recovery	Diabetes
				NICE implementation and audit	Hip fractures

PATIENT SAFETY

Our commitment

The safety of our patients is central to everything we want to achieve as a provider of healthcare. We are committed to continuously improve the safety of our services and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by conducting thorough investigation and analysis when things go wrong, identifying and sharing learning and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident and will strive to eliminate avoidable deaths as a consequence of care we have provided. We will also work to better understand and improve our safety culture and to successfully implement proactive patient safety improvement programmes.

Report on our patient safety objectives for 2012/13

Objective 1

We wanted to meet our targets for participation in the NHS South West Quality and Patient Safety Improvement Programme

AMBER

The Trust has been participating in this regional patient safety programme for adult services since 2009. The programme, supported by the Institute for Healthcare Improvement (Boston, USA), aims to deliver sustainable improvement over a five year period which is due to end in October 2014. The overall objective is a 15% reduction in patient mortality (as measured using the Hospital Standardised Mortality Ratio) and a 30% reduction in adverse events compared with the start of the programme in 2009. A 15% reduction in mortality rate (from a baseline HSMR of 86.83 to 73.81) means that approximately one further death will be avoided out of every ten expected. There are five distinct work streams within the programme: leadership, perioperative care (care given before during and after surgery), the general ward, medicines and critical care.

At the end of 2012/13, the Trust had achieved an overall score of 3.0 points out of a possible five on the programme's assessment scale, against a target of 4.0: this is because we only succeeded in making the planned level of improvements in three out of our five work streams (leadership, perioperative care and critical care). Recovery plans are in place for the remaining two workstreams. The Trust's headline mortality rates, HSMR and SHMI (see pages 40-42), continue to be better than the NHS average, and we are already achieving the overall programme objective of a 15% reduction in patient mortality.

Key achievements in the work streams have included:

- Patient safety walk-rounds led by executive directors becoming embedded practice
- Perioperative measures being sustained at 95% compliance, including new theatres opened at South Bristol Community Hospital. These measures include: keeping a patient's temperature at 36 degrees or higher, ensuring diabetic patients have their blood glucose kept within the range of 5 and 11 millimols and carrying out a safety briefing at the start and finish of every theatre list. In 2013/14, we will be monitoring whether these changes lead to an overall reduction in the number of adverse events, infections and cardiovascular events that can happen following an operation.

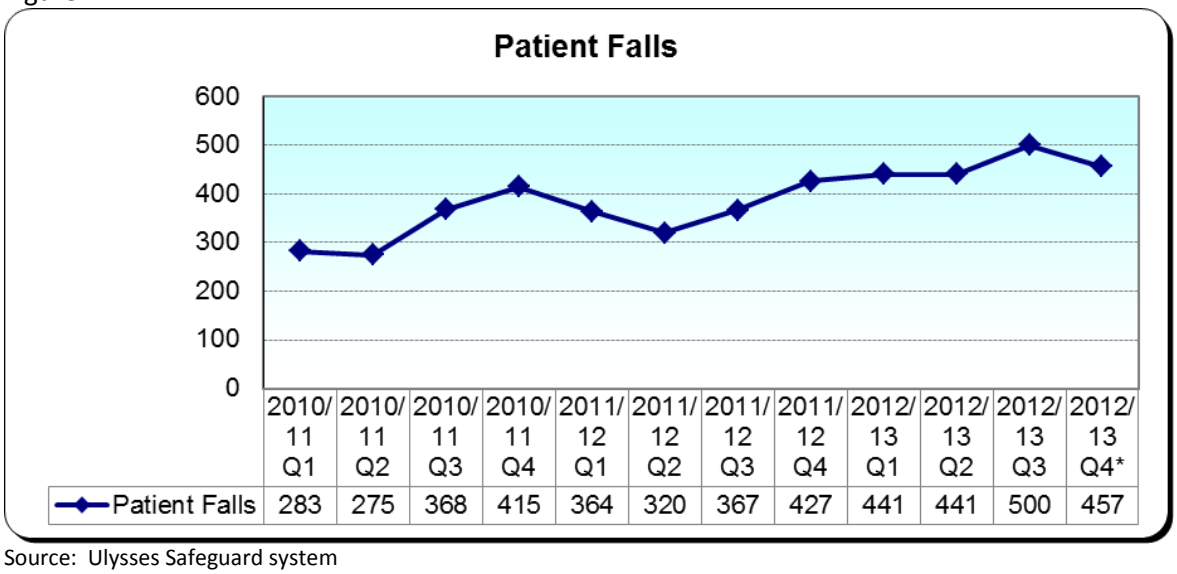
- Significant progress in the critical care workstream (moving from a score of 1.5 to 3.5 during 2012/13). 100% of patients have received a multi-disciplinary ward round and had daily goals set for them during their time on the adult intensive care unit.
- In the general ward work stream we have improved recognition of the deteriorating patient for five out of last six months of 2012/13, 100% of patients in our case note review audit sample had complete observations (target 95%). There is further work to do to ensure that all patients receive an appropriate response when their observations indicate this is required and we will be focussing on this in 2013/14.

As part of our participation in the programme, we are also targeting improvements in reported patient falls, pressure ulcers, medication errors and hospital acquired thrombosis: we have seen a reduction in medication errors and good performance in venous thromboembolism risk assessment, however falls and pressure ulcers have been significant challenges for the Trust throughout the year. We have provided a short commentary below on our performance in each of these areas in 2012/13.

Patient falls

Patient falls are the most commonly reported safety incident in the NHS inpatient setting and occur in all adult clinical areas. Falls in hospital lead to injury in about 30% of cases, with 1-5% leading to serious injury. Up to half of all falls involve a degree of cognitive impairment, with 75%[7] of falls occurring in patients aged 65 or over. The number of elderly patients admitted by the Trust is rising steeply: we are currently developing an approach to estimating the impact the age of our patients has on the incidence of inpatient falls. The majority of falls are not witnessed and a significant number occur in the early hours of the morning; not all falls can be prevented.

Figure 1



	2010/11 Q1	2010/11 Q2	2010/11 Q3	2010/11 Q4	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4*
Patient Falls	283	275	368	415	364	320	367	427	441	441	500	457

Source: Ulysses Safeguard system

Our target for 2012/13 was to achieve a total number of reported patient falls of less than the national average of 5.6 per 1000 bed days (National Patient Safety Agency data): disappointingly, our rate of reported patient falls was 6.04 per 1000 bed days. This represents 1905 falls, including 158 incidents where the patient was assisted to the floor; this compares with a total of 1429 falls in 2011/12 (5.01 falls per 1000 bed days). In 2012/13, 22 falls were recorded as serious incidents involving fractures.

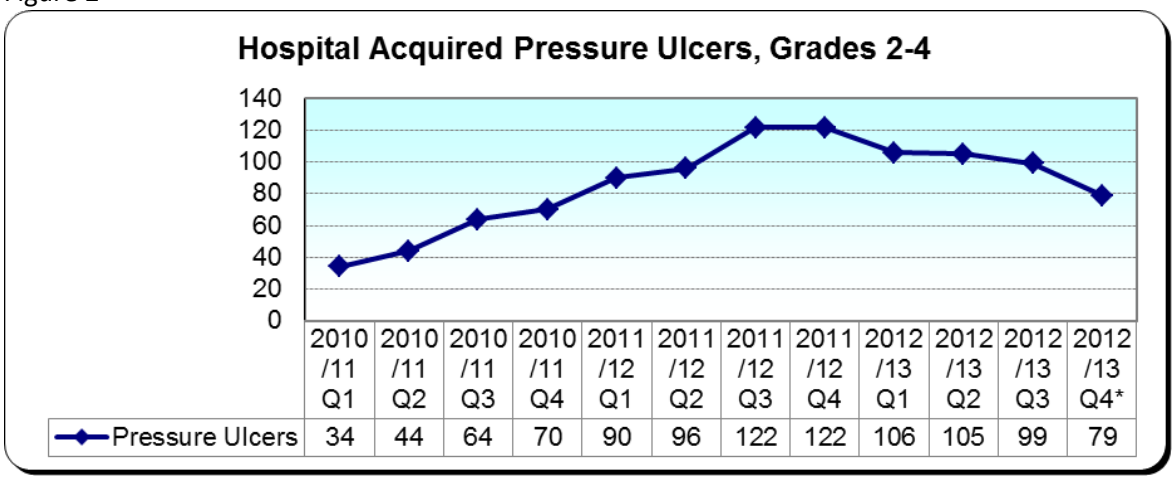
[7] National Patient Safety Agency, 2007 data

In August 2012, clinical leads for falls were identified within the Trust to co-ordinate and support the work of the Falls Steering Group to reduce the incidence of falls and subsequent harm to patients in our care. In November, the Trust implemented the Royal College of Physicians (RCP) Fallsafe Care Bundle package across three pilot wards led by the clinical leads. Fallsafe was developed from a quality improvement project which sought to prevent inpatient falls in hospital by 'closing the gap' between the evidence base for effective care and the care that patients actually receive. Our pilot ended in February 2013, demonstrating a sustained reduction in falls where the care bundles were fully implemented. Following evaluation of this project, a phased implementation will take place across the Trust between May and September 2013. Other work has included a revised patient information leaflet which encourages a partnership approach to the prevention of falls in hospital: it explains to patients, carers and relatives what they can do to help us and what we can and cannot do to prevent falls in hospital. 'Falling Star' magnets have also been introduced as a way of identifying patients who have been assessed as being at risk of falls to prompt multi-professional management

Pressure ulcers

Pressure ulcers range from being small areas of sore or broken skin to the more serious type of skin damage that can lead to life-threatening complications. Our focus on pressure sore prevention and management reflects the priorities of our staff, carers, governors and commissioners. The reduction of newly acquired grade 3 and 4 pressure ulcers is a national quality priority within the NHS Outcomes Framework.

Figure 2



	2010/11 Q1	2010/11 Q2	2010/11 Q3	2010/11 Q4	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4*
Pressure Ulcers	34	44	64	70	90	96	122	122	106	105	99	79

Source: Ulysses Safeguard system

Our target for 2012/13 was to achieve a total incidence of pressure sores (grades 2-4) of less than 0.651 per 1000 bed days (based on a percentage reduction of a previous NPSA benchmark): we achieved a rate of 1.28 per 1000 bed days.

Data for the period January-June 2012 showed that despite positive actions taken up to that point, the overall incidence of hospital acquired pressure ulcers had not changed significantly. An external review was commissioned by the Chief Nurse. The review took place in August 2012: the reviewing team produced ten key recommendations which have formed the basis of a recovery plan.

Actions taken in 2012/13 included:

- Repair and replacement of foam mattresses following an annual trust-wide audit: a system is now in place to ensure that all foam mattresses are checked in between patients and repaired or replaced immediately if necessary.
- Completion of work to upgrade the existing bed store: a robust system for managing mattresses across the Trust has been agreed.
- Development with the University of the West of England of a package for trained nurses to educate them and increase their skills in pressure ulcer prevention and management.
- The Division of Medicine is trialling new masks for non-invasive ventilation[8] patients – the masks have a gel seal instead of silicone. Learning from this will be shared across all Divisions.
- All Divisions continue to be required to complete and submit detailed recovery plans to our Executive Director-led Quarterly Reviews. These plans are monitored at a monthly performance meeting attended by the Chief Nurse or Deputy Chief Nurse.

We are encouraged that our score in March 2013 (0.85 pressure ulcers per 1,000 bed days) was the best we have achieved for two years[9].

Medication errors

In 2012/13, we continued to monitor an objective we set ourselves in both 2010/11 and 2011/12 to reduce the proportion of medication incidents classified as causing 'moderate', 'major' or 'catastrophic' harm. The reduction of medication errors causing serious harm is a national quality priority within the NHS Outcomes Framework.

99% of reported medication incidents at our Trust in 2012/13 did not result in major harm to patients (22% of incidents were low harm, 58% negligible harm (defined as no obvious harm or damage to the patient) and 19% were identified as a 'near miss'. Our target was to improve on our 2011/12 performance when 1.61%[10] (21/1301) of reported medication incidents to involved moderate, major or catastrophic harm to patients. In 2012/13, 0.88% (14/1594)[11] of medication related incidents resulted in moderate (13/14), major (0/14) or catastrophic (1/14) harm, representing a year-on-year improvement which we continuously strive for.

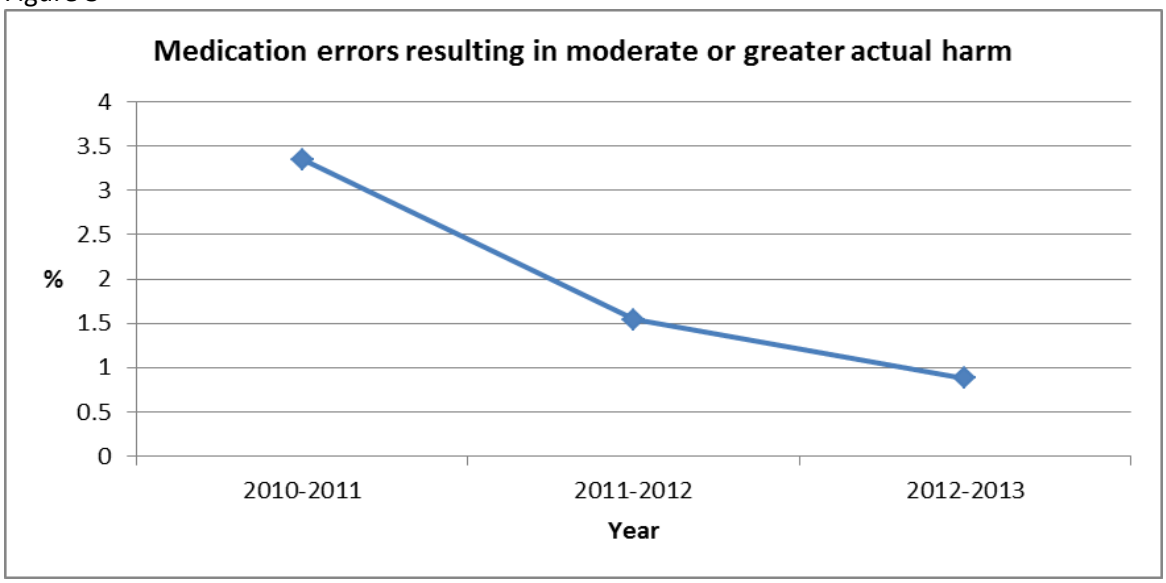
Our Medicines Safety Group continues to meet on a monthly basis to review reported medication incidents and ensure lessons are learned to achieve a sustainable reduction in the proportion of medication incidents resulting in moderate, major or catastrophic harm.

We also set ourselves two new goals. Firstly, we wanted to reduce omitted doses of critical medicines. This is important to patient safety and quality of care to ensure that the patient receives the maximum benefit from their medicines. From a baseline of 4.3% of patients having a non-purposeful omitted dose (measured by sampling methodology in over 500 patients each month, monitoring the previous three days of treatment), our target was to achieve less than 3.75%. Performance was assessed in the period October 2012 to March 2013: we were successful in reducing the percentage of omitted doses of critical medicines to 2.59%. In 2013/14 we plan to further reduce the proportion of omitted doses of medicines. Secondly, we

[8] i.e. the delivery of ventilation to a patient that does not involve a tube into the wind pipe, e.g. different types of oxygen masks
[9] April 2011 (0.721%)
[10] This figure differs marginally from the one indicated in the 2011/12 Quality Report (1.54%) – this follows the validation of 2011/12 incident data which had not taken place at the time of the publication of the 2011/12 Quality Report)
[11] Incident data validated 5/7/13

wanted to improve medicines reconciliation (getting the medicines right). We set a target to carry out complete medicines reconciliation within one working day for more than 95% of patients admitted to our hospitals via our three main admission wards and for more than 90% of patients admitted to three of our cardiac wards (from baseline data of 77% in the second quarter of 2012). We met both of these targets, achieving 97% on our admission wards and 91% on our cardiac wards. In 2013/14, we plan to extend the monitoring of medicines reconciliation to cover other wards that may receive direct patient admissions.

Figure 3



Source: Ulysses Safeguard system

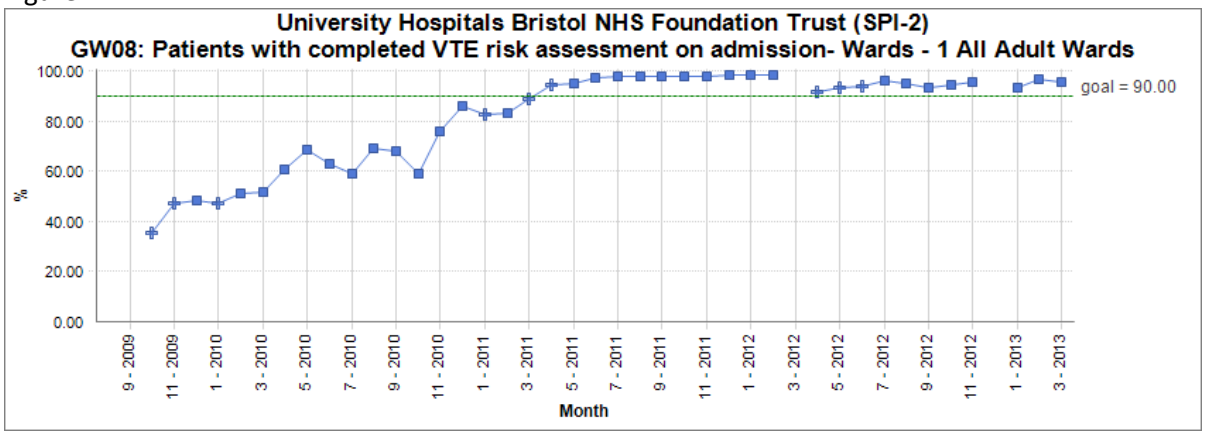
Venous thrombo-embolism
(Mandatory indicator)

Venous thrombo-embolism (VTE) is a significant cause of mortality, long term disability and chronic ill health. It is estimated that there are 25,000 deaths from VTE each year in hospitals in England: reducing incidence of VTE is a national quality priority within the NHS Outcomes Framework. We wanted to sustain improvements in Venous Thrombo-embolism (VTE) prevention by continuing to screen patients for risk of VTE and ensuring patients at risk receive appropriate thromboprophylaxis. The Trust achieved a 90%+ target for VTE risk assessment in every month during 2012/13. For the year as a whole, 96.4% of inpatients received a risk assessment. This compares with 97.4% in 2011/12.

We also achieved a 90%+ target for appropriate thromboprophylaxis for seven of the 12 months during 2012/13: in Quarter 4 we did not achieve our target, and data was unavailable for two other months[12]. For the year as a whole, 94.6% of inpatients identified at risk received appropriate thromboprophylaxis. This compares with 93.2% in 2011/12.

[12] This was because of vacancies in the post of VTE nurse

Figure 4



Source: PAS system and local audits, reported as part of South West Quality and Patient Safety Improvement Programme

The Trust considers its VTE risk assessment data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. Although the Trust does not currently collect VTE risk assessment data for all patients, we use a robust weekly audit methodology, the results of which are submitted by our Information Team to the Department of Health via the Unify system. Full details of our data quality framework for this indicator are available upon request.

The Trust has taken the following actions in 2012/13 to sustain 90%+ compliance with VTE risk assessments, and so the quality of its services:

- Revising the prescription chart containing an integrated VTE risk assessment to make it easier for staff to risk-assess and prescribe appropriate thrombo-prophylaxis for VTE prevention
- Extending the provision of a VTE project nurse to sustain and embed focus on VTE prevention and provide supplementary training by targeting teams and staff groups with reduced levels of compliance or where, through reported patient safety incidents, patients have been identified as having acquired a VTE in hospital, and
- Continuing to focus on VTE prevention training, including induction, update sessions and e-learning

Objective 2

We said we would implement and develop the use of the NHS Safety Thermometer

GREEN

The goal of the NHS Safety Thermometer is to increase the numbers of patients who are free from harm. The Safety Thermometer measures four types of harm: pressure ulcers, falls, urinary tract infection and venous thrombo-embolism. The Trust is already collecting detailed information about the four types of harm, and many others, as part of the South West Quality and Patient Safety Improvement Programme, however the NHS Safety Thermometer provides an additional opportunity for national benchmarking and cross provider working to reduce the levels of harm to patients. In 2012/13, as part of the CQUIN[13] framework, our target was to implement the Safety Thermometer, achieving at least 25% coverage in Quarter 2, at least 75%

[13] The Commissioning for Quality and Innovation (CQUIN) payment framework is a developmental process which enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. See page 58.

in Quarter 3 and 100% in Quarter 4. Since June 2012, we have audited 100% of eligible patients each month, significantly exceeding the requirements of the national CQUIN. 91.3% of patients audited were receiving harm-free care; that is, they did not have any of the four harms measured by the safety thermometer, either existing or upon admission (old harm) or since (new harm). 95.7% of patients had no new harms; that is, none of the four types of harm had been acquired since admission. For 2013/14, we will be agreeing a CQUIN with commissioners to reduce one of the four types of harm as measured by the NHS Safety Thermometer.

Objective 3

We wanted to continue to embed high quality nutritional care across the Trust

GREEN

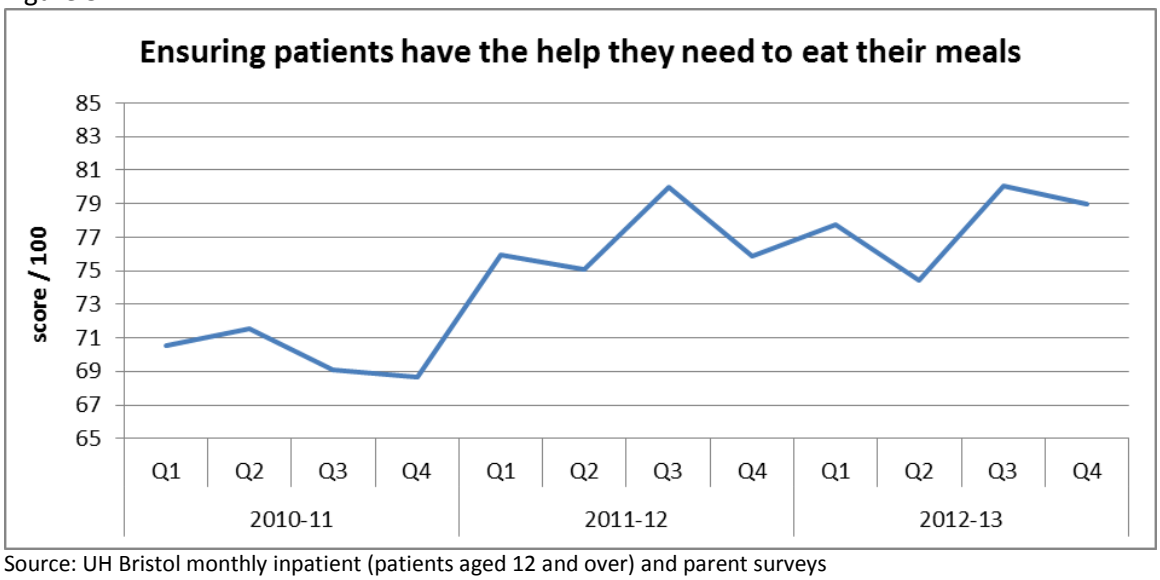
In last year's Quality Report, we described actions that we had taken to improve nutritional care following an inspection by the Care Quality Commission (CQC). We are delighted to report that when the CQC carried out an unannounced inspection of our Main Site (the Bristol Royal Infirmary and other hospitals in the city centre precinct), they found that the Trust was compliant with Outcome 5 (Meeting nutritional needs). Similar positive feedback was received from the CQC when they visited South Bristol Community Hospital in August 2012.

Over the course of the last year, 90.9% of adult inpatients received a fully completed nutritional assessment within 24 hours of admission, against a target of 90%, however in the second half of the year, we achieved in excess of 93% compliance; performance in children's services was 84%. Protected mealtimes were observed in audits of adult wards on 93.8% of occasions, against a target of 95%; performance in children's services was 100%. If a patient is assessed as being at risk of malnutrition, this risk is highlighted to members of the ward team by ticking a cutlery sign behind their bed to ensure they receive the right level of care. Throughout the year we have monitored whether this has been completed in nutrition audits: the cutlery sign was ticked for 85% of patients who needed it. Audits have also demonstrated that we are consistently ensuring patients are given the opportunity to wash their hands before meals (94% of adult patients during 2012/13) and recording patients' likes and dislikes of food (91.5%).

Since 2011, the Trust has been recruiting a team of volunteers who help patients at mealtimes, complementing nursing care. The role of the volunteers is to encourage and assist patients who for a variety of reasons find eating and drinking difficult, which can have a detrimental effect on their wellbeing and may delay their recovery. Our volunteers help by making the ward environment more conducive to the mealtime experience by tidying tables and helping with hand wiping; they also help to serve food and most importantly give encouragement and assistance to those patients who are less able. At the time of writing (May 2013), we have 39 volunteers who are assisting patients in this way and a further 21 volunteers who are working towards achieving the necessary competencies. Feedback from our patient survey (see Figure 5 below) suggests that our volunteers' efforts are making a genuine difference to patient care.

Finally, in April 2012 we introduced a three day (72 hour) review of food charts: this review facilitates appropriate support, such as referral to the dietitian for advice if food intake is continually low. Over the course of the year we have provided 10 minute 'micro' teaches to 350 ward based nursing staff and highlighted the importance of the three day review in our nutrition study days. Compliance has improved from 29% in April 2012 to 81% in March 2013. We have specified three day nutritional review as one of our corporate quality objectives for 2013/14.

Figure 5



Source: UH Bristol monthly inpatient (patients aged 12 and over) and parent surveys

Objective 4

We committed to implementing a proactive clinical audit programme for histopathology

GREEN

In our last two Quality Reports, we have reported on the Trust's response to the recommendations of an Independent Inquiry into Histopathology Services in Bristol. In our 2011/12 Quality Report we reported that members of the inquiry panel had returned to the Trust and found a genuine commitment to implement their recommendations and evidence of real progress. As part of our ongoing focus on the quality of histopathology services, we said that in 2012/13 we would develop and deliver a comprehensive programme of clinical audit. A total of 13 audits were identified by the Joint Clinical Lead for Histopathology as priorities:

Title	Sub-Specialty
Audit of supplementary reports issued after multi-disciplinary team meetings to identify discrepancies across all cancer specialties in UH Bristol	All specialties
Correlation of breast tumour grading between core biopsies and resection specimens in a screened population	Breast
Audit of The Reporting of Cutaneous Malignant Melanoma at UH Bristol	Dermatopathology
Audit of turnaround time for skin cancers: September 2011 - 2012	Dermatopathology
Reporting of high grade endometrial cancer	Gynaecology
Reporting of vulval carcinomas	Gynaecology
Appropriate indeterminate classification of Inflammatory Bowel Disease*	Paediatric
Audit of microbiology sampling in stillbirth post mortems	Perinatal
Quality of perinatal autopsy in South-West of England	Perinatal
Histological reporting of lung specimen	Pulmonary pathology
Audit on double-reporting of lung pathology cases is in progress	Pulmonary pathology

Title	Sub-Specialty
Bowel Cancer Screening Program-detected colorectal cancer resection specimens: a comparison of reporting between three trusts	Upper GI
Renal tumour reporting	Uropathology

** project changed to measure turnaround times for IBD biopsies.*

All of these projects have been completed. A number of the audits demonstrated good adherence to standards. Other audits identified a need for improvement: in these cases, action plans have been produced and will be monitored throughout the year ahead. A number of actions relate to changes to staff working arrangements includes training more biomedical scientists in skin cut up technique and the reorganisation of working practice to allow them to provide increased support to consultants. Other audits have resulted in the introduction of actions to support improved sub specialty input into complex cases. Elsewhere, a pro forma has been introduced to ensure that minimum datasets are recorded and reported accurately, providing the necessary information to inform diagnosis.

During 2013/14, joint histopathology clinical audit meetings will be held between UH Bristol and North Bristol NHS Trust to allow the sharing of results and practice between the two trusts. The first joint meeting took place in April 2013.

Objective 5

We wanted to see improvements in rates of complications, misadventures and re-admissions following gynaecological surgery

AMBER

In February 2011, the Trust's Quality Intelligence Group received a report from CHKS (the Trust's provider of clinical benchmarking data) which highlighted complications, misadventures and re-admissions following gynaecological surgery as statistical outliers that warranted further local investigation/monitoring. The most recent CHKS data (which is for 2012) shows that the Trust's mortality and misadventure rates are now similar to its clinical peer group (0.06% UHB v 0.08% peer for mortality; 0.45% v 0.43% for misadventures). Our re-admission rate remains higher than our peer group (7.3% v 5.5%), however there is a downward trend and case note reviews have identified that a significant number of the 'readmissions' are either gynaecology oncology patients (when beds in the Bristol Haematology and Oncology Centre are unavailable) or post-operative ward review cases on occasions when no gynaecology follow up outpatient slots have been available. In respect of the three measures described, we are therefore assured that the data is either around the statistical norm (mortality and misadventures) or that there is a valid explanation for variation (re-admissions).

Benchmarking reports continue to indicate that the Trust is an outlier for complications following gynaecological surgery. The Trust has an active Gynaecology Morbidity and Mortality (M&M) meeting where cases of morbidity identified by CHKS are reviewed in depth in order to learn lessons and improve quality and safety of care; learning from case note reviews has been disseminated within the service. We have also found that some 'complications' identified by CHKS are not complications but are a standard part of the operative procedure, e.g. adhesiolysis appropriately carried out at a laparotomy. Further investigation and case note review is required. We will continue to monitor all of these indicators during 2013/14 and will report on progress in next year's Quality Report.

Review of patient safety 2012/13

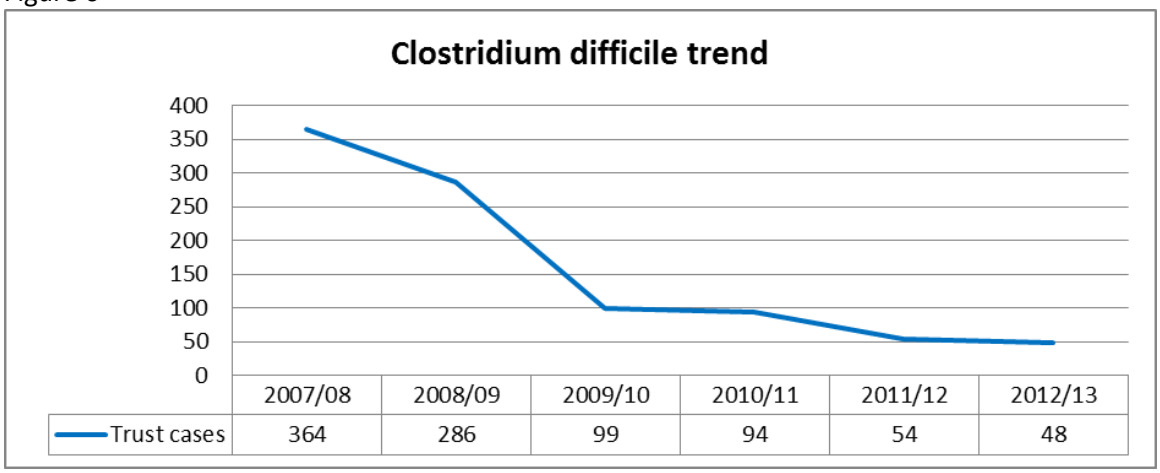
This section explains how the Trust performed during 2012/13 in a number of other key areas relating to patient safety, which are in addition to our stated annual objectives.

Healthcare acquired infections

(Mandatory indicator – C Diff)

Although not a formal quality objective, the focus on preventing healthcare acquired infections (HCAIs) has remained a key priority for the Trust in 2012/13 and will remain so in future years. In 2012/13, we achieved national targets for ***Clostridium difficile***: the Trust reported 48 cases of infection in 2012/13, six fewer than the target for the year of 54. Historically, the number of C. diff cases shows a strong seasonal profile, with around 60% of cases being reported in the first half of each year. In the first two quarters of the year, the Trust reported a higher number of cases than Monitor's 'flat phasing' of the annual target, however, significant reductions in cases were seen in Quarters 3 and 4 to bring the Trust back within target at year-end. This is the second consecutive year that our performance has been better than our target.

Figure 6



Source: Public Health England Data Capture System

The Trust considers its *Clostridium difficile* data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. This framework governs the collection and validation of the data and its submission to a national database (full details are available upon request).

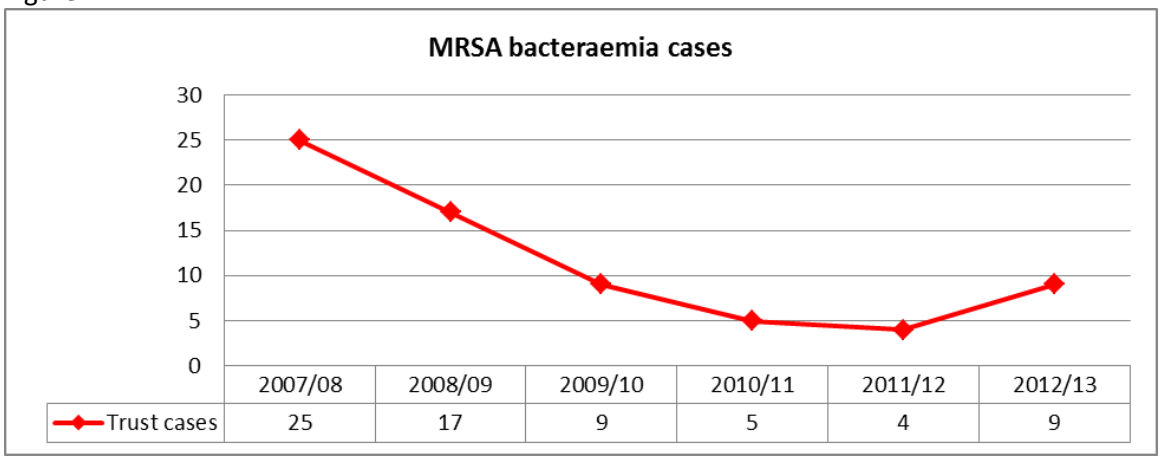
The Trust has taken the following actions in 2012/13 to achieve reductions in *Clostridium difficile* infection and so improve the quality of its services:

- Patients are nursed in a separate cohort area and are not admitted back into the general patient population for their duration of stay in hospital.
- Patients are monitored on a daily basis by the Infection Control Team. When patients are discharged, patients' rooms are deep-cleaned. A hydrogen peroxide vapour is used for added assurance of cleaning.
- Antibiotic prescribing is monitored, and staff undertake 'saving lives' care bundles and hand hygiene audits each month. If the required standard is not reached, audits are repeated weekly until three consecutive weeks at the required standard are achieved.
- Patients are clinically managed by Gastro Intestinal Consultants and Infection Control Doctor.

Improvements in testing, specimen sending guidance and overall management of Clostridium *difficile* will put us in a strong position to achieve our target of 35 cases for 2013/14.

Disappointingly however, our target of two cases of **MRSA** (Meticillin Resistant *Staphylococcus Aureus*) bacteraemia was not achieved – ten cases were reported. The Root Cause Analysis identified an emerging theme of intravenous lines (IVs) being the route of infection in a majority of cases. An action planned was implemented in the latter half of the year which focused on improvements in IV line care management. Since the implementation of the plan, a further two bacteraemias have been reported. The most recent bacteraemia was in an immuno-compromised patient and was not related to IV line care. The Trust is using the learning from this case, and from one of the highest performing trusts in the country, to further enhance its recovery plan, with the aim of meeting the Department of Health's target of having no MRSA bacteraemias in 2013/14.

Figure 7



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Trust cases	25	17	9	5	4	9

Source: Public Health England Data Capture System

Elsewhere, MSSA bacteraemias continue to fall year on year, although we exceeded our set target of 27 cases by nine.

We continue to train all staff in infection prevention and control – at the end of March 2013, 86% of our staff were compliant with initial or update training. Hand hygiene has remained a priority: regular auditing on wards has shown that hand cleaning takes place on 96.2% of occasions when it is needed, meeting our 95%+ target for 2012/13. Hand hygiene facilities continue to be upgraded where necessary and alcohol hand gel is widely available close at the point of patient care and at the entrances to wards and departments in response to requests from the public and visitors.

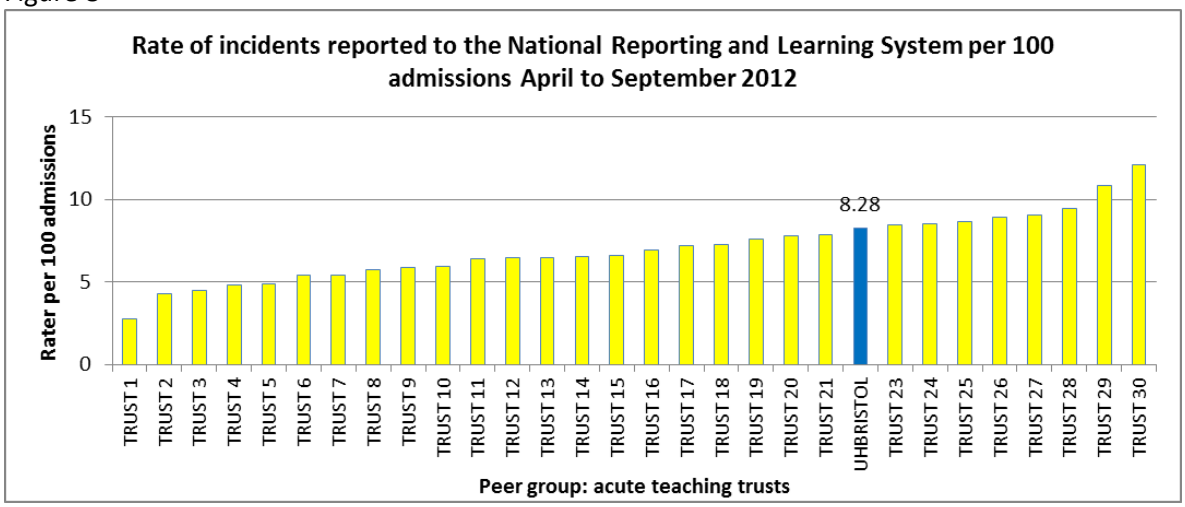
Norovirus continues to present a challenge. We have seen three peaks during the year, in May, November and February (consistent with regional trend). In total, 88 areas were closed (30 ward and 58 bay closures) but improved management has meant wards remained closed for an average of seven days, which is two days fewer than in 2011/12.

Rate of patient safety incidents reported and proportion resulting in severe harm or death
(Mandatory indicator)

We are pleased that we are reporting more patient safety incidents and seeing fewer incidents which result in severe patient harm. Reporting of incidents at University Hospitals Bristol has increased steadily since 2009/10. The Trust is ranked in the top 50% of its peer group, improving its position to just below the best quartile. It is widely recognised that organisations that report more incidents usually have a better and more effective safety culture: you cannot learn and improve if don't know what the problems are.

Based on the latest available data from the National Reporting and Learning System for the six month period April to September 2012, the rate of patient safety incidents reported at University Hospitals Bristol is 8.28 per 100 admissions (5273 incidents). This represents an increase in reporting when compared to the previous six month period (7.26 per 100 admissions, 4662 incidents) and to the same period in 2011/12 (6.66 per 100 admissions, 4274 incidents). The national average for incidents per 100 admissions in the corresponding period of 2012 was 6.44. The provisional[14] rate of patient safety incidents for 2012/13 as a whole was 8.84 per 100 admissions.

Figure 8



Source: National Reporting and Learning System

The percentage of reported incidents resulting in severe harm is 0.7% (35 incidents) for the period April-September 2012. This represents a reduction compared both to the previous six months (1.0%, 46 incidents) and the corresponding period in 2011/12 (1.1%, 47 incidents) as reported in our 2011/12 Quality Report. The percentage of reported incidents resulting in death remains at 0.1% (four deaths), the same rate reported in 2011/12 and below the average rate of our peer group (0.15%). The provisional percentage of reported incidents resulting in severe harm or death was 0.63% (66 severe harm incidents; and four potentially avoidable deaths) for 2012/13 as a whole.

The Trust considers its incident reporting data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. This framework governs the identification and review of incident data prior to submission to the National Reporting and Learning System (full details are available upon request).

In 2013/14, the Trust intends to take the following actions to continue to reduce harm from avoidable patient safety incidents:

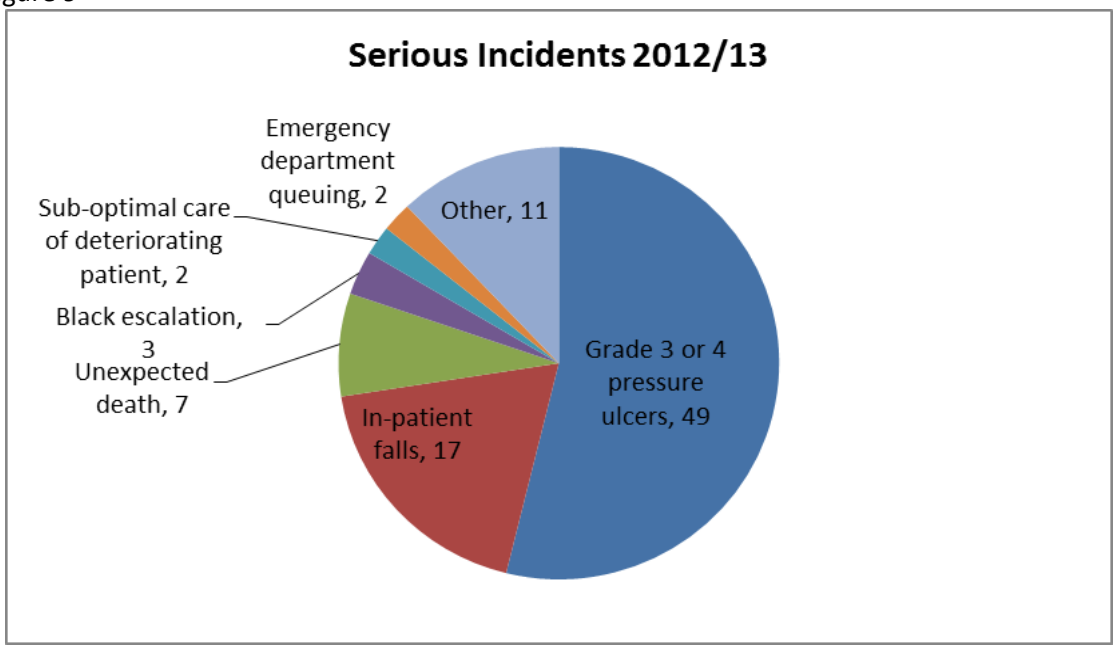
[14] Verified data for October 2012 – March 2013 is not available from the NRLS until September 2013

- Continuing to implement the South West Quality and Patient Safety Improvement Programme
- Investigating incidents proportionally to their level of harm or risk, learning and sharing lessons and taking action to reduce the chance or impact of the same kind of incident happening again
- Focussing on improving key patient safety issues for the Trust such as reducing the number of non-purposeful omitted doses of critical medicines, reducing pressure ulcers and in-patient falls and improving the identification of the deteriorating patient and ensuring prompt review by a senior clinician

Serious incidents

The purpose of identifying and investigating serious incidents, as with all incidents, is to understand what happened, learn and share lessons and take action to reduce the risk of a recurrence. The decision that an event should be categorised as a serious incident is usually made by an executive director. Throughout 2012/13, the Trust Board was informed of serious incidents via its monthly quality dashboard. The total number of serious incidents for the year was 91, of which five were either downgraded or a downgrade request has been made at the time of writing (April 2013). A breakdown of the themes from these incidents is provided in Figure 9 below.

Figure 9



Source: UH Bristol Serious Incident Log
N.B.: The category "other" includes all categories where only one serious incident of its type was reported

Completed serious incident investigations will have robust action plans which are being implemented to reduce the risk of recurrence. Actions taken by the Trust to reduce falls and hospital-acquired pressure ulcers are documented on pages 8-10 of this report.

Never Events

'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They are incidents where there is clear potential for causing severe harm or death. "Never" is an aspiration: these errors should not happen and all efforts must be made to prevent these mistakes from being repeated. This means that the overriding concern for the NHS in implementing the national Never Event policy framework is to discuss these events when they occur and to learn from the mistakes that were made (Department of Health 2010).

One never event occurred in University Hospitals Bristol in 2012/13 which involved a retained swab following an instrumental delivery in the obstetric theatre. Whilst there is a robust Standard Operating Procedure (SOP) in place to ensure all swabs, instruments and needles are counted at the end of a procedure, this was not followed in this case. Theatre staff have been reminded of their roles and responsibilities in relation to the Standard Operating Procedure. A process of continuous audit of compliance with the SOP has been introduced in obstetric theatres and the Central Delivery Suite.

National Patient Safety Agency Alerts

The two outstanding National Patient Safety Alerts for University Hospitals Bristol reported in our Quality Report for 2011/12 have been closed. At the end of 2012/13, there were no outstanding alerts relating to University Hospitals Bristol.

Patient Safety objectives for 2013/14

- To increase harm-free care as measured via the NHS Safety Thermometer
- To reduce hospital-acquired healthcare infections
- To reduce medication errors
- To extend medicines reconciliation ('getting the medicines right')
- To improve the early identification and escalation of care of deteriorating patients
- To improve levels of nutritional screening and specifically 72 hour nutritional review of patients

These objectives have been agreed with staff in our clinical Divisions and with our governors. The themes broadly reflect a continuation of previously stated goals and our ongoing commitment to participation in the South West Quality and Patient Safety Programme. Our governors have proposed that reducing hospital-acquired healthcare infections should be a standing annual quality objective.

Specific targets will be agreed with commissioners through the CQUIN process.

The Chief Nurse and Medical Director will be the executive directors responsible for achieving these objectives. Progress will be monitored during the year by the Trust's Clinical Quality Group, Trust Management Executive and by the Quality and Outcomes Committee of the Board.

PATIENT EXPERIENCE

Our commitment

We want all our patients to have a positive experience of healthcare. All our patients and the people who care for them, are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support. Our staff should be afforded the same dignity and respect by patients and by their colleagues. Our commitment to 'respecting everyone' and 'working together' is enshrined in the Trust's Values. Through our core patient surveys, we have a strong understanding of the things that matter most to our patients: these priorities continue to guide our choice of quality objectives. Our Clinical Divisions continue to be focused on providing a first class patient experience.

Report on our patient experience objectives for 2012/13

Objective 6

We wanted to implement the first year of our Patient Experience and Involvement Strategy for 2012-2015

GREEN

By implementing our previous patient experience strategy for 2010-2012, we established a comprehensive system for routinely gathering feedback from patients about the quality of our services: this consisted of ward-based interviews and comment cards, and a monthly post-discharge survey, in addition to a comprehensive annual outpatient survey. We have continued this model in our strategy for 2012-2015. For 2012/13 – the first year of our new strategy – we identified five groups of people whose experience of service we wanted to improve: emergency patients, children, carers, patients with a learning disability, and frail elderly patients including patients with dementia and those in end of life care.

Emergency patients

The Trust's adult emergency department sees approximately 200 patients each day, ranging from minor injuries to very complex cases. The department aims to treat and then admit, transfer or discharge all patients within four hours. Understanding patient experience is key to helping us develop the quality of our service. We achieved excellent results in the 2012 National Accident and Emergency survey with 16 scores classed as statistically "better" than the national average and eight of these scores being the highest scores nationally. During 2012/13 we have worked closely with representatives from the Red Cross who have a team located within the emergency department to assist with patient discharge. We have also actively involved patients in conversations about the redevelopment of the Bristol Royal Infirmary so that the final designs reflect their needs.

What our patients said in our monthly survey:

"In A&E, the doctors and nurses were absolutely brilliant"

Children

The Bristol Royal Hospital for Children provides a local service for Bristol children and a referral service for specialist care for families across the South West of England and nationally. It is important to us that we engage and involve children in the planning and delivery of services that matter to them. Over the last two years, we have been developing Teen Zones: 'young people friendly' environments with (restricted) access to the internet, books, magazines and health information targeted at this age group. After a successful pilot at the Bristol Eye Hospital, a second Teen Zone area has been opened in the Children's Hearing Centre at St Michael's Hospital. Signage for the Zones has been designed by members of the UH Bristol Youth Council and young people from the Knowle West Media Centre. Elsewhere, the Youth Council undertook a 'mystery shopping' exercise in October 2012 to test front-of-house services in various areas of the Trust: this involved visiting the main reception areas and evaluating the service provided, including whether it was young person-friendly. The Disabled Children's Working Group (DCWG) ran a "You Said, We Did" event at the *@Bristol* centre for a second year running, aimed at families with children who have disabilities or complex needs. Based on feedback from this event, the DCWG has developed a specialist assessment for children with disabilities

What parents said in our monthly survey:

"My child has a disability and had a hospital passport. This was brilliant and made the whole experience much better for him than previous ones had been."

Carers

Carers have a unique and valuable role to play in the provision of healthcare, particularly if the person they care for is in hospital. Carers are, in effect our "expert partners in care". Engaging carers is an ongoing activity which we remain committed to with our partners at the Carers Support Centre, our Carers Reference Group and colleagues at North Bristol NHS Trust, with whom we have established a joint Carers Charter. By the end of March 2013, approximately 3,000 staff had received care awareness training. From May 2013, this training will be extended to ward-based and dementia befriending volunteers: we hope that this will enable more 'hidden carers' to be identified through volunteers' work with patients on wards. A new Carer Liaison & Development worker was appointed and from January 2013 has been working on wards 4, 7 and 23 to support carers and staff, particularly around the discharge process. Towards the end of 2012/13, a new Carers Strategy and action plan was approved by the Trust's Patient Experience Group.

In the National Inpatient survey 2012, UH Bristol scored 'better than most other trusts' for ensuring that the patient's family / someone close to them got all of the information they needed to care for the patient.

Patients with a learning disability

The Learning Disabilities Steering Group is committed to ensuring that the Trust improves the experience of care amongst patients with learning disabilities and their carers, and in doing so meets its obligations to patients with a learning disability within the current legislative framework, i.e. with regard to the Equality Act (2010), the Mental Capacity Act (2005) and implementation of the Confidential Inquiry into the premature deaths of people with learning disabilities within an acute setting (2010-2013). In 2012/13:

- We have continued to work closely with user groups such as Health First, People First, Health work group.
- We have implemented the University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust Carers Charter as a commitment to ensure a greater focus on carers.
- The Trust has developed an admission pack including use of staff photographs, information about accommodation, facilities and car parking.
- We have introduced a differentiated inpatient comments card in an `Easy Read' format.
- We have launched a selection of accessible information leaflets.
- We are developing patient and carers' appointment letters in Easy Read formats, to include: appointment letters, hospital admission letters and change of appointment letters.
- We have launched the 'Hospital Passport' across the Trust – this is a document which patients complete prior to admission, and which moves with them as their care is transferred. The passport is accessible for download from the Trust external web page and can be emailed via a secure link direct to the learning disabilities nurse in preparation for admission.
- We have "recruited" over 40 link nurse in adult services across the Trust supporting the role of the hospital liaison nurse and raising awareness about patients with learning disabilities.

Also see information about risk assessment of patients with a learning disability on page 38 of this report.

Frail elderly patients including patients with dementia and those in end of life care.

In 2012/13, we undertook a comprehensive trust-wide audit of end of life care, with a key objective to establish whether patients at the end of their lives were recognised as dying, enabling the delivery of a uniform standard of care on an agreed care pathway. This project was linked to a CQUIN target that at least 45% of all adult deaths occurring on our wards should have their care directed by the Trust's End of Life tool. The audit identified that 65% of the deaths included in the audit were directed by the End of Life tool; 18% of deaths were sudden and could not have been anticipated; whilst the remaining 17% could have been anticipated but the tool was not used. Since that time we have continued to monitor the use of the tool and to investigate reasons why wards might not use the tool.

Also see detailed report on dementia care on page 37 of this report.

Objective 7

We wanted to reduce patient-reported noise at night from staff

AMBER

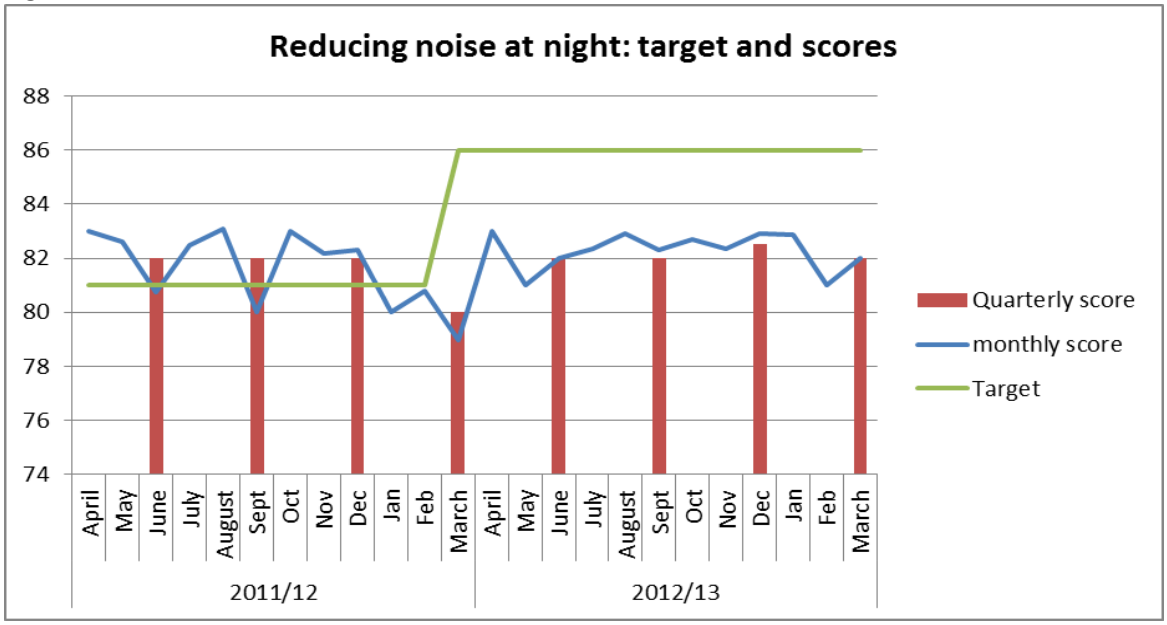
What our patients said in our monthly survey:

"Staff are excellent, very caring, informative and supportive - would help any way they could. The only thing would be the noise at night. Some things are unavoidable but general chat should be kept at low level."

"On the Adolescence ward, the doors on the bays shut slowly to start, then bang!"

We chose this objective as a continuation of a goal we set ourselves for 2011/12. We currently measure performance through a question in our monthly post-discharge patient survey. In 2011/12, we improved our score from a baseline of 78 points out of 100[15], to 82: a statistically significant change. This year we scored 83 points[16]: a small improvement, although we did not achieve our CQUIN target (84-86 points). Actions taken in 2012/13 to improve noise at night included further purchases of silent-closing bins and the use of 'Sound Ear' noise monitors on our wards[17]. Our corresponding score in the 2012 National Inpatient Survey was 84 points (categorised as statistically 'about the other same' as other NHS trusts): this compares with a 66 point score for noise at night caused by patients (also 'about the other same' as other NHS trusts), i.e. patients are more likely to be disturbed at night by other patients than by staff.

Figure 10



Source: UH Bristol monthly inpatient survey (patients aged 16 and over)

[15] In this instance, the score means that 78% of patients had not been disturbed by noise at night from staff. The baseline was Quarter 4 2011/12

[16] The CQUIN was based on patient feedback in the third quarter of 2012/13

[17] *Sound Ears* are monitors which display a warning light when a pre-determined noise level (decibels) is breached

Objective 8

We wanted to ensure that patients are treated with kindness and understanding

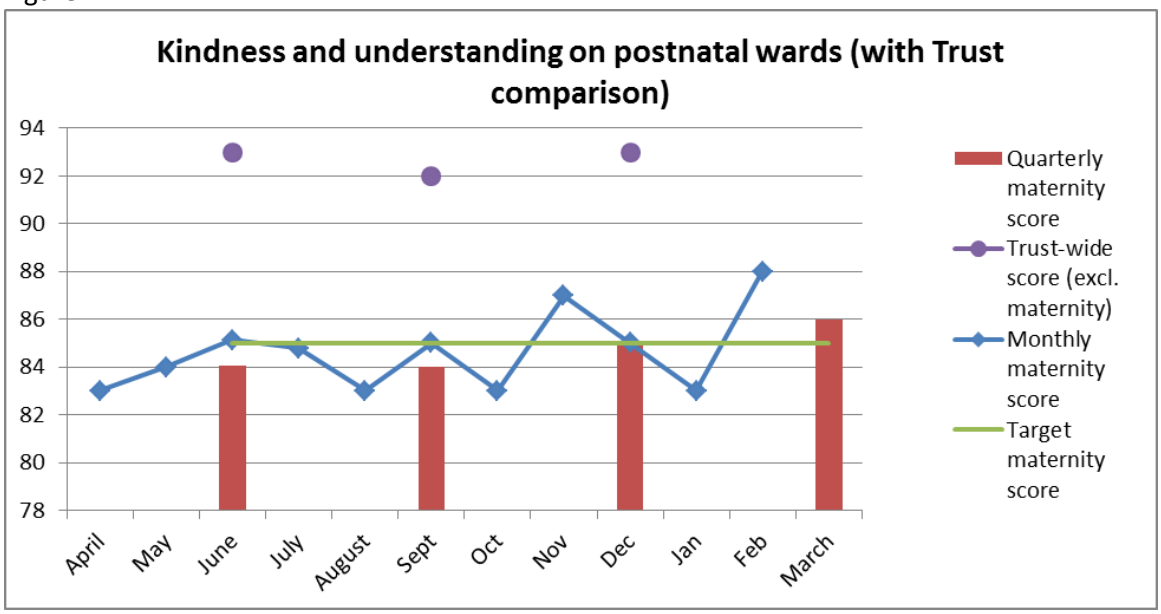
GREEN

What our patients said in our monthly survey:

"My midwife who delivered by baby was excellent, she was kind, friendly, helpful and made me feel a million times better in my situation as it was my first time in labour"

The three-yearly National Maternity Survey includes a question about whether mums felt that they had been treated with kindness and understanding – an important part of what 'compassionate care' looks and feels like in practice. In the first instance, we wanted to improve our maternity score. This followed a disappointing score for this question in the 2010 National Maternity Survey[18]. We therefore agreed a related CQUIN target with our commissioners (85/100 points), to be measured in the third quarter of the year. We achieved this score, and therefore the CQUIN. At the same time, we decided that kindness and understanding was something we wanted to measure across *all* inpatient services. We started to do this in the second quarter of the year and have achieved quarterly scores in excess of 90 points. One of our ambitions for 2013/14 is to sustain this trust-wide score.

Figure 11



Source: UH Bristol monthly maternity survey; UH Bristol monthly inpatient (patients aged 12 and over) and parent surveys. Data shown is for the year 2012/13. To avoid duplication with the National Maternity Survey, we did not undertake a local maternity survey in March 2013

[18] our score of 74 points was on the borderline of being in the "worst 20%" of NHS trusts

Objective 9

We wanted to improve specific aspects of communication with patients

AMBER

What our patients said in our monthly survey:

"I have received very professional care, staff were very warm and helpful. However, I felt as a patient I should receive more precise information about my situation"

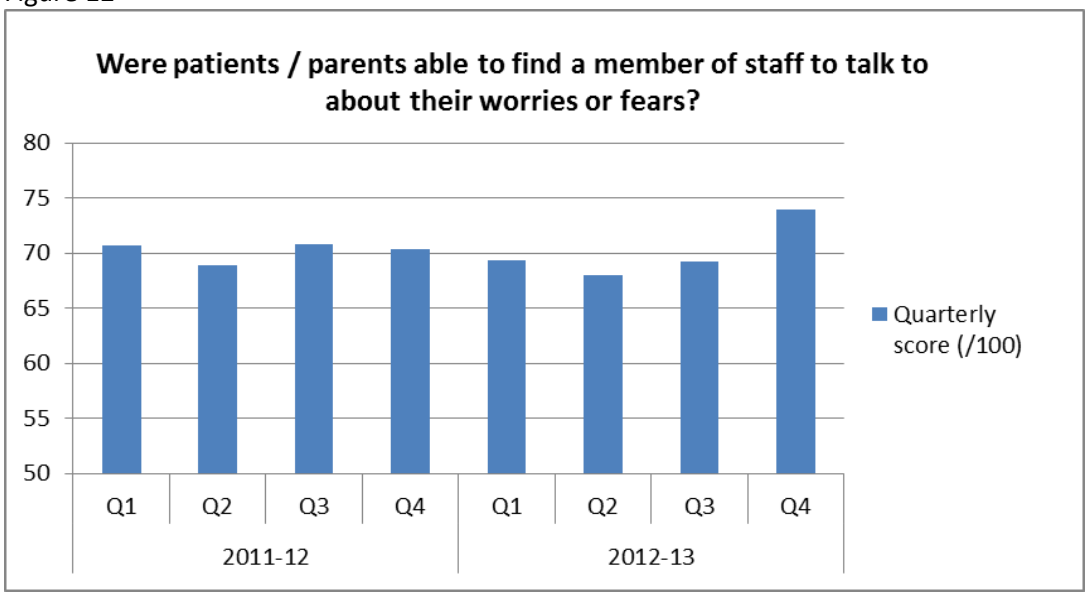
Failures in communication with patients are at the heart of many reported complaints from patients and their families. This is true for our Trust and across the wider NHS. For 2012/13, we agree two specific aspects of communication that we wanted to improve: keeping outpatients informed about waiting times in clinics, and making sure inpatients are able to find someone to speak to if they have worries or fears.

Explaining reasons for delays in outpatient clinics was UH Bristol's lowest score in the 2011 National Outpatient Survey: our score of 25/100 was also on the borderline of being among the worst 20% of NHS trusts, albeit that that the best score achieved by an NHS trust was only 49 points. The methodology of the National Outpatient Survey is such that the patient sample is skewed towards a small number of high volume outpatient clinics (e.g. Ophthalmology, Audiology, Radiology) rather than being representative of the experience across all clinics. When we asked the same question in our own 2011 outpatient survey – replicating the national survey methodology but using a much larger patient sample with a more even distribution across our clinics, we scored 38/100: better, but still the lowest-rated of 30 questions in the survey. 59% of patients said that they had not been told how long they would have to wait. Improving our performance for this aspect of patient experience has been one of the objectives of a major outpatient improvement programme known as the 'Productive Outpatient' project. Status boards have been place in outpatient clinics, with the exception of the Bristol Eye Hospital (BEH), with colour-coded displays to show if the clinic is running late and if so by how long. Staff are also encouraged to re-enforce this message verbally at regular intervals during the clinic. The results of our 2013 local outpatient survey show a virtually unchanged patient-rated performance (score of 38/100; 58% had not been told how long they would have to wait). We know that the practice of nurses giving verbal updates to patients varies considerably between outpatient clinics and that further work is required with our matrons and nurse managers to ensure that giving a verbal update as part of the process of updating the status board becomes a core responsibility of the nurse in charge. The BEH is currently seeking to procure an electronic patient queue and calling system as we have found that clinic status boards are not effective in this location due to the large number of different waiting rooms for patients.

In the 2011 National Inpatient Survey, when patients were asked whether they could find someone to talk to about their worries and fears, we received an overall score of 62/100: this was statistically 'about the same' as other NHS trusts but some way short of the best score for an NHS trust, which was 79. Our score in the 2012 National Inpatient Survey was 63: once again, this was statistically 'about the same' as other NHS trusts (the best score was 78). We have also monitored this question via our own monthly inpatient survey: Figure 12 shows a

statistically consistent pattern throughout the year, with scores varying slightly around a mean of 70 points[19] and indications of an improvement in the fourth quarter of the year.

Figure 12



Source: UH Bristol monthly inpatient (patients aged 12 and over) and parent surveys

Objective 10

We wanted to reduce numbers of complaints, and respond as quickly as possible if people do complain

AMBER

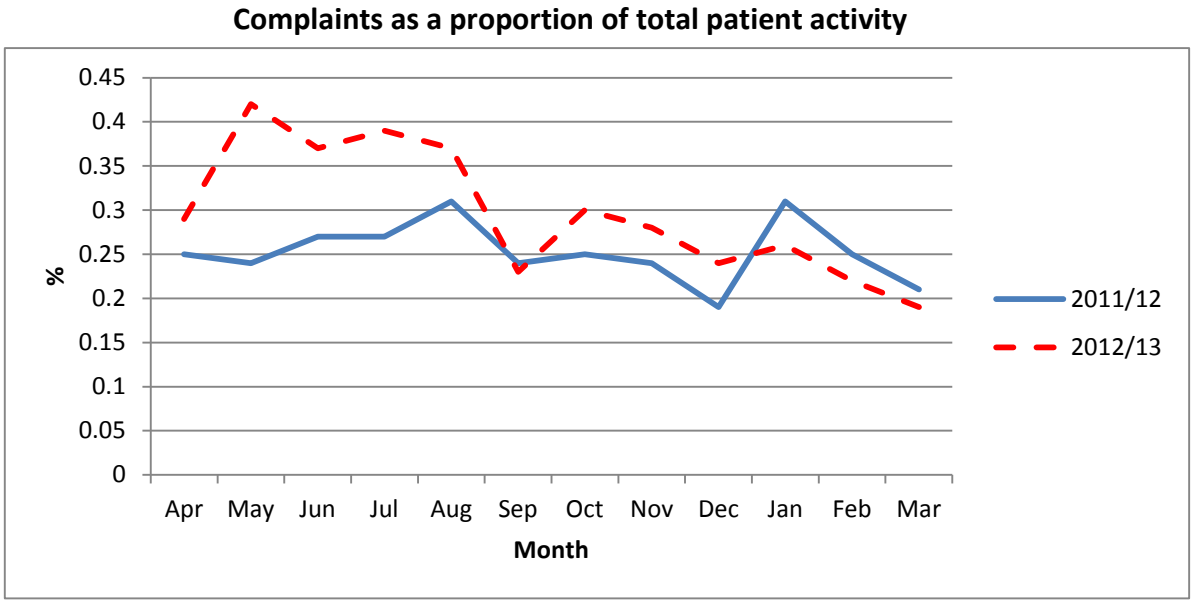
In last year's Quality Report, we explained that that we had received significant numbers of complaints about delayed or cancelled appointments at the Bristol Eye Hospital and the Bristol Royal Infirmary Trauma and Orthopaedic Department; also that Urology and Lower and Upper Gastrointestinal services received the largest number of complaints about cancelled or delayed surgery. We explained that this would be addressed through the Trust's 'Transforming Care' programme, which seeks to improve patient experience through better use of beds, booking and waiting list improvements, clinical process redesign, urgent care improvement and the use of enhanced recovery[20]. A great deal of work has taken place throughout 2012/13 and we are confident that this will be reflected in reductions in reported complaints in 2013/14.

Overall in 2012/13, 1651 complaints were received by the Trust, representing a 12.7% rise compared to the 1465 complaints received in 2011/12 (1532 in 2010/11). This equates to 0.257% of all patients episodes, against a target of <0.21%. Figure 13 demonstrates that complaints peaked during May 2012: this was at least partly attributable to the introduction of the Trust's new patient administration system, Medway, and to cancelled and delayed outpatient appointments and operations. By the final quarter of 2012/13, our rate of complaints was tracking consistently lower than in the equivalent quarter of the previous year. Analysis of the cause of complaints has not revealed any significant new trends.

[19] Since 2012, the Care Quality Commission has presented national survey scores out of a maximum of 10 points rather than 100. We have presented all scores out of 100 in this report to enable comparison of national and local survey data (i.e. scores reports in national patient survey reports have been multiplied by ten)

[20] See page 38

Figure 13



Source: UH Bristol Ulysses Safeguard system

We have a target that there should be no more than three complainants each month who tell us that they are dissatisfied with the quality of our response: in 2012/13, we achieved this target in 10 out of 12 months (annual total 25 cases). Learning from complaints is shared at Trust and Divisional Board meetings, and at the Trust's Patient Experience Group.

In 2012/13, we reported to the Board that 95.2% of complaints had been responded to within a timescale agreed with the complainant (compared with 91.1% in 2011/12) however as part of the process of producing this Quality Report, we have identified an administrative error which affects the validity of this data. Unfortunately, the indicator has been measured using as its end-point the date when the clinical Division completes its investigation and prepares a response to the complainant; not the date when the response letter is sent to the complainant, which generally occurs two or three days later. It has not been possible to retrospectively recalculate data for 2012/13, however from April 2013 onwards, we will ensure that the appropriate end point is recorded, and that this indicator is correctly measured and reported to the Board.

From May 2013 onwards, if an agreed timescale for a response to a complaint is breached, or if a complainant is unhappy with the quality of our response to a complaint, the relevant Trust Division will be required to complete an exception report, firstly in order to validate the data, but more importantly to consider what steps could be taken to prevent a recurrence.

Finally, from April 2013, the Trust's Patient Support & Complaints Team has temporarily relocated to the Bristol Dental Hospital. The service will return to the Bristol Royal Infirmary later in 2013/14 following the completion of planned refurbishment works and will be a key part of the new Welcome Centre.

Objective 11

We wanted to reduce reported incidence of discrimination against staff

GREEN

We chose this objective following a request from our Non-Executive Directors that we should select a quality objective which was staff-focussed. We were concerned that 14% of respondents to the 2011 National Staff Attitude Survey had said that they had experienced discrimination at work in the previous 12 months: this was an increase of 3% from the previous year and worse than the national average.

In 2012/13, we took a range of actions in support of this objective, including:

- Continuing to deliver Equality and Diversity and 'Respecting Everyone' training for staff and managers; 'Living the Values' training is also being rolled out to all staff in UH Bristol
- Using clear signage to communicate to patients and visitors the expectation to treat staff appropriately and with respect
- Strengthening our processes, procedures and policy to tackle harassment and bullying in the workplace, including a revised and simplified Violence & Aggression Policy which follows NHS Protect guidance
- Developing a joint Equality and Diversity and Health and Wellbeing Steering Group to drive forward the equalities and wellbeing agenda

In the 2012 National Staff Attitudes survey, 12% of staff stated that they had experienced discrimination at work during the previous 12 months: a decrease of 2% from the 2011 survey, although remaining slightly above an 11% average for acute trusts in England (but within statistical margins of error).

- 7% of respondents (29 people) stated that they had personally experienced discrimination at work from patients/service users/relatives/other members of the public: a reduction of 1% from 2011

- 8% of respondents (35 people) stated that they had personally experienced discrimination at work from their manager, team leader or other colleagues: an encouraging reduction of 3% from 2011

Although the Trust score for staff receiving equality and diversity training in the previous 12 months had slightly decreased since 2011 and, at 50% was below the national average, 88% of respondents said that they had received this training either in the past 12 months or more than 12 months ago – which is 2% above the national average. 90% of respondents stated that they believed that the Trust provided equal opportunities for career progression/promotion, which is above the national average of 88%.

Review of patient experience 2012/13

What our patients said in our monthly survey:

"All the staff I came into contact with during and after my op were amazing. NHS at its best. Well done."

"At no time did I feel anxious or afraid in your hospital. The staff (from consultant, doctors, nurses, catering, cleaning), were all courteous, helpful and caring."

This section explains how the Trust performed during 2012/13 in a number of other key areas relating to patient experience, which are in addition to the specific objectives that we identified.

Board assurance about patient experience

Each month, our Trust Board reviews data for three 'global' indicators which provide assurances about patient-reported experience of care: an aggregate survey score based on the national patient experience CQUIN; an aggregate tracker score based on some of the key things our patients have told us matter to them when they are in hospital; and a local measure of the 'net promoted score' (similar to the question which will be used in the NHS Friends and Family Test in 2013/14).

National Patient Experience CQUIN (Mandatory indicator)

The national patient experience CQUIN[21] uses an aggregate score based on responses to a 'basket' of five questions:

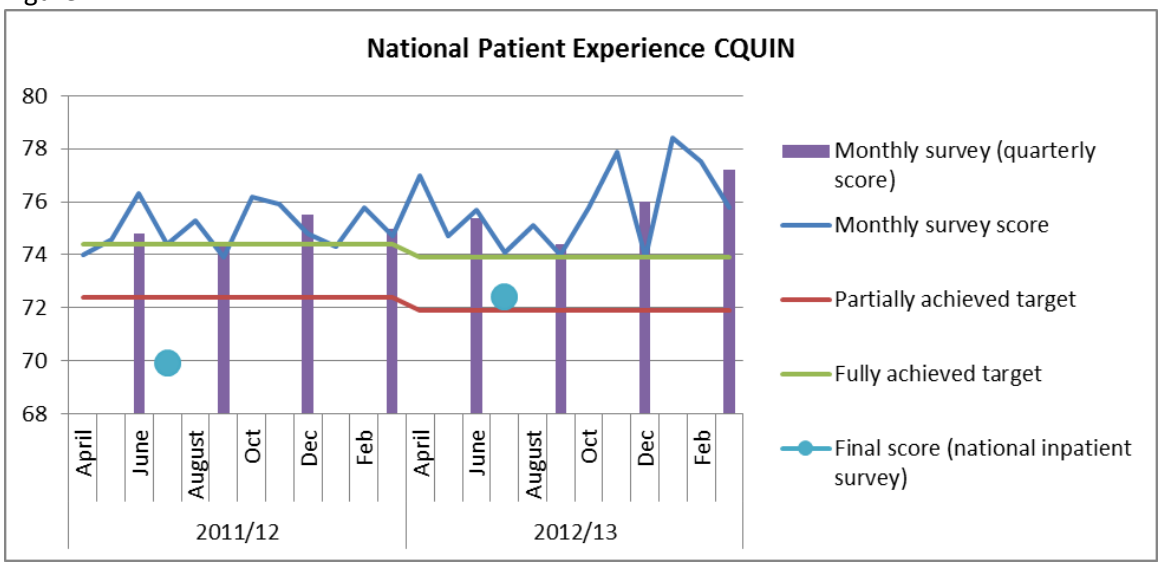
- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition and treatment?
- Did a member of staff tell you about medication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

Our official CQUIN score is based on the results of the annual National Inpatient Survey, which reflects the experience of a relatively small sample (400+) of our patients during the month of July each year. In 2012/13, we achieved a score of 72.4 points, compared to our minimum target of 71.9[22]. This compares well with our peers and is an improvement over our scores for 2011/12 and 2010/11 (69.9 and 70.4 respectively). The 2012/13 and 2011/12 scores are marked as dots in Figure 14.

[21] Referred to in list of mandatory reportable indicators as "Responsiveness to inpatients' personal needs"
[22] Our target for maximum CQUIN value was 73.9 points

However, we also monitor this indicator using our own monthly survey – this survey replicates the methodology of the national survey, so the scores are broadly comparable. Figure 14 shows our performance against this indicator measured across the last two years using our own survey data: the 'zig-zag' line reveals encouraging signs of improvement in patient-reported experience towards the end of 2012/13, a pattern which is mirrored in Figures 15 and 17.

Figure 14



Source: UH Bristol Monthly inpatient survey (patients aged 16 and over); 2012 National Inpatient Survey (for final score)

The Trust considers this data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. The framework governs the selection of patients who are invited to participate in these surveys; the collection and analysis of feedback is outsourced to an approved contractor; and in the case of the official national CQUIN score, the results (from the National Inpatient Survey) are independently published by the Care Quality Commission. Our local monthly survey largely replicates the methodology of the National Inpatient Survey[23].

In 2012/13, a number of the themes which contribute to this national indicator have been reflected in Patient Experience Action Plans developed by our clinical Divisions. In 2013/14, this national indicator will be replaced by the NHS Friends and Family Test.

Local patient experience 'tracker' score

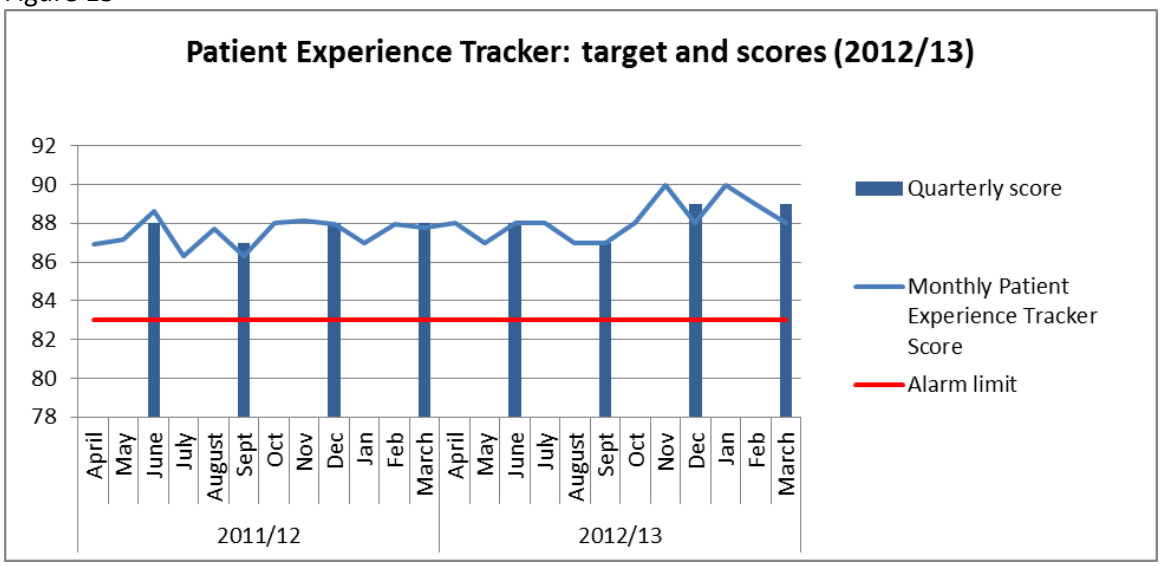
Our local patient experience tracker is based on the following aspects of care that our patients have said (through previous surveys) matter most to them:

- Involvement in decisions about care and treatment
- Being treated with respect and dignity
- Doctors and nurses giving understandable answers to the patient's questions (i.e. communication)
- Ward cleanliness

[23] The key differences are that our survey goes out to the patient much sooner after their discharge from hospital, we include parents and patients aged 12 and over (the national survey is 16+ years only) and we send one survey reminder letter rather than two

Figure 15 shows a similar pattern of improvement in patient-reported experience during the second half of 2012/13.

Figure 15

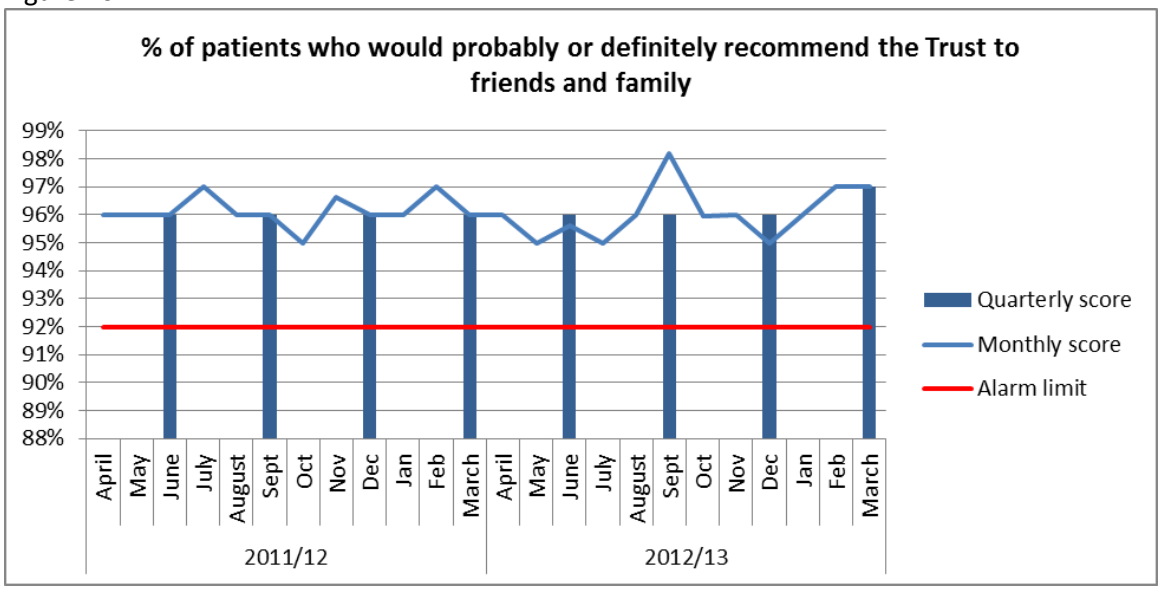


Source: UH Bristol Monthly inpatient survey (patients aged 12 and over)
Note: the alarm limit would represent a statistically significant deterioration in the Trust's score, prompting us to take action in response

Net promoter score

The 'net promoter score' asks patients whether they would recommend the Trust to their friends or family. In 2012/13, 96% of patients said they would either "definitely" or "probably" recommend us. An NHS-wide equivalent of this question, known as the Friends and Family Test (FFT), was introduced nationally on 1 April 2013. During 2013/14, we will continue to publish our own survey measure alongside FFT data to enable continuity and assist the Board's understanding of reported FFT scores.

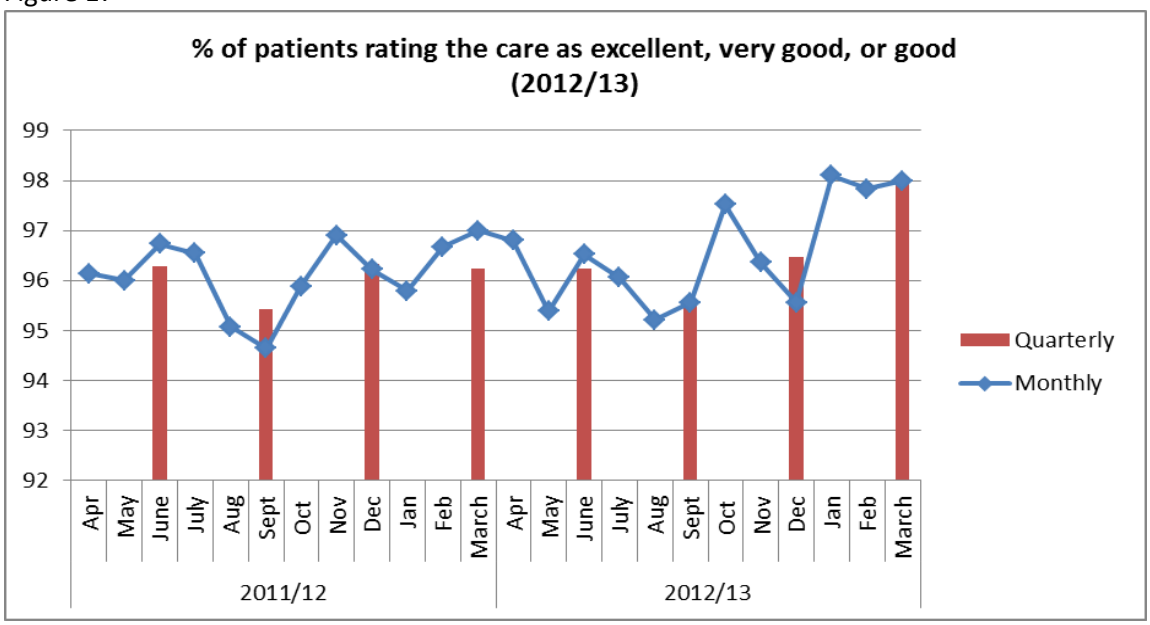
Figure 16



Source: UH Bristol Monthly inpatient (patients aged 12 and over) and parent surveys
Note: the alarm limit would represent a statistically significant deterioration in the Trust's score, prompting us to take action in response

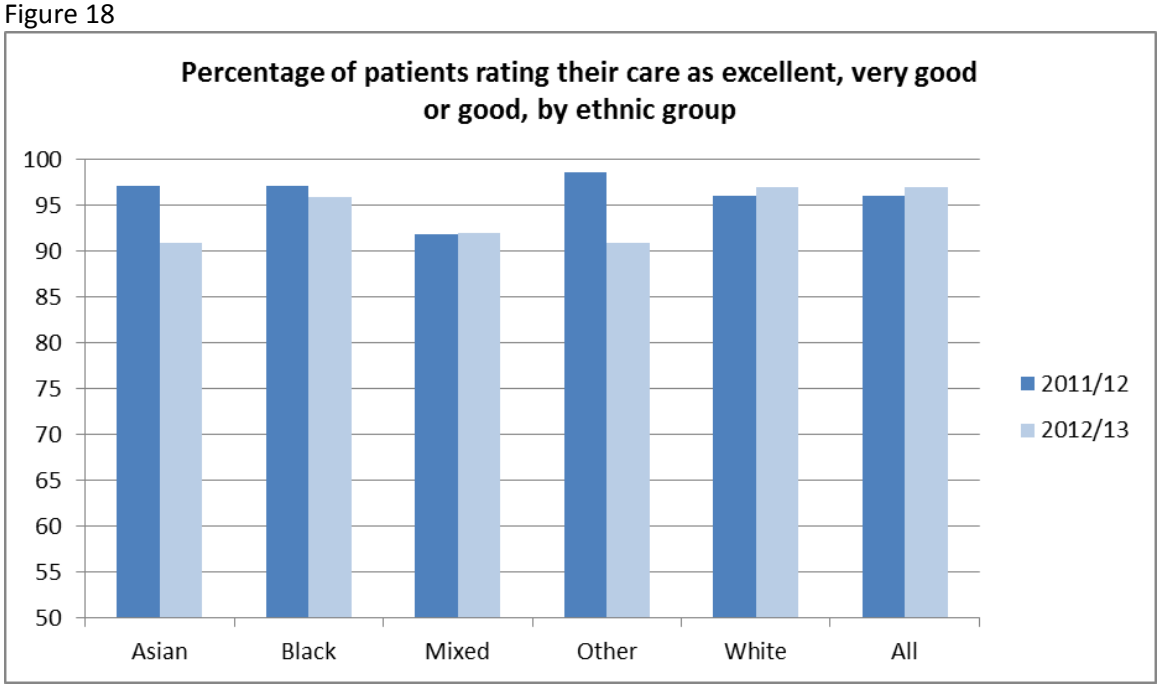
Finally, our Patient Experience Group also monitors a fourth global measure of patient experience: how people rate their hospital experience overall. In 2012/13, 96% of inpatients described their experience of care as "excellent", "very good" or "good", the same as in 2011/12 (see Figure 17). Last year, we published this data by ethnic group and we have repeated the exercise this year: all of the year-to-year changes noted in Figure 18 are within normal margins of statistical error, i.e. they are not statistically significant.

Figure 17



Source: UH Bristol Monthly inpatient (patients aged 12 and over) and parent surveys

Figure 18



Source: UH Bristol Monthly inpatient survey (patients aged 12 and over)

National Staff Survey 2012

As in previous years, in line with the recommendations of the Department of Health, we are including in our Quality Report a range of indicators from the annual National Staff Survey which

have a bearing on quality of care. Relevant results from the 2012/13 survey are presented below. Questionnaires were sent to a random sample of staff across the Trust (this includes only staff employed directly by the Trust): 455 staff at UH Bristol took part in this survey, representing a response rate of 55%, which is above average for acute trusts in England.

A key priority for the Trust is to ensure that our patients not only receive excellent clinical treatment but are treated respectfully and with dignity and compassion at every stage of their care. It is also vital for us to ensure that our staff are treated and treat each other in line with the Trust's values, and with the same level of dignity and respect which we expect for our patients. These values (respecting everyone, embracing change, recognising success and working together) are a guide to our staff about how they are expected to behave towards patients, relatives, carers, visitors and each other. The values are embedded in recruitment and staff induction and are clearly and regularly communicated.

'Key finding'	**UH Bristol score 2012**	**UH Bristol score 2011**	**UH Bristol score 2010**	**National average score 2012**	**National best score 2012**
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	79%	74%	76%	78%	89%
Percentage of staff agreeing that their role makes a difference to patients	92% Highest (best) 20%[24]	92%	92%	89%	95%
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (to other staff or to patients)	39% Highest (worst) 20%	39%	39%	34%	20%
Percentage of staff stating that they or a colleague had reported potentially harmful errors, near misses or incidents in the last month	91%	96%	91%	90%	96%
Staff recommendation of the Trust as a place to work or receive treatment *(Mandatory indicator[25])*	3.66	3.65	3.68	3.57	4.08

The Trust considers that this data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. The reported data is taken from a national survey[26], which the Trust participates in through an approved contractor, adhering to

[24] i.e. this score was in the upper quintile (best 20%) of NHS trusts

[25] In the NHS Staff Attitude Survey, trusts receive a score out of a maximum of five points for each question: this score equals the average response given by their staff on a scale of 1-5 where 5 means that they 'strongly agreed' with the statement "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation". The mandatory indicator on p5 of this report, made available by the National NHS Staff Survey Co-ordination Centre, analyses the same data in a slightly different way: in this instance, the indicator measures the percentage of staff who said that they either 'agreed' or 'strongly agreed' with the statement, "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation".

[26] Important note: the UH Bristol figures quoted for 2010 and 2011 are those which will be found in the 2010 and 2011 NHS Staff Attitude Survey reports. The 2010 figures differ from the 2010 figures quoted in the 2011 NHS Staff Attitude Survey report; and the 2011 figures differ from the 2011 figures quoted in the 2012 report. This is because the Picker Institute, which runs the surveys, re-calculates the data each year. The Picker Institute has advised that

guidance issued by the Department of Health. In 2013/14, the Trust and each of its Divisions will develop action plans to address key areas of improvement arising from the NHS Staff Attitude Survey.

Patient experience objectives for 2013/14

- We will implement the NHS Friends and Family Test
- We will ensure that patients continue to be treated with kindness and understanding
- We will explain medication side effects to inpatients when they are discharged
- We will focus on improving the experience of maternity patients

These objectives have been agreed with staff in our clinical Divisions and with our governors. The Friends and Family Test is major new development for all NHS hospitals in 2013/14: although we have been reporting a slightly different version of the 'net promoter score' to our board for some time, the challenge of giving all inpatients, A&E attenders and maternity patients the opportunity to say whether or not they recommend us will be a considerable one. We have retained the 'kindness and understanding' objective because we see this as fundamental to the quality of patient experience: our overall score in 2012/13 was good, so our objective in 2013/14 is to achieve a score which is at least as good as this. Explaining medication side effects to patients was not one of our stated quality objectives for 2012/3, however it was a CQUIN agreed with our commissioners: although results from the 2012 National Inpatient Survey show that we do relatively well compared to the rest of the NHS, in absolute terms our performance is not what we would hope for. We have therefore included this as an objective for 2013/14. Finally, improving the experience of maternity patients is the stated objective of the second year of our Patient Experience and Involvement Strategy.

The Chief Nurse will be the Executive Director responsible for achieving these objectives. Progress will be monitored by the Trust's Clinical Quality Group and by the Quality and Outcomes Committee of the Board.

either version of the data is appropriate for publication: we have chosen to use the original data for purposes of consistency and transparency.

CLINICAL EFFECTIVENESS

Our commitment

We will ensure that the each patient receives the right care, according to scientific knowledge and evidence-based assessment, at the right time in the right place, with the best outcome.

Report on our clinical effectiveness objectives for 2012/13

Objective 12

We wanted to ensure that at least 90% of stroke patients were treated for at least 90% of the time on a dedicated stroke ward

RED

Improving the care of stroke patients is a national priority within the NHS Outcomes Framework. There is extensive evidence to show that care on a dedicated stroke unit care reduces patient mortality, disability and the likelihood of requiring institutional care following stroke. In last year's Quality Report, we reported that we had established such a unit in Ward 12 of the Bristol Royal Infirmary. Patients suspected as suffering from a stroke should be directly admitted to the Stroke Unit from the Emergency Department, although in some cases patients are only identified as suffering from a stroke once they have been admitted to the Medical Assessment Unit or an inpatient ward.

There is a national standard which states that at least 80% of stroke patients must be treated for at least 90% of the time on a dedicated stroke unit: for 2012/13, we retained the previous year's stretch objective that *90*% should spend 90% of their time on Ward 12. We achieved the national target (80%+) for the last seven months of 2012/13, narrowing missing the target for the year as a whole (79.3%). Operational challenges similar to those we reported for 2011/12 – admitting patients directly to the unit, and protecting beds for use by stroke patients during times of increased patient activity in our hospitals – prevented us from achieving the 90% stretch target. It has been agreed that we will continue to pursue this target in 2013/14.

This year, our governors have asked us to include a comment about how the Trust seeks to achieve effective continuity of care when stroke patients are discharged from hospital. The Trust has funded an Early Supported Discharge Team to enable early discharge from hospital by providing specialist care at home. During the period April 2012 - January 2013, the team took home 42% of stroke patients admitted from the Bristol area (the national target is 40%). The team is resourced to cover South Bristol patients and the Trust is currently exploring the resource implications of extending the service into North Somerset. Patients who do not require ongoing therapy are discharged to their GP: all patients (where physically appropriate) are offered a follow up appointment with a consultant in the Bristol Royal Infirmary, or at South Bristol Community Hospital where we run a monthly multidisciplinary clinic. This appointment is usually six weeks after discharge, at which time any ongoing specialist care is individually assessed.

Objective 13

We wanted to develop the use of service-specific standardised mortality ratios to monitor clinical outcomes

AMBER

Information about the Trust's headline mortality rates can be found on pages 38-40 of this report. During 2012/13, we experimented with the inclusion of Divisional SHMI (Summary Hospital-level Mortality Indicator) data in Divisional quality dashboards, however this information was withdrawn after concerns were expressed by clinicians about misleading conclusions which could be drawn from the use of non-risk-adjusted data (i.e. data which has not been adjusted to account for the relative severity of a patient's condition) with large confidence intervals. Condition-specific benchmarking data, including mortality rates, is reviewed regularly by the Trust's Quality Intelligence Group (working in partnership with CHKS benchmarking) however this data does not necessarily map neatly to clinical specialties or Divisions. A robust process is in place to ensure that any alerts are investigated, initially through a coding review and then if required, by clinical case note review/audit. We have also agreed a corporate quality objective for 2013/14 to commence an exercise to scope out the current availability of outcomes data across all clinical specialties.

Objective 14

We committed to continuing to implement our dementia action plan

GREEN

In 2013/14, for the fourth consecutive year, the Trust has included care of dementia patients as a corporate objective, underlining the importance we place on meeting the needs of this group of patients. The term dementia covers a range of progressive, terminal brain conditions which affects more than 73,000 people in the South West of England. Enhancing the quality of life of people with dementia is a priority of the NHS Outcomes Framework.

In 2012/13, we made significant progress both in relation to meeting the requirements of the NICE Quality Standard for Dementia (Statements 1, 5 and 8) and the South West Dementia Standards. In February 2013, the Trust received a very positive dementia peer review site visit as well as encouraging results from the second round of the National Audit of Dementia. We continue to work collaboratively with North Bristol NHS Trust to ensure that people with a dementia receive care that is consistent across the city of Bristol. By the end of the financial year, 56% of relevant staff had attended 'An Hour to Remember' training and we are on schedule to achieve our target of 90% compliance by August 2013.

Progress in relation to the South West Standards in 2012/13 has included the appointment of a lead nurse for Dementia to co-ordinate this work and the identification of 125 'Dementia Champions' across the Trust both in clinical and non-clinical roles. 'This is me' documentation has been rolled out across the Trust, enabling a greater understanding of patients' wishes about their treatment and care, and the 'Forget me not' used to identify patients with dementia / cognitive impairment has been adopted across the Trust, ensuring a consistent approach with North Bristol NHS Trust where the symbol is already in use.

We have established a befriending scheme pilot project utilising volunteers to offer activities and companionship to frail older adult inpatients and frail older adults with a dementia. The scheme was launched in October 2012 with the appointment of a project lead supported by the WRVS. Elsewhere, the Trust secured £15k funding from the Prime Minister's Challenge fund to

improve the environment on Ward 4, utilising the King's Fund principles of design: we have been able to provide a separate seating area with a television, handrails in the walkway corridor, bright colours to define each bay / cubicle and suitable signage to improve way finding.

A challenging national CQUIN for Dementia was set for 2012/13 in three parts: finding/ identifying people with a dementia, assessing them, and referring them to their GP. Latest available data for February 2013 shows that the Trust is achieving 62.8% compliance for stage 1 (finding) and 100% compliance for stages 2 and 3 (assessing and referring). We anticipate that stage 1 compliance will increase following the implementation in May 2013 of an electronic discharge summary for patients aged 75 years and above.

Objective 15

We wanted to ensure that patients with a learning disability received a prompt risk assessment and patient-centred care plan

AMBER

Patients with a known learning disability should receive an assessment within 48 hours of admission to an inpatient bed. The purpose of the risk assessment is to ensure that patients with learning disabilities have reasonable adjustments made following inpatient admission to ensure their care needs are identified early.

The Trust's local target for 2012/13 (based on a previous CQUIN) is 85% compliance. Over the year as a whole, we were disappointed to achieve 81.2%, albeit that this was an improvement on our performance in 2011/12 (76.5%). We were however encouraged by our year-ending score of 91.3% in March 2013. During the year, a number of exceptions have been in the adult Emergency Department Observation Unit where patients with a known learning disability who have attended the Emergency Department and do not need admission to an inpatient bed are accommodated for a short period of time (a few hours) whilst their safe discharge is arranged.

During the fourth quarter of the year, we have focussed on identifying the areas requiring additional support within the Division of Medicine, such as the Medical Assessment Unit (MAU) and provide training and guidance to staff within these clinical areas, whilst maintaining effectiveness throughout the other divisions.

Objective 16

We wanted to develop the use of enhanced recovery

GREEN

Enhanced recovery seeks to improve patients' experience of surgery by providing better education and effective management of expectations, and to improve clinical outcomes by ensuring patients are in optimal condition for surgery and post-operative recovery. There are four nationally accepted principles of Enhanced Recovery:

- All patients should be on a pathway to enhance their recovery. This enables patients to recover from surgery, treatment, illness and leave hospital sooner by minimising the physical and psychological stress responses.
- Patient preparation ensures the patient is in the best possible condition, identifies the risk and commences rehabilitation prior to admission or as soon as possible.

- Pro-active patient management components of enhanced recovery are embedded across the entire pathway; pre, during and after operation/treatment.
- Patients have an active role and take responsibility for enhancing their recovery

This initiative, part of the Trust's *Transforming Care* programme, has two specific objectives: to reduce patients' recovery period in hospital, and ensure there is no increase on current levels of re-admissions in each speciality. By the end of 2012/13, the following surgical specialties had adopted enhanced recovery principles: thoracic, gynaecology, oesophagectomy, colorectal and cardiac. Planning is underway for the following specialties to join the programme: maxillary facial surgery and obstetrics (elective caesarean sections). Data relating to re-admissions and recovery times is currently being validated.

Objective 17

We committed to re-focusing on ensuring compliance with guidance published by the National Institute for Health and Clinical Excellence

AMBER

There were two elements to this objective, which had been proposed by our Director of Pharmacy: timely implementation of NICE Technology Appraisal Guidance (TAGs) within three months of publication, and of NICE-related clinical audits agreed with the Bristol North Somerset and South Gloucestershire (BNSSG) Commissioning College.

18 relevant TAGs were issued for implementation by NICE during 2012/13: 15/18 (83%) had implementation plans agreed with the Commissioning College within the three month timescale. 25 clinical audit priorities were identified by the Commissioning College (later revised to 24): at the end of the financial year, 20/24 (83%) projects were either in progress or had been completed (an improvement from 63% in 2011/12). Three of the four audits which had not been commenced were in specialties where other priority NICE audits were being undertaken. We have agreed with the Commissioning College that the remaining audits will be prioritised by the Trust in our 2013/14 programme. The full list of 2012/13 clinical audits is as follows:

Specialty	**Ref**	**Title**	**Current status**
Cardiology	TA95	Arrhythmia - implantable cardioverter defibrillators	In progress
Dermatology	TA177	Alitretinoin - hand eczema (chronic)	Complete
	TA103	Psoriasis - etanercept	Complete
	TA146	Psoriasis - adalimumab	Complete
	TA180	Ustekinumab - psoriasis	In progress
	TA134	Psoriasis - infliximab	Not yet commenced
Endocrinology	TA188	Growth failure in children - human growth hormone	In progress
	TA203	Diabetes (type 2) - liraglutide	In progress
	TA151	Diabetes - Insulin pump therapy	Not yet commenced
ENT	TA166	Hearing impairment - cochlear implants	In progress
Gastroenterology	TA187	Crohn's disease - infliximab and adalimumab	In progress
Specialty	**Ref**	**Title**	**Current status**
Oncology	TA70	Leukaemia (chronic myeloid) - imatinib	Complete
	TA171	Multiple myeloma - lenalidomide	Complete

	TA34	Breast cancer - trastuzumab	In progress
	TA65	Non-Hodgkin's lymphoma - rituximab	In progress
	TA109	Breast cancer (early) - docetaxel	In progress
	TA129	Multiple myeloma - bortezomib	In progress
	TA193	Leukaemia (chronic lymphocytic, relapsed) rituximab	Not yet commenced
	TA192	*Lung cancer (non-small-cell, first line) - gefitinib*	*No longer required by BNSSG CC*
Ophthalmology	TA155	Macular degeneration (age-related) - ranibizumab and pegaptanib	In progress
Rheumatology	TA143	Ankylosing spondylitis - adalimumab, etanercept and infliximab	Complete
	TA130	Rheumatoid arthritis - adalimumab, etanercept nfliximab	In progress
	TA161	Osteoporosis - secondary prevention including strontium ranelate	In progress
	TA204	Denosumab - osteoporotic fractures	In progress
Vascular Surgery	TA167	Abdominal aortic aneurysm - endovascular stent-grafts	Not yet commenced

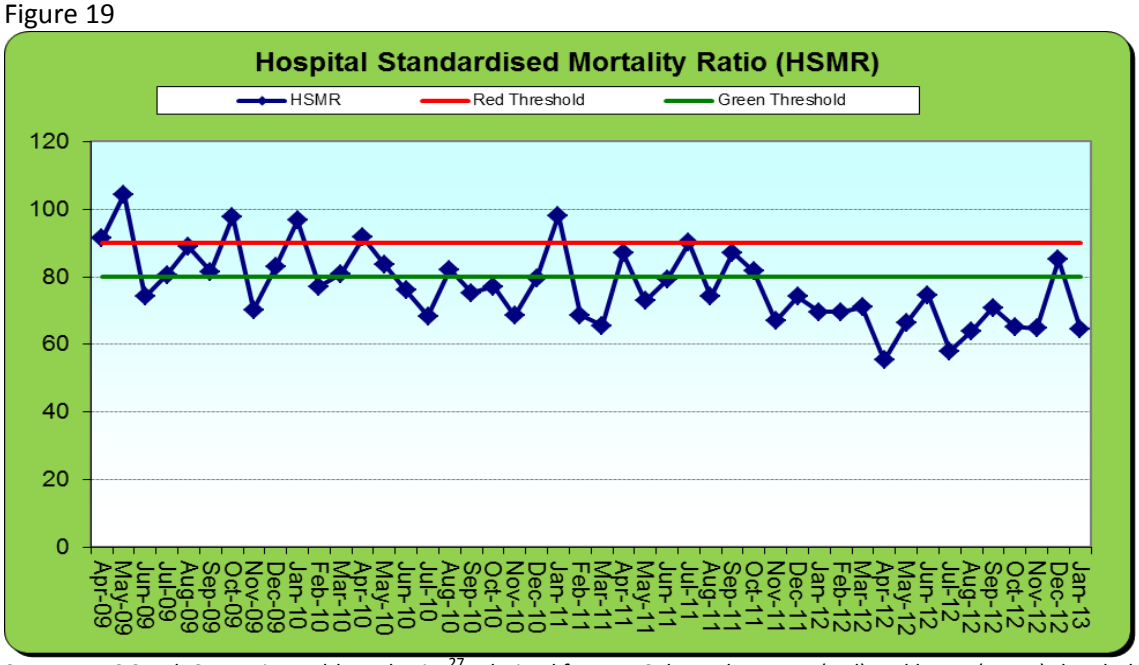
Review of clinical effectiveness 2012/13

This section explains how the Trust performed during 2012/13 in a number of other key areas relating to clinical effectiveness, which are in addition to the specific objectives that we identified.

Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI)

The Trust Board actively monitors two 'global' measures of patient mortality: the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-Level Mortality Indicator (SHMI). Based on a subset of diagnoses which give rise to 80% of in-hospital deaths, the HSMR is a broad measure covering the majority of hospital activity where risk of death is significant. As such, it is an effective screening tool for identifying where there may be problems with avoidable mortality. HSMR is calculated using routinely collected Hospital Episode Statistics: this data is analysed by Imperial College London, who publish a benchmark mortality standard which Trusts can compare against. Data is available two months in arrears to allow for this benchmarking process to take place. It should be noted that the HSMR does not provide definitive answers: rather it poses questions which Trusts have a duty to investigate. In simple terms, the HSMR 'norm' is a score of 100 – so scores of less than 100 are indicative of Trusts with lower than average mortality. University Hospitals Bristol continues to have a very low overall HSMR.

Figure 19

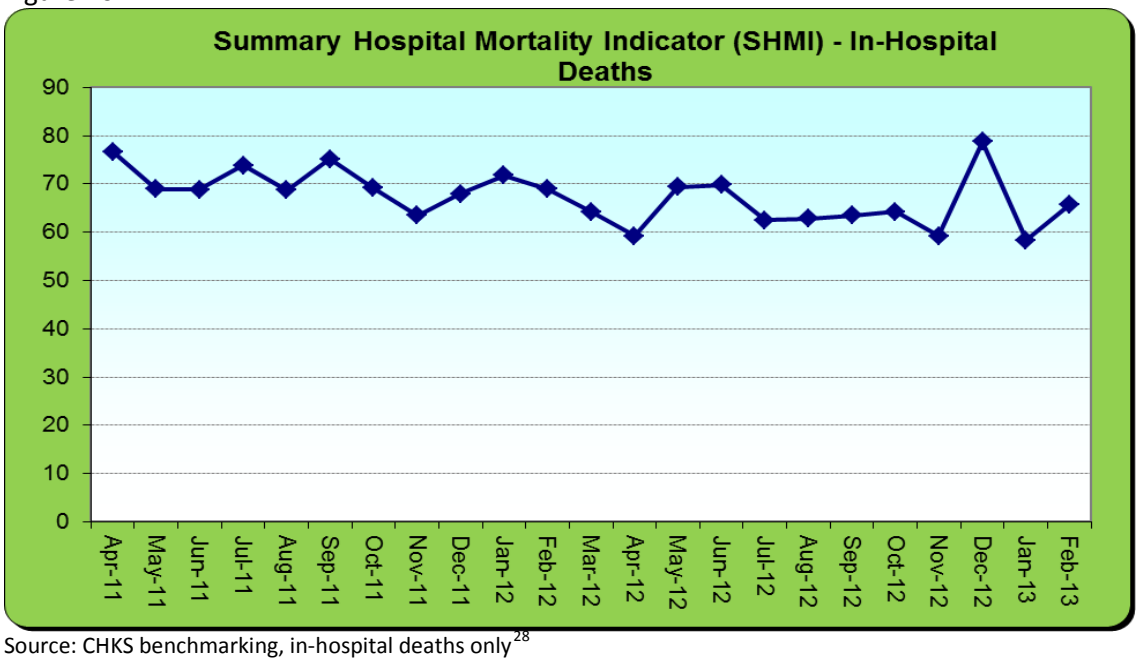


Source: NHS South Strategic Health Authority[27] - derived from HES data. The upper (red) and lower (green) thresholds are set by the Trust.

(Mandatory indicator)

Unlike HSMR, the dataset used to calculate SHMI includes all deaths in hospital, plus those deaths occurring within 30 days after discharge from hospital. As per HSMR, the 'norm' is represented by a figure of 100, with scores of less than 100 representing better outcomes.

Figure 20



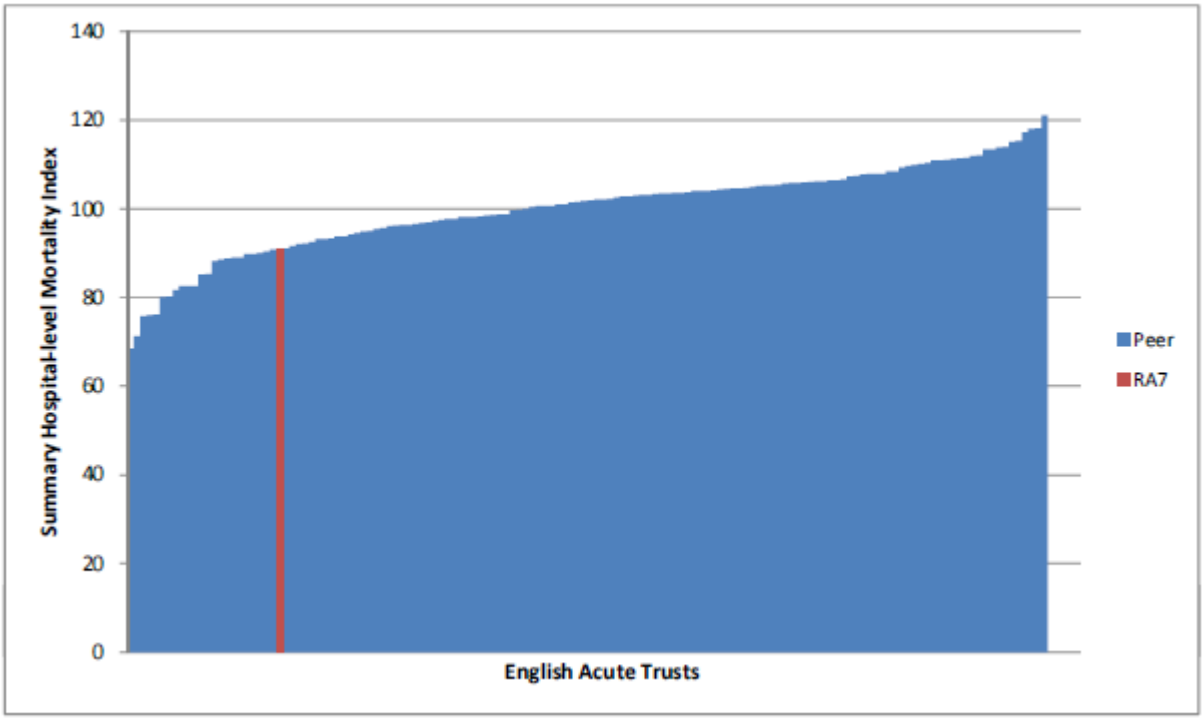
Source: CHKS benchmarking, in-hospital deaths only[28]

[27] It should be noted that the data in this graph uses a 2009/10 baseline. We report HSMR in this way in order to track progress of the South West Quality and Patient Safety Improvement Programme. The HSMR will have been re-based in subsequent years by Dr Foster, so the HSMR score credited to the Trust in the annual Dr Foster *Hospital Guide* (for example) will be higher than stated here.

[28] Nationally, SHMI also includes death within 30 days of discharge.

Figure 20 shows the Trust's SHMI scores *for in-hospital mortality only*, using 2012 baseline data. This information is made available to us, two months in arrears, by our provider of clinical benchmarking data, CHKS. 'True' SHMI however also includes deaths within 30 days of discharge from hospital. The most recent data currently available to us is shown in Figure 21, covering the period October 2011 to September 2012. This shows UH Bristol (referenced as 'RA7') as having a SHMI of 91.1[29].

Figure 21



Source: CHKS benchmarking

The Trust considers its SHMI data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework (full details are available upon request). This includes data quality and completeness checks carried out by the Trust's IM&T Systems Team.

Adult Cardiac Surgery Outcomes

The Bristol Heart Institute is one of the largest centres for cardiac surgery in the United Kingdom. Cardiac surgery outcomes at the Trust have been openly published since the 1990s: with rare exceptions, the Bristol Heart Institute's mortality figures have been better than the UK average for all procedures since data has been available. Data is published annually and can be viewed in detail on the Trust's website (http://www.uhbristol.nhs.uk/about-us/key-publications).

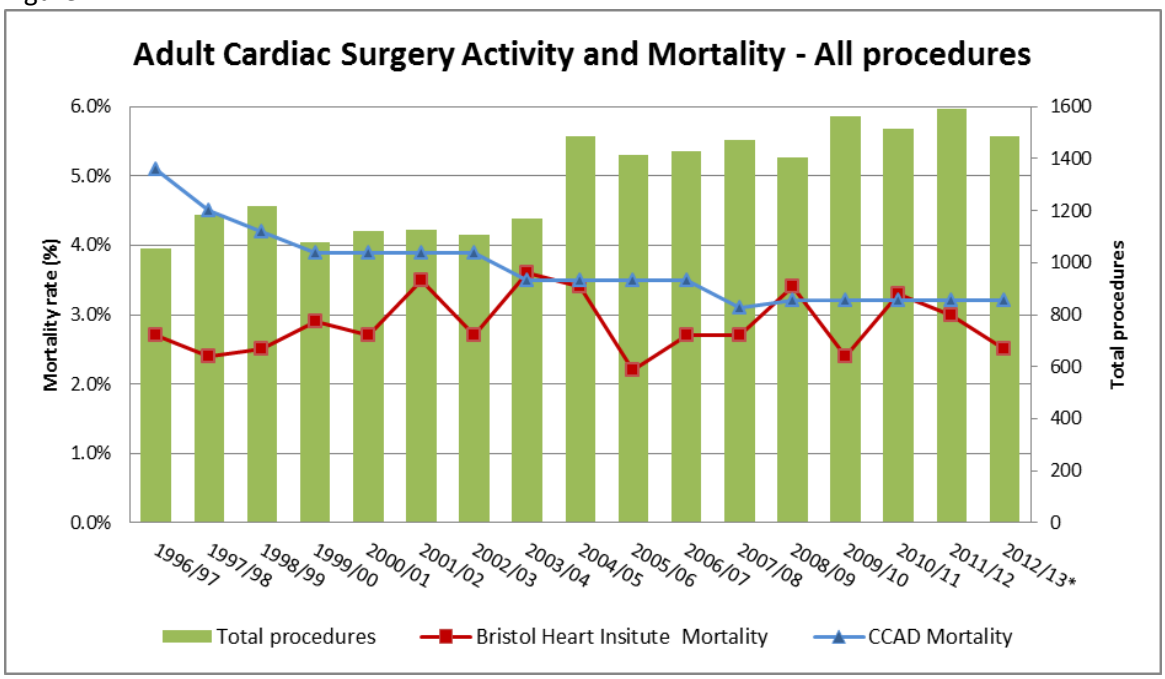
Figure 22 below shows a pattern of increasing levels of surgical activity, and a combined crude mortality rate which is below the national average. It should be noted that the 2012/13 data is preliminary at time of writing (April 2013) as the discharge status of some patients has yet to be verified/validated.

[29] Calculated as 1663 actual deaths divided by 1826 'expected' deaths (total cases 75155)

During the financial year, responsibility for the management of national cardiac audit data passed to the National Institute of Cardiac Outcomes Research (NICOR). NICOR will be changing the way that mortality rates are calculated: for this reason, the national benchmark figure used in Figure 22 (CCAD Mortality) is the most recent nationally verified marker available (relating to mortality up until 2010) and is taken from the latest NICOR annual report published in 2013. Further information about the work of NICOR can be found at http://www.ucl.ac.uk/nicor.

As of July 2013, consultant level data relating to the outcomes of patients undergoing cardiac surgical procedures will be published via the Society for Cardiothoracic Surgery as part of an NHS England initiative known as *Everybody Counts*. This data will be made available via the Trust's website.

Figure 22



Source: Central Cardiac Audit Database / Patient Analysis Tracking System
* Latest available data, yet to be fully verified

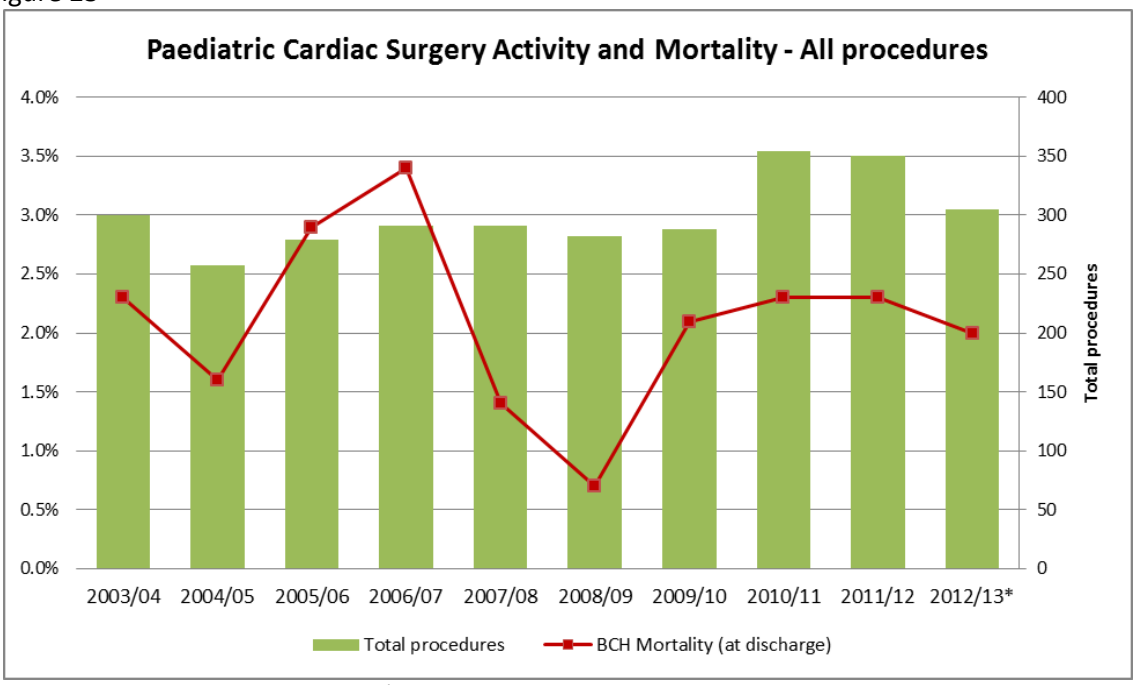
Paediatric Cardiac Surgery Outcomes

The Bristol Royal Hospital for Children provides a paediatric congenital cardiac service to the South West of England and South Wales. The paediatric cardiac units in Bristol and Cardiff operate as a single provider: consultants from Cardiff also have sessions in Bristol.

Crude mortality within 30 days of paediatric cardiac surgery has reduced over the course of the last decade (see Figure 23). Despite the increasing complexity of procedures, our mortality rate has been around 2%, which reflects the national norm[30].

[30] National Institute for Cardiovascular Outcomes Research data: detailed national comparative data not available

Figure 23



Source: Central Cardiac Audit Database / NICOR

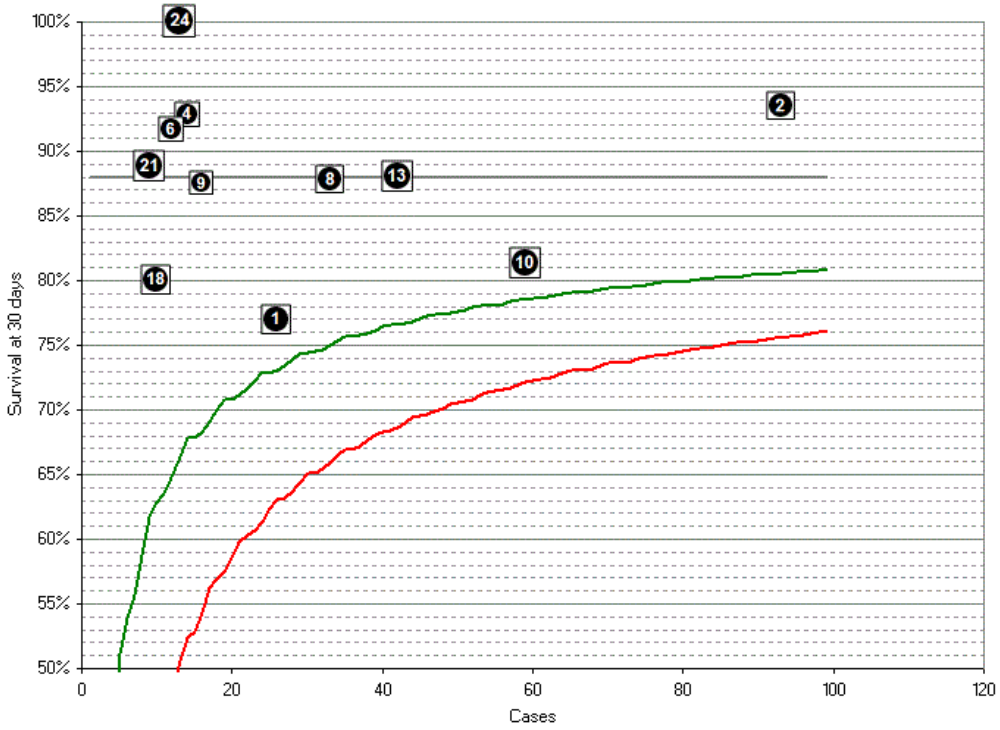
A word of caution is necessary when interpreting this data. Crude mortality data can be misleading as it does not account for case mix, i.e. a cardiac centre that only performed easy cases would appear to perform very well when compared with centres that deal with complex cases (such as this Trust). Furthermore, unlike adult cardiac surgery, where there are a small number of well-defined operations, it is hard to standardise a congenital unit's practice as there are many different types of operation performed. Although a child may be born with a particular heart abnormality, they may have many other congenital abnormalities: in order to compare the relative performance of two centres, we therefore need a means of assessing the contributions of the risk presented by these other abnormalities to the heart abnormality. This is a highly complex process and is being addressed by a number of groups both nationally and internationally. The Trust is involved in a centrally supported[31] research project which aims to improve the differentiation of risk between individuals by 'risk-stratification'. These considerations are particularly pertinent in understanding the crude mortality data presented above for the last two years. In each year, following cardiac surgery, two sets of parents requested discontinuation of ongoing care as their child had other major congenital abnormalities that were incompatible with life. These outcomes are included in the data above as discontinuation occurred within 30 days of the surgery.

In 2009, after careful preparation, we introduced a programme for dealing with children born with 'hypoplastic left heart syndrome'. It is recognised that these are some of the sickest children that congenital cardiac surgical teams deal with and therefore require the highest quality of care from every element of the team. Figure 24 is based on the most recently available data. Bristol is marked as number 4, with performance better than the national average. Further information is available at http://www.ccad.org.uk/congenital.

[31] National Institute for Health Research grant application

Figure 24

Norwood procedure 2009-2012



Source: CCAD national database
(UH Bristol is marked as number 4; straight grey line is national average; upper green line is 95% alert limit; lower red line is 99.95% outlier alarm limit)

In 2012/13, following an extensive national review[32] of paediatric cardiac surgery aimed at rationalising the number of centres undertaking these procedures, Bristol was confirmed as one of seven centres selected to provide paediatric cardiac surgery in the future.

Patient Reported Outcome Measures (PROMs)
(Mandatory indicator)

Since 2009, Patient Reported Outcome Measures (PROMs) have been collected by all NHS providers for four common elective surgical procedures: groin hernia surgery, hip replacement, knee replacement and varicose vein surgery. Two of these procedures - groin hernia surgery and varicose vein surgery - are carried out at the Bristol Royal Infirmary, part of the University Hospitals Bristol. PROMs comprise questionnaires completed by patients before and after surgery to record their health status. Outcomes are measured in three ways: a tool called the 'EQ-5D index' asks patients questions about things like mobility, activities and pain levels; patients also rate their health on a scale of 0-100 using a 'visual analogue scale' (VAS); and finally (in the case of varicose veins) patients are asked questions about the specific condition for which they are having surgery.

The most recent full-year data available to from the NHS Health and Social Care Information Centre is for 2011/12. This shows that fewer than 30 UH Bristol patients who underwent varicose vein surgery returned PROM questionnaires: this data is therefore not publishable due to inherent statistical unreliability. 77 patients returned groin hernia PROM questionnaires, 55.8% of whom (43/77) scored more highly on the EQ-5D index after surgery than before; this

[32] Known as *Safe and Sustainable*

compares with 51.0% in England (11327/22211). 39.0% of UH Bristol patients (30/77) scored more highly on the EQ-VAS scale after surgery than before; this compares with 38.3% in England (8516/22221).

Early 2012/13 PROM data for varicose veins and groin hernias is currently not publishable due to low numbers of patients.

The Trust considers its groin hernia PROM data to be as described. The Trust follows nationally determined PROM methodology and outsources administration to an approved contractor. Based on the number of varicose vein operations currently being performed at UH Bristol, it is highly unlikely that publishable data will become available for this PROM; we will however seek to improve our response rate for the groin hernia PROM to enable continuing publication of data above the threshold of 30 cases.

28 day readmissions
(Mandatory indicator)

The Trust monitors the level of emergency readmissions within 30 days of discharge from hospital. Readmissions within 30 days is used as the measure, rather than 28 days, to be consistent with Payment by Result rules and contractual requirements. The level of emergency readmissions within 30 days of a previous discharge from hospital was lower in 2012/13 than in the previous year (3.0% in 2012/13 v 3.4% in 2011/12). The most recent national risk adjusted data (2010/11) shows the 28-day emergency readmission rates for the Trust to be just above the national range for adults (16 and over year olds), with a national average of 11.42% and a Trust readmission rate of 11.90% (with 95% confidence that the Trust's rate is between 11.54% and 12.27%). Although these figures are standardised for patient age, sex, diagnosis and procedure, it is likely that the risk adjustment does not take full account of the complexity and co-morbidities of the patients treated by the Trust. The risk adjusted figures for readmissions for patients under the age of 16 shows the Trust to have a significantly lower rate than the national average, with a readmission rate of 8.26% (with 95% confidence that the Trust's rate is between 7.65% and 8.90%), against a national average of 10.15%.

The Trust considers its readmission data is robust because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. These includes checks on the completeness and quality of the clinic coding, checks conducted of the classification of admission types and lengths of stay as recorded on the Patient Administration System, and the reviews undertaken of the data quality returns on the Commissioning Data Sets (CDS) received from the Secondary Uses Service (SUS).

The Trust continues to review specialty-level benchmarking data through its Quality Intelligence Group, to monitor and improve readmission rates, and so the quality of its services. Where specialties are identified as having higher readmission rates than expected, relative to the national and/or clinical peer group, in-depth case notes reviews are conducted to identify any underlying causes of the increased levels of readmissions.

Clinical effectiveness objectives for 2013/14

- We will ensure that at least 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke ward
- We will achieve the best practice tariff for hip fractures (this involves achieving eight indicators including surgery within 36 hours of admission to hospital)
- We will ensure patients with diabetes have improved access to specialist diabetic support
- We will ensure that patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan
- We will continue to implement our dementia action plan
- We will commence a baseline review of available clinical outcome data

These objectives have been agreed with staff in our clinical Divisions and with our governors. The themes reflect a continuation of previous commitments (dementia and learning disabilities), an improvement priority identified by our governors (hip fractures), an improvement area identified through quality reporting during the past year (diabetes), and a developmental objective (clinical outcomes) which aligns with national directions expressed in the Francis Report and NHS Outcomes Framework.

The Medical Director will be the Executive Director responsible for achieving these objectives. Progress will be monitored by the Trust's Clinical Quality Group and by the Quality and Outcomes Committee of the Board.

PERFORMANCE AGAINST KEY NATIONAL PRIORITIES

Summary of performance against national access standards

Last year proved to be a challenging year for the Trust, although improvements in performance against the national standards continued to be made in some key areas. In particular, the achievement of the target reductions in the annual number of *Clostridium difficile* (C. diff) cases, along with sustained performance against all 18-week Referral to Treatment Times (RTT) standards, including the new standard for incomplete pathways, stood-out as significant achievements for the year. Year-on-year improvements were also seen for reperfusion times for patients suffering a heart attack (Door to Balloon times), and rates of mothers initiating breast feeding.

The 18-week RTT standards were achieved in each month of the year for admitted and non-admitted pathways. A new 18-week RTT standard came into effect on the 1st April 2012, which the Trust also achieved on a monthly basis. Overall, performance against the cancer standards remained strong, with six of the eight national cancer standards being achieved in every quarter. The 62-day wait for treatment for patients referred from a screening programme was not achieved in Quarter 3, and the 62-day wait for GP referred patients was not achieved in Quarter 4. However, the issues leading to the dips in performance in these two standards were addressed in the year, and the Trust is expecting full achievement of the cancer standards again going forward.

Disappointingly the Trust failed to achieve the 95% A&E four-hour standard in three quarters of the year. However, in Quarter 4 the Trust launched a significant programme of ten projects on patient flow, which should put the Trust on a strong footing for achievement of the national standard in 2013/14. The focus will primarily be on alleviating the bed pressures which caused the deterioration in performance, especially in the last quarter of the year. This will also help to reduce the numbers of patients being managed in the Bristol Royal Infirmary (BRI) Emergency Department, which should enable more consistent achievement of the 15-minute target for initial assessment.

The Trust did not achieve the national standard for operations cancelled at the last minute for non-clinical reasons, despite the improvements made in the previous years. The planned programme of work on patient flow should significantly improve bed availability, which was the leading cause of last-minute cancellations in the year. The target reduction in MRSA (Meticillin Resistant *Staphylococcus Aureus*) bacteraemia cases also proved to be very challenging this year for the Trust. However, from the themes emerging from the Root Cause Analysis, an action plan was implemented in the latter half of the year, with a strong focus on improvements in line care management. Continued focus on maintaining exacting standards for line care management along with the implementation of the good practice being identified in the highest performing trusts, should effect reductions in bacteraemias in 2013/14.

Full details of the Trust's performance in 2012/13 compared with 2011/12 are set out in the table below, which shows the cumulative year-to date performance. Further commentary regarding the 18 week RTT, A&E 4 hour, cancer, healthcare associated infections and other key targets is provided overleaf.

Performance against national standards

National standard	2010/11	2011/12	2012/13 Target	2012/13	Notes
A&E maximum wait of 4 hours	94.98%	96.0%	98%	93.8%	Target met in 1 quarter in 2012/13 (Q2)
A&E Time to initial assessment (minutes) 95th percentile within 15 minutes		26	15 mins	57	Target met in 3 quarters in 2012/13 (not Q1)
A&E Time to Treatment (minutes) median within 60 minutes		20	60 mins	53	Target met in every quarter in 2012/13
A&E Unplanned re-attendance within 7 days		1.7%	< 5 %	2.6%	Target met in every quarter in 2012/13
A&E Left without being seen		1.0%	< 5%	1.9%	Target met in every quarter in 2012/13
MRSA Bloodstream Cases against trajectory	5	4	Trajectory	10	
C. diff Infections against trajectory	94	54	Trajectory	48	Cumulative target failed in Q1 and Q2 in 2012/13
Cancer - 2 Week wait (urgent GP referral)	95.6%	95.9%	93%	95.0%	Target met in every quarter in 2012/13
Cancer - 2 Week wait (symptomatic breast cancer not initially suspected)	93.3%	98.2%	93%	96.8%	Target met in every quarter in 2012/13
Cancer - 31 Day Diagnosis To Treatment (First treatment)	98.2%	98.1%	96%	97.0%	Target met in every quarter in 2012/13
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	95.5%	96.7%	94%	94.9%	Target met in every quarter in 2012/13
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	99.8%	99.9%	98%	99.8%	Target met in every quarter in 2012/13
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	99.7%	99.3%	94%	98.7%	Target met in every quarter in 2012/13
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	86.2%	87.0%	85%	84.1%	Target met in 3 quarters in 2012/13 (not Q4)
Cancer 62 Day Referral To Treatment (Screenings)	90.9%	94.4%	90%	90.0%	Target met in 3 quarters in 2012/13 (not Q3)
18-week Referral to treatment time (RTT) admitted patients	93.0%	91.7%		92.4%	Target met in every month in 2012/13
18-week Referral to treatment time (RTT) non-admitted patients	98.3%	97.9%		95.7%	Target met in every month in 2012/13
18-week Referral to treatment time (RTT) incomplete pathways		N/A	92%	92.2%	Target met in every month in 2012/13
GUM Offer Of Appointment Within 48 Hours	100%	100%	98%	100%	Target met in every month in 2012/13
Number of Last Minute Cancelled Operations	1.31%	0.87%	0.80%	1.13%	
28 Day Readmissions *(following a last minute cancellation)*[33]	91.0%	93.3%	95%	91.1%	
Primary PCI - 150 Minutes Call To Balloon Time[34]	80.4%	84.0%	90%	83.1%	
Primary PCI - 90 Minutes Door To Balloon Time[2]		91.0%		92.4%	Target met in every quarter in 2012/13
Infant Health - Mothers Initiating Breastfeeding[35]	76.3%	76.2%	76.3%	80.6%	Target met in every quarter in 2012/13

 Achieved for the year and each quarter

 Achieved for the year, but not each quarter

 Not achieved for the year

 Target not in effect

[33] IMPORTANT NOTE: this indicator must not be confused with the mandatory indicator reported elsewhere in this Quality Report which measures readmissions to hospital within 28 days *following a previous discharge*

[34] The Primary Percutaneous Coronary Intervention (PCI) Call to Balloon standard shown is a local network target; figures shown for both Primary PCI targets are for April 2012 to February 2013.

[35] The Infant Health standard shown is a target set by the Trust

Extended narrative about national access targets

18 weeks Referral to Treatment (RTT)
The Trust achieved an 18-week Referral to Treatment Time (RTT) for over 90% of admitted patients, and 95% of patients not requiring an admission as part of their treatment, in every month in 2012/13. In addition, the Trust achieved the target for incomplete pathways, which came into effect from April 2012, with over 92% of patients waiting less than 18 weeks at each month-end. In so doing, the Trust met all the 18-week RTT standards in Monitor's 2012/13 Compliance Framework. In 2013/14 there will be further focus on achievement of these standards at a specialty level.

A&E 4-hour maximum wait
The Trust failed to meet the 95% national standard, for the percentage of patients discharged, admitted or transferred within four hours of arrival in one of the Trust's Emergency Departments. Performance was below the national standard in Quarters 1, 3 and 4. The primary cause of the failure to achieve the 95% standard varied across the three quarters. The lack of a ward bed to admit emergency patients to was a consistent theme across quarters, although for different reasons.

During the first half of Quarter 1 we saw a significant increase in the length of stay for emergency medical patients who had been admitted to the Bristol Royal Infirmary (BRI). At the same time there was a significant increase in the number of over 75, and over 90 year olds, attending the Bristol Royal Infirmary (BRI) Emergency Department (ED), and an increase in delayed discharges (i.e. patients medically fit for discharge but needing support services, such as a care package, or placement in a residential home to be in place before they could be discharged). Older patients often have more complex health conditions and need more intensive medical input before they can leave hospital. This steep rise in the age of patients being admitted to hospital, which has continued through much of 2012/13 and also contributed to the dip in performance in Quarter 4, may represent a significant change in the demand for the Trust's services for future years which will need to be reflected in service planning.

In Quarter 3, performance against the 4-hour standard was unexpectedly lower than in previous years due to a significant influx of paediatric patients with respiratory problems. In the local community, the levels of bronchiolitis were unusually high in November and December 2012. This mirrored the national peak in respiratory conditions during the same period. Although the numbers of children admitted via the Bristol Royal Hospital for Children's ED was not higher than in previous seasons, the children needing admission were particularly unwell and required intensive management in the ED along with longer stays in hospital.

Levels of *norovirus* within the community remained a challenge for the Trust, especially in Quarter 4, with a number of wards having to be closed during a two-week period in the last quarter of the year in the BRI and Bristol Heart Institute (BHI). This coincided with higher levels of emergency admissions, which put additional pressure on bed availability and led to black escalation[36] being declared. The Trust has recently launched a wide-ranging programme of work on patient flow with the aim of reducing any unnecessary emergency admissions and reducing lengths of stay in hospital. This should help to improve bed availability and the Trust's

[36] Black escalation is the highest status of alert the Trust can be on. This is when the Trust is operating significantly in excess of its planned capacity due to exceptional levels of demand for services. During black escalation, additional actions are taken to ensure the Trust continues to be able to care for patients in a safe environment.

responsiveness to meet fluctuations in levels of emergency demand. This work will also help to ensure full achievement of the Accident and Emergency quality of care indicators.

Cancer

Performance against six of the eight key national cancer waiting times standards remained strong in 2012/13, with full achievement in every quarter of the year. The 62-day wait from GP referral with a suspected cancer to treatment failed to be achieved in Quarter 4. This was due to a combination of high volumes of late referrals from other providers, clinical complexity, patient choice, but also higher levels of cancellations of non-emergency surgery during exceptional levels of emergency pressures and the norovirus outbreak which led to black escalation being declared. The 62-day standard for screening referred patients also failed to be achieved in Quarter 3. The delays were within the bowel screening service, with longer waiting times for specialist screening practitioner appointments (SSP), and colonoscopy diagnostic procedures, during October and November 2012. The waiting times for SSP appointments increased due to the departure of a number of members of staff at the same time, which severely limited capacity. The waiting times for colonoscopies increased as a result of a general increase in demand for the procedure which could not be responded to quickly due to delays in the opening of additional service capacity at South Bristol Community Hospital. However, both issues that contributed to delays in 62-day screening pathways were addressed at the end of Quarter 3 and performance improved significantly towards the latter half of Quarter 4. Both 62-day cancer standards are expected to be met again in 2013/14.

To consolidate the achievement of the national standards, the Trust will continue to carry-out quarterly reviews of the reasons why the cancer standards are not met for individual patients. This will inform the quarterly improvement plans. Being a specialist provider of cancer treatment, the Trust receives many complex cases each year. These patients are often managed across a number of providers (hospitals and other facilities) and may require more tests to diagnose and treat their cancer, which can introduce delays. The Trust will therefore continue to focus on ways of minimising delays to cancer patient pathways which are within the control of the Trust, to ensure the cancer waiting times standards continue to be met despite the inevitable challenges that our patient group brings.

Other standards

During 2012/13, the Trust cancelled 1.1% of operations on the day of the procedure for non-clinical reasons. Disappointingly, this was higher than the cancellation rate in the previous year. The robust process for escalating potential cancellations of surgery to the Divisional Management teams, which was put in place in 2011/12 and helped the Trust achieve the 0.8% national standard in March 2012, continues to be operated. The escalation process remains very effective in reducing the levels of cancellations by supporting operational teams in finding ways of avoiding the cancellation. However, the primary cause of the higher levels of cancellations this year was a ward bed not being available to admit a patient to. This reflected the significant emergency pressures seen in the latter half of the year. The programme of work that has been launched which is focusing on patient flow should improve bed availability in 2013/14 and reduce the last-minute cancellation rate. This should also help the Trust readmit patients within 28 days of their operation being cancelled, as achievement of this standard is very dependent upon the level of cancellation of operations at any point in time.

During Quarter 3, the Trust received a performance notice from NHS Bristol in relation to the failure to meet the standard of 99% of diagnostic tests being carried-out within six weeks. A remedial action plan was agreed in response, with a target trajectory for improvements in performance. The main diagnostic tests for which the six week target wait was not being met was endoscopic gastrointestinal diagnostic procedures, including colonoscopies and gastroscopies. This was due to a significant rise in demand for the procedures, which is a pattern that has been seen both regionally and nationally. The rise in demand could not be responded

to quickly due to delays in the opening of additional facilities at South Bristol Community Hospital, however the remedial action plan included a range of options for increasing capacity, including putting on additional weekend sessions and using other capacity across the community. At the end of March, the Trust was one month ahead of its target trajectory to achieve the 99% standard by the end June 2013.

In 2012/13, the Trust reported a significant improvement in the percentage of mothers initiating breast feeding. Improvements were also reported in the Door to Balloon 90 minute reperfusion standard. The Door to Balloon time measures the time from the arrival of the patient in the Trust through to the time when the reperfusion treatment commences (i.e. balloon inflation in the blood vessel). During the year, 92.4% of patients received reperfusion within the 90 minute standard. The Call to Balloon times 150 minute standard measures the time from the call for professional help through to the commencement of reperfusion treatment. The Trust failed to meet the 90% local stretch target, however this mainly reflected the time it took for the patient to get to the hospital (Call to Door time), rather than the time from arrival to treatment.

APPENDIX A - Statements of assurance from the Board

1. Review of services

During 2012/13, University Hospitals Bristol NHS Foundation Trust provided clinical services in 63[37] specialties via five clinical Divisions (i.e. Medicine; Surgery Head & Neck Services; Women's & Children's Services; Diagnostics and Therapy; and Specialised Services).

During 2012/13, the Trust Board has reviewed selected high-level quality indicators (e.g. infection control, HSMR) as part of monthly performance reporting. The data reviewed covered the three dimensions of quality i.e. patient safety, patient experience and clinical effectiveness. Sufficient data was available to provide assurance over the services provided by the Trust. The Trust also receives information relating to the review of quality of services in all specialties via, for example, the Clinical Audit Annual Report. The income generated by University Hospitals Bristol NHS Foundation Trust services reviewed in 2012/13 therefore, in these terms, represents 100% of the total income generated from the provision of NHS services by the Trust for 2012/13.

2. Participation in clinical audits and national confidential enquiries

For the purpose of the Quality Account, the Department of Health published an annual list of national audits and confidential enquiries, participation in which is seen as a measure of quality of any trust clinical audit programme. This list is not exhaustive, but rather aims to provide a baseline for Trusts in terms percentage participation and case ascertainment. The detail which follows, relates to this list.

During 2012/13, 41 national clinical audits and three national confidential enquiries covered NHS services that University Hospitals Bristol NHS Foundation Trust provides.

During that period University Hospitals Bristol NHS Foundation Trust participated in 90% (37/41) national clinical audits and 100% (3/3) national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2012/13 are as follows:

Name of audit / Clinical Outcome Review Programme	Eligible	Participated
Acute		
Adult community acquired pneumonia (British Thoracic Society)	Yes	No
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes
Emergency use of oxygen (British Thoracic Society)	Yes	Yes
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes
National Joint Registry (NJR)	Yes	Yes
Non-invasive ventilation - adults (British Thoracic Society)	Yes	Yes
Renal colic (College of Emergency Medicine)	Yes	Yes

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

Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme	Yes	Yes
Potential donor audit (NHS Blood & Transplant)	Yes	Yes
Cancer		
Bowel cancer (NBOCAP)	Yes	Yes
Head and neck oncology (DAHNO)	Yes	Yes
Lung cancer (NLCA)	Yes	Yes
Oesophago-gastric cancer (NAOGC)	Yes	Yes
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes
Adult cardiac surgery audit (ACS)	Yes	Yes
Cardiac arrhythmia (HRM)	Yes	Yes
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Yes	Yes
Coronary angioplasty	Yes	Yes
Heart failure (HF)	Yes	Yes
National Cardiac Arrest Audit (NCAA)	Yes	Yes
National Vascular Registry	Yes	Yes
Long term conditions		
Adult asthma (British Thoracic Society)	Yes	No
Bronchiectasis (British Thoracic Society)	Yes	Yes
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	Yes
Diabetes (Paediatric) (NPDA)	Yes	Yes
Inflammatory bowel disease (IBD)	Yes	Yes
National Review of Asthma Deaths (NRAD)	Yes	Yes
Pain database	Yes	Yes
Renal replacement therapy (Renal Registry)	Yes	Yes
Older People		
Carotid interventions audit (CIA)	Yes	Yes
Fractured neck of femur (College of Emergency Medicine)	Yes	Yes
Hip fracture database (NHFD)	Yes	Yes
National audit of dementia (NAD)	Yes	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes
Other		
Elective surgery (National PROMs Programme)	Yes	Yes
Women's & Children's Health		
Child health programme (CHR-UK)/ Child Health Clinical Outcome Review Programme (CH-CORP)	Yes	Yes
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes
Maternal, infant and newborn programme (MBRRACE-UK)*/ Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP)	Yes	Yes
Neonatal intensive and special care (NNAP)	Yes	Yes
Paediatric asthma (British Thoracic Society)	Yes	Yes
Paediatric fever (College of Emergency Medicine)	Yes	No
Paediatric intensive care (PICANet)	Yes	Yes
Paediatric pneumonia (British Thoracic Society)	Yes	No

*This programme was previously also listed in our 2010/11 and 2011/12 Quality Accounts as 'Perinatal Mortality'.

Of those national audits that the Trust did not participate in, the reasons/details of future participation are outlined below:

- British Thoracic Society audit programme – Other national asthma audit undertaken
- Paediatric fever (College of Emergency Medicine) – Data collection period missed

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust participated in, and for which data collection was completed during 2012/13 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Name of audit / Clinical Outcome Review Programme	% Cases Submitted
Acute	
Adult community acquired pneumonia (British Thoracic Society)	
Adult critical care (Case Mix Programme – ICNARC CMP)	100% (1212/1212)
Emergency use of oxygen (British Thoracic Society)	8*
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	88% (8/9)
National Joint Registry (NJR)	58% (19/30)
Non-invasive ventilation - adults (British Thoracic Society)	18*
Renal colic (College of Emergency Medicine)	100% (50/50)
Severe trauma (Trauma Audit & Research Network, TARN)	27*
Blood and Transplant	
National Comparative Audit of Blood Transfusion programme	232*
Potential donor audit (NHS Blood & Transplant)	
Cancer	
Bowel cancer (NBOCAP)	89% (164/185)
Head and neck oncology (DAHNO)	89% (52/71)
Lung cancer (NLCA)	72% (130/180)
Oesophago-gastric cancer (NAOGC)	100% (142/142)
Heart	
Acute coronary syndrome or Acute myocardial infarction (MINAP)	100% (866/866)
Adult cardiac surgery audit (ACS)	100% (1452/1452)
Cardiac arrhythmia (HRM)	765*
Congenital heart disease (Paediatric cardiac surgery) (CHD)	100% (766/766)
Coronary angioplasty	100% (1331/1331)
Heart failure (HF)	384*
National Cardiac Arrest Audit (NCAA)	106*
National Vascular Registry	98% (45/46)
Long term conditions	
Adult asthma (British Thoracic Society)	
Bronchiectasis (British Thoracic Society)	17*
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	100% (89/89)
Diabetes (Paediatric) (NPDA)	382*

Inflammatory bowel disease (IBD)	100% (40/40)
National Review of Asthma Deaths (NRAD)	100% (2/2)
Pain database	145*
Renal replacement therapy (Renal Registry)	
Older People	
Carotid interventions audit (CIA)	100% (46/46)
Fractured neck of femur (College of Emergency Medicine)	100% (50/50)
Hip fracture database (NHFD)	100% (342/342)
National audit of dementia (NAD)	100% (40/40)
Sentinel Stroke National Audit Programme (SSNAP)	100% (111/111)
Other	
Elective surgery (National PROMs Programme)	70% (168/239)
Women's & Children's Health	
Child health programme (CHR-UK)/ Child Health Clinical Outcome Review Programme (CH-CORP)	100% (1/1)
Epilepsy 12 audit (Childhood Epilepsy)	100% (59/59)
Maternal, infant and newborn programme (MBRRACE-UK)*/ Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP)	N/A
Neonatal intensive and special care (NNAP)	795*
Paediatric asthma (British Thoracic Society)	100% (17/17)
Paediatric fever (College of Emergency Medicine)	
Paediatric intensive care (PICANet)	100% (682/682)
Paediatric pneumonia (British Thoracic Society)	

* No case requirement outlined/unable to establish baseline from HES data

The reports of ten national clinical audits were reviewed by the provider in 2012/13. University Hospital Bristol NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

College of Emergency Medicine audits

- A joint sepsis protocol has been developed with the Emergency Department and the Medical Admissions Unit
- Teaching sessions have taken place to highlight need for cultures and lactate measurement and the early use of antibiotics
- A process for the rapid assessment and triage of patients has been implemented

Epilepsy 12 audit (Childhood Epilepsy)

- Children with a new diagnosis of epilepsy are to be prioritised for referral to the Epilepsy Specialist Nurse
- An 'appropriate first clinical assessment' proforma is being developed to help ensure developmental and emotional/behavioural assessments are undertaken

National Cancer Audits

- To improve the quality of cancer data, a 'data entry guide' will be created to help identify the correct places for key cancer information to be recorded on the Somerset Cancer Registry
- Regular checks for missing gaps in datasets will be conducted through the use of formal data quality reports created via the information team
- A review of administrative services for cancer (including data collection resources) is taking place and a business case for a data co-ordinator has been put forward

National Cardiac Arrest Audit (NCCA)

- It has been agreed that all cardiac arrests will be reported on the Trust incident reporting system (Ulysses Safeguard) to improve data quality and to enable learning from these incidents.

National comparative re-audit of platelet transfusion

- The Trust has developed a Standard Operating Procedure for quick reference to pre transfusion checking / patient identity / care of transfused patients to improve practice in transfusion care.

The reports of 197 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2012/13; summary outcomes and actions reports were reviewed on a quarterly basis by the Clinical Audit Group. Details of the changes and benefits of these projects will be published in the Trust's Clinical Audit Annual Report for 2012/13[38].

3. Participation in clinical research

Our researchers lead and contribute to world class research which helps us to understand diseases better and develop new treatments for the benefit of patients and the NHS. Providing healthcare, research and teaching of the highest quality to improve outcomes for patients is at the centre of what we do at UH Bristol. Research is embedded in the care we provide, and we aim to offer the chance of taking part in research to as many of our patients as we can. We work with our university and NHS partners to develop and deliver high quality, peer-reviewed, externally funded research, as well as research which is funded locally or carried out by students as part of their training and qualifications. We hold grants from the National Institute for Health Research (NIHR) and other organisations, and carry out hosted research across our specialties. Research led from UH Bristol includes studies in Cardiovascular disease, Nutrition, Eye Disease, Emergency Medicine, Surgery, Cancer, Paediatrics, Rheumatology, Respiratory Medicine, Health Services Research and, Medical Physics. In 2012/13, we recruited 5971 patients into non commercial studies, of whom 5099 were into NIHR portfolio studies.

Our two NIHR Biomedical Research Units (BRUs) opened on 1 April 2012. The units are in Cardiovascular Disease, and Nutrition Diet and Lifestyle. Projects in the Nutrition BRU include investigations of nutrition in cancer, long term childhood conditions, surgery and sedentary behaviour in people with diabetes. In the Cardiovascular BRU, we are continuing thematic work around improving the outcomes in cardiac surgery and translating laboratory research into clinical trials.

Number of active studies		
	Non-Commercial NIHR Portfolio[39] Studies	350
	Non-Commercial, Non-Portfolio Studies	148
	Commercial Portfolio Studies	71
	Commercial, Non-Portfolio Studies	34
Recruitment		
	Non-Commercial Portfolio Studies	5099
	Non-Commercial, Non-Portfolio Studies	872
	Commercial Studies	406

[38] Available via the Trust's internet site from June 2013

[39] The National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio is a database of high-quality clinical research studies. Non-commercial NIHR portfolio studies are eligible for support from the NIHR Clinical Research Network or through other NIHR infrastructure funding in England.

The number of patients receiving relevant health services provided or sub-contracted by University Hospitals Bristol NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 6505.

4. CQUIN framework (Commissioning for Quality and Innovation)

The amount of potential income in 2012/13 for quality improvement and innovation goals was £6.961 million, based on the sums agreed in the contracts. Associated payments in 2012/13 totalled £6.483 million, including the guaranteed payment agreed by BNSSG[40] commissioners. Total payments in 2011/12 amounted to £3.372m[41].

An explanation of the factors contributing to the failure to earn all of the potential CQUIN rewards is provided at the end of this section. A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between University Hospitals Bristol NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The delivery of the CQUINs is overseen by the Trust's Clinical Quality Group. Further details of the agreed goals for 2012/13 and 2013/14 are available electronically at http://www.uhbristol.nhs.uk/about-us/how-we-are-doing/ .

The CQUIN goals were chosen to reflect both national and local priorities. Thirty one CQUIN targets were agreed, including four nationally specified goals: reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE); improve responsiveness to personal needs of patients, to incentivise the identification of patients with dementia and other causes of cognitive impairment alongside, and to incentivise the measurement of harm from pressure ulcers, falls, urinary tract infections in patients with catheters and VTE, using the NHS Safety thermometer.

The Trust has achieved 18 of the 31 CQUIN targets and 7 in part, as follows:

- Venous thrombo-embolism (VTE) risk assessment (in part)
- Patient experience (in part)
- Dementia (in part)
- NHS Safety Thermometer
- High Impact Innovations (in part)
- Enhanced Recovery Programme (Surgery Head and Neck, and Cardiac Surgery)
- Nutrition (in part)
- Medication errors
- Emergency Theatre waiting times
- Diabetes care for surgical patients
- Acute Oncology (in part)
- Cardiac Surgery
- Paediatric disability
- Improvement in spontaneous vaginal deliveries (*possibly in part – to be confirmed)*
- Histopathology
- Quality dashboards
- Neonatal CONS infections
- Increasing the number of babies receiving timely TPN
- Paediatric Intensive Care Unit (PICU) - unplanned extubation

[40] Bristol, North Somerset and South Gloucestershire
[41] A provisional total of £3.363m had been published in the 2011/12 Quality Report

- PICU – unplanned readmissions within 30 days of cardiac surgery
- PICU – reduction of acquired line sepsis
- Increasing proportion of cardiac patients access catheterisation laboratory procedures
- Cystic Fibrosis

CQUINs which were not achieved include increasing the percentage of patients going direct to the appropriate assessment area/ward; referrals to GP Support Unit and ambulatory care; time to antibiotics for patients with neutropenic fever; and improving compliance in the use of the Situation, Background, Assessment and Recommendation (SBAR) communication tool. At the time of writing, completion of Early Warning Scores (EWS) is 93.3% against a target of 95% as measured by the Trust's Quality in Care Tool, however further data needs to be included in the analysis to ensure complete coverage of adult areas for the purposes of this CQUIN – it is therefore not yet possible to report whether the 95% target has been achieved.

There has been an on-going concerted effort across the Trust to improve patient flow and pathways, ensuring patients are seen at the appropriate place and time. The direct admission and admission avoidance CQUINs were introduced for the first time in 2012/13. The targets were challenging to deliver and whilst the CQUIN wasn't achieved, it did direct a focus on this area and work will continue to ensure improvements continue. VTE prophylaxis CQUIN was not achieved due to a notable fall in achievement in Q4, the quarter being measured, due to the departure of the VTE nurse.

The neutropenic fever related CQUIN was linked primarily to improvements in recording and whilst some progress was made during the year it did not meet the level required to meet the CQUIN. Whilst it will not remain in place for 2013/14 as a CQUIN work will continue to focus on this area going forward.

For the EWS and SBAR CQUINs, data available from the Quality in Care Tool for the three months September to November 2012 indicates a very positive performance. However this did not include data from all wards and as such has not been used to assess overall CQUIN performance. These CQUINs will remain in place for 2013/14 and robust measurements are in place to ensure a continued focus on this important area of patient safety.

The planning, training and facilities improvements required for neonatal breastfeeding CQUIN took longer than planned so was not achieved. This CQUIN is being taken forward into 2013/14. Bed and staffing issues have resulted in not achieving the cardiac surgery CQUIN. Cancer data field compliance is partial due to ongoing issues with completion of cancer staging data.

(Also see page 28 for information regarding the national Patient Experience CQUIN).

5. Care Quality Commission registration and reviews

University Hospitals Bristol NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without compliance conditions'. The Trust received four CQC inspections during 2012/13. The CQC has taken enforcement action against University Hospitals Bristol in 2012/13 in respect of Outcome 13 (Staffing).

The Trust received a Scheduled Inspection of its Main Site on 21 June 2012. In an otherwise very positive report (Outcomes 1, 4, 5, 6, 7, 14 and 16), the Trust was found to be non-compliant with Outcome 13 (Staffing), specifically in relation to the regulated activity 'maternity and midwifery services'. The Trust submitted a detailed action plan to the CQC on 30 August 2012: a re-inspection took place on 26 April 2013 and the Trust was found to be compliant.

South Bristol Community Hospital received a CQC Dignity and Nutrition inspection on 15 August 2012, confirming compliance with Outcomes 1 (Respecting and involving people who use services) and 4 (Care and welfare of people who use services).

On 5 September 2012, the CQC undertook a responsive review of Ward 32 at the Bristol Royal Hospital for Children. The Trust was found to be non-compliant with Outcomes 4 and 14 (Supporting Staff) and was issued with a Warning Notice in respect of Outcome 13. Action plans were submitted to the CQC and the Warning Notice was lifted following a positive re-inspection on 19 November 2012. A further re-inspection took place on 26 April 2013, confirming compliance with Outcomes 4 and 14.

Finally, on 4 October 2012, the Trust received a CQC re-inspection at Central Health Clinic. This inspection confirmed that the Trust had addressed previous non-compliance associated with completion of documentation pertaining to the 1968 Abortion Act.

During 2012/13, the Trust received two Outlier Alerts from the CQC. Outlier Alerts are triggered when data received by the CQC suggests that a healthcare provider's clinical performance (typically mortality or complication rates following surgery) is found to be significantly different to that of other providers. An Alert does not draw conclusions – it is a prompt for the provider to make further investigations.

On 16 August 2012, the Trust received a maternity alert for 'readmissions within 42 days of delivery'. We undertook a detailed investigation, attributing the cause of the outlier status to incorrect coding – however opportunities to improve other aspects of clinical practice were identified and acted upon. This alert has been closed by the CQC (i.e. the CQC is satisfied with our explanation and response).

On 8 February 2013, we received a maternity outlier alert for 'puerperal sepsis and other puerperal infections within 42 days of delivery'. This was a repeat of a previous alert received in August 2011. The Trust undertook a comprehensive review, identifying over-diagnosis and treatment of urinary tract infection as a possible cause. A detailed action plan was submitted to the CQC. The alert was closed by the CQC on 1 May 2013.

6. Data quality

University Hospitals Bristol NHS Foundation Trust submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was: 99.1% for admitted patient care; 99.7% for outpatient care; and 93.7% for accident and emergency care (these values are the same as in 2011/12 except for A&E which had slight decrease in 2012/13).
- which included the patient's valid General Practice code was: 100% for admitted patient care; 100% for outpatient care; and 100% for accident and emergency care (this is the second year running that the Trust has achieved 100% in all areas).

(Data source: NHS Information Centre, SUS Data Quality Dashboard, April 2012 - January 2013 as at Month 10 inclusion date)

UH Bristol's 2012/13 score for Information Quality and Records Management in the Information Governance Toolkit was 69%. The Information Governance Assessment Report overall score was 68% and was graded red. The Information Quality and Records Management section in the Information Governance Assessment Report was graded green.

UH Bristol was not subject to the Payment by Results clinical coding audit during 2012/13 by Capita Health (which has replaced the Audit Commission).

UH Bristol commissioned an external company to provide an Information Governance Clinical Coding audit of 1000 Finished Consultant Episodes. The audit covered a random sample of admitted patients across both surgical and medical specialties and the following levels of accuracy were achieved:

- Primary procedure accuracy: 91.6%
- Primary diagnosis accuracy: 92.6%

(Please note that these results should not be extrapolated further than the actual sample audited)

The Trust has taken the following actions to improve data quality:

- The data quality programme involves a number of regular data quality checks and audits throughout the year including checking against patient notes. This takes place across the Trust and all issues with data quality are reported back to the Information Governance Management Group for appropriate action.

- The Trust's Data Quality Framework is in the process of being finalised, with completion due in Quarter 1, 2013/14. The framework details the processes by which the Trust assures the quality of data used to monitor key performance indicators (KPIs), including the validation process, 'freeze' dates and ownership of the data. The framework includes an assessment - for each KPI - of the level of assurance against the Six Dimensions of Data Quality, following the recommendations of the Audit Commission (Audit Commission: *Figures you can trust: A briefing on data quality in the NHS*, March 2009).

APPENDIX B – Extract from UH Bristol Quality Strategy 2011-2014

How the Trust assesses, seeks improvements in and assurances about quality of services:

APPENDIX C – Feedback about our Quality Report

a) Statement from the Council of Governors of the University Hospitals Bristol NHS Foundation Trust

The Council of Governors welcomes the opportunity to make comment on the Trust's quality report. The content is the result of extensive consultation, auditing and assurance processes in relation to patient safety, patient experience and clinical effectiveness.

The Trust has an overarching objective of putting quality at the heart of everything it does and has demonstrated a determined approach to this throughout what has proved to be a very difficult year. Corporate objectives were affected by higher than expected levels of activity, acuity and the increased numbers of elderly patients needing treatment. The inability to discharge to suitable providers of care in the community put severe pressures on bed availability.

Governor involvement

Last year, the Trust's Council of Governors received regular reports relating to quality issues from its governor groups and challenged the Trust Board to account for any failings in the quality of care.

The governors' Quality Report Focus Group contributed to the development of the Quality Report early in 2013 with suggestions on format and content. The governors are aware that the order in which the content of the Quality Report appears deviates from that recommended by the Department of Health and Monitor, however we think that this is the right approach in order to make the report readable and accessible.

Comment on progress with the quality objectives in the Quality Report

PATIENT SAFETY: *There were five objectives in this section, three were fully achieved and two partially achieved.*

We did not meet our target for reducing patient falls and numbers were higher than last year despite various initiatives. The Fallsafe pilot projects have shown that further reductions this year are possible.
A similar situation exists with the objective of reduction in the incidence of hospital acquired pressure ulcers where the Trust failed to meet its target overall, however recent figures indicate an improving trend.
Medicine safety data indicates steady progress in the reduction of errors and missed doses.
The Trust has continued to put in a strong performance above target for venous thrombo-embolism patient assessment and prophylaxis with new initiatives introduced to sustain performance.
Last year we commented on the steady progress on meeting the nutritional needs of patients and it is good to see that further care improvements have resulted in an excellent outcome.
The Trust's Histopathology service was the subject of clinical audit as part of a continuing process of improvement and all 13 projects were completed satisfactorily.

National data indicated that our trust was underperforming in Rates of Complication, Misadventure and Readmissions following Gynaecological Surgery. Investigation highlighted certain anomalies in data sets so the service will be monitored again next year.
The review of patient safety for 2012/13 includes information about hospital acquired infections. The target for Clostridium Difficile was achieved but not the target for MRSA blood stream infections. The target was no more than two cases but ten cases were recorded, so the Trust introduced an intravenous line care management programme which we hope will reduce the number of cases to nil, which is next year's target. Governors have asked that control of hospital acquired infections is kept as a standing item for reporting every year.
We note that our Trust is reporting more patient safety incidents but has had fewer incidents resulting in severe harm or death. There were four deaths as a result of safety incidents during the reporting period which was the same as last year 2011/12. This rate is below the rate for similar hospitals.

PATIENT EXPERIENCE: *There were six objectives in this section, three were fully achieved and three partially achieved.*

The Trust implemented its Patient Experience and Involvement Strategy with the aim of gathering feedback on the quality of services provided. The governors welcome this proactive approach of routine survey targeting specific groups with the feedback provided helping to improve service. This is especially the case with our Emergency Department where we scored better than average in the 2012 National Accident and Emergency Survey.
We note and commend the various initiatives to improve the experiences of patients and carers at the Bristol Royal Hospital for Children with the development of young people friendly environments, patient reception testing by the members of the Trust's Youth Council and the development of a specialist assessment system for families with children having disabilities or special needs. Coupled with this is the emphasis the Trust has placed on supporting carers with one aspect being their roll out of care awareness training for staff.
There are new initiatives to help patients with learning disabilities together with a programme of prompt risk assessment (a clinical objective) which we commend.
We continued a project to reduce night time noise in wards and although we achieved a marginal improvement over last year we did not meet the target set.
We did achieve the target set for Treating Mothers with Care and Understanding in our maternity unit. This target was set to deal with the poor result achieved in the 2010 National Maternity Survey. It was decided to extend this measure to all inpatient services and excellent results were recorded although these suggested more work is needed to bring the Maternity Services result closer to our general inpatient score.
Two national surveys indicated areas where we should improve communication with patients so this objective measured the quality of information given at outpatient clinics especially that related to waiting times and the availability of staff to talk to about any fears or worries they might have. The results from this last survey would suggest that there is more work to do and the Productive Outpatient Project is helping to improve the outpatient communication process.
In relation to the objective to reduce numbers of complaints and to respond quickly when they do occur the governors are able to draw on their experiences of contact with patients and relatives and can confirm that they usually indicate a high level of satisfaction with the care received so the increase of 12.7% in the number of complaints is disappointing. However, there are still issues relating to administration and efficiency in such areas as outpatient administration, cancelled appointments/operations and communication failures. We hope that the Productive Outpatient project will address these failures together with further progress in the Transforming Care programme.
Although our Trust was rated above average for staff engagement in the 2011 National Staff Attitude Survey we scored badly on incidence of discrimination against staff with a 3% increase in reported cases. The 2012 result showed an improvement of 2% which we commend but note

that we are still worse than the national average. We are pleased that the Trust associates quality of care with staff attitudes and effective engagement and the recent survey has indicated improvements in job satisfaction.
We are also encouraged by signs of a possible upward trend in patient-reported experience of inpatient services in the second half of 2012/13.

CLINICAL EFFECTIVENESS: *There were six objectives in this section, two were achieved***,** *three were partially achieved and one was not achieved.*

We did not achieve our stretch target of 90% of stroke patients spending 90% of their time on a stroke unit. Stroke beds are only protected and available when the demand for beds is not affected by red and black escalation processes. Governors were anxious to know how the Trust managed effective continuation of care of discharged stroke patients in the community. We note that they have set up an Early Supported Discharge Scheme to provide specialist care at home and, although still short of the national target, significant progress has been made.
The objective to develop service specific standardised mortality ratios was not fully realised due to concerns about the use of non-risk adjusted data. Overall however, the Trust continues to enjoy below average mortality rates by comparison with national data (measured by HSMR and SHMI). As in previous years, we are pleased to note that our trust had significantly fewer deaths than the national average.
It is obvious from the report that a great deal of effort has been channelled into improvements in dementia care. There has been substantial progress towards meeting national targets. Training initiatives plus the key appointment of a lead nurse with Dementia Champions throughout the Trust should ensure that we will be well placed to deal with future challenges.
Another important clinical objective was the drive towards the development of Enhanced Recovery centred on educating and informing the patient and taking steps to ensure their condition is optimal pre and post operatively. This was fully achieved as part of the Transforming Care programme.
Adult Cardiac Surgery at the Trust's Bristol Heart Institute has maintained its good record with a mortality rate which is below the national average. Paediatric Cardiac Surgery mortality rates at our Trust are running at levels similar to the national average but the Trust has a complex case mix with some children presenting with severe congenital defects making successful outcomes less likely.

PERFORMANCE AGAINST KEY NATIONAL PRIORITIES:

Most waiting time targets were met during the year but the achievement is tarnished by non-achievement of Accident and Emergency waiting times, MRSA bloodstream infections and some Cancer targets. We also have problems with Last Minute Cancelled Operations and Readmissions. The fourth quarter of the year carries an annual risk of underachievement in some standards due to ward closures, staff sickness and a higher level of activity. We make the comment that there should be greater attention paid to planning for this period of the year to ensure that it is sufficiently resourced and that we should not take the view that it is a problem for all trusts and therefore acceptable.

SUMMARY

We commend this report for its transparency and thoroughness and feel that it is an accurate representation of the Trust's position on quality issues. Progress on quality objectives has been achieved during the year but the rate of improvement has slowed and, as stated at the beginning of this commentary there are factors at play which can only be mitigated by

additional resources (or reduced activity) either internally generated (by further efficiency savings) or through initiatives by our external healthcare partners. The Trust will have a delicate balance to manage with the challenges to its quality agenda by increasing levels of activity, greater sickness in the community it serves, the increasingly elderly patient profile, and funding. We state again that we would like to see more attention paid to demand management in the fourth quarter in years to come.

17th May 2013

b) Statement from Bristol Local Involvement Network (disbanded 31 March 2013)

Bristol LINk welcomes the opportunity to contribute to the Quality Report prepared by University Hospitals Bristol. The LINk notes a positive and constructive working relationship with the Trust, and the continued willingness throughout the year to discuss issues raised by LINk participants through three Working Groups (the Acute Hospital Working Group, the Older People's Working Group and the South Bristol Community Hospital Working Group). In addition, LINk participants have been able to access clear and timely responses to reports resulting from our Listening Events and ad hoc requests for information.

The activity LINk has undertaken over the past year includes:

- Supporting the opening of the South Bristol Community Hospital and making representations on behalf of LINk participants concerning signage, transport and access issue.
- Understanding the impact on patient care of the Trust's Productive Wards Programme.
- Receiving a presentation on and participating in the design plans for the redevelopment of the Bristol Royal Infirmary and in particular the Welcome Centre.
- A visit to UH Bristol to observe the nutritional care received by patients following work undertaken by LINk last year
- A workshop and site visit to UH Bristol to discuss the Trusts progress in improving the discharge process for adults
- Participation in the Bristol Health and Social Care Overview and Scrutiny workshop at UH Bristol
- An assessment of the British Red Cross A&E Assisted Discharge Service Pilot at the Trust's adult Emergency Department
- An assessment of the ambulatory screens used at the Trust's adult Emergency Department

The LINk wishes to note the support given to the Bristol and South Gloucestershire LINk Pathfinder Programme by the Trust during the transition period to Healthwatch.

c) Statement from South Gloucestershire Local Involvement Network (disbanded 31 March 2013)

South Gloucestershire LINk welcomes the opportunity to contribute to the Quality Report prepared by University Hospitals Bristol. The LINk hopes that, with advent of Healthwatch, a stronger relationship will emerge between the Trust and those communities in South Gloucestershire who use the health care services provided at UH Bristol. The LINk notes, however, the opportunities it has had to contribute to the South Bristol Community Hospital, the planned transfer of children's services from Frenchay Hospital to the Bristol Royal Hospital for Children and the joint work it has undertaken with Bristol LINk at UH Bristol, in particular joint enter and view events, ambulance screening and hospital discharge.

The LINk wishes to note the support given to the Bristol and South Gloucestershire LINk Pathfinder Programme by the Trust during the transition period to Heathwatch.

d) **Statement from South Gloucestershire Health Scrutiny Select Committee**

The Trust was invited to a meeting of the South Gloucestershire Public Health & Health Scrutiny Committee on 17th April to present its draft Quality Report 2012-13. Due to timing issues it was not possible for the Committee to receive the full Quality Report so instead the Trust was asked to give a 10 minute presentation and focus on areas of concern, what its priorities are going forward and how it is performing in terms of infection control.

The Committee was pleased to receive information about the Trust's priorities and actions plans, which included actions to reduce inpatient falls and work to further reduce hospital acquired pressure ulcers.

In terms of infection control the Committee noted the downward trend in cases of Clostridium Difficile and the steady reduction in MRSA cases over the previous five years, although there was a slight increase from 2011/12. In response to whether patients are swabbed when they transfer between wards the Trust reported that its compliance rates for screening / swabbing are very high and it meets the national standard, which is to ensure that all patients are swabbed upon admission to hospital. However, in addition to this the Trust is exploring whether to swab patients when they transfer between wards. This was welcomed by the Committee.

In response to questioning about recent cancellations of planned procedures the Trust reported that during February there was a period of 'black escalation', which meant it had been difficult to avoid emergency patients taking up ward beds and some elective surgery being postponed. However, the Trust aims to be rigorous with patient discharge in order to avoid elective postponements wherever possible.

The Trust was asked about staff hours and some staff working long shifts. In response the Trust reported that last year in consultation with staff and the trade union it had reviewed shifts and they were due to be reviewed again shortly.

The Committee commented on the importance of good patient nutrition, particularly as the Trust has documented that there is a close link between poor nutrition and pressure ulcers.

e) Statement from Bristol Health and Adult Social Care Scrutiny Commission

The Scrutiny Commission received a presentation at its meeting of 22nd April 2013 summarising the key issues that will be included in UHB's Quality Report.

The Scrutiny Commission is pleased to see that dementia is being addressed across the Trust and welcomes the news that there are dementia champions on each ward. However members are very concerned to note that the number of patient falls has significantly increased and are keen that the Trust increases its efforts to address this.

The Commission is alarmed to see the rise in hospital acquired pressure ulcers. Whilst acknowledging that the increasing number of elderly patients is a factor in this, members are interested to see the core themes arising from the Root Cause Analyses, and wish to see ongoing investigation of these in order to support a sustained reduction in numbers.

Despite this being marked as an objective that has been achieved, councillors have had complaints about the food provided in hospital and given the importance of good nutrition for patients request that this continue to be given attention.

f) Statement from NHS Bristol Primary Care Trust (abolished 31 March 2013)

This statement on the University Hospitals Bristol NHS Foundation Trust Quality Report 2012/13 is made by Bristol Clinical Commissioning Group following a review by the Director of Quality and Governance for the Bristol, North Somerset and South Gloucestershire Primary Care Trust Cluster up to 31 March 2013.

It is considered that the report for 2012/13 provides a fair reflection of the work of the Trust and includes the mandatory elements required.

All of the data presented has been reviewed and we are satisfied that this gives an overall accurate account and analysis of the quality of services. This is in line with data provided and reviewed as part of contract performance management.

Bristol Clinical Commissioning Group continues to work with the Trust to ensure that patient safety, data accuracy and information governance remains a key priority at all times. We welcome the approach of the monthly quality report to the board beginning with a patient story.

The account identifies significant progress in relation to:

- In-patients' confidence in the services reflected in a high number saying they could recommend the services to their family and friends.
- Improvements in nutritional care across the Trust.

We support the ongoing work to improve the patient experience and reduce the incidence of pressure ulcers.

We will continue to work closely with the Trust to:

- Improve performance and deliver the improvement plan in relation to MRSA infections and ensuring that targets are met.
- To provide further assurance in relation to staffing levels for paediatric cardiac surgery (Ward 32 and paediatric intensive care) following the risk summit and CQC inspection.
- Mitigate the risks to patients resulting from the pressures on emergency admissions and unscheduled care.
- Revitalise involvement in the patient safety improvement programmes.

The on-going engagement of clinicians working closely with the commissioner will remain crucial in 2013/14 and it is anticipated will be strengthened as the result of the establishment of clinical commissioning groups.

The Quality Report follows the Quality Accounts toolkit framework.

Lindsey Scott
Director of Nursing and Quality
NHS England: Bristol, North Somerset and South Gloucestershire Area Team

APPENDIX D – Statement of Directors' Responsibilities

2012/13 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

  Board minutes and papers for the period April 2012 to May 2013;

  Papers relating to Quality reported to the Board over the period April 2012 to May 2013;

  Feedback from the commissioners received 20/05/2013;

  Feedback from governors dated 17/05/2013;

  Feedback from Bristol Local Involvement Network[42] received 30/04/2013;

  Feedback from South Gloucestershire Local Involvement Network received 30/04/2013;

  The Trust's complaints data as reported to the Board for the period April 2012 to March 2013.

  The 2012 National Inpatient Survey published 16/04/2013;

  The 2012 National Staff Attitude Survey published 28/02/2013;

  The Head of Internal Audit's annual opinion over the Trust's control environment dated 22/05/2013;

  Care Quality Commission quality and risk profile dated 31/03/2013;

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

[42] On 1st April 2013, Local Involvement Networks were succeeded by local Healthwatch organisations

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

John Savage, Chairman
29 May 2013

Robert Woolley, Chief Executive
29 May 2013

APPENDIX E to Quality Report – External audit opinion

Independent Auditor's Limited Assurance Report to the Council of Governors of University Hospitals Bristol NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of University Hospitals Bristol NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Bristol NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 in the Quality Report that have been subject to limited assurance consist of the following national priority indicators as mandated by Monitor:

- Number of *Clostridium difficile* infections; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

We refer to these national priority indicators collectively as the "specified indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the assessment criteria referred to in page 64 of the Quality Report (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2012 to the date of signing this limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2012 to the date of signing this limited assurance report;
- Feedback from the Commissioners received 20 May 2013;

- Feedback from Governors dated 17 May 2013;
- Feedback from Bristol Local Involvement Network received 30 April 2013;
- Feedback from South Gloucestershire Local Involvement Network received 30 April 2013
- The Trust's complaints data as reported to the Board for the period April 2012 to March 2013;
- Feedback from other stakeholders involved in the sign-off of the Quality Report; The South Gloucestershire Health Scrutiny Committee and the Bristol Health and Adult Social Care Scrutiny Commission received 14 May 2013
- The latest national patient survey dated 16 April 2013;
- The latest national staff survey dated 28 February 2013;
- Care Quality Commission quality and risk profiles dated 31 March 2013;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 22 May 2013;

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the **"**documents**"**). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospitals Bristol NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospitals Bristol NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospitals Bristol NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- Making enquiries of management
- Limited testing, on a selective basis, of the data used to calculate the specified indicators back to supporting documentation.
- Comparing the content requirements of the FT ARM to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Directors' interpretation of the Criteria in page 64 of the Quality Report.

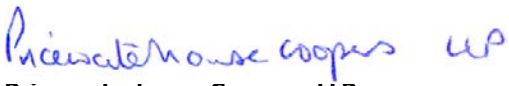
The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by University Hospitals Bristol NHS Foundation Trust;

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2013,

- The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is not consistent in all material respects with the documents specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria.



PricewaterhouseCoopers LLP
Chartered Accountants
Bristol
29 May 2013

The maintenance and integrity of the University Hospitals Bristol NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Accounts for the year ended 31 March 2013

Paul Mapson CPFA, Director of Finance
and Information

Trust HQ
Finance Department
Marlborough Street
PO Box 1053
BRISTOL BS99 1YF

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Accounts for the year ended 31 March 2013

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2013 have been prepared by the University Hospitals Bristol NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Services Act 2006.

Robert Woolley, Chief Executive

Statement of Comprehensive Income for the year ended 31 March 2013

	Note	Year ended 31 March 2013 £'000	Year ended 31 March 2012 £'000
OPERATING INCOME			
Income from activities from continuing operations	3	413,709	398,411
Other operating income from continuing operations	4	101,123	108,416
Other operating income from discontinued operations	4	13,377	26,912
TOTAL OPERATING INCOME		**528,209**	**533,739**
OPERATING EXPENSES			
Operating expenses from continuing operations	5-6	(500,261)	(488,806)
Operating expenses from discontinued operations	5-6	(13,377)	(26,907)
TOTAL OPERATING EXPENSES		**(513,638)**	**(515,713)**
OPERATING SURPLUS/(DEFICIT)			
Surplus from continuing operations		14,571	18,021
Surplus from discontinued operations		-	5
TOTAL OPERATING SURPLUS/(DEFICIT)		**14,571**	**18,026**
FINANCE COSTS			
Finance income	9.1	222	361
Finance costs	9.2	(431)	(411)
Finance expense unwinding discount on provisions	18	(6)	(8)
Public dividend capital dividends payable		(9,672)	(8,983)
NET FINANCE COSTS		**(9,887)**	**(9,041)**
SURPLUS/(DEFICIT) FOR THE YEAR		**4,684**	**8,985**
OTHER COMPREHENSIVE INCOME/(EXPENDITURE)			
Impairments charged to revaluation reserve		(1,833)	-
Revaluation losses on property plant and equipment		-	(2,959)
Revaluation gains		430	5,323
Revaluation losses on intangible assets		-	-
Other recognised gains and (losses)		(30)	58
TOTAL COMPREHENSIVE INCOME/(EXPENDITURE) FOR THE YEAR		**3,251**	**11,407**

Discontinued operations relate to the cessation of the hosting arrangements for Skills for Health at the close of business on 31 March 2013. See note 21.

The notes on pages 6 to 55 form part of these Accounts.

Statement of Financial Position as at 31 March 2013

	Note	31 March 2013	31 March 2012
		£'000	£'000
NON CURRENT ASSETS			
Intangible assets	10	6,740	4,504
Property, plant and equipment	11	344,385	311,451
TOTAL NON CURRENT ASSETS		**351,125**	**315,955**
CURRENT ASSETS			
Inventories	12	8,816	7,118
Trade and other receivables	13	20,656	17,851
Other financial assets	14.1	104	146
Assets held for sale	14.2	700	7,482
Cash and cash equivalents	19	35,118	41,481
TOTAL CURRENT ASSETS		**65,394**	**74,078**
CURRENT LIABILITIES			
Trade and other payables	15	(56,617)	(50,231)
Borrowings and bank overdrafts	17	(472)	(188)
Provisions	18	(445)	(6,666)
Other liabilities	16	(2,782)	(4,449)
TOTAL CURRENT LIABILITIES		**(60,316)**	**(61,534)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**356,203**	**328,499**
NON CURRENT LIABILITIES			
Trade and other payables	15	-	-
Borrowings	17	(30,431)	(5,953)
Provisions	18	(211)	(236)
TOTAL NON CURRENT LIABILITIES		**(30,642)**	**(6,189)**
TOTAL ASSETS EMPLOYED		**325,561**	**322,310**
TAXPAYERS' EQUITY			
Public dividend capital		191,011	191,011
Revaluation reserve		63,899	69,773
Other reserves		85	85
Income and expenditure reserve		70,566	61,441
TOTAL TAXPAYERS' EQUITY		**325,561**	**322,310**

The accounts on pages 2 to 55 were approved by the Board on 29 May 2013 and signed on its behalf by:

Robert Woolley, Chief Executive, 29 May 2013

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2013

Changes in Taxpayers' equity in the current year	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	Total £000
Taxpayer's Equity at I April 2012	**191,011**	**69,773**	**85**	**61,441**	**322,310**
Surplus (deficit) for the year	-	-	-	4,684	4,684
Impairments	-	(1,833)	-	-	(1,833)
Revaluation losses on property plant and equipment and intangible assets	-	-	-	-	-
Revaluation gains	-	372	-	-	372
Asset disposals	-	(1,321)	-	1,321	-
Other recognised gains and (losses)	-	-	-	(30)	(30)
Transfers between reserves	-	(3,150)	-	3,150	-
Other reserve movements	-	58	-	-	58
Total comprehensive income for the year	-	(5,874)	-	9,125	3,251
Taxpayers' Equity at 31 March 2013	**191,011**	**63,899**	**85**	**70,566**	**325,561**

Changes in Taxpayers' equity in the prior year	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	Total £000
Taxpayer's Equity at I April 2011	**191,011**	**71,746**	**85**	**48,061**	**310,903**
Surplus (deficit) for the year	-	-	-	8,985	8,985
Revaluation losses on property plant and equipment and intangible assets	-	(2,959)	-	-	(2,959)
Revaluation gains	-	5,323	-	-	5,323
Asset disposals	-	-	-	-	-
Other recognised gains and (losses)	-	-	-	58	58
Transfers between reserves		(4,337)	-	4,337	-
Other reserve movements	-	-	-	-	-
Total comprehensive income for the year	-	(1,973)	-	13,380	11,407
Taxpayers' Equity at 31 March 2012	**191,011**	**69,773**	**85**	**61,441**	**322,310**

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.

Statement of Cash Flows for the year ended 31 March 2013

	Note	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus from continuing operations		14,571	18,021
Operating surplus from discontinued operations		-	5
OPERATING SURPLUS		**14,571**	**18,026**
NON CASH INCOME AND EXPENDITURE			
Depreciation and amortisation	10-11	18,729	18,107
Impairments	9.3	1,086	1,356
Reversal of impairment	11	-	(2,187)
(Gain)/loss on disposal		97	(82)
(Increase)/decrease in trade and other receivables	13	(2,873)	2,279
(Increase)/decrease in other assets	14	42	-
(Increase)/decrease in inventories	12	(1,698)	(89)
Increase/(decrease) in trade and other payables	15	8,253	968
Increase/(decrease) in other liabilities	16	(1,316)	(8,174)
Increase/(decrease) in provisions	18	(5,926)	6,143
(Gain)/loss on disposal of discontinued operations		6,175	-
Other movements in operating cash flows		(1,224)	(2,049)
NET CASH GENERATED FROM OPERATIONS		**35,916**	**34,298**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		223	360
Purchase of property, plant and equipment	11	(58,063)	(36,578)
Purchase of intangible assets	10	(2,838)	(2,521)
Sales of assets held for sale		7,568	2,550
Sales of property, plant and equipment		-	-
Cash flows attributable to investing activities of discontinued operations		(4,940)	-
NET CASH USED IN INVESTING ACTIVITIES		**(58,050)**	**(36,189)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		-	-
Public dividend capital repaid		-	-
Loans received from the FT Financing Facility		24,950	-
Capital receipts		967	
Capital element of finance lease rental payments		(188)	(164)
Interest paid		(12)	(1)
Interest element of finance leases		(387)	(411)
PDC dividends paid		(9,559)	(9,067)
Cash flows from other financial activities		-	-
NET CASH GENERATED/(USED) IN FINANCING ACTIVITIES		**15,771**	**(9,643)**
INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(6,363)**	**(11,534)**
CASH AND CASH EQUIVALENTS AT START OF YEAR	19	**41,481**	**53,015**
CASH AND CASH EQUIVALENTS AT END OF YEAR	19	**35,118**	**41,481**

Notes to the Accounts

1. Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *Foundation Trust Annual Reporting Manual (FT ARM)* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *FT ARM 2012/13* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (*FReM)* 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 on a going concern basis under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. Income from partially completed spells is calculated on a pro-rata basis based on the expected length of stay.

1.3 Expenditure on employee benefits

Employee benefits - short term

Salaries, wages and employment-related payments are recognised in the year in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the year is recognised in the financial statements.

An assessment of annual leave owing to staff at 31st March 2013 has been calculated using a sample of staff across all staff groups of a size sufficient to ensure above 95% confidence in the value of the liability. As staff have personal annual leave years, the number of hours taken has been compared with the pro-rated allocation of hours to the 31st March. The average annual leave owed to staff groups in the sample has been used to calculate the total number of hours owed to all staff in post in March 2013. An average hourly cost has been applied to each staff group to calculate the cost of annual leave owed.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found at the NHS Pensions website www.pensions.nhsbsa.nhs.uk. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for any NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the

retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, Plant and Equipment

Recognition
Property, Plant and Equipment is capitalised where:

- individually its cost is in excess of £5,000; or
- it forms a group of similar assets with an aggregate cost in excess of £5,000 (where the assets have an individual cost in excess of £250, are functionally interdependent, have broadly similar purchase dates, are expected to have similar lives and are under single management control); or
- it forms part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of individual or collective cost;
  and
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be provided to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably.

Where a significant asset, for example a building, includes a number of components with different economic lives, then these components are treated as separate assets within the building's classification and depreciated over their own useful economic lives.

Measurement (Valuation)
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value.

Land and buildings
All land and buildings are revalued using professional valuations every five years and in addition in a year where assets are subject to significant volatility annual 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.

In accordance with guidelines issued from the Department for Health any new valuations carried out post 1 April 2008 are completed on a Modern Equivalent Assets (MEA) basis. For specialised operational property the depreciated replacement cost is used. For non-specialised property and non-operational specialised property fair value is used as market value for its existing use.

Assets in the course of construction are initially recorded at cost and then valued by professional valuers as part of the five year review, or, for significant properties, when they are brought into use.

Other assets
Other assets include plant, machinery and equipment and are held at depreciated historical cost which is considered to be an appropriate proxy for current value.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the year in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment, which have been reclassified as 'Held for Sale', cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining useful life of the asset as assessed by the NHS Foundation Trust's professional valuers. Leaseholds are depreciated over the primary lease term. Other items of property, plant and equipment are depreciated on a straight line basis over their estimated remaining useful lives, as assessed by the Trust. The remaining maximum and minimum economic lives of property, plant and equipment assets held by the Trust are as follows

Asset Type	**Minimum Life**	**Maximum Life**
Buildings excluding dwellings	3 years	42 years
Dwellings	15 years	33 years
Plant and machinery (incl medical equipment)	1 year	10 years
Transport equipment	1 year	7 years
Information technology	1 year	8 years
Furniture and fittings	1 year	9 years

In a year of revaluation the accumulated depreciation at the date of revaluation is eliminated against the gross carrying amount of the asset, and the net amount is restated to the revalued amount of the asset.

Revaluation gains and losses
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

The Trust transfers the difference between depreciation based on the historical amounts and revalued amounts from the revaluation reserve to retained earnings.

Impairments
In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets
Donated and grant funded plant property and equipment assets are capitalised at their current value on receipt. The donation/grant is credited to income at the same time unless the donor has imposed a condition that the future economic benefits are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.6 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised where they have a cost in excess of £5,000, where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated intangible assets such as goodwill, brands, customer lists and similar items are not capitalised. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets (except for emission allowances – see note below) are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value.

Intangible assets are held at amortised historical cost which is considered to be an appropriate proxy for fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Allowances granted under the EU greenhouse gas emission scheme are held at fair value. Changes to fair value are recognised in the Statement of Comprehensive Income as an item of "other comprehensive income", except for impairments which are recognised in operating income.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits (except for emission allowances – see below).

The remaining maximum and minimum economic lives of intangible assets held by the Trust are as follows:

Asset type	Minimum life	Maximum ife
Software (purchased)	2 years	10 years
Other (purchased)	1 year	1 year

Purchased computer software licences are amortised over the shorter of the term of the licence and their estimated economic lives. Emission allowances are not amortised as they are used to extinguish liabilities arising under the scheme.

1.7 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match that expenditure.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of inventories. A provision is made where necessary for obsolete, slow moving and defective inventories.

1.9 Financial instruments (financial assets and liabilities)

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.10 below.

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

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement
Financial assets are categorised as 'Fair value through income and expenditure', loans and receivables or 'Available-for-sale financial assets'. Financial liabilities are classified as 'Fair value through income and expenditure' or as 'Other financial liabilities'.

Financial assets and financial liabilities at 'Fair value through income and expenditure'
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless

they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date. Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to 'Finance Costs'. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices where possible, otherwise by appropriate valuation techniques.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision. The allowance/provision is then used to write down the carrying amount of the financial asset, at the appropriate time, which is determined by the Trust on a case by case basis.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Lessee accounting:

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to 'finance costs' in the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Lessor accounting:

Operating leases

Assets acquired and held for use under operating leases are recorded as fixed assets and are depreciated on a straight line basis to their estimated residual values over their estimated useful lives. Operating lease income is recognised within operating income.

1.11 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates as per the table below, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.35% in real terms.

Expected cash outflows	Years	HMT real rate (%)	
		2012/13	2011/12
Short term	1-5	-1.8	2.2
Medium term	6-10	-1.0	2.2
Long term	10 or more	2.2	2.2

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS

Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 18.3.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

Other Provisions
Other provisions identified are disclosed in note 18.

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 22.1 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 22.2, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the NHS Foundation Trust's predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. Average relevant net assets are calculated as a simple average (mean) of opening and closing relevant net assets.

1.14 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation Tax

NHS foundation trusts are potentially liable to corporation tax in certain circumstances. A review of other operating income is performed annually to assess any potential liability in accordance with the guidance on the

HM Revenues and Customs website. As a result of this review, the Trust has concluded that there is no corporation tax liability for the year ended 31 March 2013.

1.16 Financial Risk

IFRS 7, 'Financial Instruments: Disclosures', requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities (see note 26).

The Trust's activities expose it to a variety of financial risks: market risk (including interest rate risk, and foreign exchange risk), credit risk and liquidity risk. Risk management is carried out by the Trust's Treasury Management Department under policies approved by Trust Board.

a) Market risk

(i) Interest-rate risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only elements of the Trust's assets that are subject to variable rate are short-term cash investments. The Trust is not, exposed to significant interest-rate risk. These rates are reviewed regularly to maximise the return on cash investment.

(ii) Foreign currency risk

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the year in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

The Trust has negligible foreign currency income and expenditure.

b) Credit risk

Credit risk arises from cash and cash equivalents and deposits with financial institutions, as well as outstanding receivables and committed transactions. The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. This means that there little risk that one party will fail to discharge its obligation with the other. However disputes can arise, around how amounts are calculated, particularly due to the complex nature of the Payment by Results regime. For financial institutions, only independently rated parties with a minimum rating (Moody) of P-1 and A1 for short-term and long-term respectively are accepted.

c) 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 is also required to comply and remain within the Prudential Borrowing Limit set by Monitor. For 2012/13 this was set at £189.9m. This represents maximum long term borrowing of £152.4m and an approved working capital facility of up to £37.5m. A working capital facility of £37.5m was renewed for a further year from 1 September 2012. Therefore the Trust has little exposure to liquidity risk. See note 23.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in note 27 to the accounts, in accordance with the requirements of HM Treasury's *Financial Reporting Manual*.

1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note 29 is compiled directly from the losses and compensations register which reports on a cash basis with the exception of provisions for future losses.

1.19 Accounting standards that have been issued but not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretation Committee (IFRIC) but not yet required to be adopted.

Change published	**Published by IASB**	**Financial year for which the change first applies**
IFRS 9 Financial Instruments Financial Assets: Financial Liabilities:	November 2009 October 2010	Uncertain. Not likely to be adopted by the EU until the IASB has finished the rest of its financial instruments project.
IFRS 10 Consolidated Financial Statements	May 2011	Effective date of 2013/14 but not yet adopted by the EU
IFRS 11 Joint Arrangements	May 2011	Effective date of 2013/14 but not yet adopted by the EU
IFRS 12 Disclosure of Interests in Other Entities	May 2011	Effective date of 2013/14 but not yet adopted by the EU
IFRS 13 Fair Value Measurement	May 2011	Effective date of 2013/14 but not yet adopted by the EU
IAS 12 Income Taxes amendment	December 2010	Effective date of 2012/13 but not yet adopted by the EU
IAS 1 Presentation of financial statements, on other comprehensive income (OCI)	June 2011	Effective date of 2013/14 but not yet adopted by the EU
IAS 27 Separate Financial Statements	May 2011	Effective date of 2013/14 but not yet adopted by the EU

IAS 28 Associates and joint ventures	May 2011	Effective date of 2013/14 but not yet adopted by the EU
IAS 19 (Revised 2011) Employee Benefits	June 2011	Effective date of 2013/14
IAS 32 Financial Instruments: Presentation-amendment. Offsetting financial assets and liabilities	December 2011	Effective date of 2014/15 but not yet adopted by the EU
IFRS 7 Financial Instruments: Disclosures – amendment: Offsetting financial assets and liabilities	December 2011	Effective date of 2013/14 but not yet adopted by the EU.

The Trust has not adopted early any new accounting standards, amendments or interpretations. Also the impact of these new standards will have on the Trust's financial statements in the year of initial application is not known at this stage.

1.20 Critical accounting estimates and judgements

Estimates and judgments are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Critical judgements in applying the entity's accounting policies
The Trust has made no judgements in applying the accounting policies other than those involving accounting estimates.

Critical accounting estimates and assumptions
The Trust makes estimates and assumptions concerning the future. The resulting accounting estimates will, by definition, seldom equal the related actual results. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are addressed below.

a) Depreciation
Depreciation is based on automatic calculation within the Trust's Fixed Asset Register which is calculated on a monthly basis throughout the year. When an asset is added to the Fixed Asset Register, it is given a useful economic life by the capital accountant, depending on the class of asset (i.e. vehicle, IT equipment etc). Buildings can be assigned a useful economic life of up to 50 years by the District Valuer as part of their valuations, depending on their state of repair and intended use. Useful economic life can be adjusted on the Fixed Asset Register if required. For example where an external valuation by the District Valuer report identifies a change in existing useful life or where management review identifies a requirement. This judgement will take into account past experience. Typically more expensive items have a longer lifespan which reduces the degree of sensitivity of charges.

b) Holiday Pay Accrual (see 1.3)

c) Revaluation
Indexation is used in the 2012/13 Accounts, based on indices provided to the Trust by the District Valuer. The District Valuer is an expert, therefore there is a high degree of reliance on the valuer's expertise.

d) Impairment
Impairments are based on the District Valuer's revaluation, on application of indices or on revaluation of individual assets e.g. when brought into operational use, or identified for disposal. Assumptions and judgments are that indices or valuations used are applicable to the Trust's circumstances. Additionally, management reviews would identify circumstances which may indicate where an impairment has occurred.

e) Partially completed spells
This is an estimate of income due in relation to patients admitted before the year end, but not discharged. It is calculated at spell level and is based on the actual number of unfinished days at the end of the financial year. If, due to the timing of the final accounts this figure is not available, then the PCT and the Foundation Trust agree a realistic estimate. The day of admission counts as an unfinished day.

The rates are regularly reviewed to ensure they are consistent with the proportion of actual income that is received. In calculating the proportion of actual income, the first two days of each spell will attract a disproportionate amount of the income in recognition that some costs are heavily weighted towards the beginning of the spell. For surgical specialties 45% of the income should be allocated to the first 2 days with the remaining 55% apportioned equally over the total length of stay, for medical specialties the figures are 25% and 75% respectively. The income is accrued and agreed with local PCTs.

In making this estimate the volume of unfinished activity is calculated using an average of the first 11 months of the year. The rates used are calculated at specialty level, the greatest level of detail that can be determined for unfinished activity, and reflect the distribution of costs through the spell in recognition of the early days of the spell generally being the most expensive.

1.21. Discontinued operations

Discontinued operations are defined as activities that genuinely cease without transferring to another entity, or which transfer to an entity outside the boundary of Whole of Government Accounts, such as the private or voluntary sectors. The trust reviews its activities to determine whether any activities meet the definition of a discontinued operation and is recognised in the accounting year in which the decision is made to discontinue the operation.

1.22 Changes in accounting policy

Foundation Trusts may change an accounting policy only where it is required by a new standard or interpretation (including any revisions to the FT ARM) or voluntarily only if it results in the Trust's financial statements providing reliable and more relevant information about transactions, events, conditions, or the financial position, financial performance or cash flows.

The changes arising from the introduction of a new standard or interpretation will be implemented in accordance with the specific transitional provisions, if any, of that standard or interpretation. Where no such specific transitional provisions exist, or where the Trust changes an accounting policy voluntarily, the changes will be applied retrospectively i.e. through a prior period adjustment. In accordance with IAS 8 any prior period adjustments will be effected by restating each element of equity (reserves) at the start of the prior year as if the accounting policy had always applied. There were no such changes this year.

2. Segmental analysis

The Trust has two reportable operating segments: Healthcare and Skills for Health.

The Healthcare segment delivers a range of healthcare services, predominantly to primary care trusts and to the South West Strategic Health Authority Specialist Commissioning Group. The Trust has a number of directorates, all of which operate in the healthcare segment. These directorates are used for internal management purposes and divide the healthcare and other services of the Trust into various medical and surgical specialties. While these are reported on internally for financial and activity purposes, they have been consolidated, as permitted by IFRS 8 paragraph 12, into Trust wide figures for these accounts.

Skills for Health is the sector skills council for the health sector, ensuring that a skilled, flexible and productive workforce is developed, to improve the quality of health and healthcare. All income is received from external customers, i.e. there is no intra segment trading. The significant majority of income for Healthcare is derived from primary care trusts. The significant majority of income for Skills for Heath is received from the Department of Health. The aggregate income, retained surplus and net assets for the two segments reconciles to the Trust's primary statements.

From 1 April 2013 the Trust will no longer host Skills for Health as it is transferring to a new company, Skills for Health Ltd, which is outside the 'Whole of Government Accounting'. Further details are given in Note 21.

	Healthcare £000	Skills for Health £000	Total £000
Year ended 31 March 2013			
Income	514,832	13,377	528,209
Retained surplus (deficit) for year	4,684	-	4,684
Net assets at 31 March 2013	325,561	-	325,561
Year ended 31 March 2012			
Income	506,827	26,912	533,739
Retained surplus (deficit) for year	8,980	5	8,985
Net assets at 31 March 2012	322,310	-	322,310

For 2012/13, University Hospitals Bristol Healthcare was operationally managed through five clinical divisions and a corporate service function. Expenditure and non-service agreement income is reported against these operational areas for management information purposes and reported to the Board. The out-turn position for 2012/13 was as follows:

	£000
Expenditure net of non-service agreement income	
Diagnostic and Therapies	(43,027)
Medicine	(61,198)
Specialised Services	(67,317)
Surgery, Head and Neck	(93,499)
Women's and Children's	(90,612)
Corporate Services	(84,999)
Total net expenditure	(440,652)
Service Agreement Income	445,336
Surplus for year	4,684

Notes to the Accounts

3. Income from activities

3.1 Income from activities

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Acute trusts:		
Elective income	77,657	80,037
Non elective income	98,782	105,619
Outpatient income	68,271	68,414
Accident and emergency income	11,920	11,224
Other NHS Clinical income *	147,235	121,557
All Trusts:		
Private patients	1,114	2,191
Other non-protected clinical income	8,730	9,369
TOTAL	**413,709**	**398,411**

*Significant items comprise:	£000	£000
Critical care bed days	33,914	32,962
'Payment by results' exclusions	16,838	14,324
Bone marrow transplants	7,071	6,907
Excess bed days	7,654	7,105
Radiotherapy Inpatient Treatments	7,175	7,531
Diagnostic imaging	1,328	2,297
Direct access	5,937	5,049
Regular day and night attenders	1,061	1,766
'At cost' contracts	5,576	4,847
Rehab	5,068	5,826
N.I.C.E. drugs and devices	21,299	17,360

3.2 Income by type

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Income from activities		
NHS Foundation Trusts	17	-
NHS Trusts	134	122
Strategic Health Authorities	1,154	13
Primary Care Trusts	401,957	384,839
Local Authorities	1	2
Non-NHS Private Patients	1,114	2,191
Non-NHS Overseas Patients	108	257
NHS Injury Scheme	215	803
Other **	9,009	10,184
Total	**413,709**	**398,411**

**Significant items comprise:	£000	£000
Territorial Bodies (Health Commission Wales)	8,435	8,968
Bodies outside of Whole of Government Accounts	208	145
National Commissioning Group	-	1,072
NHS Injury Scheme	366	-

3.3 Mandatory and non mandatory split of income from activities

The majority of the Trust's income should be derived from prior agreements, including contracts and agreed intentions to contract with service commissioners. This is described as mandatory income. Of the total income from activities, £402.5m (2012 £387.4m) is mandatory and £11.2m (2012 £11.0m) is non-mandatory.

3.4 Private patient cap

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required to be reported.

4. Other operating income

4.1 Other operating income

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Research and development	27,334	29,301
Education and training	39,043	39,821
Charitable and other contributions to expenditure	578	887
Donated Assets – PPE	1,044	1,479
Non-patient care services to other bodies	27,312	41,280
Reversal of impairment of property, plant, and equipment	-	2,416
Gain on disposal of assets held for sale	462	190
Salary Recharges	4,715	4,850
Other*	14,012	15,104
TOTAL	**114,500**	**135,328**

*The 'Other' category above comprises mainly:	£000	£000
Distinction awards granted from the Department of Health	3,451	3,595
Patient transport	628	421
Income generation	2,093	2,243
Rental income from operating leases	1,312	699
Catering	721	802
Staff accommodation rentals	328	288
Car Park income	786	802
Childcare Vouchers	1,407	1,410

The Trust's income includes an element that might be classified as 'commercial' and any profit might be subject to corporation tax in future years. This income totals £2.093m and comprises of Medical Equipment Management Organisation (£0.920m), Pharmacy income (£1.109m) and Estates (£0.064m).

Notes to the Accounts

4.2 Operating lease income

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Rents recognised as income	1,312	698
TOTAL	**1,312**	**698**

4.3 Future minimum lease payments due to the Trust

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Future minimum lease payments due		
- not later than one year	1,221	549
- later than one year but not later than five years	600	484
- later than five years	1,639	1,529
TOTAL	**3,460**	**2,562**

Notes to the Accounts

5. Operating expenses

5.1 Operating expenses

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Services from other NHS Foundation Trusts	585	479
Services from NHS Trusts	2,108	1,151
Services from other NHS bodies	5,073	96
Services from non NHS bodies	2,782	4,393
Purchase of healthcare from non NHS bodies	1,809	1,812
Executive directors costs	1,202	1,209
Non executive directors costs	168	168
Staff costs	311,772	310,498
Drug costs	59,271	53,069
Supplies and services:		
- Clinical	39,427	41,562
- General	6,767	6,934
Establishment	4,672	4,961
Transport	368	386
Premises	15,143	15,763
Bad debts	(1,508)	2,475
Depreciation of property plant and equipment	17,848	17,304
Amortisation of intangible assets	881	803
Impairment of property plant and equipment	1,086	1,356
Auditor's remuneration;		
- statutory audit	50	63
- regulatory reporting	8	7
- other non-audit services	309	-
Research and innovation hosting	14,364	15,355
Clinical negligence	7,120	6,687
Loss on disposal of property, plant & equipment	559	108
Other*	21,774	29,074
TOTAL	**513,638**	**515,713**

*Other expenditure includes the following:	£000	£000
External contractors	933	1,971
Operating leases	5,834	1,146
Training, courses and conferences	4,094	5,616
Research costs	3,068	3,218
Redundancy costs	859	5,126
Liability re transfer of Skills for Health to successor body in 2012/13 (see note 21)	-	6,175
Pre-employment scheme	-	341
Childcare vouchers	1,207	1,301
Early retirement costs (NHSPA)	-	252

There is a limitation of £1 million liability in respect of audit services unless unable to be limited by law.

Notes to the Accounts

5.2 Operating leases

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Operating lease payments	5,834	1,146
	5,834	**1,146**

There are no non-cancellable operating leases for land and buildings. Future minimum lease payments due under other non-cancellable operating leases are as follows:

Future minimum lease payments	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Not later than one year	4,974	1,144
Later than one year but not later than five years	19,363	3,598
Later than five years	5,207	3,468
TOTAL	**29,544**	**8,210**

The Trust leases various equipment and buildings. The most significant is the South Bristol Community Hospital which the Trust has leased for a 5 year period from 1 April 2012 at an annual cost of £4,084k.

6. Staff costs and numbers

6.1 Staff costs:

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Salaries and wages	258,532	256,750
Social security costs	21,226	21,911
Employer contributions to NHS Pension Scheme	28,635	29,568
Termination benefits	859	5,378
Income in respect of salary recharges netted off	(2,177)	(2,291)
Agency contract staff	7,079	5,769
TOTAL	**314,154**	**317,085**

In 2012-13, the Trust made £133k (2012, £136k) contributions to the NHS Pension Scheme in respect of executive directors.

6.2 Average number of employees

	Year ended 31 March 2013 Number	Year ended 31 March 2012 Number
Medical and dental staff	999	983
Administration and estate staff	1,535	1,579
Healthcare assistant & other support staff	737	766
Nursing, midwifery & health visiting staff	2,510	2,598
Nursing, midwifery & health visiting learners	6	6
Scientific, therapeutic and technical staff	1,114	1,118
Bank and agency staff	377	362
TOTAL	**7,278**	**7,412**

Numbers are expressed as average whole time equivalents for the year.

6.3 Employee benefits

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

6.4 Management costs

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Management costs	17,480	18,281
Income	528,209	533,739
Percentage of income	3.3%	3.4%

Analysis	**2012/13**			**2011/12**		
	University Hospitals Bristol	Skills for Health	Totals	University Hospitals Bristol	Skills for Health	Totals
	£'000	£'000	£'000	£'000	£'000	£'000
Management costs	16,830	650	17,480	17,009	1,272	18,281
Income	514,832	13,377	528,209	506,827	26,912	533,739
Percentage of income	3.3	4.9	3.3	3.4	4.7	3.4

Management costs are as defined as those on the Management Costs Website: www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en.

6.5 Retirements due to ill health

During the year ended 31 March 2013 there were 5 (2012: 11) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill-health retirements will be £0.147m (2012: £0.890m). The cost of these ill health retirements will be borne by the NHS Business Services Authority – Pensions Division.

6.6 Staff exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	5 (11)	6 (31)	11 (42)
£10,000 - £25,000	3 (10)	10 (23)	13 (33)
£25,001 - £50,000	2 (8)	5 (21)	7 (29)
£50,001 - £100,000	4 (2)	1 (14)	5 (16)
£100,001 - £150,000	0 (3)	0 (8)	0 (11)
£150,001 - £200,000	0 (1)	0 (3)	0 (4)
>£200,001		0 (1)	0 (1)
Total number of exit packages by type	**14 (35)**	**22 (101)**	**36 (136)**
Total resources cost	**£431,643 (£1,218,138)**	**£427,462 (£3,908,187)**	**£859,105 (£5,126,325)**

Analysis	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Skills for Health			
Total number of exit packages by type	7 (28)	0 (47)	7 (75)
Total resources cost	£229,457 (£949,487)	- (2,279,099)	£229,457 (£3,228,586)
University Hospitals Bristol Healthcare			
Total number of exit packages by type	7 (7)	22 (55)	29 (61)
Total resource cost	£202,186 (£268,651)	£427,462 (£1,629,088)	£629,648 (£1,897,739)

The table above shows the number of staff exit packages and costs (termination benefits). Termination benefits are payable when employment is terminated by the Trust before the normal retirement date, or whenever an employee accepts voluntary redundancy in exchange for these benefits. The Trust recognises termination benefits when it is demonstrably committed to either: terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal; or providing termination benefits as a result of an offer made to encourage voluntary redundancy.

Comparative figures for 2011/12 are shown in brackets.

6.7 Hutton Review of Fair Pay

The Trust is required to disclose the relationship between the remuneration of the highest-paid director in the organisation and the median remuneration of the organisation's workforce.

The annualised banded remuneration of the highest-paid director in the financial year 2012/13 was £195k-£199k (2011/12, £195k-£199k). This was 7.0 times (2011/12, 7.1) the median remuneration of the workforce, which was £28,209 (2011/12, £27,839). In 2012/13, nil (2011/12, 1) employee received remuneration in excess of the highest-paid director. Remuneration ranged from £14.2k to £194.2k.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The figures exclude bank and agency staff.

	2012/13	2011/12
Band of highest paid Directors total remuneration (£'000)	195-199	195-199
Median Total remuneration (£)	28,209	27,839
Ratio	7.0	7.1

Notes to the Accounts

6.8 Director's remuneration: Salaries and allowances	12 Months to 31 March 2013 (bands of £5,000) £000	12 Months to 31 March 2012 (bands of £5,000) £000
Chair		
John Savage	50-54	50-54
Executive Directors		
Robert Woolley, Chief Executive	170-174	170-174
Paul Mapson, Director of Finance	140-144	135-139
Steve Aumayer, Director of Workforce and Organisational Development (until 30 April 2012)	5-9	105-109
Claire Buchanan, Acting Director of Workforce and Organisational Development (from 1 May 2012)	90-94	n/a
Alison Moon, Chief Nurse and Director of Governance (until 17 March 2013)	110-114	110-114
Helen Morgan, Acting Chief Nurse (from 18 March 2013)	0-4	n/a
Deborah Lee, Director of Strategic Development (and Deputy Chief Executive from 23 January 2013)	110-114	110-114
Sean O'Kelly, Medical Director (from 18 April 2011)	195-199	184-189
James Rimmer, Chief Operating Officer (from 4 July 2011)	120-124	84-89
Jane Luker, Acting Medical Director (from 1 October 2010 until 30 April 2011)	n/a	4-9
Jim O'Connell, Acting Chief Operating Officer, on secondment (from 21 February 2011 to 8 July 2011)	n/a	35-39
Non-executive Directors		
Emma Woollett	15-19	15-19
Kelvin Blake	10-14	10-14
Iain Fairbairn	15-19	15-19
Lisa Gardner	15-19	15-19
Selby Knox (until 31 May 2012)	0-4	10-14
Paul May	15-19	15-19
John Moore	15-19	15-19
Guy Orpen (from 1 June 2012)	10-14	n/a

No Directors received any other remuneration or benefits in kind during 2012/13. No Directors received any exit packages during either year. Aggregate salary cost for 2012/13 was £1,108k (2011/12, £1,113k). The aggregate employer contribution to the pension scheme was £133k (2011/12, £136k). The total number of Directors to whom benefits are accruing under defined benefit schemes is 7 (2011/12, 7).

Notes to the Accounts

Pension benefits for the year ended 31 March 2013

Name and title	Real increase in pension at age 60 at 31 March 2013	Real increase in lump sum at age 60 at 31 March 2013	Total accrued pension at age 60 at 31 March 2013	Lump sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real Increase in Cash Equivalent Transfer Value	Employer funded contribution to growth in CETV
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Robert Woolley, Chief Executive	2.5-4.9	10-12.4	40-44	130-134	858	724	114	64
Paul Mapson, Director of Finance	2.5-4.9	7.5-9.9	60-64	180-184	1,334	1,206	94	53
Steve Aumayer, Director of Workforce and Organisational Development (until 30 April 2012)	(0-2.4)	n/a	5-9	n/a	72	69	-	-
Claire Buchanan, Acting Director of Workforce and Organisational Development (from 1 May 2012)	2.5-4.9	12.5-14.9	20-24	70-74	405	306	83	49
Alison Moon, Chief Nurse and Director of Governance (until 17 March 2013)	(0-2.4)	(0-2.4)	35-39	110-114	682	646	18	10
Helen Morgan, Acting Chief Nurse (from 18 March 2013)	0-2.4	0-2.4	25-29	70-79	484	427	2	1
Deborah Lee, Director of Strategic Development (and Deputy Chief Executive from 23 January 2013)	0-2.4	2.5-4.9	15-19	55-59	345	303	34	19
Sean O'Kelly, Medical Director (from 18 April 2011)	0-2.4	5-7.4	50-54	160-164	1,040	942	72	40
James Rimmer, Chief Operating Officer (from 4 July 2011)	2.5-4.9	10-12.4	35-39	105-109	582	497	70	39

This table includes details for the Directors who held office at any time in 2012/13.

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

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

Notes to the Accounts

Pension benefits for the year ended 31 March 2012

Name and title	Real increase in pension at age 60 at 31 March 2012	Real increase in lump sum at age 60 at 31 March 2012	Total accrued pension at age 60 at 31 March 2012	Lump sum at age 60 related to accrued pension at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	Real Increase in Cash Equivalent Transfer Value	Employer funded contribution to growth in CETV
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Robert Woolley, Chief Executive	2.5-4.9	10-12.4	35-39	115-119	724	608	95	66
Paul Mapson, Director of Finance	(0-2.4)	(0-2.4)	55-59	170-174	1,206	1,117	51	35
Steve Aumayer, Director of Workforce and Organisational Development	0-2.4	n/a	5-9	n/a	69	41	27	19
Alison Moon, Chief Nurse and Director of Governance	0-2.4	0-2.4	35-39	110-114	646	552	75	52
Deborah Lee, Director of Strategic Development (substantive from 4 February 2011)	0-2.4	2.5-4.9	15-19	50-54	303	243	51	36
Sean O'Kelly, Medical Director (from 18 April 2011)	0-2.4	5-7.4	50-54	150-154	942	796	113	79
Jane Luker, Acting Medical Director (from 1 October 2010 until 30 April 2011)	0-2.4	0-2.4	55-59	165-169	864	896	(5)	(4)
James Rimmer, Chief Operating Officer (from 4 July 2011)	2.5-4.9	10-12.4	30-34	90-94	497	342	107	75
Jim O'Connell, Acting Chief Operating Officer (from 21 February 2011 to 8 July 2011)	(0-2.4)	(0-2.4)	35-39	105-109	623	555	13	9

This table includes details for the Directors who held office at any time in 2011/12.

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

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

Notes to the Accounts

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. In some cases, the real increase in the CETVs show a significant difference, when comparing this year's values with last year's. This difference is due to a change in the factors used to calculate CETVs, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for 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 due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme, or arrangement) and uses common market valuation factors for the start and end of the year.

Robert Woolley, Chief Executive

7. Better Payment Practice Code

7.1 Measure of compliance

	Year ended 31 March 2013		Year ended 31 March 2012	
	Number	Value £000	Number	Value £000
Total Non NHS trade invoices paid in the year	159,332	195,884	153,674	169,618
Total Non NHS trade invoices paid within target	138,690	175,413	141,275	154,629
Percentage of Non NHS trade invoices paid within target	87.0%	89.5%	91.9%	91.1%
Total NHS trade invoices paid in the year	4,561	60,075	4,828	56,007
Total NHS trade invoices paid within target	3,735	54,828	4,199	52,412
Percentage of NHS trade invoices paid within target	81.9%	91.3%	87.0%	93.6%

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 £nil (2012: £nil) arising from claims made under this legislation. No other compensation was paid to cover debt recovery cost under this legislation.

8. Loss on disposal of property, plant and equipment

The net loss on the disposal of property, plant and equipment of £0.097m (2012: net surplus of £0.081m) related exclusively to non-protected assets. There were no protected assets disposed of during the year.

9. Finance

9.1 Finance income

	Year ended 31 March 2013	Year ended 31 March 2012
Interest on loans and receivables	222	361
TOTAL	**222**	**361**

9.2 Finance costs

	Year ended 31 March 2013	Year ended 31 March 2012
Bank charges	-	1
Loan interest	44	-
Finance leases	387	410
TOTAL	**431**	**411**

9.3 Impairments

Net impairment of property plant and equipment, intangibles and assets held for sale	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Loss or damage from normal operations	-	1,356
Changes in market price	2,919	2,088
Reversal of impairments	-	(2,187)
TOTAL	**2,919**	**5,270**

Impairments occur when the carrying amounts of property, plant and equipment are reviewed by the District Valuer by application of indices or formal valuation. This review is undertaken annually to ensure assets are reflected at fair value in the accounts, when they are brought into use or when they are identified as assets held for sale. Of the total impairments arising during the year £1.086m (2012: £1.356m) was charged to operating expenses within the Statement of Comprehensive Income. The impairment losses relate to the following:

	Land £000	Buildings £000	Dwellings £000	Total £000
Indexation of property, plant and equipment	-	836	-	836
Assets held for sale – Kingsdown site	164	40	46	250
Total	**164**	**876**	**46**	**1,086**

10. Intangible assets

	Software licences £000	Other £000	Assets under construction £000	Total £000
Cost at 1 April 2012	4,894	266	2,072	7,232
Additions	304	-	2,534	2,838
Reclassifications from PPE	95	-	285	380
Reclassifications within intangibles	224	-	(224)	-
Revaluations	-	(58)	-	(58)
Disposals	(25)	(43)	-	(68)
Cost at 31 March 2013	**5,492**	**165**	**4,667**	**10,324**
Accumulated amortisation at 1 April 2012	2,667	61	-	2,728
Charged during the year	881	-	-	881
Disposals	(25)	-	-	(25)
Accumulated amortisation at 31 March 2013	**3,523**	**61**	**-**	**3,584**
Net book value at 31 March 2012				
Purchased	2,227	205	2,072	4,504
Total net book value at 31 March 2012	2,227	205	2,072	4,504
Net book value at 31 March 2013				
Purchased	1,969	104	4,667	6,740
Total net book value at 31 March 2013	**1,969**	**104**	**4,667**	**6,740**

Other intangibles assets are emission allowances granted under the EU Emissions Trading Scheme. These allowances are held at fair value.

	Software licences £000	Other £000	Assets under construction £000	Total £000
Cost at 1 April 2011	4,445	563	-	5,008
Additions	163	111	2,358	2,632
Reclassifications	286	-	(286)	-
Revaluations	-	(342)	-	(342)
Disposals	-	(66)	-	(66)
Cost at 31 March 2012	**4,894**	**266**	**2,072**	**7,232**
Accumulated amortisation at 1 April 2011	1,864	61	-	1,925
Charged during the year	803	-	-	803
Accumulated amortisation at 31 March 2012	**2,667**	**61**	**-**	**2,728**
Net book value at 31 March 2011				
Purchased	2,581	502	-	3,083
Restated net book value at 31 March 2012	2,581	502		3,083
Net book value at 31 March 2012				
Purchased	2,227	205	2,072	4,504
Total net book value at 31 March 2012	**2,227**	**205**	**2,072**	**4,504**

11. Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2012	**26,317**	**230,278**	**4,711**	**41,380**	**72,681**	**607**	**17,405**	**2,243**	**395,622**
Additions – purchased	-	247	-	49,148	4,142	116	1,229	-	**54,882**
Additions – donated	-	-	-	-	222	-	-	-	**222**
Impairments		(1,833)							**(1,833)**
Reclassifications to intangibles	-	-	-	(380)	-	-	-	-	**(380)**
Reclassifications within PPE	-	7,088	-	(13,917)	6,389	5	391	44	**-**
Transferred to assets held for sale	(248)	(151)	(175)	-	-	-	-	-	**(574)**
Revaluations	283	(9,701)	73	-	-	-	-	-	**(9,345)**
Disposals	-	-	-	(570)	(9,968)	(19)	(1,505)	(1,035)	**(13,097)**
Cost or Valuation at 31 March 2013	**26,352**	**225,928**	**4,609**	**75,661**	**73,466**	**709**	**17,520**	**1,252**	**425,497**
Accumulated Depreciation at 1 April 2012	**713**	**23,768**	**1,371**	**-**	**46,181**	**292**	**10,026**	**1,820**	**84,171**
Charged during the year	-	9,296	144	-	6,344	91	1,822	151	**17,848**
Impairments charged to operating expenses	-	836	-	-	-	-	-	-	**836**
Revaluations	-	(9,769)	(6)	-	-	-	-	-	**(9,775)**
Disposals	-	-	-	-	(9,434)	(18)	(1,481)	(1,035)	**(11,968)**
At 31 March 2013	**713**	**24,131**	**1,509**	**-**	**43,091**	**365**	**10,367**	**936**	**81,112**
Net book value at 31 March 2013									
Purchased	25,639	185,912	3,100	75,661	28,674	344	7,126	316	**326,772**
Donated	-	10,464	-	-	1,701	-	27	-	**12,192**
Finance leases	-	5,421	-	-	-	-	-	-	**5,421**
Total at 31 March 2013	**25,639**	**201,797**	**3,100**	**75,661**	**30,375**	**344**	**7,153**	**316**	**344,385**
Net book value at 31 March 2012									
Purchased	25,604	189,938	3,340	41,380	24,349	315	7,347	422	**292,695**
Donated	-	10,877	-	-	2,151	-	32	1	**13,061**
Finance leases	-	5,695	-	-	-	-	-	-	**5,695**
Total at 31 March 2012	**25,604**	**206,510**	**3,340**	**41,380**	**26,500**	**315**	**7,379**	**423**	**311,451**

Impairments charged to operating costs are included within accumulated depreciation, with those charged to reserves reducing asset cost.

The Trust's property, plant and equipment was last valued on 1st April 2009 on a depreciated replacement cost, Modern Equivalent Asset Valuation (MEA) basis by the District Valuer. For 2012/13 the value of these assets has been estimated by using valuation indices for the year provided by the District Valuer. This has resulted in a net decrease in the value of Trust assets by £2.669m.

Land, buildings and dwellings transferred to and from property, plant and equipment to assets held for sale net to £574k. See note 14.2 for further details regarding assets held for sale.

Depreciation expenses of £17.848m (2011/12: £17.304m) have been charged to operating expenses (note 5) within the Statement of Comprehensive Income.

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation at 1 April 2011	**29,492**	**236,977**	**5,279**	**16,647**	**71,724**	**503**	**15,506**	**2,233**	**378,361**
Additions – purchased	-	525	-	36,279	1,284	104	1,173	-	**39,365**
Additions – donated	-	-	-	-	678	-	28	-	**706**
Impairments charged to Revaluation Reserve	(567)	(1,521)	-	-	-	-	-	-	**(2,088)**
Reclassifications	-	9,187	18	(11,546)	1,610	-	721	10	**-**
Transferred to assets held for sale	(2,772)	(4,124)	(586)						**(7,482)**
Revaluations	164	(10,766)	-	-	-	-	-	-	**(10,602)**
Disposals	-	-	-	-	(2,615)	-	(23)	-	**(2,638)**
Cost or Valuation at 31 March 2012	**26,317**	**230,278**	**4,711**	**41,380**	**72,681**	**607**	**17,405**	**2,243**	**395,622**
Accumulated Depreciation at 1 April 2011	**713**	**31,963**	**987**	**-**	**42,401**	**217**	**8,250**	**1,623**	**86,154**
Charged during the year	-	8,765	180	-	6,288	75	1,799	197	**17,304**
Impairments charged to Operating expenses	-	1,152	204	-	-	-	-	-	**1,356**
Reversal of Impairments charged to Operating expenses	-	(2,187)	-	-	-	-	-	-	**(2,187)**
Revaluations	-	(15,926)	-	-	-	-	-	-	**(15,926)**
Disposals	-	-	-	-	(2,507)	-	(23)	-	**(2,530)**
At 31 March 2012	**713**	**23,768**	**1,371**	**-**	**46,181**	**292**	**10,026**	**1,820**	**84,171**
Net book value at 31 March 2012									
Purchased	25,604	189,938	3,340	41,380	24,349	315	7,347	422	**292,695**
Donated	-	10,877	-	-	2,151	-	32	1	**13,061**
Finance leases	-	5,695	-	-	-	-	-	-	**5,695**
Total at 31 March 2012	**25,604**	**206,510**	**3,340**	**41,380**	**26,500**	**315**	**7,379**	**423**	**311,451**
Net book value at 31 March 2011									
Purchased	28,779	188,434	4,292	16,647	27,013	286	7,250	582	**273,283**
Donated	-	10,640	-	-	2,310	-	6	28	**12,984**
Finance leases	-	5,940	-	-	-	-	-	-	**5,940**
Total at 31 March 2011	28,779	**205,014**	**4,292**	**16,647**	**29,323**	**286**	**7,256**	**610**	**292,207**

11.1 Net book value of assets held under finance leases

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

Buildings excluding dwellings	**Year ended 31 March 2013 £000**	**Year ended 31March 2012 £000**
Cost or valuation at 1 April	6,356	6,270
Reclassifications	61	86
Cost or valuation at 31 March	**6,417**	**6,356**
Accumulated depreciation at 1 April	661	330
Provided during the year	335	331
Accumulated depreciation at 31 March	**996**	**661**
Net book value at 31 March	**5,421**	**5,695**

11.2 Net book value of land building and dwellings

The net book value of land, buildings and dwellings comprises:

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Freehold	225,115	229,759
Long leasehold	5,421	5,695
TOTAL	230,536	235,454

11.3 Protected and non-protected assets

Details of the values of property, plant and equipment which are protected/non-protected are as follows:

	Total	Land	Buildings	Dwellings	AUC*	P&M*	Transport	IT*	F&F*
Protected (£000)	198,751	20,740	178,011	-	-	-	-	-	-
Non-protected (£000)	145,634	4,899	23,786	3,100	75,661	30,375	344	7,153	316
Total at 31 March 2013	**344,385**	**25,639**	**201,797**	**3,100**	**75,661**	**30,375**	**344**	**7,153**	**316**

	Total	Land	Buildings	Dwellings	AUC*	P&M*	Transport	IT*	F&F*
Protected (£000)	203,168	20,365	182,803	-	-	-	-	-	-
Non-protected (£000)	108,283	5,239	23,707	3,340	41,380	26,500	315	7,379	423
Total at 31 March 2012	**311,451**	**25,604**	**206,510**	**3,340**	**41,380**	**26,500**	**315**	**7,379**	**423**

*Key:

AUC: Assets under construction
P&M: Plant and machinery
IT: Information technology
F&F: Furniture and fittings

12 Inventories

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Raw materials and consumables	8,816	7,118
TOTAL	**8,816**	**7,118**
Inventories recognised as an expense in the year (2012 restated)	80,648	77,407
Impairments	-	-
TOTAL	**80,648**	**77,407**

13. Trade and other receivables

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Current:		
NHS receivables	13,091	12,226
Other receivables (restated 2012)	8,636	8,631
Provision for impaired receivables	(3,987)	(5,639)
PDC Dividend receivable (restated 2012)	-	66
Prepayments	2,326	2,006
Accrued income	590	561
Total current:	**20,656**	**17,851**

2012 restatement: PDC dividend receivable reclassified from other receivables

Non-current:		
Other receivables	-	-
Provision for impaired receivables	-	-
Total non-current:	**-**	**-**

Provision for irrecoverable debts (impairment of receivables):	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Balance at start of year	**5,639**	**3,568**
New Provisions	144	3,081
Utilised in year	(144)	(404)
Reversed in year	(1,652)	(606)
Balance at end of year	**3,987**	**5,639**

Ageing of impaired receivables	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
By up to three months	7,246	8,301
By three to six months	1,662	1,693
By more than six months	3,011	3,844
TOTAL	**11,919**	**13,838**

Ageing of non-impaired receivables past their due date	£000	£000
By up to three months	124	127
By three to six months	-	-
By more than six months	-	-
Total	**124**	**127**

14. Other assets

14.1 Other financial assets

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Other current assets	104	146
TOTAL	**104**	**146**

This relates to a section 106 deposit paid to Bristol City Council.

14.2 Assets held for sale

	PPE land	PPE buildings excl dwellings	Dwellings	Total
	£000	£000	£000	£000
Net book value at 1 April 2012	2,772	4,124	586	7,482
Assets classified as available for sale in the year	248	151	175	574
Assets sold in year	(2,396)	(4,124)	(586)	(7,106)
Impairment of assets held for sale	(164)	(40)	(46)	(250)
Net book value at 31 March 2013	**460**	**111**	**129**	**700**

The assets held for sale relate to Kingsdown Garage and 6 Kingsdown Parade following the approval of the Finance Committee.

	PPE land	PPE buildings excl dwellings	Dwellings	Total
	£000	£000	£000	£000
Net book value at 1 April 2011	610	-	860	1,470
Assets classified as available for sale in the year	2,772	4,124	586	7,482
Assets sold in year	(610)	-	(860)	(1,470)
Net book value at 31 March 2012	**2,772**	**4,124**	**586**	**7,482**

15. Trade and other payables

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Current amounts:		
NHS payables	2,789	3,301
Capital payables	1,517	4,698
Tax and social security	6,383	6,508
Other payables	15,377	10,184
Related parties	3,828	3,782
PDC dividend payable	47	-
Accruals	26,676	21,758
TOTAL	**56,617**	**50,231**

Non-current amounts:
There are no non-current trade and other payables.

Outstanding pension contributions of £3.828m (2012: £3.559m) to the NHS Pension scheme and £3.443m for PAYE (2012: £3.540m) and National Insurance £2.940m (2012: £2.968m) are included in Trade and Other payables.

16. Other liabilities

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Current amounts:		
Deferred income	2,509	4,133
Deferred government grants	273	316
TOTAL	**2,782**	**4,449**

17. Borrowings

17.1 Current borrowings:

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Loans from Foundation Trust Financing Facility	260	-
Finance lease obligations	212	188
TOTAL	**472**	**188**

17.2 Non-current borrowings:

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Loans from Foundation Trust Financing Facility	24,690	-
Finance lease obligations	5,741	5,953
TOTAL	**30,431**	**5,953**

During the year the Trust has taken out an unsecured loan of £24.950m from the Foundation Trust Financing Facility. This comprises of £4.950m at an interest rate of 1.73% over 19 years and £20.000m at an interest rate of 3.71% over 16.5 years.

17.3 Finance lease obligations

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Payable:		
Not later than one year	575	575
Later than one year but not later than five years	2,300	2,300
Later than five years	5,990	6,564
Sub-total	**8,865**	**9,439**
Less finance charges allocated to future years	(2,912)	(3,298)
Net obligation	**5,953**	**6,141**

The finance lease arrangement relates to the Education Centre which will expire in June 2028.

17.4 Net finance lease obligations

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Payable:		
Not later than one year	212	188
Later than one year but not later than five years	1,091	994
Later than five years	4,650	4,959
Net obligation	**5,953**	**6,141**

17.5 Finance Lease commitments

There are no finance lease commitments at 31 March 2013 (31 March 2012 Nil.)

18. Provisions for liabilities and charges

	Legal Claims £000	Other £000	Total £000
At 1 April 2012	475	6,427	6,902
Arising during the year	109	43	152
Utilised during the year	(122)	(6,248)	(6,370)
Reversed unused	(34)	-	(34)
Unwinding of discount	6	-	6
At 31 March 2013	**434**	**222**	**656**
At 1 April 2011	499	541	1,040
Arising during the year	170	6,349	6,519
Utilised during the year	(145)	(355)	(500)
Reversed unused	(57)	(108)	(165)
Unwinding of discount	8	-	8
At 31 March 2012	**475**	**6,427**	**6,902**

The expected timing of any resulting outflows of economic benefits, analysed between 'not later than one year', between 'one and five years' and 'later than five years' is set out in the table below.

Timing of economic outflow	Legal Claims £000	Other £000	Total £000
Not later than one year	223	222	445
Later than one year but not later than five years	108	-	108
Later than five years	103	-	103
Total	**434**	**222**	**656**

18.1 Legal claims

The provision for legal claims at 31 March 2013 includes the following:

a) Provision for staff injuries

A staff injuries provision of £0.240m, (2012: £0.263m) in respect of staff injury allowances payable to the NHS Business Services Authority (Pensions division).

b) Provision for liabilities to third parties

A provisions for liabilities to third parties of £0.194m (2012: £0.213m) representing the excess payable by the Trust, under the NHS Litigation Authority (NHSLA) Liabilities to Third Parties Scheme.

18.2 Other provisions

Other provisions at 31 March 2013 of £0.222m (2012: £6.427m) relate to the charge for carbon emissions under the EU Emissions Scheme. The EU Emission provision is stated at market value.
The liability for the transfer of Skills for Health which accounted for £6.175m of this balance at 31 March 2012 has been utilised during the year.

18.3 Clinical negligence

The NHS Litigation Authority has included a £55.394m provision in its accounts (2012: £49.510m) in respect of clinical negligence liabilities of the Trust.

19. Cash and cash equivalents

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Cash with the government banking service	34,881	40,905
Commercial cash at bank and in hand	237	576
Total cash and cash equivalents	**35,118**	**41,481**

20. Capital commitments

Commitments under capital expenditure contracts at 31 March 2013 were £68.272m (2012:£92m), comprising:
- Bristol Royal Infirmary Redevelopment - £40.432m
- Centralisation of Specialist Paediatrics - £19.629m
- Welcome Centre - £1.361m
- BHOC Redevelopment - £6.850m

21. Post-Statement of Financial Position (SoFP) Events

Skills for Health hosting arrangement
Skills for Health agreed with the Trust to cease the current hosting arrangement of the Sector Skills Council by UHBFT with effect from the close of business on 31 March 2013. All staff attributable to Skills for Health TUPE transferred to a separate legal entity under their existing terms and conditions including accrued redundancy and superannuation rights under the NHS Pension Scheme.
The cessation of the hosting arrangement is financially neutral to UH Bristol NHS Foundation Trust as the funding for the costs of Skills for Health is ring-fenced and separate to that for the provision of healthcare services – see note 2.

22. Contingencies

22.1 Contingent assets

The Trust has no contingent assets at 31 March 2013 (2012: £nil).

22.2 Contingent liabilities

Contingent liabilities at 31 March 2013 comprise:

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. There have been no claims made to the Trust.

Other contingencies

The Trust has contingent liabilities in relation to any new claims that may arise from past events under the NHS Litigation Authority's "Liability to Third Parties" and "Property Expenses" schemes. The contingent liability will be limited to the Trust's excess for each new claim.

23. Prudential Borrowing Code

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

a) the maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's compliance framework determines one of the ratios and therefore can impact on the long term borrowing limit.
b) the amount of any working capital facility approved by Monitor.

Further information on the Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

At the 31 March 2013 the Trust's Prudential Borrowing Limit was £189.9m (2012: £140.0m). This represents maximum long term borrowing of £152.4m (2012: £102.5m) and an approved working capital facility of £37.5m (2012: £37.5m). At 31 March 2013 the Trust had £30.903m (2012: £6.141m) outstanding for long term borrowings, and had utilised £nil (2012: £nil) funds from its working capital facility. During the year ending 31 March 2013 the Trust took out new loans totalling £24.950m from the Foundation Trust Financing Facility to finance its strategic capital development programme.

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

Financial ratio	Actual ratios year ended 31 March 2013	Approved PBL ratios year ended 31 March 2013	Actual ratios year ended 31 March 2012	Approved PBL ratios year ended 31 March 2012
Minimum dividend cover (multiple)	3.4x	>1x	3.9x	>1x
Minimum interest cover (multiple)	77x	>3x	83x	>3x
Minimum debt service cover (multiple)	52x	>2x	59x	>2x
Maximum debt service to revenue	0.1%	<2.5%	0.1%	<2.5%

At 31 March 2013 the Trust was performing within all of the approved Prudential Borrowing Limit ratios.

24. Related party transactions

The University Hospitals Bristol NHS Foundation Trust is a Public Benefit Corporation authorised under the National Health Service Act 2006.

During the year none of the Board members or members of the key management staff has undertaken any material transactions with the University Hospitals Bristol NHS Foundation Trust. With regards to related parties, one Trustee of the Above and Beyond Charity is a Trust Board member, one Trust Board member is a Pro-vice Chancellor of the University of Bristol and another is connected with St Peter's Hospice (Bristol).
The income and expenditure, or outstanding balances as at year end for these bodies are listed below:

Figures stated in £m	31 March 2013		31 March 2012		2012/13		2011/12	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
University of Bristol	0.14	0.31	0.45	0.32	1.97	7.78	2.84	7.28
St Peter's Hospice (Bristol)	0.03	-	0.4	-	0.13	-	0.14	-
Above and Beyond Charity	See notes re charitable funds below							

Notes to the Accounts

All bodies within the scope of Whole of Government Accounting are related parties to the Trust. This includes the Department of Health and its associated departments. Entities where income or expenditure, or outstanding balances as at 31 March 2013, exceeded £500,000 are listed below.

Figures stated in £m	31 March 2013		31 March 2012		2012/13		2011/12	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Avon and Wiltshire Mental Health Partnership NHS Trust					0.72	0.61	0.93	0.55
NHS Bath and North East Somerset					13.50		13.13	
NHS Birmingham East and North					0.99		0.95	
NHS Bristol	4.58		4.89		269.11	6.52	256.88	
Central Manchester University Hospitals NHS FT					0.50		0.92	
NHS Cornwall and the Isles of Scilly					1.21		0.92	
NHS Devon					1.90		1.91	
NHS Dorset					0.94		0.76	
East of England SHA							0.95	
NHS Gloucestershire			0.53		11.16		10.56	
Great Western Hospitals NHS FT						0.68		0.71
Gloucestershire Hospitals NHS FT						1.48		1.55
Dorset County Hospitals NHS FT						0.54		
NHS Hampshire					0.76		0.88	
Health Protection Agency						2.83		2.81
NHS Blood and Transplant						5.62		6.89
NHS Litigation authority						7.13		6.71
NHS Business Services Authority						0.57		
North Bristol NHS Trust	1.33	1.78	1.13	1.51	4.62	7.72	4.88	7.74
NHS North Somerset	1.43		0.55		48.32		45.80	
London SHA					1.56		1.27	
North West SHA					4.22		6.96	
Liverpool Community Health NHS Trust								0.51
Poole Hospital NHS FT						0.97		1.09
Bristol City Council						2.07		1.82
Royal Bournemouth & Christchurch Hospitals NHS FT						1.32		1.22
Royal National Hospital for Rheumatic Diseases NHS FT								0.53
Royal United Hospital Bath NHS Trust						1.27		1.32
Royal Devon and Exeter Foundation Trust						1.11		0.55
NHS Somerset					15.67		15.57	
NHS South Gloucestershire	0.58				35.31		34.04	
Salisbury NHS FT						0.70		0.63
South West SHA					38.74		39.34	
South Gloucestershire Council								0.60
NHS Swindon					1.44		2.26	
Taunton and Somerset NHS Foundation Trust						1.10		1.24
Welsh Assembly			0.78		8.16		8.77	
Weston Area Health NHS Trust					1.56	0.85	1.51	1.09
Yeovil District Hospitals NHS FT						0.72		0.79
NHS South East Essex					0.52			
NHS Wiltshire					8.26		7.99	
National Insurance Fund		2.94				21.26		21.31
UK Commission for Employment & Skills							2.181	
HM Revenue and Customs	1.32	3.44					0.80	
Department of Health	1.08		1.13		29.20	2.59	35.50	0.65
NHS Pension Scheme		3.83		3.80		28.72		30.84

In addition the Trust pays HM Revenue and Customs tax and national insurance on behalf of employees which totalled £55.82m in 2012/13 (£58.00m in 2011/12). The Trust also pays the NHS Pension Scheme for employees' contributions which totalled £17.20m in 2012/13 (£14.73m in 2011/12). Employers' contributions to the pension scheme are included in the above table. The comparator figures for 2011/12 have been restated to reflect that we now include employer's National Insurance and pension contributions in the above table.

The Trust has also received income from a number of charitable funds, including Above and Beyond and the Grand Appeal. Transactions in 2012/13 relating to Above and Beyond were receipts of donated assets (£92k), income (£811k) and expenditure (£446k). Transactions relating to the Grand Appeal were receipts of donated assets (£332k), income (£36k) and expenditure (£5k).

25. Private Finance Transactions

At 31 March 2013 the Trust has no PFI schemes (2012: none).

26. Financial Instruments

26.1 Financial instruments by currency

The Trust has negligible foreign currency transactions or balances.

26.2 Financial instruments by category

Financial assets per Statement of Financial Position	31 March 2013 £000	31 March 2012 £000
Loans and receivables:		
NHS trade and other receivables	12,726	10,511
Other trade and other receivables	4,286	4,867
Other financial assets	104	146
Cash at bank and in hand	35,118	41,481
Total	**52,234**	**57,005**

Loans and receivables are held at amortised cost.
Provision for NHS receivables is included within other trade receivables.

Financial liabilities per Statement of Financial Position	31 March 2013 £000	31 March 2012 £000
NHS trade and other payables	3,597	3,786
Non NHS trade and other payables	46,590	46,112
Borrowings	24,950	-
Finance lease obligations	4,501	4,537
Total at 31 March	**79,638**	**54,435**

Financial liabilities are held at amortised cost.

26.3 Fair values

At 31 March 2013 and 31 March 2012 there was no significant difference between the fair value and the carrying value of the Trust's financial assets and liabilities which are all classified as current assets.

26.4 Maturity of financial assets

At 31 March 2013 all financial assets were due within one year.

26.5 Maturity of financial liabilities

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Less than one year	50,660	50,087
In more than one year but not more than two years	489	205
In more than two years but not more than five years	5,186	704
In more than five years	23,303	3,439
Total	**79,638**	**54,435**

27. Third Party Assets

At 31 March 2013 the Trust held £nil (2012: £nil) cash at bank and in hand which relates to moneys held by the Trust on behalf of patients.

28. Intra-Government Balances

	Receivables: current £000	Payables: current £000	Borrowing: current £000	Borrowing: non-current £000
At 31 March 2013				
Foundation Trusts and NHS Trusts	2,577	2,789	260	24,690
Department of Health	1,083	79	-	-
Strategic Health Authority	-	64	-	-
Primary Care Trusts	9,526	445	-	-
NHS WGA bodies	169	220	-	-
TOTAL NHS	**13,355**	**3,597**	**260**	**24,690**
Other WGA bodies	1,366	10,634	-	-
TOTAL at 31 March 2013	**14,721**	**14,231**	**260**	**24,690**

	Receivables: current £000	Payables: current £000	Borrowing: current £000	Borrowing: non-current £000
At 31 March 2012				
Foundation Trusts and NHS Trusts	2,737	3,092	-	-
Department of Health	346	1,125	-	-
Strategic Health Authority	275	143	-	-
Primary Care Trusts	8,731	258	-	-
NHS WGA bodies	313	424	-	-
TOTAL NHS	**12,402**	**5,042**	**-**	**-**
Other WGA bodies	1,540	10,311	-	-
TOTAL at 31 March 2012	**13,942**	**15,353**	**-**	**-**

There are no non-current receivables or payables in either year.

29. Losses and Special Payments

There were 359 cases of losses and special payments totalling £0.156m paid during the year ended 31 March 2013 (2012: 352 cases totalling £0.179m).

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

The NHS Act 2006 states that the chief executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the University Hospitals Bristol NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Bristol NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual 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 Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

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

Robert Woolley, Chief Executive Date: 29 May 2013

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of [insert name of provider] NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in University Hospitals Bristol NHS Foundation Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership

The strategic direction of the Trust Board of Directors is the key driver for addressing risks associated with achieving its stated strategic and corporate objectives. The Board also retains responsibility for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The strategic direction set by the Board is documented in the strategic and corporate objectives which it approves each year.

The Board's tolerance of risk associated with the achievement of these objectives is defined in a 'statement of risk appetite' specified by the Board after due consideration of opportunities and threats within the operation and performance of the Trust. The statement of risk appetite is set out in the Risk Management Strategy which was reviewed in March 2012. The Board monitors the achievement of its objectives, and the management of associated risks, through the annual cycle of Board reporting— including the Quality and Performance Report, Board Assurance Framework, Corporate Risk Register and quarterly reports supporting Board self-certifications to Monitor.

Whilst the Board retains accountability for ensuring that risk is effectively addressed throughout the Trust's operations, responsibility for the management of risk is delegated to the Chief Executive. This duty is discharged through the formal leadership, accountability and management frameworks established by the Chief Executive as part of the system of internal control, including the Trust's risk and performance management arrangements.

Following a comprehensive review of the effectiveness of patient safety and risk management in 2011/12 we continued to strengthen our organisational capacity to manage risk in 2012/13 by appointing a new Trust Risk Manager in January 2013. The Trust Risk Manager leads a programme of work to further increase our capacity and capability to handle risk with particular focus on developing a risk-awareness culture. The Board deploys two committees to augment its monitoring of risk management. The Audit Committee reviews the establishment and maintenance of an effective system of governance, risk management and internal control

across the whole of the organisation's activities; the Quality and Outcomes Committee reviews the suitability and implementation of risk mitigation plans with regard to their potential impact on patient outcomes.

The review of Board governance conducted by the Internal Auditor in 2011-2012 confirmed that the system of Board monitoring and scrutiny of risk management as set out in the terms of reference for both of these committees was operated to a standard that did not attract any audit recommendations for improvement. A similarly thorough pattern of monitoring and scrutiny was adopted in 2012-2013.

Risk Training and Awareness

Whilst considering priorities for action in relation to strengthening risk and patient safety arrangements, the Trust Management Executive recognised that a pervasive culture of risk-awareness and good practice throughout the Trust remain the key factors in ensuring the achievement of strategic aims and objectives. The Executive continued to run a broad programme of staff training and awareness throughout the year, providing suitable training to staff depending on their responsibilities and authority with regard to risk. Extending this programme of awareness and training is a core function of the new role of Trust Risk Manager, appointed in-year as reported above.

The Risk Management Strategy, reporting protocols and guidance were again refreshed and re-issued as part of this programme, and we continue to see increased levels of risk and incident reporting through the year in comparison to previous years. Increased risk reporting supports the Trust's approach to learning from experience and demonstrates increased risk awareness in practice.

The risk and control framework

The 'Risk Appetite' defined by the Trust Board of Directors is defined in the Risk Management Strategy and takes into account organisational risk across potential areas of exposure to risk.

In determining its risk appetite, the Board's overarching objective is to achieve maximum sustainable outcomes and value from all the activities of the Trust. In particular, the Board considers the challenge of maintaining the quality, safety and sustainability in the provision of services to patients in the context of exacting cash releasing savings targets to be the most significant potential source of risk to achieving its corporate or strategic objectives.

For 2012/13, the Trust Board of Directors defined its Risk Appetite as follows:

a) The Trust Board of Directors has zero tolerance for harm to patients and staff through the actions or omissions of the Trust[1],

b) The Trust will consider strategic and operational decisions in the context of risk-assessed strategies, business cases and projects to allow for these decisions to be taken with due regard to the quality, safety and sustainability of services to patients,

c) The Trust Board of Directors requires the reporting of risk exceptions of high and extreme risks to the Board by quarterly presentation of the Corporate Risk Register and the Board Assurance Framework.

The Board Assurance Framework was used to identify any key risks to our strategic objectives, the controls in place to mitigate these risks, our framework for taking assurances that our controls were effective throughout the year, and the positive assurances received in the form of progress reports against actions. Where

[1] Where clinical risks are known to be associated with treatment, these risks will be professionally assessed, understood, and discussed in full with patients and/or carers prior to commencement of any such treatment or procedure.

appropriate, risks to strategic objectives on the Board Assurance Framework were added to the Corporate Risk Register.

Risks-based decision-making supported business planning in 2012/13, and divisional operating plans were drawn up to explicitly address risks to divisional objectives with treatment plans to address risks that may arise as a result of service developments and redesigns.

The Trust Risk Management Group, consisting of the Executive Directors supported by the Trust Risk Manager, specialist risk advisers and divisional risk management leads, takes overall responsibility for the co-ordination of risk management across the Trust. This formal management group, chaired by the Chief Executive, and reporting to the Trust Management Executive, is supported by the Service Delivery and Clinical Quality Groups which respectively address risks to operations and clinical quality as described in the their Terms of Reference and those of the Risk Management Group.

The Service Delivery Group oversees the management of operational service provision, including the management of operational risk. The Clinical Quality Group is tasked with ensuring the continuation of good risk management practices in all clinical services, ensuring the required standards are achieved, investigating and taking action on sub-standard performance, planning and driving continuous improvement, identifying, sharing and ensuring delivery of best-practice, and, identifying and managing any risks to the quality of care.

Named senior officers of the Trust, including each of the Executive Directors and the Heads of Division, have had personal responsibility for the management of risk. Heads of Division have discharged these responsibilities through the divisional risk management arrangements, including Divisional Management Boards and local risk management groups. Standardised terms of reference for Divisional Boards with regard to risk management have been adopted by all of the Divisional Boards.

These 'hub and spoke' arrangements are systematically linked into the Trust-wide management groups with standardised risk registers, risk reporting arrangements and risk calculation algorithms. The hub and spoke model allows for the identification, evaluation and control of changing risk profiles. Examples of this identification and control process include the use of a standard Clinical Risk Impact Assessment employed during any proposed change to services, such as during a transformation programme; and, the inclusion of standard Equality Impact Assessments during any proposed change to procedural documentation (i.e. strategy, policy, procedure and protocol documents).

The Risk Management Policy sets out provisions for the escalation of risks from a 'hub' to the 'centre' and the circumstances where this is required. Divisional Boards are each required to maintain a Divisional Risk Register and to provide assurance to the Risk Management Group that divisional processes for managing risk remain effective. The performance of Divisional risk management arrangements is appraised by the Chief Executive during regular Divisional reviews.

To complement the risk management strategy and management provisions, the Trust Board of Directors maintains comprehensive standards for the governance of quality in the Trust. These standards are reported at each of the public meetings of the Board in the regular Quality and Performance Report. Statistical variances are identified through trend analysis and are addressed through agreed prioritised actions.

The quality of performance information used by the Board is regulated as described in the Data Quality Strategy which sets out the responsibility of individuals and groups within the Trust for ensuring the reliability of data used in performance monitoring and reporting. Data contained in reports to the Trust Board of Directors, including quarterly Monitor certifications, is reviewed for accuracy at specified stages of the Board reporting process.

Key data for Monitor compliance submissions are prepared as part of the Trust management reporting process and are incorporated into the regular Board reporting schedule. Data are extracted by experienced analysts

directly from the Trust's management systems, including the patient administration system and the general ledger. Draft reports are reviewed for consistency by the Trust Management Executive Group. The Finance Committee and the Quality and Outcomes Committee each review relevant sections of performance reports and Monitor submissions for which they have oversight. Reports and Monitor submissions are amended if necessary to take into account the Board Committee and Trust Management Executive reviews. In this regard, I take assurances from the Internal Auditor's conclusions following a 'Monitor compliance code review' that the Trust's procedures to provide accurate and reliable data for the completion, approval and submission of annual plans and quarterly reports submitted to Monitor are sound and operating effectively.

I have chosen to present a narrative account of patient experiences to the Trust Board of Directors at each of its public meetings. These accounts are presented and discussed to place patients' experiences of our services at the centre of the Board's focus and to identify organisational learning from errors and omissions and from exemplary practices.

In seeking on-going assurance as to the suitability and efficacy of its provisions for governing quality, the Board has directed the Quality and Outcomes Committee to have due regard for the Monitor Quality Governance Framework as a guide to good practice. Monitor developed the Quality Governance Framework in response to the findings of their internal audit report into the lessons learned from the failings at Mid Staffordshire NHS Foundation Trust. It is used by Monitor to assess NHS Trusts seeking authorisation as NHS Foundation Trusts; it also forms the basis for Foundation Trust Boards' quarterly self-certification for Quality Governance as set out in the Compliance Framework 2012-13.

Whilst the Quality and Outcomes Board Committee is deployed by the Board to augment its own monitoring and scrutiny of quality, the management of quality is addressed through the management arrangements established by the Trust Management Executive. The Clinical Quality Group, which reports to the Trust Management Executive, takes overall responsibility for the co-ordination of quality management across the Trust.

The role of the Clinical Quality Group is to discharge the responsibility of the Trust Management Executive to manage clinical quality and clinical risk to achieve the best possible outcomes for patients, their families, carers, and staff. Its function is to ensure the continuation of good clinical practices and clinical risk management to ensure that required standards of quality (as defined by Monitor) are achieved. It conducts investigations into and takes action on sub-standard performance whilst planning and driving continuous improvement, identifying, sharing and ensuring delivery of best practice, and identifying and managing risks to the quality of care.

The Clinical Quality Group oversees the work of a set of sub-groups with responsibility for providing specialist management functions for: quality intelligence, patient safety, patient experience, clinical effectiveness, clinical audit, infection prevention and control, quality in care, safeguarding adults and children, clinical record keeping, mental health, resuscitation, medicines, cancer services, dementia, end of life, and regulatory compliance.

Each of these specialist functional areas is monitored and co-ordinated through a rolling programme of quality and compliance reporting to the Clinical Quality Group. For example, the Regulatory Compliance Group assesses compliance with the sixteen Care Quality Commission (CQC) Judgement Framework (registration) requirements and the fifty criteria of the NHS Litigation Authority Risk Management Standards for Acute Trusts. It reports to the Clinical Quality Group on compliance with these each quarter. Reports are generated by the operational leads for each of the requirements who actively monitor and test operational compliance within the Divisions.

Prominent Risks

(a) The Risk and Control Framework addressed a number of prominent clinical and non-clinical risks during 2012/13. For example, risks to the achievement of Cash Releasing Efficiency Savings could have compromised the achievement of the planned income and expenditure surplus. These risks were mitigated through the active engagement of Executive Directors in close monitoring of achievement versus plan throughout year and the proactive risk-assessment of any schemes

under development. Control of staff vacancies and procurement were both monitored at monthly performance meetings.

(b) The Cash Releasing Efficiency Savings risk remained prominent in 2012/13. Our savings targets are challenging—but the Trust continues to develop capacity to achieve these savings through a programme of service transformation. Outcomes were assessed through monthly reports to the Finance Committee and exception reports will be made to Trust Board of Directors.

(c) Risk of sub-optimal midwifery care associated with lower-than-recommended levels of maternity staffing were mitigated through the flexible deployment of staff, investment in additional midwives, escalation plans with neighbouring units, and demand-management for out of area births.

(d) The maternity staffing risk continues into 2013/14. Capital projects to increase capacity, and transformation of the model of care are planned as additional mitigation actions. Outcomes will be assessed through quarterly risk register reports to the Trust Board of Directors with monthly monitoring by the Trust Management Executive and Risk Management Groups.

(e) The risk that patients may receive sub-optimal care whilst waiting to be seen in the Emergency Department due to the increased incidence of ambulance-queuing remained a focus in 2012/13. The risk was mitigated through an agreement with Great Western Ambulance NHS Trust to ensure appropriate care for patients in waiting ambulances, initial assessment by Emergency Department staff of all patients awaiting handover, and prioritising high risk or deteriorating patients for transfer to the Emergency Department.

(f) The Emergency Department risk remains in 2013/14. We continue to work with our partners and other stakeholders across the healthcare system in and around Bristol to reduce the incidence of ambulances queuing. Outcomes will be measured through monthly quality and performance reports, and quarterly risk register reports to the Trust Board of Directors with on-going monitoring by the Trust Management Executive and Risk Management Groups.

(g) During 2012/13 the risk of harm to patients due to the acquisition of pressure ulcers, from falling whilst in hospital and from contracting healthcare-acquired infections, has been recorded in risk registers. Mitigation of these risks continues to be a focus of the Trust Board of Directors when considering essential standards of care.

(h) The NHS Safety Thermometer was implemented in 2012/13. The safety thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care with a particular focus on patient falls, pressure ulcers, venous thromboembolism and urinary tract infections. This will enable accurate benchmarking and learning from best practice. Progress in the South West Quality and Patient Safety Improvement Programme will also support the provision of safer care which will be measured and reported in the quality and performance reports to the Trust Board of Directors.

(i) Looking ahead, and in addition to those risks continuing from 2012/13, a key new risk for 2013/14 is that activity could exceed the levels agreed in contracts and anticipated in the operating plan. This might arise as a result of demographic pressures and/or unsuccessful demand-management. The result would be a negative impact on the ability of the Trust to maintain performance in key areas such as Accident and Emergency, cancer pathways and cancelled operations. We will mitigate this risk through robust assessment of activity against plan in monthly reviews with commissioners.

Care Quality Commission (CQC) Registration

At the time of drafting the Annual Governance Statement, the trust was not compliant with CQC registration requirements for Outcomes 4 (Care and welfare of people who use services) and 14 (Supporting Staff) at its Main Site following a responsive review of Ward 32 at the Bristol Royal Hospital for Children on 5 September 2012. We were also judged to be non-compliant with Outcome 13 (Staffing) following a scheduled inspection of the Main Site on 21 June 2012: in this instance, the non-compliance related specifically to the registered activity 'maternity and midwifery services'. In both cases, the Trust has submitted detailed action plans and is awaiting CQC re-inspections to test current compliance.

Involvement of Public Stakeholders

The Trust Board of Directors further increased its interaction with the Council of Governors with a regular representation of Governors at meetings of the Trust Board of Directors and a complementary attendance of Directors at meetings of the Council of Governors. Additionally, the Council of Governors utilised Governor Working Groups to extend its involvement in contributing to the Trust's insights into public perceptions of strategy, quality and membership engagement.

Each of these Governor Working Group meetings was attended by relevant Executive Directors and other senior managers of the Trust to ensure on-going dialogue and collaboration between Governors and senior leadership. These interactions were in addition to the formal joint meetings of the Council of Governors and the Trust Board of Directors. In addition, the Chairman hosted regular meetings to encourage open dialogue between the Council of Governors and the Trust Board of Directors. These meetings encourage the exchange of views and ideas in a spirit of openness and transparency towards the governors and the public.

The Trust continued to build on previous public and patient involvement mechanisms and worked actively with a number of groups involving patient and public representatives in the design and planning of its services. This engagement is designed to reduce risks associated with the design or re-design of services, and to ensure that any blind spots where services may not be meeting the needs of patients are illuminated through direct feedback.

Public and patient stakeholder engagement has been extended through significant participation in consultations and other dialogues between the Trust, the public, voluntary organisations, staff, Local Involvement Networks, and Overview and Scrutiny Committees.

The Trust Board of Directors has continued to pursue the principles set out in its Membership Strategy and continues to maintain and develop systems to involve the public and particularly, members of seldom heard groups. A number of membership engagement activities were attended by staff, governors, members and the public in this reporting period, including the popular 'medicine for members' events.

The Trust began its preparations for Governor elections with a publicity and advertising campaign designed to reach a diverse range of potential candidates. The elections will conclude in May 2013 and we expect to successfully fill each of the governor seats.

Information Governance

The Trust is a data controller as defined by the Data Protection Act 1998 and takes its responsibility for the security of personal and corporate data very seriously.

The Information Governance Management Group, chaired by the Medical Director, who is the Senior Information Risk Owner, oversaw the Trust's plan to demonstrate compliance with the requirements of the Information Governance Toolkit.

For version 10 of the Information Governance Toolkit, we declared and published our out-turn position as at 31 March 2013 of 68%. The Trust is required to achieve Level 2 for all 45 requirements of the Toolkit but failed to do so on 3 requirements this year. This resulted in a continued 'red' rating as calculated by the Information Governance Toolkit. Action plans are in place to address this shortfall in 2013 - 2014 and these will be reviewed and monitored by the Information Governance Management Group.

The information risk ownership structure continues to be consolidated in line with the requirements of the Information Governance Toolkit, and significant emphasis has been placed on ensuring that all staff receive Information Governance training.

No serious untoward incidents were reported in year.

Climate Change

University Hospitals Bristol NHS Foundation Trust has undertaken climate change risk assessments and our Sustainable Development Management Plan is in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

In January 2013 The Trust Board reviewed progress with our environmental campaign 'The Big Green Scheme' and we are progressing with embedding sustainability in all our activities, including the development of sustainable models of care, procurement and travel. In Partnership with the University of Bristol the Trust is continuing with 'Green Impact Hospitals' to inspire staff action in reducing the Trust's impact of our activities on the environment.

We are implementing projects to reduce our energy consumption across the estate, focussing on reducing waste, improving efficiency and impact control. This includes installing a heat recovery system to capture and re-use otherwise waste heat from our boiler house flue gases.

We are working with our Bristol City Council to develop projects to reduce environmental impacts on our city, exploring opportunities for a city-wide district heating scheme and the installation of renewable technologies to our buildings.

NHS Pension Scheme

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

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

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

The Trust Board of Directors continues to adopt a structured approach to ensuring the economy, efficiency and effectiveness of the use of resources, the importance of which is underscored by the scale of medium-term cost savings required in the current economic and operating environment. This structured approach emphasises the importance we place on taking a transformational approach to the way the Trust provides patient care. The Trust has a well-developed approach to service transformation, having first established an innovation team in 2006, formalising these arrangements in 2009 as the 'Making Our Hospitals Better' programme with revised

governance arrangements agreed in 2010, and a rolling 'Transforming Care' programme of innovation and transformation being pursued in 2011-2012-2013.

I established the Transformation Programme Board in 2011 to lead, oversee and coordinate the programme of change and service improvement to achieve improvements in quality, productivity and economic efficiency across the Trust. It is authorised by me to commit and deploy resources to the programme of work within the limits of the authority delegated to the Chief Executive in the Scheme of Delegation and other provisions of the Standing Financial Instructions. This authority extends to the deployment of the transformation budget as set out within the Annual Operating Plan of the Trust. The Transformation Programme Board reports to the Trust Management Executive and I provide a quarterly update report (or an immediate exception report where significant) to the Trust Board of Directors on the progress of the transformation programme.

The Transforming Care Programme aims to achieve improvements in the quality, efficiency, effectiveness and sustainability of patient care whilst supporting a wider programme of cash releasing efficiency savings, which are monitored routinely by the Finance Committee and the Trust Board of Directors.

The Internal Auditor has reviewed and reported upon internal control, governance and risk management processes, based on an audit plan approved by the Audit Committee. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Audit Standards. Where scope for improvement was identified during an internal audit review, appropriate recommendations were made and action plans were agreed for implementation.

Annual Quality Report

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

Whilst these reporting requirements contribute to ensuring that the content of the Quality Report presents a balanced view of the quality of services provided by the Trust, we also take steps to ensure that appropriate controls are in place to ensure the accuracy of the data upon which we base our statements on quality. These controls are undertaken in accordance with the Quality Strategy (2011-2014) and the Data Quality Strategy which describe the standards of data quality assurance required for data supporting information used by the Board and for public reporting. Examples of data accuracy controls for the Quality Report include checks by the author to ensure that published data is consistent with that reported to the Board during the year, a Data Quality Framework covering metrics mandated for Quality Reports from 1 April 2013, and the External Auditor examines the accuracy of three of the indicators.

The Clinical Quality Group monitors the progress of quality objectives at quarterly intervals during the year; this monitoring is reported to the Board. This process ensures there is continuity throughout the production of Quality Reports, and any inconsistencies are challenged by the Clinical Quality Group.

Our Governors are instrumental in agreeing the content of sections of the Quality Report in which we have freedom to report other key quality themes from the past year. The Governors undertake this work formally under the auspices of the Governors' Quality Working Group.

We follow good practice guidance such as those issued by the Kings Fund by ensuring a wide degree of continuity for clinical themes reported from one year to the next. This ensures that we remain demonstrably committed to ensuring transparency as well as keeping the Quality Report current and fresh.

We invite third parties to comment on an early draft of the Quality Report and listen to requests to amend content or introduce any new quality themes which those third parties feel might be necessary to achieve a fair and balanced view of quality during the year.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality and Outcomes Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In my previous Annual Governance Statement, I reported that the Board had undertaken a broad revision of its corporate governance provisions, and had adopted revised ways of addressing its responsibilities. The Board's review of corporate governance indicated areas where the Board could establish clearer lines of accountability, particularly with regards to risk management. This resulted in the formal delegation of responsibility for risk management to the Chief Executive. The Board also established the Quality and Outcomes Committee, and refocused the Audit and Assurance Committee in a revised format as the Audit Committee.

I introduced revised Executive management and accountability arrangements to coincide with the revised Board governance arrangements. These are described in more detail earlier in this Annual Governance Statement under the 'risk and control framework'. These revised management arrangements are considered by the Trust Board of Directors, and the Trust Management Executive, to ensure a robust treatment of any identifiable risks to quality and safety. This is a conclusion we have reached having derived significant assurances as to the efficacy of the system of internal control from a range of internal and external sources which are summarised in reports received by the Board throughout the year. These are recorded in the Board Assurance Framework document, the corporate risk register, the reported work of the Trust Management Executive and Risk Management Group, reports of the Board Committee Chairs, and the results of a number of external visits, inspections and accreditations. These have included Monitor, the Care Quality Commission and the NHS Litigation Authority.

The effectiveness of the system of internal control is constantly assessed by the Trust Management Executive through the work of the Risk Management Group, and by the Board through the work of the Audit Committee and the Quality and Outcomes Committee. 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.

I also consider the views of Monitor with respect to Board governance and the successful achievement of NHS Litigation Authority (NHSLA) Level 2 accreditation as external indicators that the Trust's systems of internal control are competent and responsive.

The Board's revised governance arrangements were assessed by the Internal Auditor who, having concluded that there were no significant concerns to report, provided the Head of Internal Audit Opinion as follows:

"Significant assurance can be given 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. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk."

Taking this opinion into account, and noting that one exception occurred during the year (which is described as a never event in the Quality Report), I have initiated an internal review of divisional accountability and performance management with a view to achieving increased clinical engagement in the Transforming Care programme, assisted by better-supported management arrangements. This review will conclude in the next reporting period and I expect to see the returns iterated in the 2013-2014 Annual Governance Statement.

Conclusion

No significant systematic internal control issues have been identified. I consider the revised corporate governance, accountability, management and reporting arrangements to have significantly improved provisions for risk management, patient safety, internal control and Board assurance, and will continue to develop the system of internal control by addressing any inconsistent application of controls where this is identified.

Robert Woolley, Chief Executive Date: 29 May 2013

Appendix E – Independent Auditors' Report to the Council Of Governors of University Hospitals Bristol NHS Foundation Trust

We have audited the financial statements of University Hospitals Bristol NHS Foundation Trust for the year ended 31 March 2013 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual 2012/13 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective responsibilities of directors and auditors
As explained more fully in the Directors' Responsibilities Statement the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13. Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of University Hospitals Bristol NHS Foundation Trust in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the audit of the financial statements
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report and Accounts to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements
In our opinion the financial statements:

- give a true and fair view, of the state of the NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure and cash flows for the year then ended; and

- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13; and

- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;

- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or

- we have qualified, on any aspect, our opinion on the Quality Report.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Lynn Pamment (Senior Statutory Auditor)
For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Bristol
29 May 2013

Notes:

(a) The maintenance and integrity of the University Hospitals Bristol NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.