University Hospitals Bristol NHS Foundation Trust

Annual Report and Accounts 2010 – 2011

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1. Chairman's Statement

Welcome to the Annual Report for University Hospitals Bristol NHS Foundation Trust for the year from 1 April 2010 to 31 March 2011.

The Governors and I were delighted to appoint Robert Woolley as Chief Executive of the Trust in September 2010. Robert is providing the Trust with strong leadership as it moves into a time of significant change for the NHS: alterations to funding regimes and changes to the commissioning of services both come at a time of acute economic challenge. The year closes at 31st March with the Trust in a strong financial position and reporting an amber-green rating to Monitor, the Foundation Trust regulator. These are some of the measures of success that help to demonstrate the commitment of all staff to delivering excellent compassionate care to the people of Bristol and beyond.

In June 2010 the Trust launched its new values:

Respecting Everyone,

Embracing Change,

Recognising Success and

Working Together.

They came from six months' consultation with staff, patients, members and Governors and are already shaping delivery of services; providing the Trust with a solid foundation for the future.

In December 2010 the Trust published the report from the Independent Inquiry into allegations of misdiagnosis in its histopathology service. The report from this exhaustive investigation found no evidence that the histopathology department at University Hospitals Bristol provided anything other than a safe service.

As recommended by the report, and since publication, there has been ever closer partnership working with North Bristol NHS Trust to fully integrate the two histopathology departments in Bristol. A joint director of histopathology services has been appointed and the two organisations, in collaboration with NHS Bristol, are implementing the action plan which is reported to the Care Quality Commission and, for University Hospitals Bristol, to Monitor. Both Trusts are in full agreement that the Inquiry report makes it clear that the system is most safe when all parts of it contribute in a spirit of openness and collaboration, putting the patient's interests first. University Hospitals Bristol and North Bristol NHS Trust are determined to learn from the mistakes made and are implementing the recommendations of the Inquiry panel in full partnership with each other.

Highlights of the year have included the following:

- St Michael's Hospital became the first hospital in the world to successfully deliver xenon gas to a newborn baby in a bid to prevent brain injury following a lack of oxygen at birth. Professor Marianne Thoresen led the work, with Dr John Dingley from Swansea University. The research study is being funded by Sparks.
- The Trust was part of the Bristol Festival of Ideas with the Bristol Heart Surgery film being shown to a large audience at St George's Concert Hall with a live commentary from cardiac surgeon Gavin Murphy and a debate led by Professor Gianni Angelini.
- A special animated film called One of a Kind, featuring characters based on children who received radiotherapy in Bristol and the Midlands, was launched to help all

children who are preparing for treatment. The short film included four children from the West Country, was directed by Aardman and Arthur Cox director Emma Lazenby and was the brainchild of Jancis Kinsman, Advanced Practice Therapy Radiographer at Bristol Haematology and Oncology Centre.

- It was a privilege to welcome His Royal Highness Prince Michael of Kent to celebrate 200 years of visionary care at the Bristol Eye Hospital. A whole series of events were held for patients, staff and academics and the Prince unveiled a plaque to mark the bicentenary.
- Miss Clare Bailey, a Consultant Ophthalmologist at the Bristol Eye Hospital received the Best Practitioner of the Year, awarded in the clinical services category from the Macular Disease Society.
- The design and execution of the Bristol Heart Institute received two prestigious awards from the Royal Institute of British Architects, including its top accolade, The Ibstock Premier Award.
- University Hospitals Bristol and North Bristol NHS Trust signed a formal Partnership Agreement, approved by both Boards in November 2010, enshrining principles of co-operation and outlining a number of areas for joint working.
- The £1.5million investment into the refurbishment of the Bristol Haematology and Oncology Centre was unveiled, supported by the Trust, Above and Beyond Charities and the Friends of the Centre.
- Demolition has started on the former nurses' home on Terrell Street, behind the Bristol Royal Infirmary, to make way for a new ward block, which the Trust Board hopes to approve in 2011/12.

The Trust Board said goodbye to two Executive Directors, Irene Scott as Chief Operating Officer, who retired from the NHS and Dr Jonathan Sheffield OBE, Medical Director and Deputy Chief Executive, who left after six years to take up the post of Chief Executive for the Clinical Research Network of the National Institute for Health Research based at the University Of Leeds.

We are delighted to have appointed Deborah Lee as Director of Strategic Development from February 2011, Dr Sean O'Kelly as Medical Director, starting with the Trust in April 2011 and James Rimmer as Chief Operating Officer, joining from July 2011.

I offer my sincere thanks to the Trust Board, to every member of the Trust's staff who work hard every day delivering care to patients and my gratitude to the Trust's Governors and members for continued support and challenge to the Trust's decision-making. All ultimately help to shape improved hospital care for the people of Bristol and beyond.

John Savage CBE

Chairman, 03 June 2011

2. Chief Executive's Foreword

Introduction

University Hospitals Bristol NHS Foundation Trust continues to deliver excellent patient care, teaching and research, whilst maintaining a strong financial position which allows us to continue to improve service quality.

This year the Trust has focused on recovering our performance through a particularly challenging winter, and we are delighted to be ending the year for 2010/11 reporting an amber-green rating to Monitor, our regulator, for performance and a risk rating of four for our finances.

Histopathology Inquiry

However, the Trust has faced significant issues. The publication of the Independent Inquiry into allegations of misdiagnosis in our histopathology service was published in December, after an exhaustive 18 month inquiry, chaired by Jane Mishcon of Hailsham chambers.

The Inquiry's report found that we deliver nothing other than a safe service, but highlighted management failings. The Inquiry found that the Trust did not promptly and thoroughly investigate concerns about services at the time that those concerns arose. If that had been done, it is clear that professional and public confidence in services could have been maintained and an inquiry of this scope and cost could have been avoided.

Once concerns had escalated, however, to the point where public confidence was in danger of being undermined, the Trust Board were determined to secure external, independent scrutiny both of our histopathology practice and our management of those concerns. The Trust has accepted the report in its totality and in partnership with North Bristol Trust, is implementing the action plan in full.

Clinical services

University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of hospitals in the heart of Bristol. We are one of the largest teaching hospital trusts in the country.

Our priority is, and has always been, to provide the highest standard of care possible for our community. We provide non-specialist services to approximately 350,000 people who live in central and south Bristol and the north of North Somerset but we also offer very specialist services to people from all over the South West. The specialist services that we are known for include neonatal intensive care services, other children's services, services for cancer patients and cardiac services.

During 2010/11 we made good progress on many areas that matter to patients. All staff worked hard to continue to reduce the number of healthcare associated infections and we are very proud of this achievement. Working to ensure that our services are as safe as they can possibly be, we assessed more than 90 percent of adult inpatients for risk of developing thrombosis in hospital and reduced the number of hospital acquired pressure ulcers by 22 percent in one year.

We also worked hard to ensure patients were seen as rapidly as possible and we achieved many performance targets such as the rapid access chest pain two week wait, 48-hour access standards for stroke care and genito-urinary medicine and the 18-week referral to treatment standards for admitted and non-admitted patients.

Unfortunately, during the year we did not achieve all national cancer waiting time standards and we are looking very closely at the reasons behind this so that we can ensure that we meet this in the future. In addition, we experienced a large increase in the number of people using our Emergency Department and, as a result, our performance against the 4 hour Accident and emergency waiting time standard dipped in the last quarter.

During 2010/11 we received external recognition for our clinical effectiveness. The Dr Foster Hospital Guide 2010 listed University Hospitals Bristol NHS Foundation Trust as having "lower than expected" Hospital Standardised Mortality Ratio (HSMR). But perhaps most pleasing of all, we received good feedback from our patients. During the year 85 percent of our patients rated the care they received in our hospitals as either "very good" or "excellent" and 86 percent said they were treated with respect and dignity on the ward.

Highlights in the year included a celebration of 200 years of visionary care at the Bristol Eye Hospital and a visit from HRH Prince Michael of Kent who joined us for the celebrations. In addition, Miss Clare Bailey, a consultant ophthalmologist at the Bristol Eye Hospital, was nominated to receive the best practitioner of the year award in the clinical services category from the Macular Disease Society, for the untiring work she does with the visually impaired.

Research and innovation

In 2010/11 we developed a new five-year research and innovation strategy and established a vibrant research committee to manage research activities in the Trust. Working with North Bristol NHS Trust, we appointed a Joint Director of Research, Professor David Wynick. We also celebrated another joint appointment. With the University of the West of England we appointed Professor Margaret Fletcher to a new Chair of Nursing to lead nursing and allied health professional research in Bristol. The opportunity to join forces with both organisations has been invaluable and we look forward to reaping the rewards.

One of the other partnership highlights of the year was a joint development with the University of Bristol of CRIC-Bristol (the Clinical Research and Imaging Centre) which is available for use by researchers from the University as well as other research teams running studies in the South West, enabling high quality clinical investigation for translational medicine and developing new, novel treatments. Research studies planned for the centre include neonatal brain injury studies, imaging before and after cardiac surgery, experimental psychology studies and sleep studies in children.

In 2008, the Trust and the University of Bristol were given the funding by the National Institute for Health Research (NIHR) to set up a Cardiovascular Biomedical Research Unit and in early April we officially opened the unit with a visit from Professor Dame Sally Davies, Chief Medical Officer and Chief Scientific Advisor for the Department of Health and the NHS.

Our staff continued to publish research and make breakthroughs that will in the years to come transform the care our patients receive.

- Pradeep Narayan, Senior Registrar in Cardiothoracic Surgery at the Bristol Heart Institute, become the first UK winner of the Hans G Borst Award for Thoracic Aortic Surgery for the research paper he presented in Switzerland at the annual meeting of the European Association of Cardiothoracic Surgery (EACTS) in September 2010. The EACTS annual meeting, one of the largest of its kind, is attended by cardiothoracic surgeons from all over the world. The study presented by Pradeep looked at the treatment options for conditions affecting the lower part of the main artery of the body present inside the chest, the descending thoracic aorta. Led by consultant cardiac surgeon Mr Gavin Murphy, it compared open surgical intervention with minimally invasive or endovascular intervention (TEVAR). The study found that

TEVAR had a better outcome for patients in the short term. However, the risk of re-intervention was much higher and in three to four years both interventions had similar results.

- St Michael's Hospital became the first hospital in the world to successfully deliver xenon gas to a newborn baby in a bid to prevent brain injury following a lack of oxygen at birth. This pioneering technique has been developed by Marianne Thoresen, Professor of Neonatal Neuroscience at the University of Bristol and Dr John Dingley, Consultant Anaesthetist and Reader in Anaesthetics at Swansea University's School of Medicine. St Michael's Hospital and the University of Bristol have pioneered new treatments for brain injury in babies since Marianne Thoresen first started cooling babies in 1998, showing that cooling after a lack of oxygen could reduce damage in the newborn brain.
- Professor David Marks and his team at the Bristol Haematology and Oncology Centre are at the forefront of research that could lead to more adults surviving leukaemia, by working on changing the way bone marrow transplants are carried out so chemotherapy and radiotherapy do not cause subsequent harm.

Teaching and learning

If we are going to continue to improve the care we provide to our patients then we need a workforce with the right skills. As a teaching hospital Trust, we support the teaching of undergraduates, newly qualified members of staff, and the on-going education and training of clinical and other staff at all levels.

When a member of staff joins us they attend a comprehensive induction programme and agree a personal, annual development plan with their manager. This covers mandatory training requirement as well as personal and professional development needs. We are currently developing a careers advisory service to support staff further.

As one of the UK's leading teaching hospitals, closely linked to the Universities of Bristol and the West of England and other bodies worldwide, we are very well–placed to develop clinical skills and careers. We positively encourage postgraduate study and research, with an active programme of workshops and seminars keeping professionals up to date with the latest clinical developments. We also offer training and learning opportunities for non-clinical members of staff and a wide range of National Vocational Qualifications (NVQs).

The Trust has particularly strong partnerships with the Severn Deanery, University of Bristol and the University of West of England. Further education partnerships are being strengthened, including collaborative working with the City of Bristol College and involvement in the South Bristol Academy. We value these partnerships highly and will continue to develop them.

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

Board of Directors

I was delighted to be appointed to the post of Chief Executive in September 2010, after acting into the post for the previous seven months. It is my great privilege serve the people of Bristol and beyond and provide leadership to our 8,000 staff working across our nine hospital sites, the Bristol Royal Infirmary, the Bristol Eye Hospital, St Michael's Hospital, the Bristol

General Hospital, The University of Bristol Dental Hospital, the Bristol Haematology and Oncology Centre, the Homoeopathic Hospital, the Bristol Royal Children's Hospital and the Central Health Clinic.

Two Executive Directors left the Trust, Dr Jonathan Sheffield OBE, Medical Director and Deputy Chief Executive, and Irene Scott, Chief Operating Officer. I am enormously grateful to Dr Jane Luker for providing leadership in the role of Acting Medical Director and to her team, and to Tony Ranzetta and more recently Jim O'Connell for their work in the role of Acting Chief Operating Officer. I was delighted to welcome Deborah Lee to the post of Director of Strategic Development in February 2011 and we look forward to welcoming Dr Sean O'Kelly as Medical Director in April, and James Rimmer as Chief Operating Officer in July.

Looking forward

2011/12 will be a very challenging year for all public services and UH Bristol will be no exception, but I am confident in the leadership team and the support we have from our Non-Executive Directors and the Membership Council, made up of our 38 Governors. The Board has established three priorities for the coming year, to improve patient flow throughout the organisation, review the management of outpatients and build our change capacity. We will be looking at everything we do to see how we can do it more effectively and efficiently, driving up quality and delivering savings. This Trust has a history of innovation and research and we will harness that to enable us to be fit for the future and make our hospitals better for patients, staff and the population of Bristol and the South West.

In April 2011 the Board will consider the Full Business Case for the redevelopment of the Bristol Royal Infirmary and the Centralisation of Specialist Paediatrics in Bristol. Delivering care to patients in a building built in 1735 is no longer acceptable to us and through the building of a new ward block on the site of the old nurses' home on Terrell Street, we will be able to provide a state of the art environment that will match the professionalism and dedication of our staff. We will also be able to co-locate services together, improving the patient experience and ensuring that wherever possible patients can be treated quickly in one area and do not need to travel long distances through the hospital.

It remains to thank all those who work within University Hospitals Bristol NHS Foundation Trust, our members and Governors for their dedication to excellent patient care, teaching and research; to our official charity Above & Beyond for their continuing support and the very successful Care Appeal which brought about real improvements to the Bristol Haematology and Oncology Centre (BHOC), supported by the Friends of the BHOC, as well as The Grand Appeal for their work with the Children's Hospital and St Michael's through the Cots for Tots Appeal, and all our other charitable partners who help support our patients and our staff each and every year.

3. Directors' Report

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, providing healthcare services in the three principal domains of: clinical service provision, teaching and learning and research and innovation. The most significant of these in terms of income generation and workforce is the clinical service portfolio consisting of local, non-specialised services 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 are 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.

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

We host a number of local or regional screening services including the national breast and bowel screening programmes.

Whilst not significant income generators when contrasted to clinical service provision, the Trust places great importance on its role as a teaching hospital and research centre. It has strong links with both of the city's universities and teaches students from medicine, nursing and 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.

Directors of the Trust

The Trust Board of Directors, which is accountable for the performance of the Trust, consists of the Chairman, Chief Executive, seven Non-Executive Directors and six Executive Directors as follows:

Non-Executive Directors	Executive Directors
• John Savage – Chairman • Emma Woollett – Vice Chair • Iain Fairbairn – Senior Independent Director • Kelvin Blake – Non-executive Director • Paul May – Non-executive Director • Lisa Gardner – Non-executive Director • Selby Knox – Non-executive Director • John Moore – Non-executive Director	• Robert Woolley – Chief Executive • Paul Mapson – Director of Finance • Alison Moon – Chief Nurse • Steve Aumayer – Director of Workforce and Organisational Development • Deborah Lee – Director of Strategic Development • Jane Luker – Acting Medical Director • Jim O'Connell – Acting Chief Operating Officer

Biographies of the members of the Board are provided at "Biographies of Members of the Trust Board of Directors" on page 61 of this report.

Statement as to Disclosure to Auditors

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

- so far as the Director was aware, there was no relevant audit information of which the NHS Foundation Trust's auditor was unaware; and
- the Director had 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 was aware of that information.

Business Review

Our performance in 2010/11, an overview of regulatory risk ratings

During 2010/11 the Trust attained a Green or Amber-Green Governance Risk Rating in each quarter, which was within the forecast rating in the Annual Plan. This is in contrast to the previous year, in which the Trust declared three consecutive Red ratings against a Green forecast rating. The improvement in ratings in 2010/11 was mainly due to a significant improvement in performance against the 31- and 62- day cancer standards, building on the continued strong performance against challenging healthcare associated infection trajectories.

	Annual Plan 2009/10	**Q1 2009/10**	**Q2 2009/10**	**Q3 2009/10**	**Q4 2009/10**
Financial Risk Rating	4	3	4	4	4
Governance Risk Rating	**GREEN**	**GREEN**	**RED**	**RED**	**RED**

	Annual Plan 2010/11	**Q1 2010/11**	**Q2 2010/11**	**Q3 2010/11**	**Q4 2010/11**
Financial Risk Rating	4	3	4	4	4
Governance Risk Rating	**AMBER-GREEN**	**AMBER-GREEN**	**GREEN**	**GREEN**	**AMBER-GREEN**
Standards declared at risk/not met	Cancer standards: 62-day GP/screening 2-week wait symptomatic breast	Cancer standards: 2-week wait symptomatic breast MRSA Elective Screening Access standards for people with learning disabilities	MRSA Elective Screening		Cancer standards: 62-day GP/screening A&E 4-hour maximum wait

Review of quarterly performance

In January 2010 the Trust submitted a plan to Monitor and committed to a trajectory for recovering performance in three specific areas:

- Accident and Emergency maximum waiting time of 4 hours.
- Cancer standard (31- and 62-day).
- 18-week Referral to Treatment Times.

All of the above standards were achieved in quarter 1 as per the agreed trajectories. The Breast 2-week wait for symptomatic patients, which came into effect in quarter 4 2009/10, failed to be achieved in quarter 1 due to capacity constraints. This had been flagged as a risk in the Annual Plan. Compliance against the MRSA elective screening standard dipped below the 100% standard in quarters 1 and 2, with 97% of patients being screened across both quarters. This standard was judged to be at low risk in the Annual Plan assessment. The failure was due to a very small number of patients not being screened at pre-operative assessment, and insufficient time being available to take action to rectify this prior to patients' admission to hospital. Corrective action was taken in quarter 2 to increase the frequency of operational monitoring of compliance, which enabled the 100% standard to be achieved in quarters 3 and 4. The Trust did not achieve the required standards for access for patients with learning disabilities in the first quarter, but expedited its plans to achieve compliance by the end of the following quarter.

During the year the Trust continued to make strong progress in reducing levels of healthcare associated infections, meeting the quarterly trajectories for both Clostridium Difficile (C. diff) infections and Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemias. A high standard of performance was also maintained against the 4-hour maximum Accident and Emergency wait and cancer standards throughout quarters 2 and 3, with all standards being met in full. However, following a prolonged outbreak of Norovirus at the end of January 2011, one of the cancer standards (62-day screening) and the 4-hour Accident and Emergency standard, failed to be achieved. This resulted in an Amber-Green rating being declared in the final quarter of the year. The 62-day screening standard had been flagged as a risk in the Annual Plan, due to the challenges posed by the bowel screening pathway and the impact of high levels of patient choice to defer diagnostic tests.

The Trust will continue to analyse the reasons behind failures to achieve the national cancer waiting times standards for individual patients, and use this to inform its on-going cancer improvement plan. Achievement of the 4-hour Accident and Emergency standard was judged to be low risk in the 2010/11 Annual Plan due to the actions already taken in quarter 4 2009/10 to address under-performance. The Trust will further review the actions that need to be taken to mitigate the risks to achievement of the 4-hour standard, along with the new A&E Clinical Quality Indicators, in light of the sustained growth in emergency admissions over the past year and the need to enhance contingency arrangements for managing more significant and prolonged outbreaks of Norovirus.

Annual performance against national access standards

In addition to the standards included in Monitor's Compliance Framework, the Trust continued to achieve a range of performance standards which were formerly in the Care Quality Commission's Quality of Services Assessment. This included achievement of the rapid access chest pain 2-week wait, breast-feeding and maternal non-smoking rates, stroke care and genito-urinary medicine (GUM) 48-hour access standards. The 18-week referral to treatments standards for admitted and non-admitted standards continued to be met each

month, after the standards were removed from Monitor's Compliance Framework at the end of quarter 1. The Trust did not achieve the national standards for last-minute cancelled operations and re-admission within 28 days. Achievement of these standards, along with the 4-hour maximum wait, is the focus of a significant programme of work on patient flow and bed availability, which commenced in the last quarter of 2010/11.

Annual performance against key national standards in 2009/10 and 2010/11

National standard	**Target**	**2009/10**	**2010/11 Expected**
A&E maximum wait of 4 hours	98%	Achieved	Achieved
MRSA bloodstream cases against trajectory	Trajectory	Achieved	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%	Failed	Achieved
Cancer – 31-day diagnosis to treatment (First treatment)	96%	Achieved	Achieved
Cancer – 31-day diagnosis to treatment (subsequent surgery)	94%	Under-achieved	Achieved
Cancer – 31-day diagnosis to treatment (subsequent drug therapy)	98%	Achieved	Achieved
Cancer – 31-day diagnosis to treatment (subsequent radiotherapy)	94%	Target not in effect	Achieved
Cancer – 62-day referral to treatment (urgent GP referral)	85%	Under-achieved	Achieved
Cancer – 62-day referral to treatment (screenings)	90%	Under-achieved	Achieved
18 weeks referral to treatment admitted	90%	Achieved	Achieved
18 weeks referral to treatment non admitted	95%	Achieved	Achieved
GUM offer of appointment within 48 Hours	98%	Achieved	Achieved
Number of last minute cancelled operations	0.80%	Under-achieved	Under-achieved
28 day readmissions	95%	Under-achieved	Under-achieved
Data quality on ethnic group	85%	Achieved	Achieved
60 minute thrombolysis call to needle time	68%	Achieved	Achieved
Primary PCI – 150 minutes call to balloon time	75%	Under-achieved	Achieved
Rapid access chest pain 2 week wait	98%	Achieved	Achieved
Mothers who are not smokers at delivery	87.9%	Achieved	Achieved
Mothers initiating breastfeeding	71%	Achieved	Achieved
Stroke care	60%	Achieved	Achieved

Requirements shown are as per the Care Quality Commission 2009/10 Quality of Services assessment and/or the 2010/11 NHS Operating Framework.

An overview of quality

The Trust's commitment to providing the highest quality patient care can be summed up in the following statements from the 2010/11 Quality Report which is set out at Appendix F – Quality Report 2010/11.

- The safety of our patients is central to everything we want to achieve as a provider of healthcare: we will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them.
- All our patients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.
- We will ensure that each patient receives the right care for them, according to scientific knowledge and evidence-based assessment.

This document includes a review of progress against quality objectives for 2010/11 and details of agreed quality objectives for 2011/12. The structure of the Quality Report is based around Lord Darzi's model for quality (patient safety, patient experience and clinical effectiveness), and incorporates guidance issued by the Department of Health and Monitor.

Patient Safety

We reduced the rate of MRSA bloodstream infections in patients who are in hospital for more than two days to 0.016 per 1,000 bed days (this equated to five cases, compared to nine in 2009/10).

We also achieved all the targets set by the Department of Health and NHS Bristol for reducing C. diff infection: 94 cases equated to 0.32 per 1,000 bed days, compared to 100 cases in 2009/10.

Every case of hospital acquired infection is, of course, one too many and we will continue to strive to reduce these numbers in 2011/12.

We achieved our targets for reducing the numbers of high risk medication errors which led to actual harm in patients. By the end of the year, we assessed more than 90% of adult inpatients for risk of developing hospital acquired thrombosis (Venous thromboembolism (VTE)). We also reduced hospital acquired pressure ulcers by 22%.

In 2010, University Hospitals Bristol commissioned an Independent Inquiry into allegations of serious misdiagnosis in histopathology services at the Trust between 2000 and 2008. An exhaustive Independent Inquiry found no evidence to suggest that the histopathology department at University Hospitals Bristol provides anything other than a safe service (see the Chief Executive's Foreword to this report).

In October 2010, an inspection team from the Care Quality Commission carried out a review of compliance in respect of nutritional care in our hospitals. The Trust received a formal written report from the CQC which included positive feedback about the quality of nutritional care they had observed. However, they also noted that protected mealtimes were not always observed by staff, and that levels of nutritional screening and care planning needed to be improved. The Trust implemented an urgent recovery plan and the Trust anticipates returning to a position of compliance in early 2011/12.

For patient safety, 2011/12 will be a 'year of learning'. The Trust will continue to participate in the NHS South West Quality and Safety Programme. Reflecting patient safety priorities

agreed with our commissioners as part of the Commissioning for Quality and Innovation (CQUIN) scheme for 2011/12, we will in particular seek further improvements in:

- Hospital Acquired Thrombosis (Venous thromboembolism (VTE)).
- Medication errors.
- Inpatient falls.
- Pressure ulcers.

Patient experience

In 2010/11, we implemented a new Patient and Public Involvement Strategy. During the course of the year, more than 10,000 patients gave us their views about our services; comment cards were made available in 66 inpatient locations across the Trust; whilst additional ward-based surveys explored themes including what it means to treat people with compassion: our clinical divisions then developed Patient Experience Action Plans in response to what our patients were saying.

- Overall, 85% of patients rated the care they received in our hospitals as either 'very good' or 'excellent'.
- 86% of inpatients told us they were always treated with respect and dignity on the ward.

For patient experience, 2011/12 will be a year when we extend our strategy for obtaining systematic patient feedback from inpatients into outpatient settings. It will also be a year when we turn learning into action. In particular, we will:

- create a range of opportunities for carer feedback and engagement, with a particular focus on carers of patients with dementia,
- achieve measurable reductions in patient-reported hospital noise at night,
- ensure that patients who need assistance at mealtimes receive this,
- review the provision of ward-based patient information ensuring that this meets our patients' needs, and,
- develop staff customer care training in response to what our patients tell us matters to them.

Clinical effectiveness

University Hospitals Bristol continues to have a low overall Hospital Standardised Mortality Ratio (HSMR) and was listed in the Dr Foster Hospital Guide 2010 as having 'lower than expected' HSMR. The same report listed the Trust as having 'lower than expected' mortality for an indicator which covers five specific conditions which contribute to the HSMR: heart attacks, stroke, pneumonia, congestive heart failure and broken hips.

We have made significant progress towards meeting the requirements of the NICE Quality Standard for Dementia.

Our Quality Report for 2010/11 includes two particularly notable developments: the inclusion of five-year survival data for patients undergoing surgery for oesophageal cancer; and the first set of nationally published data for Patient Reported Outcome Measures (groin hernia surgery and varicose vein surgery are carried out at the Bristol Royal Infirmary).

For clinical effectiveness, the Trust's goal in 2011/12 is to maintain its 'lower than expected mortality' rating for headline HSMR. Alongside this, we have identified four specific areas where we would like to see progress in 2011/2012:

1. One-year survival rates for colorectal, breast and lung cancer patients – in particular, we will implement the recommendations of Improving Outcomes: a strategy for cancer (Department of Health, 2011).
2. Achieving improvements in the Dr Foster rating for stroke care – in particular, we will establish a specialist stroke unit: our target is that 90% of patients who suffer a stroke will spend 90% of their care in a specialist unit.
3. Increasing the proportion of spontaneous vaginal births.
4. Dementia care – implementing our action plan in response to the National Institute for Health and Clinical Excellence (NICE) Quality Standard for Dementia, and delivering a range of actions related to agreed standards of dementia care within the South West.

Contractual performance

As part of the 2010/11 contract with the lead commissioner, NHS Bristol, the Trust committed to the achievement of key national standards as well as some additional stretch targets (under the Commissioning for Quality and Innovation Framework, CQUINs). Financial rewards were attached to achievement of CQUIN targets. In addition there were a number of national penalties for non-achievement of key national standards, such as Clostridium Difficile (C. diff), 18-week Referral to Treatment Time (RTT) standards and A&E 4-hour maximum wait.

In 2010/11 the CQUIN income was conditional on achievement of certain key national access standards. These 'gateway' standards, which had to be achieved before any CQUIN income was payable, included: all the national cancer standards, 4-hour maximum wait (95%) and 18-week RTT admitted and non-admitted standards. In addition there were three other standards which, depending upon the number achieved, determined the scale of the reward. These three standards were: a reduction in the number of MRSA (Methicillin Resistant Staphylococcus Aureus) bacteraemias relative to the 2008/09 baseline, achievement of a maximum six-week wait for at least 99.5% of high volume diagnostic tests and achievement of the national standard for the cancellation of operations at last minute.

The Trust achieved all three mandatory gateway standards together with two of the three other gateway standards. In so doing it was eligible for up to 90% of the total £5.26 million CQUINs financial rewards. The CQUIN standards included a range of quality and efficiency improvement indicators, ranging from reductions in length of hospital stays and patient experience measures to smoking cessation for staff and improved outcomes in paediatric care. The final figures are expected to confirm the Trust achieved a number of the CQUIN standards, including:

- Increased use of the World Health Organisation (WHO) surgical checklist,
- Reduction in MRSA bacteraemias,
- Improved outcomes in paediatric cardiac surgery (reduced re-admission and mortality rates),
- Improved outcomes in adult and paediatric Bone Marrow Transplant (BMT),
- Reduction in medication errors, and,
- Reduction in hospital acquired pressure ulcers.

The financial reward associated with these improvements in clinical quality is forecast to total £1.13 million for 2010/11. This figure excludes the potential rewards that could be realised as

a result of improvements in scores from the National Adult Inpatient Survey (a potential further £0.48 million), the results of which were awaiting finalisation.

At the time of this report the Trust was also forecasting financial penalties of £0.15 million due to the non-achievement of certain national quality standards, including last-minute cancelled operations, breaches of same sex accommodation standards, and the percentage of women booking an appointment before week 13 of pregnancy. In addition the Trust was forecasting a £0.58 million loss due to the impact of contract limiters around the level of emergency re-admissions, levels of consultant derived referrals to outpatients and an increase in the likelihood of admission from attendance at one of the Trust's Emergency Departments (Accident and Emergency conversion rate). This figure is net of the emergency admission marginal tariff adjustment.

The Trust has recently established an adult Ambulatory Care Centre within the Bristol Royal Infirmary, with the aim of reducing emergency admissions to the Trust. During 2011/12 the Trust will be continuing the work it started in the last quarter of 2010/11, in identifying and taking forward opportunities to reduce levels of avoidable emergency re-admissions.

During the year the Trust received a performance notice from NHS Bristol for non-achievement of the breast 2-week wait standard following a poor period of performance in the first quarter of the year. However, the 93% standard was achieved in quarter 2 to 4, with the strong performance in the last quarter in particular enabling the standard to be achieved for the year as a whole. A performance notice was also received during the second quarter of the year, for the level of last-minute cancelled operations. A refreshed action plan was agreed in response. Bed pressures remained the leading causes of last-minute cancellations of surgery, with 41% of all procedures being cancellations during the year for this reason (including those cancellations recorded as happening due to lack of time in theatres, which are often due to late starts as a consequence of bed pressures). This reflected the continued heightened demand for beds for emergency admissions during the year. Improving bed availability through actions to improve patient flow remains a key focus in 2011/12 to ensure improvements are realised against this important indicator of both patient experience and service efficiency.

Research and Innovation

The overarching theme for research through 2010/11 has been working in partnership. The Trust continues to work with our partner universities and NHS Trusts to deliver a shared strategy, common goals and aspirations for clinical and health services research. The Trust, North Bristol NHS Trust, NHS Bristol, Avon and Wiltshire Mental Health Partnership, the University of Bristol and the University of the West of England work together in a pan-Bristol health research and innovation collaboration, BRIG-H (Bristol Research and Innovation Group for Health). BRIG-H is actively working towards creation of an Academic Health Science Centre for Bristol.

The Trust has benefited from the partnership with North Bristol NHS Trust with the appointment of a Joint Director of Research, Professor David Wynick. As the two largest research-active Trusts in the South West, the opportunity to join forces and learn from each other how to create the right environment for high quality research and then how to sustain research effort has been invaluable. The Trust has developed: a new five-year research strategy; a vibrant research committee to manage research in the Trust; processes for achieving financial transparency for research funds; a pump-priming funding scheme to support researchers who apply for National Institute for Health Research grant funding schemes; structures to support research within each Division and the expansion of Divisional Research Units with core funded staff and appropriate line management.

In partnership with the University of the West of England, the Trust has appointed Professor Margaret Fletcher to a new Chair of Nursing to lead Nursing and Allied Health Professionals research in Bristol.

We are delighted to announce the opening of CRIC-Bristol (the Clinical Research and Imaging Centre at Bristol) which houses a 3-T Siemens Skyra MRI scanner, state-of-the-art physiological sleep/monitoring facilities, and fully equipped clinical research rooms. CRIC-Bristol is a partnership between the Trust and the University of Bristol. CRIC houses staff experienced in all aspects of imaging and provides a full research support package.

Our National Institute for Health Research (NIHR) Biomedical Research Unit in cardio-vascular disease continues to support translational research of direct patient benefit and the themes have expanded to include a new theme on imaging – supported by a dedicated cardiac MR scanner and the appointment of a consultant senior lecturer in cardiac imaging who also works as joint director of CRIC-Bristol. We were delighted that Professor Dame Sally Davies attended the opening of the Biomedical Research Unit and was able to tour the facilities both in the new Bristol Heart Institute and CRIC-Bristol.

Innovation partnerships with BRIG-H member organisations continue and the Trust was a co-sponsor of a recent regional innovation showcase event at University of the West of England where innovators from across the region gathered to share ideas and establish new collaborations. Of particular note is the work starting to link the world-leading large-scale population cohort studies, such as the Avon Longitudinal Study of Parents and Children (Children of the Nineties) study, which has been following mothers, fathers and their offspring for 20 years and has substantial biological and clinical data, including genome-wide genetic data and cell lines. This and other studies based in the school of Social and Community Medicine, offer substantial opportunities for collaboration between academic and clinical staff.

Work continues in our NIHR funded programme and other funded research and the Trust has been rewarded for our success in recruiting patients into complex clinical trials by receiving the highest amount of funding awarded to a member organisation from the local comprehensive research network.

Our wider role and future developments

We are committed to involving and consulting patients and the public in the planning of services, considering service changes and making decisions that affect the way in which services operate. The Trust does so in accordance with Section 242 of the NHS Act 2006 and a detailed report on patient involvement activities during 2010/11 is set out in the Experience section of the Quality Report. In addition to activities associated with our core patient experience strategy, in 2010/11 the Trust approved a further 70 patient surveys, and hosted 13 focus group events which sought a deeper understanding of patients' experience of the quality of, and access, to services.

Additionally, the Trust works in partnership with the local health community, where service reconfiguration is proposed, for example:

- The decision to centralise Ear, Nose and Throat, Oral and Maxillo-facial Surgery and Head and Neck services.
- The centralisation of specialist children's services in Bristol.
- The development and implementation of the South Bristol Community Hospital.
- The review of Pathology services and plans to develop in integrated local histopathology service.

- The development of involvement processes to engage seldom heard groups.

The Trust also works in partnership with communities of interest, relevant to the specific services University Hospitals Bristol provides, to develop a range of projects such as:

- The plans to redevelop the Bristol Royal Infirmary.
- The development of a helipad at the Trust.
- The decommissioning of the Bristol General Hospital.
- The planning and implementation of the developments at the Bristol Eye Hospital.
- The planning and implementation of developments at the Bristol Haematology & Oncology Centre.
- The review and continued development of services with Bristol and South Gloucestershire LINks.
- The establishment of lay reference groups to support and develop services for patients with dementia, learning difficulties, cancer and for carers.

Many of these examples of consultation and involvement are on-going and will continue into 2011/12.

Despite the challenging financial climate, the Trust is committed to a number of developments in the coming years. These are largely service-related developments, but also include two significant redevelopments of our estate.

Service developments planned for the period ahead include:

- the expansion of adult critical care services to include the development of an additional four beds; this development will significant reduce the operational impact associated with a lack of capacity in this area and will include improvements in the cancellation of elective care and delivery of cancer standards,
- the expansion of Neonatal Intensive Care (NICU) cots to reduce the number of babies that are refused local care and transferred to more remote level 3 NICU facilities,
- the introduction of national screening programmes for Down's Syndrome and Aortic Aneurysm and the age expansion of the national breast screening service and the development of a supra-regional service for the management of children with Osteogenesis Imperfecta, commissioned by the National Commissioning Group,
- the provision of a significant volume of day case and outpatient services from South Bristol Community Hospital, which will provide care closer to the population of South Bristol and provide welcome improvements in available day case capacity on the main campus, and,
- the establishment of University Hospitals Bristol as the head and neck cancer services provider to the cancer network area and the creation of new ward facilities to accommodate the transfer of patients from North Bristol, Bath and Weston.

Infrastructure developments planned for the period ahead include:

- An £80 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 70-bed integrated assessment unit and a significant increase in the proportion of single rooms,

- A £30 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, and,
- The procurement and roll-out of a new clinical information system, which will transform the way in which we use technology to support service delivery.

About our staff

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

Staff and management representatives consult on change programmes, policy development and strategic issues.

Over the past year, the Trust has consulted with staff on a number of service changes, and on changes to terms and conditions of employment for staff covered by the national employment contracts. The financial pressures faced by this, alongside every other Trust, make it likely that there will be further consultation on service 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.

Staff survey results 2010

The 2010 staff survey demonstrated a slight positive move in staff perceptions of working for the Trust and a stronger positive move compared with other Trusts.

The Trust scored in the top 20% of all participants for 15 scales (same as 2009) and above average for a further 12 scales (eight in 2009).

The Trust scored in the top 20% of all participants for overall staff engagement.

Other areas with positive overall scores related to feeling supported by line managers, valued by colleagues, having an interesting job, Trust commitment to work-life balance and flexible working, development opportunities, incident reporting and general scales around job satisfaction. The results of the survey are detailed below. The ratings are one a scale of 1-5 where they do not relate to percentages.

Areas where staff experiences have improved most since 2009/10:

Area	**2010 score and comparison with other Trusts**	**2009 score**
% staff suffering from work-related injury in the last 12 months	13% – Lowest (best) 20% Trusts	18%
% staff believing the Trust provides equal opportunities for career progression and promotion	92% – Above (better than) average	87%
Work pressure felt by staff	3.05 – Below (better than) average	3.14
Fairness and effectiveness of incident reporting procedures	3.54 – Highest (best) 20% of Trusts	3.49

Areas where staff experiences have deteriorated since 2009/10:

Area	2010 score and comparison with other Trusts	2009 score
% staff reporting errors, near misses or incidents witnessed in the last month	91% - Lowest (worst) 20% of Trusts	97%
% staff saying hand washing materials are always available	53% - Lowest (worst) 20% of Trusts	62%
Trust commitment to work-life balance	3.49 – Remains in highest (best) 20% of Trusts	3.54
Staff intention to leave jobs	2.42 – Remains below (better than) average	2.37

Top four ranking scores:

Area	2010 score	2009 score	Relative performance
% staff using flexible working options	70%	63%	Highest (best) 20% of Trusts
% staff feeling valued by their work colleagues	81%	76%	Highest (best) 20% of Trusts
Support from immediate managers	3.75	3.61	Highest (best) 20% of Trusts
Staff job satisfaction	3.59	3.48	Highest (best) 20% of Trusts

Bottom four ranking scores:

Area	2010 score	2009 score	Relative performance
% staff reporting errors, near misses or incidents witnessed in the last month	91%	95%	Lowest (worst) 20% of Trusts
% staff saying hand washing materials are always available	53%	67%	Lowest (worst) 20% of Trusts
% staff witnessing potentially harmful errors, near misses or incidents in the last 12 months	39%	37%	Highest (worst) 20% of Trusts
Percentage of staff appraised with personal development plans in the last 12 months	62%	66%	Below (worse than) average

The Trust scored in the bottom 20% for three scores (same as 2009) and below average for a further three (six in 2009). These related to staff having development plans, health and safety training and bullying and harassment.

The Trust is developing an action plan to ensure we build on the positive movement we have in our scores while tackling the areas where our staff have told us that we need to improve. This plan will be fully integrated with the Trust values of working together, embracing change, recognising success, respecting everyone.

The Chief Executive holds regular staff meetings and everyone is encouraged to attend. These provide an opportunity for staff to hear about issues affecting the Trust and a chance to contribute their views. In addition, the weekly Trust email bulletin Newsbeat provides a mix of staff and Trust news and information, including an update on performance.

In 2011 the Chief Executive sent a letter to all staff advising them of the financial landscape in which the Trust is now operating and the implications of this around service developments and the availability of funding for work. In addition, this letter highlighted some of the changes to terms and conditions that the Trust was making.

A team briefing process has been introduced this year to encourage the formal cascade of information through the Trust and to provide a consistent way for staff to raise issues through the management chain.

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

The bi-monthly staff magazine Voices provides a medium through which news relating to the Trust and its employees activities can be communicated in an informal and interesting way.

Staff costs and headcount are detailed in the Annual Accounts.

Statement of approach to equality and diversity

The Trust is committed to eliminating unlawful discrimination, promoting equality of opportunity and providing an environment which is inclusive for patients, carers, visitors and staff. 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 Chief Executive and the Trust Board are ultimately accountable for ensuring that the Trust's commitment to equality and diversity is implemented at all levels of the organisation and that all business is carried out in accordance with the values of the organisation.

The Trust has public duties in the domains of race, gender and disability and has prepared for the new public sector general duty to be implemented from 5 April 2011. The Director of Workforce and Organisational Development is the nominated lead director for equality and diversity on the Trust Board.

Implementation of the Single Equality Scheme and Action Plan is monitored on a six-monthly basis by the Trust Board. The life of the scheme has been extended until April 2012 by the Trust Board. Preparations for the forthcoming Equality Delivery System have taken place since November 2010.

Statement of compliance with publication duties

The Trust publishes its Valuing Diversity Strategy, Single Equality Scheme (2008-2012), Diversity Monitoring Data (includes staff and patient data), as well as Equality Impact Assessments. An annual web audit conducted by the South West Strategic Health Authority confirmed the Trust has remained compliant.

Action plans and timeframes to address any shortfalls

The Single Equality Scheme is the Trust's public commitment to meet statutory duties required by equality legislation. The scheme contains detailed action plans on issues affecting all equality and diversity strands. The scheme covers the period 2008 – 2012.

The Trust has made good progress and has completed 35 out of 43 items (75%). The scheme is being updated in the light of the Equality Act 2010, operational since October 2010. New actions resulting from this will be completed by April 2012. Work with Bristol Primary Care Trust to support the public health agenda and, specifically, health inequalities, is on-going.

The Equality Delivery System setting out a new range of equality and diversity objectives will supersede the Single Equality Scheme during 2011/12.

Summary of performance – workforce statistics:

Staff in post diversity profile (data point April 2011)

Gender	**Head Count**	**%**
Male	1,854	23.04%
Female	6,192	76.96%
TOTAL	**8,046**	**100%**

Ethnicity	**Head Count**	**%**
A White - British	6,322	78.57%
B White - Irish	105	1.30%
C White - Any other White background	376	4.67%
D Mixed - White & Black Caribbean	27	0.34%
E Mixed - White & Black African	16	0.20%
F Mixed - White & Asian	23	0.29%
G Mixed - Any other mixed background	42	0.52%
H Asian or Asian British - Indian	354	4.40%
J Asian or Asian British - Pakistani	41	0.51%
K Asian or Asian British - Bangladeshi	7	0.09%
L Asian or Asian British - Any other Asian background	144	1.79%
M Black or Black British - Caribbean	122	1.52%
N Black or Black British - African	244	3.03%
P Black or Black British - Any other Black background	43	0.53%

Ethnicity	Head Count	%
R Chinese	45	0.56%
S Any Other Ethnic Group	135	1.68%
Z Not Stated	0	0.00%
TOTAL	**8,046**	**100%**

Disability	Head Count	%
No	5,769	71.70%
Not Declared	263	3.27%
Undefined	1,791	22.26%
Yes	223	2.77%
TOTAL	**8,046**	**100%**

Age Profile	Head Count	%
16 - 20	95	1.18%
21 - 25	649	8.07%
26 - 30	1,102	13.70%
31 - 35	1,252	15.56%
36 - 40	1,111	13.81%
41 - 45	967	12.02%
46 - 50	945	11.74%
51 - 55	924	11.48%
56 - 60	626	7.78%
61 - 65	293	3.64%
Age Over 65	82	1.02%
TOTAL	**8,046**	**100%**

Analysis of Staff

As at 1 April 2011, the split between male and female staff is 23% and 77% respectively. This figure has not changed from last year.

There has been an increase of 0.7% in staff declaring themselves to be white British compared to the previous year. The number of black and minority ethnic staff working in the Trust is 21.43% (this figure includes White Irish and White Other backgrounds).

223 staff have declared themselves as having a disability as at April 2011, compared to 69 in the previous year. This figure has increased significantly through the Trust encouraging staff to declare any disability or impairment. As a percentage of the workforce this is 2.77% up from 0.86% in the previous year.

The number of staff employed in the age group of 16-25 is 744, a decrease of 28 from the previous year. This group of staff represents 9.25% of the workforce.

The number of staff aged 56 years or above has increased from 949 to 1001, an increase of 0.3% in the total workforce.

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

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

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

Priorities, monitoring arrangements and targets

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

All new staff complete the Trust online equality and diversity training as part of the induction programme and the aim is to increase coverage by 10% year on year and to develop further training programmes for managers. The Trust will also develop an action plan to reduce the number of incidents of harassment and bullying.

In the second half of the year, Trust Divisions will be required to identify objectives relating to their services, priorities, and patient needs, which will be used to develop the Trust's work for the Equality Delivery System. In future, equality and diversity will also form part of the performance management mechanism for Trust Divisional Boards.

The Trust understands its obligations to ensure that people with disabilities are given equal opportunity to enter into employment and progress wherever possible. Trust recruitment procedure was amended during the year in the light of changes to 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 policy and Recruitment policy.

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

The Trust is delivering bespoke training for staff who have become disabled, reviewing its approach to this activity and developing it to ensure it is both accessible and delivered in an appropriate way to participants. We are committed to developing all staff and teaching is provided in different ways to ensure access for all. The Trust has established three staff groups: 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 strategy for 2010-12 to ensure transparency and equity of opportunity for all staff. All staff are expected to have an annual appraisal in accordance with the Trust's Appraisal Policy.

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

Occupational health service

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

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

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

Occupational health is working with the Trust health and safety and human resources teams to review and improve existing provision for supporting staff in returning to work after sickness, immunisation compliance and dealing with the causes and effects of workplace stress.

A safe working environment

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

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

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

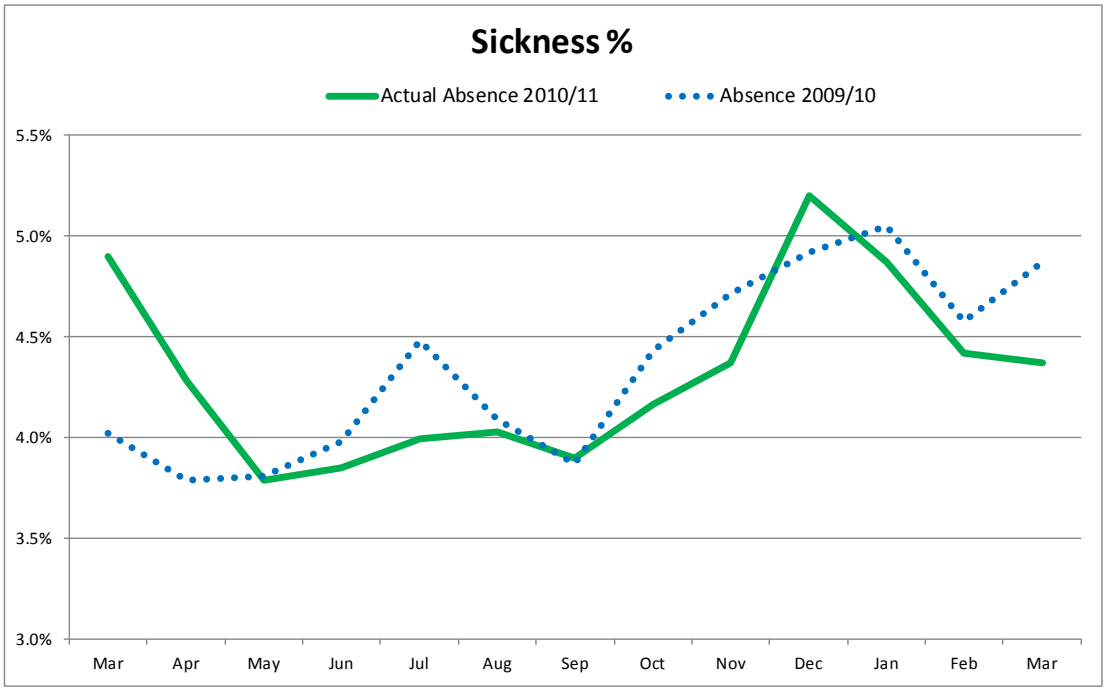
Sickness absence

The Trust-wide sickness absence rate was 4.3% for 2010/11, compared with 4.4% for 2009/10.

Average days lost to sickness per full time equivalent were 9.7 days for 2010/11.

During 2010/11, the Trust focused heavily on the area of sickness management. This has led to reductions at times of year when sickness has historically been higher.

The greater underlying reduction in sickness absence is not demonstrated in the figures, due to very high levels of absence associated with illness during the winter period. This can be seen in the graph below.



Our values

Respecting Everyone,

Embracing Change,

Recognising Success and

Working Together.

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

2010/11 has seen the values being communicated through poster campaigns and inclusion in all parts of Trust life. Values form a part of induction training as well as being included in all Trust-wide training programmes.

An ideas scheme was re-launched in 2010, linked to the values. This provides an additional way in which staff can contribute to the performance of the Trust. Staff awareness of the values is high with the vast majority of people being able to talk about them unprompted.

Financial performance

The key highlights for University Hospitals Bristol's financial performance during 2010/11 include:

- Delivery of an income and expenditure surplus of £12.039m (after a net impairment charge of £1.783m);
- A financial risk rating of '4';
- An EBITDA[1] (operating surplus) of £41.814m (8.25%);
- Achievement of cash releasing efficiency savings of £18.86m;
- Expenditure on capital schemes of over £25.4m;
- A healthy cash position (£53.0m) and a strong Balance Sheet.

University Hospitals Bristol has achieved financial break-even or better (before exceptional items) in each of the last eight years.

	Income and Expenditure Out-turn	**Normalised Income and Expenditure Position**	**Cash Balance 31 March**
	£'m	£'m	£'m
2003/04	0.1	(8.5)	0.5
2004/05	0.1	(3.8)	0.5
2005/06	3.3	6.7	0.5
2006/07	1.1	5.7	0.6
2007/08	12.8	4.5	7.7
2008/09	13.2	13.6	33.2
2009/10	11.4*	11.1	37.8
2010/11	13.8#	12.9	53.0

** Surplus before exceptional item – impairment of fixed assets at a cost of £15.7m*

 # Surplus before exceptional item – impairment of fixed assets at a net cost of £1.8m

The results for 2010/11 confirm we have delivered the third year of our financial strategy as a Foundation Trust. In summary, a good result for 2010/11 but with a lot of work to be done in 2011/12 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.

This financial position provides the bedrock for the approval of the major capital redevelopment for the Bristol Royal Infirmary and Bristol Royal Hospital for Children in 2011/12.

Statement of going concern

We have a reasonable expectation that University Hospitals Bristol 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.

[1] Earnings Before Interest Taxation Depreciation and Amortisation

Statement of Comprehensive Income (formerly Income and Expenditure)
University Hospitals Bristol reported a surplus of £12.039m for the year. The out-turn position is £6.117m better than the Annual Plan EBITDA surplus for the year.

Items	Plan for Year	Actual Year ended 31 March 2011	Variance Favourable / (Adverse)
	£'m	£'m	£'m
Operating Income*	494.312	506.620	12.308
Operating Expenses	(458.615)	(464.806)	(6.191)
EBITDA	35.697	41.814	6.117
Depreciation	(19.155)	(17.372)	1.783
Trust Debt Remuneration	(8.754)	(8.519)	0.235
Profit/(loss) on disposal	-	(0.480)	(0.480)
Interest receivable	0.146	0.296	0.150
Interest payable	(0.434)	(0.444)	(0.010)
Net Surplus before exceptional items	7.500	15.295	7.795
Exceptional item – Fixed Asset impairments	(1.220)	(3.256)	(2.036)
Total Comprehensive Income and Expenditure for the year	6.280	12.039	5.759

** Actual Operating Income includes the reversal of prior year impairments of £1.473m*

Cash Releasing Efficiency Saving plans
University Hospitals Bristol achieved cash releasing efficiency savings in excess of £18.86m in 2010/11. Income generation schemes contributed £4.23m. Reductions in pay costs of £7.42m were achieved and a further £7.21m was saved on supplies and services.

Statement of Financial Position (formerly Balance Sheet)
University Hospitals Bristol has a healthy statement of financial position which shows net working capital of £22.0m. The improvement over the year reflects the income and expenditure surplus (before exceptional items) achieved by the Trust. This is, in turn, reflected in our balances which show current assets of £81.7m and current liabilities of £59.7m.

Cash flow

University Hospitals Bristol ended the year with a cash balance of £53.0m. The cash flow statement in the Annual Accounts shows a £15.2m increase in cash over the year. This is due to the following:

	£'m
Net cash flow from operating activities	46.1
Net cash flows from investing and other financing activities	3.0
Capital expenditure	(25.4)
Public Dividend Capital dividend payment	(8.5)
Increase in cash balance 2010/11	**15.2**

Better Payment Practice Code

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

Items	**Year ended 31 March 2011**	
	Number	**Value £'m**
Total non NHS trade invoices paid in the period	147,973	152.223
Total non NHS trade invoices paid within target	132,096	133.608
Percentage of non NHS trade invoices paid within target	89.3%	87.8%

Total NHS trade invoices paid in the period	4,445	58.133
Total NHS trade invoices paid within target	4,061	54.506
Percentage of NHS trade invoices paid within target	91.3%	93.8%

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

No payments were made from claims made under the Late Payment of Commercial Debts (Interest) Act 1998 in 2010/11 (2010: £0.001m). No other compensation was paid to cover debt recovery cost under this legislation.

Capital

University Hospitals Bristol incurred capital expenditure of £25.415m. The table that follows shows a breakdown of funding and expenditure on major schemes.

	Year Ended 31 March 2011		
	Plan	Actual	Variance Fav/(Adv)
	£'000	£'000	£'000
Sources of Funding			
Donations	3,581	2,155	1,426
Retained depreciation	16,905	16,090	815
Cash balances	15,981	7,170	8,811
Total Funding	**36,467**	**25,415**	**11,052**
Expenditure			
Strategic schemes	(16,277)	(9,712)	6,565
Medical equipment	(5,651)	(4,380)	1,271
Information technology	(5,432)	(3,841)	1,591
B/Forward schemes	(2,016)	(1,601)	415
Refurbishments	(4,928)	(2,274)	2,654
Operational / other	(8,869)	(3,607)	5,262
Anticipated slippage	6,706	-	(6,706)
Total expenditure	**(36,467)**	**(25,415)**	**11,052**

University Hospitals Bristol has secured an offer of 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 Bristol Royal Infirmary. Take up of the loan is subject to approval by the Trust Board of the Full Business Case for the redevelopment project and completion of the Monitor due diligence process. The Full Business Case for the Centralisation of Specialist Paediatrics was approved by the Board in March 2011. The loan is available for staged drawdown in 2012/13 and 2013/14.

Private Patient Cap (see Note 3.3 of the Annual Accounts)
Section 44 of the 2006 Act requires that the proportion of private patient income to total patient related income should not exceed the proportion that was achieved whilst the body was an NHS trust in 2002/03, which was 1.1%. The table below summarises our performance against this requirement.

Item	**Year ended 31 March 2011**
Private patient income	£2.521m
Total patient income	£393.085m
Private patient income as a proportion of total patient related income	0.64%

University Hospitals Bristol operated within the Private Patient Cap in 2010/11.

Prudential Borrowing Limit (PBL)
University Hospitals Bristol is also required to comply and remain within the Prudential Borrowing Limit which is set by Monitor. For 2010/11 this was set at £109.4m. This represents maximum long-term borrowing of £71.9m and an approved working capital facility of up to £37.5m. A Working Capital Facility of £37.5m was put in place for two years from 1 September 2010.

University Hospitals Bristol uses the Education Centre under a Finance Lease arrangement. The liability of £6.306m is a first call against the Prudential Borrowing Limit of the Trust.

University Hospitals Bristol'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 2011**	**Approved PBL Tier 1 ratios**
Minimum dividend cover	4.9x	>1x
Minimum interest cover	95x	>3x
Minimum debt service cover	72x	>2x
Maximum debt service to revenue	0.1%	<2.5%

At 31 March 2011, University Hospitals Bristol is performing within all of the approved Prudential Borrowing Limit ratios (see Note 23 of the Annual Accounts).

Financial Risk Rating
Financial risk is assessed by 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 University Hospitals Bristol's performance against the criteria. The overall rating of 4 is a good result and reflects the sound financial position of the organisation.

Financial criteria	Metric to be scored		31 March 2011
Actual			Rating
Achievement of plan	EBITDA* Margin	8.25%	3
Underlying performance	EBITDA* Achieved	117%	5
Financial efficiency	Return on Assets	8.04%	5
Financial efficiency	I&E Surplus Margin	3.11%	5
Liquidity	Liquid Ratio	39.5 days	4
Overall rating		4 (actual weighted score = 4.25)	

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

The above table shows University Hospitals Bristol's weighted financial risk score is 4.25 and the overall financial risk rating is 4.

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

Financial outlook

We are planning to achieve the following for 2011/12:

- A surplus on the Statement of Comprehensive Income which represents an EBITDA rate of 6.7%,
- A planned surplus of £6.1m,
- A planned cash balance at the year-end of £33m,
- A savings programme of £18.4m,
- A capital programme of £47m, and,
- A Financial Risk Rating weighted score of 3.45 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, and,
- Maintenance of a strong on-going trading position which allows for management of potential downside scenarios in future years.

To achieve the planned surplus the following are required:

- Delivery of the planned savings for 2011/12,
- Conversion of non-recurring savings from 2010/11, 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, and,
- Delivery of Commissioning for Quality and Innovation targets agreed with commissioners.

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

- Primary Care Trusts are experiencing financial difficulties due to large increases in both elective and emergency activity. Attempts to restrict/cap payment to Trusts are becoming common. Over-performance on service level agreements cannot necessarily be assumed to be funded from commissioners in future, and,
- Pressures on spending and delivery of savings are intensifying and firm control is required to avoid the Trust's current financial position and its medium term plans being undermined.

Management Costs

	Year ended 31 March 2011 £000	**Year ended 31 March 2010 £000**
Management costs	18,509	18,065
Income	506,620	485,642
Percentage of income	3.7%	3.7%

Analysis by Segment	**2010/11**			**2009/10**		
	UH Bristol	Skills for Health	Totals	UH Bristol	Skills for Health	Totals
	£'000	£'000	£'000	£'000	£'000	£'000
Management costs	17,068	1,441	18,509	16,645	1,420	18,065
Income	475,007	31,613	506,620	453,280	32,362	485,642
Percentage of Income	3.6	4.6	3.7	3.7	4.4	3.7

"Management costs" are as defined as those on the Management Costs Website[2].

Retirements due to ill health

During the year ended 31 March 2011 there were 11 (2010: eight) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill-

[2] Full URL:

(www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en)

health retirements will be £0.485m (2010: £0.45m). The cost of these ill health retirements will be borne by the NHS Business Services Authority – Pensions Division.

Policies on counter-fraud and corruption

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

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

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

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

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

Work is carried out across the seven generic areas of counter fraud activity:

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

External Audit

University Hospitals Bristol's External Auditors are the Audit Commission. Audit fees in relation to the statutory audit of University Hospitals Bristol's Accounts for the year ended 31 March 2011 were £71,137 (excluding VAT).

University Hospitals Bristol also asked the Audit Commission to undertake a review of it's 2009/10 Quality Account and incurred a charge of £15,500 (excluding VAT) for this service.

The Audit Commission carried out additional work as part of a national fraud initiative at a cost of £1,175 (excluding VAT).

Remuneration for Senior Managers

Details of remuneration for all Directors of the Trust are set out in full at "Directors' Remuneration" on page 66 of this report. The remuneration of Executives is determined annually by the Trust Remuneration Committee using guidance from the Department of Health. Remuneration is based on national guidance, rather than performance. Performance is not currently a factor in remuneration of senior management.

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

4. NHS Foundation Trust Code of Governance

University Hospitals Bristol NHS Foundation Trust is a public benefit corporation and is required either to comply with the best 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.

Provisions of the Code

The Board of Directors considers that it was fully compliant with the provisions of the NHS Foundation Trust Code of Governance or had otherwise appropriate arrangements for governance in place. By year-end, the Board of Directors had made the following revisions to its corporate governance provisions (paragraphs are numbered to correspond with the provisions of the Code):

A.1 – Board of Directors

"Every NHS Foundation Trust should be headed by an effective board of directors, since the board is collectively responsible for the exercise of the powers and the performance of the NHS Foundation Trust."

The Board records that it underwent a transition during the 2010/11 year with a number of changes in both Executive and Non-Executive composition. These were as a result of the departure of directors including the previous Chief Operating Officer, Medical Director and one Non-Executive Director. The Board established suitable and appropriate interim arrangements to cover these roles, and successfully recruited and appointed to the vacancies. The Board does not consider that its performance as a whole was significantly impacted during the period of interim arrangements.

A.2 – Division of Responsibilities

"There should be a clear division of responsibilities at the head of the NHS Foundation Trust between the chairing of the boards of directors and governors and the executive responsibility for the running of the NHS Foundation Trust's business. No one individual should have unfettered powers of decision."

The Board considered the role, function and membership of its Board Committees and concluded that clearer lines of accountability for the management of risk should be established. Accordingly, the Board resolved to replace the Governance and Risk Management Committee with suitable risk management arrangements delegated to the Chief Executive. Further consideration to ensuring the independence of the Chairman concluded that he would not be a member of Board Committees other than the Nomination and Appointments Committee and the Remuneration Committee.

C.1.10 – Nominations Committee

"It is a requirement of the 2006 Act that the chairman, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are [sic] responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairman, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive."

Prior to the formal establishing of a Nomination and Appointments Committee for the appointment of Directors, this duty was discharged by the Non-Executive Directors of the Trust in accordance with the Foundation Trust Constitution. The Nomination and Appointments Committee was established by the Board in January 2011.

There is no implication that any of the decisions of the Board of Directors are impaired as a result of the adoption of this approach, but the establishing of the Nomination and Appointments Committee for the appointment of Executive Directors demonstrates clear and explicit compliance with the Code.

C.2.3 – Information about Elected Governors Standing for Re-election

"Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information such as attendance records at governor meetings and other relevant events organised by the NHS Foundation Trust for governors."

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

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

E.2.3 – Remuneration of the Non-executive Directors and Chairman

“The board of governors is responsible for setting the remuneration of non-executive directors and the chairman. The board of governors should consult external professional advisers to market-test the remuneration levels of the chairman and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.”

The Membership Council did not consult specific external professional advisers to market-test the remuneration levels of the Chairman and other Non-Executive Directors. The original recommendations made to the Membership Council were based on independent advice and guidance as issued from time to time by appropriate bodies such as the Foundation Trust Network, which provides benchmarked and externally validated guidance relevant to Foundation Trusts. Pertinently, there were no changes to the remuneration of the Chairman or the Non-Executive Directors suggested in this financial year.

Trust Board of Directors

Every NHS Foundation Trust must be headed by a Board of Directors who are collectively responsible for the exercise of the powers and the performance of the NHS Foundation Trust.

The table below sets out the names, appointment dates and tenure of the Chair, Vice Chair and Senior Independent Director of the University Hospitals NHS Foundation Trust Board of Directors:

	Appointment Date	Term of Office End Dates
Dr John Savage, CBE – Chairman	1 December 2006	30 November 2013
Mrs Emma Woollett – Vice Chair	1 January 2006	31 December 2012
Mr Iain Fairbairn – Senior Independent (Non-Executive) Director	1 December 2007	30 November 2011

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

	Appointment date	End Date
Mr Robert Woolley, Chief Executive	Acting – 23 December 2009 Substantive – 8 September 2010	Not applicable
Mr Paul Mapson, Finance Director	October 2002	Not applicable
Dr Jonathan Sheffield, Medical Director	1 September 2004	30 September 2010
Dr Jane Luker, Acting Medical Director	1 October 2010	Not applicable
Ms Alison Moon, Chief Nurse	13 July 2009	Not applicable
Mr Steve Aumayer, Director of Workforce & Organisational Development	25 June 2009	Not applicable
Mrs Irene Gray, Chief Operating Officer	10 March 2008	31 July 2010
Mr Tony Ranzetta, Acting Chief Operating Officer	26 July 2010	11 March 2011
Mr Jim O'Connell, Acting Chief Operating Officer	17 February 2011	Not applicable
Ms Deborah Lee, Acting Director of Corporate Development	17 May 2010	
Ms Deborah Lee, Director of Strategic Development	4 February 2011	Not applicable

The table below sets out the names, appointment dates and tenure of the Non-Executive Directors of the University Hospitals NHS Foundation Trust Board of Directors, all of whom are considered to be independent as defined in the Foundation Trust Code of Governance.

	Appointment date	Term of office End Dates
Emma Woollett – Non-Executive Director and Vice-Chair	1 January 2006	31 December 2012
Lisa Gardner – Non-Executive Director and Chair of Finance Committee	1 June 2007	31 May 2014
Iain Fairbairn – Senior Independent Non-Executive Director	1 December 2007	30 November 2011
Professor Selby Knox – Non-Executive Director	1 February 2008	31 January 2012
Paul May – Non-Executive Director	1 November 2008	31 October 2011
Kelvin Blake – Non-Executive Director	1 November 2008	31 October 2011
John Moore – Non-Executive Director	1 January 2011	31 December 2014

Biographies of the Chairman, Chief Executive and Directors are set out at “Appendix A – Biographies of Members of the Trust Board of Directors” on page 61 of this report.

Role and Function of the Trust Board of Directors

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 set in place by a Board of Directors 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 Board is accountable to stakeholders for the creation and achievement of strong sustainable performance and the creation of long-term stakeholder value, and is responsible for organising and directing the affairs of the Trust and its services in a manner that will promote the success of the Trust and is consistent with good corporate governance practice, and for ensuring that in carrying out its duties, the Trust meets 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 of matters reserved to it. These include 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 Trust’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.

The Trust Board of Directors discharged its duties during 2010/11 in twenty private and public meetings, and through the work of its Committees. Membership of the Committees required by the Foundation Trust Code of Governance and the Foundation Trust Constitution, and the attendance of members at meetings of the Committees is set out in the table below.

Membership and Attendance at Board and Committee Meetings

The table below shows the attendance of Directors at meetings of the Trust Board of Directors and its 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 was expected. 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	Nomination & Appointments Committee	Remuneration Committee	Audit & Assurance Committee	Finance Committee	Governance & Risk Management Committee
No. of Meetings in Year	**20**	**2**	**2**	**5**	**11**	**4**
Chairman						
John Savage	C17(20)	C2(2)	C2(2)	0(0)	10(11)	0(0)
Chief Executive						
Robert Woolley	19(20)	2(2)	1(2)	4(0)	10(11)	C3(4)
Non-Executive Directors						
Emma Woollett	17(20)	2(2)	2(2)	C4(5)	0(0)	0(0)
Iain Fairbairn	16(20)	2(2)	2(2)	4(5)	0(0)	0(0)
Lisa Gardner	20(20)	2(2)	2(2)	4(5)	11(11)	0(0)
Selby Knox	17(20)	2(2)	2(2)	0(0)	0(0)	0(0)
Paul May	20(20)	2(2)	2(2)	5(5)	0(0)	0(0)

	Trust Board of Directors	Nomination & Appointments Committee	Remuneration Committee	Audit & Assurance Committee	Finance Committee	Governance & Risk Management Committee
Kelvin Blake	15(20)	2(2)	2(2)	0(0)	9(11)	0(0)
John Moore	3(5)	2(2)	2(2)	0(0)	0(0)	0(0)
Executive Directors						
Paul Mapson	19(20)	0(0)	0(0)	4(0)	11(11)	3(4)
Deborah Lee	15(20)	0(0)	0(0)	0(0)	3(0)	2(4)
Steve Aumayer	18(20)	1(0)	0(0)	0(0)	0(0)	4(4)
Alison Moon	15(20)	0(0)	0(0)	2(0)	0(0)	3(4)
Jonathan Sheffield	8(9)	0(0)	0(0)	2(0)	0(0)	1(2)
Irene Gray	3(5)	0(0)	0(0)	1(0)	2(4)	1(1)
Acting and Interim Directors						
Jane Luker	12(13)	0(0)	0(0)	0(0)	0(0)	0(0)
Tony Ranzetta	12(14)	0(0)	0(0)	0(0)	4(10)	0(0)
Jim O'Connell	3(3)	0(0)	0(0)	0(0)	2(0)	0(0)
Pat Fields	2(3)	0(0)	0(0)	1(0)	0(0)	0(0)
Deborah Lee	15(20)	0(0)	0(0)	0(0)	3(0)	2(4)

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

Board of Directors – Remuneration and Terms of Office

The remuneration, allowances and the other terms and conditions of office, of the Chair and the other Non-Executive Directors is decided at a general meeting of the Membership Council.

Business Interests

Members of the Board of Directors are required to disclose details of company directorships or other material interests in companies held by Directors which may conflict with their management responsibilities. The Trust Secretariat maintains a register of interests, which is available to members of the public by contacting the Trust Secretariat at the address given at

"Appendix C – Contact Details" on page 71 of this report. The register also contains any significant commitments of the Chairman and any changes to these during the year.

Audit and Assurance Committee

The Audit and Assurance Committee consisting of four Non-Executive Directors, chaired by the Vice-Chair of the Trust, met on four occasions in the reporting period and once in the month after the close of the year to ensure a full and effective handover to the newly established Audit Committee.

The Audit and Assurance Committee reviews 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), that supports the achievement of the Trust's objectives.

In particular, the Committee reviews 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,
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the controls in place and the appropriateness of the disclosure statements,
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and,
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

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

Membership of and attendance at meetings of the Audit and Assurance Committee are set out in the table entitled "Membership and Attendance at Board and Committee Meetings" on page 39 of this report.

By year-end, the Audit and Assurance Committee had fully discharged the duties set out in its Terms of Reference which are publicly available; and had undertaken a formal review of its own performance.

Internal Audit

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

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal,
- Review and approval of the internal audit strategy, operational plan and more detailed programmes of work, ensuring this is consistent with the audit needs of the organisation as identified in the Assurance Framework,

- Consideration of the major findings of internal audit's work (and management's response), and ensure co-ordination between the internal and external auditors to optimise audit resources,
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation, and,
- Annual review of the effectiveness of internal audit.

At the time of writing this report, the draft Head of Internal Audit Opinion on the effectiveness of the system of internal control at University Hospitals Bristol NHS Foundation Trust for the year ended 31 March 2011 was that "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.

The basis for the Head of Internal Audit's opinion was as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes,
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses, and,
- Any reliance that is being placed upon third party assurances.

External Audit

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

- Consideration of the appointment and performance of the external auditor in line with the Code of Conduct for Foundation Trusts,
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the Trusts Annual Plan, and ensure co-ordination, as appropriate, with other external auditors in the local health economy,
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee, and,
- Review all external audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

Financial Reporting

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

- The wording in the Statement on Internal Control and other disclosures relevant to the terms of reference of the Committee,

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

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

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

Other Assurance Functions

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

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

Independence of the External Auditor in providing non-audit services

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

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

The Membership Council has approved a statement setting out when it is considered appropriate to engage the appointed auditor on non-audit work. The auditor has procedures for concluding whether possible non-audit work could compromise his independence, or be perceived to compromise it. In line with the Auditing Practice Board's ethical standards, if he cannot put in place appropriate safeguards, he will not bid for the work.

Nomination and Appointments Committee

The Trust Board of Directors has appointed a Nominations and Appointments Committee in accordance with Schedule 1 of the University Hospitals Bristol NHS Foundation Trust Constitution (paragraph 2.6) and Schedule 7 of the NHS Act 2006 (paragraph 17(4)).

The purpose of the Nominations and Appointments Committee is to appoint or remove the Executive Directors of the Trust, other than the Chief Executive who shall be appointed or removed by the Non-Executive Directors subject to approval by the Members Council.

The Committee met twice in this reporting period to make appointments to the offices of:

- Director of Strategic Development – Deborah Lee, with effect from 4 February 2011,
- James Rimmer – Chief Operating Officer, with effect from 01 July 2011, and,
- Sean O'Kelly – Medical Director, with effect from 19 April 2011.

Membership and attendance of the Committee is set out in the table entitled "Membership and Attendance at Board and Committee Meetings" on page 39 of this report.

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:

- The control and management of the finances of the Trust,
- The target level of cash releasing efficiency savings (CRES) and actions to ensure the CRES targets are achieved,
- The budget setting principles,
- The year-end forecasting,
- Information sharing and consistency of approach,
- Commissioning,
- Bank mandates, and,
- The Capital Plan.

The Committee met 11 times in the course of this reporting period and gave full consideration to its Terms of Reference.

The membership and attendance of the Finance Committee is set out in the table titled "Membership and Attendance at Board and Committee Meetings" on page 39 of this report.

Governance and Risk Management Committee

The Governance and Risk Management Committee was constituted for the purpose of establishing a strategic approach to governance and risk management throughout the Trust and was responsible for the overall coordination of governance and risk management activity. It undertook to ensure that the necessary processes were in place to achieve compliance with statutory requirements and to protect the Trust's patients, staff and assets.

The Committee met four times in the course of this reporting period and gave full consideration to its terms of reference.

The membership and attendance of the Governance and Risk Management Committee is set out in the table titled "Membership and Attendance at Board and Committee Meetings" on page 39 of this report.

As noted elsewhere in this report, the Governance and Risk Management Committee will be replaced with new corporate governance and risk management arrangements from May 2011.

Remuneration Committee

The Trust Remuneration Committee decides the pay, allowances and other terms and conditions of the Executive Directors annually, using guidance issued by the Department of Health. Remuneration is based on national guidance, not performance. No significant awards have been made to Directors and there has been no bonus payment.

Given the general pressure on budgets and pay across the NHS and the Trust, there was no uplift in salaries for Directors in 2010/11.

The Committee comprises the Chairman and Non-Executive Directors of the Trust and is advised by the Chief Executive, Director of Workforce and Organisational Development and the Trust Secretary.

The Committee met twice in this reporting period to decide the remuneration for the new appointees shown under the activities of the Nomination and Appointments Committee above.

The membership and attendance of the Remuneration Committee is set out in the table titled "Membership and Attendance at Board and Committee Meetings" on page 39 of this report.

Performance of the Trust Board of Directors and its Committees

The Trust Board of Directors undertakes an annual review of its own performance and that of its Committees to ensure that it remains fit for purpose and sustains the capacity and capability to discharge its duties effectively. This includes a consideration of the balance, completeness and appropriateness of the membership of the Board.

Each of the Committees of the Trust Board undertook a self-assessment of their effectiveness, and made recommendations for improvement where appropriate. This evaluation was undertaken in conjunction with the review of corporate governance undertaken by the Trust Secretary on behalf of the Board which resulted in recommendations for a restructuring of the roles and functions of the Committees of the Board. These revisions were approved by the Trust Board on the recommendation of the Audit and Assurance Committee in March 2011. These changes followed an assessment of the suitability of Board Committee arrangements both from a compliance point of view, and also in terms of fitness for purpose to face the future governance challenges the Trust might face.

In addition, external appraisal of the Trust Board commissioned by the Committee in 2009/10 was followed up in 2010/11, with a confirmation that all of the recommended actions had been taken. This independent assessment of the Trust Board of Directors will be repeated in 1011/12. 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 Nominations and Appointments Committee (for Non-Executive Directors).

Membership Council

The Trust is required to have a Board of Governors and a Board of Directors. We have chosen to call our Board of Governors the Membership Council and this Council is responsible for discharging the duties of a Board of Governors to hold the Board of Directors collectively to account for the performance of the NHS Foundation Trust, including ensuring the Board of Directors acts so that the NHS Foundation Trust does not breach the terms of its authorisation.

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

It remains the responsibility of the Trust Board of Directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS Foundation Trust, and the Board is accountable to the Membership Council for the performance of the Trust in this regard. The Membership Council and Trust Board of Directors communicate principally through the Chairman who is the formal conduit between the two corporate bodies. However, the Board and Membership Council members participate in a range of activities together to ensure constant and clear communication and co-operation.

The Board of Directors may request the Chair to seek the views of the Membership Council on any matters the Board of Directors may determine. Communications between the Membership Council and the Board of Directors may occur with regard to, but are not limited to:

- the Board of Directors' proposals for the strategic direction and the Annual Business Plan,
- the Board of Directors' proposals for developments,
- Trust performance, and,
- involvement in service reviews and evaluation relating to the Trust's services.

The Board of Directors also presents the Annual Accounts, Annual Report and Auditor's Report to the Membership Council.

Additionally, Directors regularly attend meetings of the Membership Council, and Governors regularly attend the public meetings of the Board of Directors.

Management of the Trust's day-to-day business is delegated to the Trust management executive by the Board which monitor progress and derives assurances through the Board reporting cycle, the activities of the Board Committees, and the detailed scrutiny of the Board Assurance Framework, particularly by Non-Executive Directors. The Board uses specialist Board Committees to extend its monitoring and scrutiny responsibility, as well as to undertake other functions on its behalf.

Meetings of the Membership Council

The Membership Council meets four times a year to discharge its statutory duties. Executive Directors from the Trust Board of Directors regularly attend these meetings both to brief the Membership Council on current events and matters of significance, and to answer any questions the Governors may wish to ask. In addition, the Council and Board of Directors have a joint meeting annually where their business is transacted with the full Council and

Board present. There is a further Annual Members Meeting at which the Trust Board of Directors is present.

The Council has established three formal working groups at to focus on specific elements of the Council and Board's business. These are the Quality Group, Membership Group, and the Strategy Group. Executive Directors participate in these group meetings as regular attendees.

Further comment on the interaction of the Membership Council and the Trust Board of Directors is provided in the Statement on Internal Control in the Annual Accounts for 2010/11 provided at Appendix E of this report.

Appointment and removal of Non-Executive Directors

Non-executive Directors are appointed by the Governors at a general meeting of the Membership Council. This includes the Chairman of the Trust Board of Directors and the Membership Council. The recruitment, selection and interviewing of Non-Executive Directors is overseen by the Nomination and Appointments Committee of Governors. The Foundation Trust Constitution requires that Non-Executive Directors are members of the public or patient constituencies.

The removal of the Chair or any other Non-Executive Director requires the approval of three-quarters of the members of the Membership Council.

Nomination and Appointments Committee

The Governor Nominations and Appointments Committee is a formal committee of the Membership Council charged with determining 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. The Committee shall seek by way of open advertisement, and other means, candidates for office and assess and select for interview such candidates as are considered appropriate. In doing so the Committee is at liberty to seek advice and assistance from persons other than members of the Committee or of the Membership Council.

The Membership Council shall resolve to appoint such candidate or candidates (as the case may be) as it considers appropriate and in reaching its decision it shall have regard to the views of the Board of Directors and of the Nominations and Appointments Committee as to the suitability of the available candidates.

Additionally, the Committee shall, on a regular and systematic basis, monitor the performance of the Chair and other Non-Executive Directors and make reports to the Membership Council from time to time when requested to do so or when, in the opinion of the Committee, the results of such monitoring ought to be brought to the attention of the Membership Council. The Committee also considers and makes recommendations to the Membership Council as to the remuneration and allowances and other terms and conditions of office of the Chair and other Non-Executive Directors.

The Committee made one new Non-executive Director appointment in 2010/11, appointing John Moore to the Board of Directors with effect from 1 January 2011.

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

The Nominations and Appointments Committee attendance record is included in the "Attendance at Membership Council and Nominations and Appointments Committee Meetings" table on page 58 of this report.

Business interests

Governors are required to disclose details of any company directorships or other material interests in companies held by Governors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS Foundation Trust. A register of Governors' interests is available to the public from the Trust Secretariat at the address provided at "Appendix C – Contact Details" on 71 of this report.

Foundation Trust membership

The Trust has continued to maintain and develop a representative membership of people from eligible constituencies so as to maintain the Foundation Trust governance model of local accountability through members and governors. We have increased our membership and continue to work to ensure that our membership remains representative of the communities we serve. We ensure that those who join as members have opportunities to be actively engaged with the Trust and the work of the Membership Council.

Membership size and variations

The changes in membership size throughout 2010/11 and estimated growth for 2011/12 are shown in the table below.

	Previous year	Next year (estimated)
Public constituency		
At year start (1 Apr 2010)	5,783	6,072
New members	478	300
Members leaving	189	200
At year end (31 March 2011)	6,072	6,172
Patient constituency		
At year start (1 Apr 2010)	5,821	6,022
New members	726	308
Members leaving	525	202
At year end (31 March 2011)	6,022	6,128
Staff constituency		
At year start (1 Apr 2010)	8,128	8,298
New members	1,243	1,050
Members leaving	1,073	1,350
At year end (31 March 2011)	8,298	7,998

Changes in membership size throughout 2010/11 and estimated growth for 2011/12

Our public and patient membership grew from 11,602 to 12,094 and staff membership was maintained at nearly 100% with just two staff opting out. The combined public, patient and staff membership as of 31 March 2011 stands at 20,392. This has been achieved by offering

membership to patients and their carers in our hospital outpatient areas, work experience students, Youth Council and at Trust events. Membership of the staff constituency is on an opt-out basis and all new staff are briefed on their membership eligibility and options during their formal Trust induction.

A total of 714 members details were removed from the membership database during a routine cleansing of the database. These will have included the details of 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. A number of tertiary patient members were no longer eligible for membership.

Analysis of current membership

The profile of the Trust's membership at the end of March 2011 is shown in the table below:

Profile of the Trust's membership at the end of 2010/11

Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	493	129,571
17-21	364	53,660
22+	4,957	624,154
Unknown	258	
Ethnicity:		
White	5,232	768,138
Mixed	77	10,848
Asian/Asian British	166	13,318
Black/Black British	150	9,856
Other	447	5,225
Socio-economic groupings:		
ABC1	4,411	351,721
C2	997	91,966
D	195	100,097
E	450	89,182
Unknown	19	174,419
Gender:		
Male	2,608	395,109
Female	3,362	412,276
Unknown	102	
Patient constituency	**Number of members**	**Eligible membership (last 3 years)**
Age:		
0-16	509	65,639
17-21	152	30,954
22+	5,361	305,809

Developing a representative and engaged membership

The Board of Directors and the Membership Council share the aim of developing an engaged membership by encouraging members to be involved in service developments and maintaining a representative membership. Our Membership Development Plan provides the framework for engaging members, building the membership, and supporting the Governors.

Our aim is to increase the least-represented group of members, which is children and young people. The Young Persons Involvement Lead together with the Membership Manager has

developed a membership package to promote young people's engagement and to attract new young members from diverse backgrounds. This includes:

- Youth Council: The Youth Council meets monthly and reports directly to the Governors Membership Working Group and to the Membership Council. Three Youth Council members had been elected as Governors. The work with the Youth Council is ground breaking and is a unique opportunity for a Foundation Trust and the Children's Hospital,
- Improving services: The Youth Council and young members continue to be involved in improving services by being part of a focus group for hospital food, commenting on patient leaflets from a young person's view, issuing a newsletter for young people, attending the Patient Environment Action Team audit at the Bristol Royal Hospital for Children, and,
- Mystery Shopping: Mystery Shopping events for young people are twice a year to test the services of six hospitals. Reports are sent to the Divisional Boards.

In addition public, patient and staff members have been involved in various opportunities including:

- Attending patient environment action team audits,
- Nominating themselves in the Governor election,
- Attending the Annual Members Meeting,
- Part of a focus group to improve the Trust's web site,
- Part of a focus group for the evaluation of clinical care,
- Attending a Staying Positive workshop for young people, and,
- Attending an education event Medicine for Member on healthy eyes.

We proactively support the involvement of our Governors in a wide range of activities within the Trust to assist the Governors in completing their statutory and mandatory responsibilities. The involvement includes attending the Trust Board and Governors are able to ask questions. They also have regular meetings with the Chairman, Chief Executive, Directors, Non-Executive Directors and Head of Division.

The Governor's formal meeting framework includes 14 formal meetings each held monthly, bi-monthly or quarterly. The Governors are involved in a many activities within the Trust (more than 120 opportunities). They include attending meetings of project teams and service improvement groups, clinical excellence awards, quality walk-rounds, PEAT audit, seminars, strategy workshops, surveying patients on wards.

Evaluation of steps to achieve a representative membership

We have increased our four to sixteen year olds membership from 798 to 1,002 members and the seventeen to twenty-one year olds from 413 to 516 members. The successful recruiting of young people is credited to the success of the Youth Council and the work experience programme. It is also pleasing to see that the Youth Council has a representative membership from many communities.

Elections

Governor elections took place between March and May 2010 in four constituencies for 14 governor seats. They were:

- Public Bristol (turnout was 24.9%),
- South Gloucestershire (turnout was 24.3%),
- Local Patients (turnout was 33.9%),
- Non-local Patients (turnout was 33.4%),
- Carers of patients 16 years and over – uncontested,
- Staff Other Clinical Healthcare Professionals – uncontested, and,
- Staff Nursing and Midwifery – uncontested.

Electoral Reform Services Ltd was appointed as the Independent Returning Officer for the elections. The elections were run in accordance with the Trust's Rules for Elections as set out in the Constitution. The election was successful in filling all the Governor seats.

In addition to those Governors who left as a result of the elections, one public Governor and three appointed Governors resigned midway through their tenure. In line with the Trust's Rules for Elections, the public vacant seat was offered to the candidate who had received the next highest vote in that constituency. The appointed organisations replaced their Governors.

Membership Strategy

The Trust's Membership Development Plan had been approved by the Board and Membership Council in May 2010. The Plan will be reviewed in 2011 by the governors, Trust Board and staff. This sets out the support for governors and the Membership Council, a detailed schedule of member recruitment and engagement events. This supplements our long-term aim to embed membership in all the Trust's development activities.

Progress against this plan has been monitored by the Governor Membership Working Group and through to the Membership Council.

The key objectives are:

- To achieve an increase in membership of new public and patient constituencies by 608. This is in addition to replacing those members who have left membership, which is estimated to be 402. Therefore, the aim is to recruit 1,010 members to replace members who leave membership and to increase the overall membership figure. We will continue to focus on recruiting membership in under-represented groups, specifically children and young people. We will do this by building on the successes of the Youth Council and our work experience and schools liaison programmes.
- To focus membership recruitment on under-represented groups from black minority and ethnic communities by linking with the Public Involvement Project Lead and the Equality and Diversity Manager. We recognise the need to continue to work towards long-term engagement of these communities.
- To maintain staff membership at 95% or higher. The aim is to work with our staff Governors to improve membership involvement in all our staff groups and link to the Foundation Trust Network commissioned Foundation Trust Staff Governor Study.
- To continue to engage our members by providing a range of involvement opportunities, including Medicine for Members events, Trust programme of events and service improvements linked with members' special interests.
- Elections will take place in 2011 for 13 Governor seats.
- Appointed and Partnership Governors have completed their first term of office in May 2011 and they will be invited to appoint the governors for a second term to 2014.

Examples of key areas to engage members include:

- Medicine for Members events: Four events per year based on members special interests. These will be education events for members to hear from consultants and members can ask questions. They will also meet their Governors.
- Members' newsletter: Three issues per year to inform the membership on membership and Trust activities, service development opportunities and Governor activity.
- Service improvements: Opportunities for members to be involved through the special interests e.g. strategic projects such as the BRI redevelopment and centralisation of specialist paediatrics.
- Trust programme of events: Opportunities for members to attend open days, drop-in sessions, complete surveys.
- Youth Council: Involve young members in improving hospital services.
- Meeting the Governors: Opportunities to meet the Governors at events.

Membership commentary

The University Hospitals Bristol NHS Foundation 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.

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.

Patient constituency

Eligibility for the patient constituency is open to all those who are recorded on the Trust's Patient Administration System as having attended 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 four years of age. There are four groups within this constituency: patients from tertiary areas, local patients, carers of patients 16 years and over, and carers of patients under 16 years. However, once eligibility for patient membership has expired, members can be switched to the public constituency, if eligible. Patient membership is by opt-in.

Staff constituency

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

The staff constituency has four groups:

- Medical and Dental.
- Nursing and Midwifery.
- Other Clinical Healthcare Professionals.
- Non-Clinical Healthcare Professionals.

Staff membership is by an opt-out and Trust staff are automatically registered as members on appointment. Information on opting out of the scheme is included in induction packs and on the intranet. Volunteers must apply to become a member.

Members communicating with their staff, public and patient governors

The Trust has 12,094 public and patient members and 8,298 staff members. A key objective of the Trust's Membership Development Plan is to communicate regularly with its members. Communication includes regular newsletters, invitations to be involved in services that members are interested in, Medicine for Members events, Meet the Governors, as well as the Membership Council and Annual Members Meetings.

Members wishing to communicate with Directors and elected members of the Membership Council, or anyone interested in finding out more about membership, should contact the Membership Office at the address given at "Appendix C – Contact Details" on page 71 of this report.

Governors by constituency – 1 April 2010 to 31 March 2011

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 South Gloucestershire	Patricia Robinson	June 2008 to May 2010	Elected
Public South Gloucestershire	David Clark	June 2008 to May 2010	Elected
Public North Somerset	Elizabeth Corrigan	June 2008 to May 2011	Elected
Public North Somerset	Anne Ford	June 2008 to May 2011	Elected
Public Bristol	Jade Scott-Blagrove	June 2010 to May 2013	Elected
Public Bristol	Sian Evans	June 2010 to May 2013	Elected
Public Bristol	Heather England	June 2008 to May 2011	Elected
Public Bristol	Mo Schiller	June 2008 to May 2011	Elected
Public Bristol	Mohsin Sajid	Oct 2010 to May 2011	Elected
Public Bristol	Jason Edgar	June 2008 to Sept 2010	Elected
Public Bristol	Elizabeth Obileye	June 2008 to May 2010	Elected
Public Bristol	George Wynne Willson	June 2008 to May 2010	Elected
Patient Governors			**Elected**
Patient Governors from tertiary areas (who live in the rest of England and Wales)	Suzanne Green	June 2010 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
Patient Governors from tertiary areas (who live in the rest of England and Wales)	Des Osborne	June 2008 to May 2010	Elected
Local patients Governors who live in	Pam Yabsley	June 2008 to	Elected

Constituency	Name	Tenure	Elected Appointed Partnership
Bristol, North Somerset and South Gloucestershire		May 2011	
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Anne Skinner	June 2008 to May 2011	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	Ken Cockrell	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	David Aldington	Oct 2009 to May 2011	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Allan Attwood	June 2008 to May 2010	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Clive Hamilton	June 2008 to May 2010	Elected
Carers of patents 16 years and over	Wendy Gregory	June 2010 to May 2013	Elected
Carers of patents 16 years and over	Garry Williams	June 2010 to May 2013	Elected
Carers of patents 16 years and over	Sylvia Smith	June 2008 to May 2010	Elected
Carers of patients under 16 years	Philip Mackie	June 2008 to May 2011	Elected
Carers of patients under 16 years	Lorna Watson	June 2008 to May 2011	Elected
Staff Governors			**Elected**
Non-clinical Healthcare Professional	Chris Swonnell	July 2009 to May 2011	Elected
Non-clinical Healthcare Professional	Jan Dykes	June 2008 to May 2011	Elected
Other Clinical Healthcare Professional	Phil Quirk	June 2010 to May 2013	Elected
Medical and Dental	Jim Catterall	June 2008 to May 2011	Elected

Constituency	Name	Tenure	Elected Appointed Partnership
Nursing and Midwifery	Florene Jordan	June 2010 to May 2013	Elected
Nursing and Midwifery	Belinda Cox	June 2010 to May 2013	Elected
Appointed Governors			
Bristol City Council	Sylvia Townsend	June 2009 to May 2011	Appointed
Bristol Primary Care Trust	David Tappin	June 2008 to May 2011	Appointed
North Somerset Primary Care Trust	James White	June 2008 to May 2011	Appointed
South Gloucestershire Primary Care Trust	Chris Payne	June 2008 to May 2011	Appointed
University of Bristol	Massimo Pignatelli	June 2008 to March 2011	Appointed
University of the West of England	John Duffield	June 2008 to April 2011	Appointed
University of the West of England	Helen Langton	Oct 2010 to May 2011	Appointed
Partnership organisations			
Avon and Wiltshire Mental Health Trust	Jane Britton	June 2008 to May 2011	Partnership
Great Western Ambulance Trust	Sharon Hinsley	August 2010 to May 2011	Partnership
Great Western Ambulance Trust	John Newman	June 2008 to August 2010	Partnership
Joint Union Committee	Jeanette Jones	June 2008 to May 2011	Partnership
Voluntary groups	Frank Palma	June 2008 to May 2011	Partnership
Community groups	Joan Bayliss	Jan 2011 to May 2011	Partnership

Attendance at Membership Council and Nominations and Appointments Committee Meetings

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

"C" denotes the Chair of the Council or Committee.

	Membership Council	Nomination and Appointments Committee
No. of meetings in Year	**8**	**3**
Chairman		
John Savage	C8(8)	C3(3)
Governors		
Public South Gloucestershire		
Pauline Beddoes	2(8)	0(0)
Mary Hodges	6(8)	0(0)
Patricia Robinson	1(2)	0(0)
David Clark	2(2)	0(0)
Public North Somerset		
Elizabeth Corrigan	8(8)	3(3)
Anne Ford	6(8)	0(0)
Public Bristol		
Heather England	7(8)	0(0)
Mo Schiller	6(8)	2(3)
Jade Scott-Blagrove	6(8)	0(0)
Sian Evans	2(8)	0(0)
Mohsin Sajid	1(2)	0(0)
Jason Edgar	2(3)	0(0)
George Wynne Willson	2(2)	0(0)
Elizabeth Obileye	1(2)	0(0)
Patient Governors from tertiary areas		
Neil Auty	5(8)	0(0)
Suzanne Green	4(8)	0(0)
Roger Loodmer	0(2)	0(0)
Des Osborne	1(2)	0(0)
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire		

	Membership Council	Nomination and Appointments Committee
Anne Skinner	8(8)	0(0)
David Aldington	7(8)	0(0)
Pam Yabsley	7(8)	0(0)
Jacob Butterly	6(8)	0(0)
Ken Cockrell	3(8)	0(0)
Allan Attwood	2(2)	0(0)
Clive Hamilton	2(2)	0(0)
Karen Smith	1(2)	0(0)
Carers of patients 16 years and over		
Wendy Gregory	6(8)	0(0)
Garry Williams	6(8)	0(0)
Sylvia Smith	0(2)	0(0)
Carers of patients under 16 years		
Philip Mackie	5(8)	3(3)
Lorna Watson	3(8)	0(0)
Staff Non-clinical Healthcare Professional		
Chris Swonnell	7(8)	0(0)
Jan Dykes	7(8)	0(0)
Staff Other Clinical Healthcare Professional		
Phil Quirk	4(8)	2(3)
Staff Medical and Dental		
Jim Catterall	3(8)	0(0)
Staff Nursing and Midwifery		
Florene Jordan	6(8)	0(0)
Belinda Cox	4(8)	0(0)
Appointed Governors		
Sylvia Townsend	6(8)	2(3)
James White	2(8)	0(0)
Massimo Pignatelli	2(7)	0(0)
Helen Langton	2(2)	0(0)
John Duffield	0(2)	0(0)
David Tappin	3(3)	0(0)

	Membership Council	Nomination and Appointments Committee
Partnership organisations		
Jeanette Jones	7(8)	2(3)
John Newman	0(2)	0(0)
Sharon Hinsley	1(2)	0(0)
Jane Britton	1(8)	0(0)
Joan Bayliss	1(1)	0(0)
Frank Palma	3(8)	0(0)
Non-Executive Directors		
Emma Woollett	4(0)	0(0)
Iain Fairbairn	1(0)	1(0)
Lisa Gardner	2(0)	0(0)
Selby Knox	1(0)	0(0)
Paul May	2(0)	0(0)
Kelvin Blake	2(0)	0(0)
John Moore	0(0)	0(0)
Executive Directors		
Robert Woolley	6(0)	0(0)
Paul Mapson	2(0)	0(0)
Deborah Lee	3(0)	0(0)
Jane Luker	0(0)	0(0)
Steve Aumayer	5(0)	0(0)
Alison Moon	4(0)	0(0)
Jonathan Sheffield	3(0)	0(0)
Irene Gray	1(0)	0(0)
Acting and Interim Directors		
Tony Ranzetta	2(0)	0(0)
Jim O'Connell	0(0)	0(0)
Pat Fields	1(0)	0(0)

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

Chairman – John Savage

John was appointed as Chairman of the University Hospitals Bristol NHS Foundation Trust on 1 December 2006. From 1989, he was full-time Chief Executive of the Bristol Initiative and, from February 1993, Chief Executive of the Bristol Chamber of Commerce and Initiative, after the merger of these two bodies.

In September 1994 he became Chief Executive of Business West, the joint operating company of the Chamber and Business Link West. He was awarded the CBE for service to Business and Regeneration in the 2006 New Year Honours List. He is Chairman of the Churches Council for Social Responsibility, a board member of the Regional Development Agency and was Chairman of the South West Learning and Skills Council from inception until its 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, Membership Council, Nomination and Appointments Committee and Remuneration Committee.

Chief Executive – Robert Woolley

Robert joined the Board of United Bristol Healthcare Trust as Director of Performance Management in 2002, co-ordinating the achievement of key standards for patient access. He took the corporate development portfolio in 2004, overseeing the £18 million expansion and refurbishment of the Bristol Dental Hospital, the construction of the new £60 million Bristol Heart Institute and the development of the Trust's ten-year strategic plan.

He was project director for the successful application for Foundation Trust status in 2008 and went on to become Acting Chief Executive in December 2009. Following a rigorous and competitive selection and interview process, Robert was appointed substantive Chief Executive on 8 September 2010.

Robert was educated at Lincoln College, Oxford, and holds an MBA with distinction from Bath University. He joined the NHS as a strategic planner at the Royal London NHS Trust in 1992. At Barts and the London NHS Trust, he rose to be assistant director for the project to re-develop the Royal London Hospital before becoming general manager for children's services across the City and East London in 1996 and later of clinical support services across St Bartholomew's, the Royal London and the London Chest Hospitals.

Non-executive Directors

Emma Woollett – Non-Executive Director and Vice-Chair

Emma was first appointed as a Non-Executive Director in January 2006 and was reappointed as Vice-Chair for three years from January 2010. She has worked in both the private and public sectors and has held senior management positions in marketing and business development. She was marketing director for Kwik Save Stores, following its merger with retailer Somerfield plc.

She left Somerfield in 2001 to set up a freelance management consultancy practice, providing analytical advice to NHS organisations on capacity planning and waiting list management. Prior to joining Somerfield, Emma spent a number of years as a management consultant for PricewaterhouseCoopers, working worldwide on projects for utility companies looking to develop more commercial approaches within a public sector environment. She

started her career in the oil industry and has degrees in physics and international relations from Cambridge University. Emma is Chair of the Audit and Assurance Committee.

Lisa Gardner – Non-Executive Director

Lisa Gardner was appointed as Non-Executive Director on 1 June 2007. She has acquired a broad range of business experience over almost 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 an associate in a local chartered accountant's practice.

Lisa is also Chair of the Finance Committee at the Trust and sits on the Audit and Assurance Committee. She also sits on the Watershed's Trust and Trading Companies Boards and has just finished her term as a Parent Governor at Westbury Park Primary School, where she was also Chair of the Finance Committee. Lisa was the financial director at Aardman for 11 years and since then has worked in the finance director role at Business West and in the retail industry.

Iain Fairbairn – Non-Executive Director

Iain Fairbairn's four-year term of office on the Board of Directors began on 1 December 2007; he is also the Senior Independent Director, a member of the Audit and Assurance Committee, and a member of the Clinical Ethics Advisory Group. He was formerly a commercial solicitor, in legal practices in both the City of London and Bristol, which included more than 20 years' experience of providing property, commercial, planning and construction advice to the NHS, covering private finance initiative projects, the establishment of NHS trusts and joint working between the NHS and other public and private bodies. He is the founder and developer of a care village for the elderly in Cornwall, which includes a nursing home, and he is a director of a not-for-profit social enterprise to support women and their families through the menopause.

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

Selby Knox – Non-Executive Director

Professor Knox began his four-year term of office on 1 February 2008 as a Non-Executive Director of the Trust. Professor Knox retired in August 2008 from the position of Pro Vice-Chancellor of the University of Bristol. He was a member of the University's senior management team, with responsibility for oversight of finance and estates, and of the Faculties of Medicine and Dentistry and Medical Sciences. He was chair of the budget and capital prioritisation committees, and a member of the University Council and its finance, estates and audit committees. He obtained a BSc in 1966 and a PhD in 1969, both from the University of Bristol. He returned there as lecturer in 1972 after postdoctoral research at the University of California, Los Angeles, and was awarded a DSc by the University of Bristol in 1985. He was promoted to Reader in 1983 and to Professor in 1990 and from 1992 to 2001 was Head of the School of Chemistry.

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

Paul May – Non-Executive Director

Paul May is a public sector strategic consultant who brings 30 years' experience at the highest levels in local government and further education. He was the Chief Executive of Wansdyke District Council, and then North Somerset Council for nearly 20 years. He was also the Executive Director of the Learning and Skills Council in the West of England, and Chief Executive of the Further Education Bureaucracy Reduction Group for England. His projects as a consultant include working on the framework for excellence quality system for further education and re-shaping the structure of the South West's Learning and Skills Council. He also took a lead role for the Sexual Assault Referral Centre for Avon and Somerset, helping agencies to work more closely together to improve the experience for victims of this crime. He is now working to help the communities of Devon and Cornwall developing sexual assault referral centres.

Kelvin Blake – Non-Executive Director

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

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

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

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

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

John Moore – Non-Executive Director

John joined the Board in January 2011, and 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 (working with BP, ICI, Avon Rubber, Wavin and Raychem), and having sold a medium sized business, John has begun undertaking Non-Executive Director roles, including University Hospitals Bristol NHS Foundation Trust, and Carbotech Wheels GmbH Austria.

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 Masters degree in Engineering and an MBA from the International Institute for Management Development. He is married with three children and lives near Bristol.

Executive Directors

Steve Aumayer – Director of Workforce and Organisational Development
Steve joined University Hospitals Bristol in July 2009 and brings with him a wealth of senior human resources experience from a variety of sectors. Over the course of his career Steve has worked extensively within consulting, retail banking and the telecommunications sectors.

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

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

Paul Mapson – Director of Finance
Paul Mapson joined the NHS as a national finance trainee in 1979. He became a fully qualified accountant in 1983 and has undertaken a wide variety of roles within the NHS in the acute sector. Paul has eight years' experience at Board level including significant experience in the management of capital projects, specialised commissioning, systems development, information technology and procurement. Before joining the Trust in 1991 as Deputy Finance Director, Paul held posts in Somerset, Southmead and Frenchay. He was appointed Director of Finance in October 2002.

Alison Moon – Chief Nurse
Alison 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 for improving standards of care – putting the patients first, delivering service improvements, influencing change and pioneering new roles both locally and nationally. She was awarded an MA for Management in 1999 from the Bristol Business School. Alison has a passion from improving the experience of our patients through staff reaching their potential and being valued for the contribution they make. She joined the Trust in July 2009 and in addition to being the Chief Nurse and professional lead for the allied health professionals, Alison has the Governance Director role for University Hospitals Bristol NHS Foundation Trust.

Dr Jane Luker – Acting Medical Director
Dr Jane Luker qualified in Dentistry from King's College, University of London. Following SHO and registrar posts in London, Bristol and Leeds she obtained her Fellowship in Dental Surgery (RCS Edinburgh) and secured an MRC training fellowship and honorary registrar in oral medicine at the University of Bristol Dental Hospital and School. During her time here she completed her PhD in Oral Pathology.

She went on to develop the dental service for medically compromised patients within the Trust before starting specialist training in dental and maxillofacial radiology accrediting in 1999.

Dr Luker was appointed consultant in dental and maxillofacial radiology at University Hospital Bristol NHS Foundation Trust in 2000 and the element lead for undergraduate teaching in

dental radiology. From 2002-2009 Dr Luker was Clinical Director/Lead Doctor for dental services. Dr Luker was appointed Deputy Medical Director in September 2008.

Dr Luker is still active in both undergraduate and postgraduate teaching and training, is a member of council of the British Society of Dental and Maxillofacial Radiology, a specialty advisor to the Royal College of Surgeons and currently secretary to the association of British Dental Hospitals & Schools.

Deborah Lee – Director of Strategic Development

Deborah 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, with distinction, from Bristol Business School.

She started her NHS management career in 1990 and has worked in acute, primary and community sectors, holding board-level appointments in three different commissioning organisations before joining University Hospitals Bristol in May 2010 as Director of Corporate Development.

In 1996, she moved to industry and held positions in the areas of policy development and health economics before returning to her first board level 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.

Chief Operating Officer

The role of Chief Operating officer was held by Tony Ranzetta and subsequently Jim O'Connell, both as non-substantive appointments whilst the role was advertised and appointed to. Following a competitive selection and interview process an appointment has been made and the new Chief Operating Officer will start his tenure with the Trust in July 2011.

6. Appendix B – Remuneration Report

Directors' Remuneration – Salaries and Allowances

Name and title	12 Months to 31 March 2011	12 Months to 31 March 2010
	Salary (bands of £5000) £000	Salary (bands of £5000) £000
Chair		
John Savage	50-54	50-54
Executive Directors		
Robert Woolley, Chief Executive (from 23 December 2009)	170-174	35-39
Robert Woolley, Director of Corporate Development (until 22 December 2009)	n/a	85-89
Paul Mapson, Director of Finance	135-139	120-124
Steve Aumayer, Director of Workforce and Organisational Development (from 6 July 2009)	110-114	80-84
Alison Moon, Chief Nurse and Director of Governance (from 13 July 2009)	110-114	80-84
Deborah Lee, Director of Strategic Development on secondment from 17 May 2010 (substantive from 4 February 2011)	94-99	n/a
Jane Luker, Acting Medical Director (from 1 October 2010)	74-79	n/a
Jim O'Connell, Acting Chief Operating Officer (from 21 February 2011, seconded)	15-19	n/a
Tony Ranzetta, Acting Chief Operating Officer (from 1 August 2010 to 20 February 2011)	110-114	n/a
Irene Gray, Chief Operating Officer (until 31 July 2010)	35-39	110-114
Jonathan Sheffield, Medical Director (until 30 September 2010)	90-94	190-194
Graham Rich, Chief Executive (Until 22 December 2009)	n/a	120-124
Alex Nestor, Acting Director of Workforce and Organisational Development (from 3 November 2008 until 5 July 2009)	n/a	20-24
Patricia Fields, Acting Chief Nurse (from 23 March 2009 until 12 July 2009)	n/a	25-29
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	10-14	10-14

Paul May	10-14	10-14
John Moore (from 1 January 2011)	0-4	n/a
Patsy Hudson (until 31 May 2009)	n/a	0-4
Sarah Blackburn (from 1 June 2009 until 31 March 2010)	0-4	10-14

No Directors received any other remuneration or benefits in kind during either period. No Directors received any Exit packages during either period. Aggregate salary cost for 2010/11 was £1,045k (2009/10, £1,033k). The aggregate employer contribution to the pension scheme was £105k (2009/10, £123k). The total number of Directors to whom benefits are accruing under defined benefit schemes is 6 (2009/10, 7).

Directors' Pension Benefits for the year ended 31 March 2011

Name and title	Real increase in pension at age 60 at 31 March 2011	Real increase in lump sum at age 60 at 31 March 2011	Total accrued pension at age 60 at 31 March 2011	Lump sum at age 60 related to accrued pension at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2010	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)	0-2.4	5.0-7.4	30-34	100-104	608	590	(13)	(9)
Paul Mapson, Director of Finance	2.5-4.9	7.5-9.9	50-54	160-164	1,117	1,089	(31)	(21)
Steve Aumayer, Director of Workforce and Organisational Development (from 6 July 2009)	0-2.4	nil	0-4	nil	41	29	10	7
Alison Moon, Chief Nurse and Director of Governance (from 13 July 2009)	0-2.4	2.5-4.9	35-39	105-109	552	571	(49)	(34)
Deborah Lee, Director of Strategic Development On secondment from 17 May 2010 (substantive from 4 February 2011)	0-2.4	2.5-4.9	15-19	45-49	243	241	(9)	(6)
Jane Luker, Acting Medical Director (from 1 October 2010)	5.0-7.4	15.0-17.4	45-49	145-149	896	803	25	18
Jim O'Connell, Acting Chief Operating Officer (from 21 February 2011)[3]	n/a	n/a	35-39	110-114	555	n/a	n/a	n/a
Tony Ranzetta, Acting Chief Operating Officer (from 1 August 2010 to 20 February 2011) [4]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Irene Gray, Chief Operating Officer (until 31 July 2010)	(0-2.4)	(5.0-7.4)	50-54	150-154	n/a	1,124	n/a	n/a
Jonathan Sheffield, Medical Director (until 30 September 2010)	0-2.4	0-2.4	75-79	235-239	1,487	1,547	(71)	(50)

[3] J. O'Connell is seconded from South Central Strategic Health Authority and figures for the movements in pension values are not available.

[4] T. Ranzetta was employed via an agency.

Directors' Pension benefits for the year ended 31 March 2010

Name and title	Real increase in pension at age 60 at 31 March 2010	Real increase in lump sum at age 60 at 31 March 2010	Total accrued pension at age 60 at 31 March 2010	Lump sum at age 60 related to accrued pension at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real Increase in Cash Equivalent Transfer Value	Employer funded contribution to growth in CETV
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Robert Woolley, Director of Corporate Development (until 22 December 2009, then acting Chief Executive)	2.5-4.9	10-12.4	30-34	90-94	590	476	91	63
Jonathan Sheffield, Medical Director	5-7.4	17.5-19.9	70-74	220-224	1,547	1,285	198	138
Paul Mapson, Director of Finance	(0-2.4)	(0-2.4)	45-49	145-149	1,089	988	52	36
Irene Gray, Chief Operating Officer	(0-2.4)	(0-2.4)	50-54	150-154	1,124	1,032	41	29
Steve Aumayer, Director of Workforce and Organisational Development (from 6 July 2009)	2.5-4.9	n/a	0-4	n/a	29	n/a	29	21
Alison Moon, Chief Nurse (from 13 July 2009)	2.5-4.9	10-12.4	30-34	95-99	571	431	85	59
Graham Rich, Chief Executive (until 22 December 2009)	0-2.4	2.5-4.9	45-49	145-149	907	791	76	53
Alex Nestor, Acting Director of Workforce and Organisational Development (until 3 July 2009)	0-2.4	0-2.4	15-19	50-54	237	178	13	9
Patricia Fields, Acting Chief Nurse (until 12 July 2009)	0-2.4	2.5-4.9	35-39	110-114	939	757	41	28

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.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The

pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. In some cases, the real increase in the CETVs show a significant difference, when comparing this year's values with last year's. This difference is due to a change in the factors used to calculate CETVs, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for CETV's (following actuarial advice) on Scheme Managers or Trustees.

Further regulations from the Department for Work and Pensions to determine cash equivalent transfer values (CETV) from Public Sector Pension Schemes came into force on 13 October 2008.

Employer funded contribution to growth in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme, or arrangement) and uses common market valuation factors for the start and end of the period.

Robert Woolley

Chief Executive, 03 June 2011

7. Appendix C – Contact Details

The Trust Secretariat and Membership Office can be contacted at the following address:

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

Trust Secretariat:	Telephone: 0117 342 3702
	Email: foundationtrust@uhbristol.nhs.uk
Membership Office:	Telephone: 0117 342 3764
	Email: foundationtrust@uhbristol.nhs.uk

University Hospitals Bristol NHS
NHS Foundation Trust

Quality Report 2010/11

Statement from the Chief Executive

Welcome to University Hospitals Bristol NHS Foundation Trust's Quality Report for 2010/11. This is the third year that the Trust has published an annual report about the quality of its services.

The purpose of Quality Reports is to ensure Trust Boards focus on quality improvement as a core function of the organisation. Our Quality Report spells out our commitment to providing a high quality, patient-focused healthcare service that meets the needs of our diverse patient population.

Quality Reports also enable NHS Foundation Trusts to be held to account by the public, as well as providing useful information for current and future patients. This Quality Report is an honest and open assessment of the quality of care patients received when they were in our care during 2010/11. While it is impossible to include information about every service the Trust provides in this kind of document, it is nevertheless our hope that the report we present here will give you confidence in our ability to deliver safe, effective and compassionate care.

This year, our Governors have been influential in determining the structure and 'flow' of our Quality Report. In particular, the Quality Report has been clearly structured around the three core themes of Safety, Experience and Effectiveness. In each case, the report explains what we achieved in 2010/11, and what our aspirations are for the year ahead.

Following the publication of last year's Quality Reports by NHS providers, the independent charity, the King's Fund, carried out an extensive review of these reports and made a number of important recommendations. We have heeded their advice in a number of ways: for example, this Quality Report is more concise and readable than last year's; we have tried to present a report that will make sense to people who are not involved in delivering healthcare; for ease of reading, we have indicated how well we did in relation to the objectives we set ourselves for 2009/10, using a 'traffic light' system of indicators and, for the first time, we have provided an analysis of overall patient satisfaction according to patients' ethnicity.

The Coalition Government has recently set out its ambitions for NHS healthcare in a new quality framework (called the 'NHS Outcomes Framework') which includes a focus on cancer survival. As such, we are particularly pleased that this year we are publishing, as part of our Quality Report, five year survival statistics following oesophageal cancer surgery. Most people diagnosed with oesophageal cancer have late-stage disease. This is complex surgery with a relatively poor prognosis – this is because patients do not usually have significant symptoms until their tumour is fairly large. Our data indicates that nearly a half of patients who received surgery for oesophageal cancer at the Trust in 2006/7 are still alive today.

This year, our Quality Report has been reviewed, prior to publication, by the Health Scrutiny Committees of our local councils; the people who fund our services (represented by our host commissioner, NHS Bristol); the Local Involvement Networks for Bristol and South Gloucestershire; our external auditors (the Audit Commission); and

by our Governors. We also welcome your feedback: if you have any comments about this Quality Report, we would be pleased to receive them. Please email chris.swonnell@uhbristol.nhs.uk or write to us at Trust Headquarters, Marlborough Street, Bristol BS1 3NU.

As Chief Executive of the University Hospitals Bristol, I confirm that, to the best of my knowledge, the information presented in this document is accurate. I am proud of the story told in this Quality Report and I hope you enjoy reading it.

Robert Woolley
Chief Executive, 03 June 2011

Contents:

Introduction

This year, we have structured our Quality Report in a way which focuses on the three key dimensions of quality in healthcare: Safety, Experience and Effectiveness. Discrete sections of the report deal with each dimension in turn, explaining how we performed against specific objectives we set ourselves for 2010/11; what else happened during the year and what our plans are for 2011/12. Each section begins with a clear commitment from the Trust, drawn from our Quality Strategy.

We have introduced some new clinical themes, but we have also attempted to provide continuity with last year's report for the purpose of transparency and to enable the reader to make comparisons. Some new themes – for example falls and pressure sores – have been introduced in recognition of their fundamental importance to patient care, whilst others have been included at the request of our Governors, Non-Executive Directors and commissioners. Other mandatory content, which the Trust is required to publish by the Department of Health and Monitor, can be found towards the end of this Quality Report.

Overview of objectives

Last year, we set ourselves six specific quality objectives. In the pages which follow, you will be able to read a detailed account of how we got on. Each strand of work within each objective has been assigned a 'traffic light' (Red/Amber/Green) rating to give the reader an idea of the progress we have made. Table 1, below, provides an overview. Two of our objectives were associated with reducing Healthcare Acquired Infections, hence there are five objectives listed here.

Table 1

We said we would…	**How did we get on?**
Reduce further the incidence of Healthcare Acquired Infections	Amber/Green
Reduce the number of high risk medication errors which caused actual harm to patients	Amber / Green
Reduce Hospital Acquired Thrombosis	Amber
Increase the level of patient and public involvement in service improvement	Green
Meet the requirements of the proposed NICE Quality Standard for Dementia	Amber

Within the respective sections of the report for Safety, Experience and Effectiveness, you will also find our quality objectives for the year ahead. In some cases, our ambitions reflect on-going commitments to quality (for example, the NHS South West Quality and Safety Programme), whilst other objectives provide a 'nod' towards the new NHS Outcomes Framework (e.g. improving cancer survival). Our Governors have debated, contributed to and ultimately approved, all our objectives; the objectives have also been presented in public session of the Health Overview and Scrutiny Committees of our local authorities, and discussed in a facilitated workshop with Local Involvement Networks.

SAFETY

Our commitment

The safety of our patients is central to everything we want to achieve as a provider of healthcare. We will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. There should be no avoidable deaths as a consequence of healthcare.

Report on our objectives for 2010/11

Objective 1
We wanted to reduce further the incidence of Healthcare Acquired Infections

Why we chose this
Reduction of healthcare-acquired infection is at the heart of our plans for improving quality and safety. Our patients have said that this is what matters to them. Meeting these expectations is key to people having confidence in our services.

We said we would…
1. Reduce the rate of MRSA (*Meticillin Resistant Staphylococcus Aureus*) infection to below 0.026 per 1,000 bed days. This equated to no more than six hospital acquired cases in the year.
2. Reduce the rate of C Diff (*Clostridium difficile*) infection to no more than 0.28 per 1,000 bed days. This equated to no more than 72 cases in the year.
3. Reduce all hospital acquired blood stream infections by 25%.
4. Reduce the number of urine infections associated with catheters to no more than two per 100 admissions.
5. Improve antibiotic prescribing compliance through the implementation of the Trust's policy

How did we do?
1. We have reduced the rate of MRSA blood stream infections in patients who are in hospital for more than two days to 0.016 per 1,000[1] bed days (5 cases).

2. We achieved all the targets set by the Department of Health and NHS Bristol for 2010/11. We have reduced the rate of C diff infection to 0.32 per 1,000 bed days. The number of cases (94) was 6% fewer than in 2009/10. Although this was higher than rate of infection we set ourselves internally (our 'stretch target'), it was below NHS Bristol's target of 97 cases.

[1] Based on bed days in 2008/9 as used in national MRSA data tables

3. Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infections became nationally reportable from January 2011 and have therefore been used as the marker for this overall reduction. We have reduced the number of MSSA blood stream in patients admitted with infections and after two days by 24% (from 112 to 85 cases)

4. In September and October 2010, we undertook a prevalence audit of the number of patients with catheters and the number that had associated infections. This audit showed 84 patients (18% of the 467 audited) with catheters and, of these, only four (0.8% of all patients) with infections. In addition, we have audited infection control precautions at insertion and for ongoing care of catheters and these results have shown 95% and 94% compliance with infection control standards.

5. During 2010/11, the Trust has fully implemented, and monitored, its policy for antibiotic prescribing. This policy sets out a 'zero tolerance' approach to non-compliance. A new prescribing chart has been introduced; specialist pharmacists monitor and intervene if prescriptions are not considered to be appropriate; weekly feedback is given to Divisions; an 'anti-infective steering group' is now led by the Deputy Medical Director. As a result, compliance of prescriptions with the policy continues to rise and was above 75% during the final quarter of the year.

As in previous years, prevention of infection was a key focus for the Trust in 2010/11. In addition to the steps described above, we have increased the percentage of staff who had infection control training (currently 93%). We've also continued to participate in the National Patient Safety Agency 'Clean Your Hands' campaign: the focus for this has been to ensure that alcohol hand gel is used by staff and visitors to clean their hands as near to the point of care delivery as possible, resulting in the relocation of alcohol hand gel dispensers from entrances and corridors to patient bedside areas (lockers, beds and entrances to bays). Not only has this change ensured that staff and visitors can clean their hands at the most appropriate point, it has also reduced the risk of injury from accidental spills and drinking of alcohol gel. The relocation of alcohol hand gel is thought to have contributed to the lowered score for hand hygiene noted in the National Staff Survey for 2010, where only 53% of staff reported that hand washing materials were always available. The lowest scores within this data came from administrative, clerical and central function staff who will not have direct clinical contact. However, in the same survey, it should also be noted that 90% of our staff agreed that the Trust does enough to promote the importance of hand washing to staff. Results of a local audit of hand washing facilities identified a lack of hand washing basins in some of the wards in the Bristol Royal Infirmary Old Building and King Edward Building, but with 93% of point of care locations having alcohol hand gel available. The practice of hand washing is monitored monthly, and our 95%+ standard has been met throughout 2010/11.

Prevention of Norovirus outbreaks remains a high priority for the Trust and, as such, decisions are taken early to close wards to new and admissions and non-essential staff upon suspicion of an outbreak, and not to re-open until we are confident that the outbreak has stopped. This is supported with prompt laboratory testing of any patient

suspected of having Norovirus infection. From January to March 2011 there were 17 ward closures due to Norovirus, with 123 patients confirmed to have the infection. Although we are confident that management of the outbreaks was effective, we have commissioned an external review of our outbreak management by the Health Protection Agency to support our plans for prevention in winter 2011/12.

Ensuring staff are fit to work and free from infection is an important aspect of our infection prevention programme. In support of this, all staff are screened for infection when they begin work at the Trust and are offered appropriate vaccinations against infectious disease. Some infections, including Tuberculosis (TB), are not fully preventable by vaccination and can become active many years after the person was initially infected. During 2010/11, as a result of TB lung infection in a member of our staff, 150 babies were contacted and given antibiotics as a precautionary measure. We are working closely with our partner Occupational Health Service to provide more awareness amongst staff of the risk of occurrence of active TB disease after initial health clearance.

Objective 2

We wanted to reduce the number of high risk medication errors which caused actual harm to patients

Why we chose this

According to the National Patient Safety Agency's *Safety in Doses* report (2009), incidents involving medicines account for one in every eleven incidents reported nationally, and closer to one in seven incidents reported by our Trust. The vast majority (95%+) of such incidents at our Trust are of low harm, or no harm, but medication incidents have the potential for causing severe harm.

We said we would…

1. Improve methodology around implementing lessons learned from reported incidents.
2. Implement National Patient Safety Agency (NPSA) guidance
3. Implement medicines reconciliation (getting medicines right)
4. Improve the quality of anticoagulation management
5. Audit of NPSA guidance implementation

The outcomes we wanted to achieve were that:

- The total number of incidents reported per quarter would be maintained
- The total number of incidents resulting in major or catastrophic harm would not increase
- The total number of incidents resulting in moderate harm would reduce
- The proportion of moderate, major and catastrophic incidents would reduce

How did we do?

1. There were regular monthly multidisciplinary reviews of reported incidents. Divisions responded to issues raised and lessons learned were shared via the Medicine Governance Group. Three medicine safety bulletins were published.

2. The NPSA has published eight patient safety publications which make reference to medicinal products. The Trust has confirmed compliance with four of these publications within the required deadlines. Of the remaining four publications, compliance is currently pending finalisation of relevant Trust policies and procedures.

3. Medicines reconciliation occurs in over 80% of patients admitted through the Medical Assessment Unit (documented within 24 hours). A new form has been introduced for clerking patients in the Divisions of Medicine, and Surgery Head and Neck. A trust-wide standard operating procedure has been developed, and we are trialling the use of GP software to gain access out-of-hours to information about patients' medication (for Adult A&E and MAU).

4. Regular in-depth review of inpatients who develop an INR (International Normalised Ratio – a measure of coagulation) score of greater than six during their stay has identified common themes: co-morbidities; use of interacting drugs (especially anti-infectives); not following the dosing guidelines on the oral anticoagulation chart. Oral anticoagulation chart has been revised to highlight these areas.

5. Four audits have focused on the following NPSA guidance: 2008/RRR04 Using vinca alkaloids minibags; 2007 Patient Safety Alert 18 – anticoagulation therapy (two audits looking at adult oral anticoagulation and anticoagulation in paediatric cardiac surgery respectively); 2007 Patient safety guidance 01 - Medicine reconciliation.

Outcomes:

Pending confirmation of quarter 4 data[2], all outcomes have been achieved (based upon a comparison of the first 9 months of 2009/10 and 2010/11).

- The average number of incidents reported per quarter has increased in 2010/11, possibly as a consequence of changes in our reporting process (878 incidents were reported during the first three quarters of 2010/11, compared with 774 incidents in the corresponding period for 2009/10)
- The number of incidents resulted in major or catastrophic harm did not increase (this year 0; last year 0)
- The number of incidents resulting in moderate or greater harm reduced (this year 20; last year 32)
- The percentage of incidents resulting in moderate harm reduced (this year 2.28%; last year 4.13%)

[2] Quarter 4 data not available at the time of writing

Objective 3

We wanted to reduce Hospital Acquired Thrombosis

Why we chose this

Venous Thromboembolism (VTE) is a significant cause of mortality, long term disability and chronic ill health. It is estimated that there are 25,000 deaths from VTE each year in hospitals in England.

We said we would…

1. Introduce a prescription chart with an integral risk assessment
2. Obtain VTE training slots on the Foundation Programme for medical staff, and roll out the Department of Health e-learning tool to medical, nursing and pharmacy staff
3. Update the VTE patient information leaflet and arrange outreach presentations on VTE for patient link groups to raise awareness
4. Make weekly prescription chart audit data for VTE risk assessment and thromboprophylaxis available to Divisional Boards via the VTE clinical champions. Continue with monthly case note review examining risk assessment and prescription of thromboprophylaxis.
5. Ask VTE champions to oversee qualitative audits undertaken by Foundation Doctors and ensure the results and actions are agreed by The Thrombosis and Anticoagulation Committee

The outcome measure for this objective was that at least 90% of adult inpatients would be assessed for their risk of developing VTE.

How did we do?

1. A full VTE risk assessment was included in the prescription chart following the initial launch of the VTE prompt in the prescription chart in May 2010. The prescription chart also includes an area for documentation of re-assessment.

2. VTE training continues for medical nursing, midwifery and allied health professionals. Staff are also required to complete online training via the Department of Health National e-VTE tool. A shorter and more focussed e-VTE programme has also been made available via the Trust's intranet site. Ward based teaching covers general aspects of VTE. The Trust has also obtained VTE training slots on the Foundation Programme for medical staff.

3. The VTE patient information leaflet was updated in the summer of 2010, and has since been further amended to incorporate information about anti-embolic stockings. The leaflet is available to all wards. Further work is required to develop staff awareness through outreach meetings.

4. Snapshot audits of compliance with VTE risk assessment and thromboprophylaxis prescription have been put 'on hold' due to increased pharmacy pressures. Monthly case note reviews (20 adult inpatients) audit for VTE compliance and have shown an improvement over a half-year period (April 2010, 11/20 cases compliant; September

2010, 17/19 compliant). Whenever a patient is identified as not having received a VTE risk assessment, the Medical Director writes to the lead consultant to underline the importance of following this practice.

5. Qualitative audits by trainee medical staff have seen poor uptake. VTE is on the Trust's audit priority list for 2011/12 and funding has instead been obtained to increase the VTE project nurse role to full-time, to include responsibility for audits of qualitative aspects of VTE risk assessment and thromboprophylaxis delivery.

Outcome:

91.6% of adult inpatients were assessed for their risk of developing VTE in March 2011. In March, the Trust made a significant change to the reporting system for VTE assessment, so that our compliance figures are now based on full census data (i.e. all patients) rather than 'snapshot' audits.

Review of 2010/11

This section explains how the Trust performed during 2010/11 in a number of key safety-related areas, which are in addition to the specific objectives that we identified.

Pressure Ulcers

In 2010/11, **we reduced the total number of hospital acquired pressure ulcers by 22%.** Pressure ulcers (bed sores or pressure sores) are damage to skin and tissue beneath the skin due to the weight of the body pressing for long periods on one specific area, friction or rubbing of the skin, or shear (layers of skin sliding against each other, for example when sliding down in the bed). Anyone can be vulnerable to getting a pressure ulcer, but people are most at risk if they:

- have trouble moving and cannot change position themselves
- cannot feel pain over part, or all, of their body
- are incontinent
- are seriously ill, or have had surgery
- have a poor diet and don't drink enough water
- are very young or very old
- have damaged their spinal cord and can neither move nor feel their bottom and legs
- older and are ill or have suffered an injury like a broken hip

In July 2010, we undertook an audit of how many patients had pressure ulcers acquired within the Trust. We identified 74 patients (11%). An audit repeated in February 2011 found 63 patients (8.5%) with Trust-acquired pressure ulcers. In order to achieve this reduction, we have instigated a range of actions including: training for staff who move patients; supportive review visits by the Chief Nurse's Team for patients with the most severe hospital acquired pressure ulcers; and a package of care which ensures that

patients at high risk of pressure ulcers are repositioned regularly, placed on the correct mattress or cushion and their skin is kept clean and dry.

Falls

Patients in hospital are also vulnerable to falling: many are elderly, and some will have previously fallen at home. Preventing inpatient falls is the responsibility of everyone in the Trust. We are committed to ensuring that the risk of falls within our environment is minimised, and that where falls may be unavoidable, the risk of injury is controlled.

2010/11 saw the establishment of a trust-wide steering group to lead on a concerted drive within the Trust on the prevention and management of inpatient falls. The falls prevention and management care plan was re-launched along with revised risk assessment documentation. Staff induction and update training now includes sessions on falls prevention. The Trust is working in collaboration with NHS Bristol in accordance with the Department of Health's Prevention Package for Older People. We also participated in National Falls Awareness Week (June 2010) and the National Audit of Falls and Bone Health (due to publish its findings in May 2011). Since January 2011, the Trust has been collecting data on patients who have fallen and who suffer from Cognitive impairment (dementia).

Table 2, below, shows a pattern of increasing numbers of patient falls during 2010/11: we believe that this reflects the focus the Trust has placed on improving the reporting of falls as safety incidents, i.e. we now have a more realistic picture of the extent of patient falls across the Trust.

Table 2

	April-June 2010	July-September 2010	October-December 2010	January-March 2011
Number of Falls	278	261	340	408
Fractures	9	5	8	6

Source: Ulysses Safeguard system – reported incidents

All recorded fractures resulting from falls have been reviewed by the Executive team to assess whether they should be classed as Serious Incidents and reported externally as such. During 2010/11, 17/28 fractures were identified and reported as Serious Incidents. The Trust continues to report, investigate and learn from these incidents.

We have benchmarked our falls rate against National Patient Safety Agency Data. This shows that **the Trust as a whole reported 4.13 falls per 1,000 bed days in 2010/11, compared to the national rate of 5.6**, however the falls rate in our Division of Medicine was above the national average at 6.6 falls per 1,000 bed days, reflecting its predominantly older and frailer patient population.

Histopathology

University Hospitals Bristol NHS Foundation Trust commissioned an Independent Inquiry into allegations of serious misdiagnosis in histopathology services at the Trust between the years 2000 and 2008, which were aired in the media in June 2009. The Trust Board accepted the Inquiry report in December 2010 and published it in full on its website and at a press conference. **The exhaustive Inquiry found no evidence to suggest that the histopathology department at University Hospitals Bristol provides anything other than a safe service**. Patients should have confidence that the Trust has learnt lessons from this Inquiry, however, and is acting on the recommendations of the panel.

Since the report's publication, UH Bristol and North Bristol NHS Trust have been working towards the integration of their two histopathology departments, as recommended by the Inquiry. The Trusts have a formal Partnership Agreement, approved by both Boards in November 2010, enshrining principles of co-operation and outlining a number of areas for joint working beyond histopathology. A joint director of histopathology services has been appointed and the two organisations, in collaboration with NHS Bristol, are implementing a comprehensive action plan in response to the Inquiry recommendations. The action plan has been shared with the Bristol Health Scrutiny Commission, the Care Quality Commission and Monitor, the Foundation Trust regulator. Monthly updates are provided to the UH Bristol public Board meeting and to the quarterly Membership Council. In addition, the Trust has set up five patients groups to explore their expectations of histopathology services.

The Inquiry report acknowledges that differences of interpretation can arise between histopathologists, especially in complex cases, and that mistakes can and do get made. While the Inquiry found the service at UH Bristol to be safe, it also found that a small number of serious diagnostic errors had occurred over the eight year period which had resulted in harm to patients. A further, recent misdiagnosis was reported to the Trust in early 2011. UH Bristol and North Bristol Trust have each conducted a detailed Root Cause Analysis investigation into this particular case, which has also been notified to the Care Quality Commission and Monitor. The Trusts have shared their respective findings and implemented measures to minimize the chance of this type of incident ever recurring.

Nutritional Care

The Care Quality Commission (CQC) has published a set of quality and safety standards which all providers of health and social care in England should meet. At the point when the Trust was required to register with the CQC (i.e. from 1st April 2010), we declared non-compliance with one of these standards which relates to 'Meeting nutritional needs' (known as 'Outcome 5'). We did this because we were not always providing the standard of nutritional care that we expected for our patients. The specific reasons why we declared non-compliance were as follows:

- Protected mealtimes (times when patients can eat without disturbance) were not always observed by staff,

- Improvements were needed regarding nutritional screening and care planning,
- Adaptive cutlery[3] needed to be made available for patients.

The last of these issues was addressed immediately and the first two concerns were the focus of targeted work across adult and paediatric services during 2010/11.

On 30th September 2010, the Trust received a letter from the CQC advising that it would be conducting a 'review of compliance' in respect of Outcome 5. The CQC subsequently carried out unannounced site visits to the Bristol General Hospital and the Bristol Royal Infirmary Queen's Building on the 12th and 14th October respectively. The Trust received a formal written report from the CQC on 12th November. Inspectors gave positive feedback about the quality of nutritional care they had observed, however they noted that:

- Despite the Trust's focus on protected mealtimes, these were not always being observed by medical clinicians,
- Patients did not always receive the food that they had requested and although they receive an alternative, this may not have been suitable for them,
- Nutrition care plans did not contain details of patient's food likes and dislikes or record whether the care plan had been discussed with the individual.

The Trust put in place a short term action plan to address each of these issues.

The latest available audit data (April/May 2011) indicates that **protected mealtimes are being observed on the majority of wards** (81% of adult wards and 67% of the children's wards). **Data also shows that 94% of adults and 84% of children are being nutritionally screened within 24 hours of admission**[4], against a target of 90%. In children's services in particular, this represents huge progress over the past year in an area of practice where the Trust is seen by its peers to be leading the way.

If current progress continues, the Trust anticipates being in a position to justify a formal declaration of compliance with Outcome 5 at the end of May 2011.

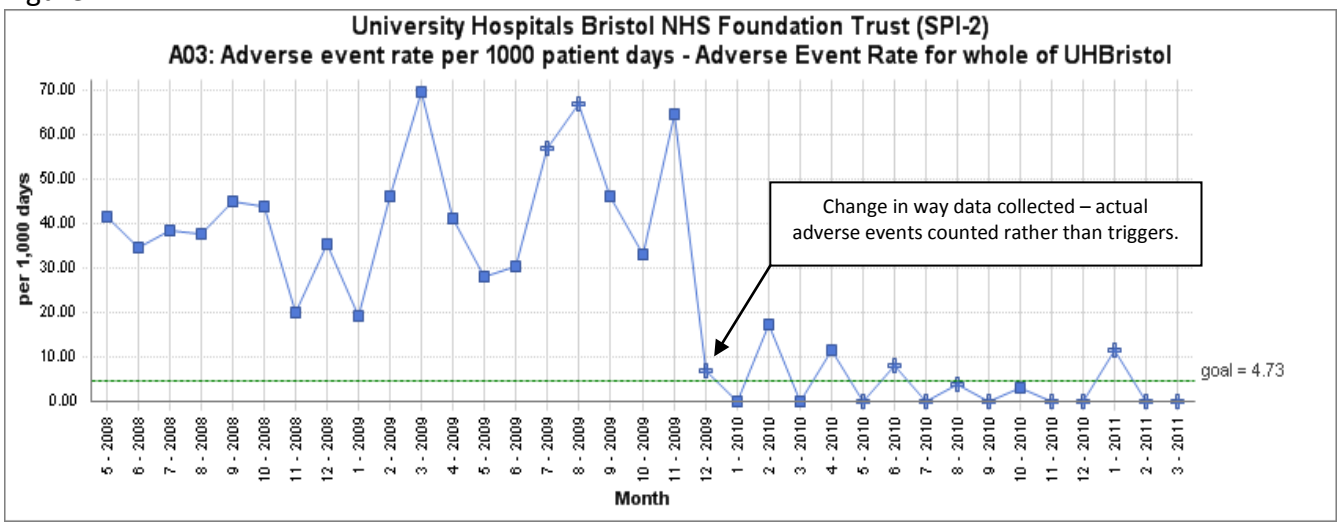
Adverse Event Rate

During 2010/11, a sample of 20 adult inpatient cases has been reviewed every month to look for adverse events relating to patient safety. A standardised proforma (the Global Trigger Tool) is used by the Trust's Patient Safety Team to identify potential harm events (called 'triggers'). A medical review of each case determines if the trigger is linked to an adverse event for the patient, the nature of the adverse event and the extent of harm sustained. **A low adverse event rate has been sustained during 2010/11**. A similar adverse event process for paediatric patients commenced in 2010 using a targeted trigger tool.

[3] i.e. cutlery which has been modified to help patients to eat independently

[4] There are two relevant measures for adult wards: the percentage of patients who received a nutritional assessment within 24 hours (94%) and the percentage who received a fully completed assessment (75%). The system in the Children's Hospital is slightly different: there is only one measure, which is the percentage of patients who received a complete assessment.

Figure 1



Source: South West Quality and Patient Safety Programme

We are committed to retaining our focus on incident reporting and organisational learning in 2011/12 and beyond.

National Patient Safety Agency Alerts

Through analysis of reports of patient safety incidents, and safety information from other sources, the National Patient Safety Agency develops advice for the NHS that can help to ensure the safety of patients. The NPSA issues 'alerts' to the NHS as and when issues arise. Alerts cover a wide range of topics, from vaccines to patient identification. During 2010/11, reviews carried out by our internal auditors highlighted a need for the Trust to improve the timeliness of responses to published NPSA Alerts. The Trust is implementing the audit recommendations. We have reviewed our current system for managing alerts: an improved system will be implemented in 2011/12 in order to achieve compliance with the relevant timescales. At the end of 2010/11, responses to seven alerts were outstanding, three of which have been addressed at the time of writing in May 2011.

Objectives for 2011/12

2011/12 will be a 'year of learning'. The Trust is midway through a five year commitment to participation in the NHS South West Quality and Safety Programme. Reflecting patient safety priorities agreed with our commissioners as part of the CQUIN[5] scheme for 2011/12, we will in particular seek further improvements in the following areas which are within the scope of the programme:

1. Hospital Acquired Thrombosis (VTE)
2. Medication errors
3. Inpatient falls

[5] See page 44 for more information about Commissioning for Quality and Innovation (CQUIN)

4. Pressure ulcers

The first two themes are a continuation of safety objectives we set ourselves in 2010/11. The last two themes address topics we have introduced to the Quality Report for the first time this year as fundamentals of good patient care. Success criteria will be defined via the CQUIN framework.

In 2011/12, we will also continue to implement the findings of the independent enquiry into our Histopathology services. The enquiry panel made a series of recommendations, which the Trust is in the process of implementing, working with its partners across the local health community. In 2011/12, specifically, we will:

- Produce a joint plan with North Bristol NHS Trust for an integrated pathology service across Bristol,
- Finalise a review of Multidisciplinary Team meetings and implement agreed developments,
- Build upon work begun in 2010/11 to involve patients and their carers to develop histopathology aspects of care pathways.

The Chief Nurse and Medical Director will be the Executive Directors responsible for achieving these objectives. Progress will be measured by the Trust's Clinical Quality Group and by the Quality and Outcomes sub-committee of the Board.

EXPERIENCE

Our commitment

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. We want all our patients to have a positive experience of healthcare.

Report on our objectives for 2010/11

Objective 4
We wanted to increase the level of patient and public involvement in service improvement

Why we chose this
The Trust is committed to providing a high quality, patient-focused healthcare service that meets the needs of a diverse patient population. To do this, we need to understand what it's like to experience our services as a patient.

We said we would…
Learn from our patients' experience, by:
1. Collecting robust patient experience metrics via a regular postal survey of discharged inpatients,
2. Developing a proactive programme of ward-based survey activities where teams of volunteers, governors and staff interview patients and record their views on electronic hand-held survey devices,
3. Giving patients, relatives, visitors and carers the opportunity to comment on the inpatient experience via comments cards available on each ward,
4. Exploring new and innovative ways of allowing patients and the public to give feedback about our services.

How did we do?
1. We introduced a **postal survey**, as planned. In fact, there are now three monthly surveys: a survey of inpatients aged 12 years and over is received by approximately 1,500 patients each month and achieves a 50% response rate; another survey is sent to approximately 350 parents and guardians of children aged 0-11 years, achieving a response rate of 40%; and a third survey is given to women using our maternity services (this has been less successful and we have recently changed the way that the questionnaire is administered).

   These surveys are designed to give the Trust Board and our clinical Divisions, high quality patient experience data, including analysis at ward level. In our first year of running these surveys, **over 10,000 patients have given us their views** about what we do well and how we could make things better.

2. We also introduced **bi-monthly ward-based surveys** to enable us to explore specific themes with patients in greater depth. These surveys have been carried out by a trained team of volunteers including staff members and Governors. In 2010/11, we explored:

- Privacy and dignity on the ward,
- 'My Ward',
- Patient communication on the ward,
- Compassion on the ward.

In each survey, we talked with around 100 patients and gathered responses using hand-held electronic devices. Patients have appreciated the opportunity to give their views and have equated this with a caring ethos.

3. **Comments cards have been made available in 66 inpatient locations across the Trust**. These are mostly used by patients at point of discharge. Patients are asked three questions: what they liked, what they would improve and what they would suggest. The cards are posted in a comments box and are reviewed weekly at staff meetings. The cards and subsequent actions are 'owned' by the wards and where possible, ward staff are empowered to respond to the comments on the cards. In some instances, actions may be escalated to Divisional Patient and Public Involvement Forums (the groups which co-ordinate patient and public involvement within our hospitals). In some locations, completed cards are posted on a notice board to that other patients, visitors, carers and staff can see them. **A random selection of completed cards is displayed at every meeting of the Trust Board and Membership Council**. Here are a few examples of how staff have responded to comments from patients:

> *"We have introduced protected meal rounds [times when patients can eat without disturbance] at the Bristol Heart Institute since introduction of the cards as many patients said that the food took a long time to serve and was often cold. The housekeeper now rings a bell at 12.20pm to prepare the ward for lunch. Service starts at 12.30pm with the nursing assistants and domestic staff all helping out. Food is now served to the right patients in a timely and presentable way and it's hot. The nursing assistants ensure that it is eaten and recorded and patients report a better service"*
>
> *"Patients said the clinic felt gloomy so we replaced the light bulbs."*
>
> *"Patients said the ward was very hot. We discovered that one of the ceiling mounted thermostats was damaged so we replaced it."*

4. We have continued to expand the use of **Focus Groups** across the Trust. Groups this year have explored Patient Safety in Surgery; Patients who have experienced a stroke; Quality of Care for Oncology Patients; Head and Neck Cancer and Quality of Care for Cardiac Patients. These facilitated groups consist of up to twelve patients and the discussions are centred on aspects of the patient care pathway. Focus groups are 'commissioned' by Divisions and are increasingly seen as an integral part of service development.

   We have been exploring the use of instant feedback approaches at the Bristol Heart Institute. Interactive **'Opinion finders'** and '**Hear Say'** events have given patients, carers and visitors opportunities to have their say on specific non-clinical issues:

   > *"As a result of patient feedback during Hear Say, we have extended the opening hours of our Atrium Café at the weekend"*
   >
   > *"Recently, a patient visited the centre to meet with staff and give feedback on his experience (arranged through the clinical nurse specialist). This has happened a few times before and staff find it very powerful to hear patients' stories".*

   Finally, we have continued to develop a pro-active approach to working with our local community. Groups such as the Royal National Institute of Blind People (RNIB), Action for Blind Bristol, The Bristol Physical Access Chain, the Council of Bristol Mosques, The Alzheimer's Society, UBAX Somali women's forum, Bristol Carer Organisations and Bristol and South Gloucestershire Local Involvement Networks (LINks) are some of the organisations engaged with the Trust in service development. Workstreams include:

   - The redevelopment of the Bristol Royal infirmary,
   - The centralisation of acute Children's Services,
   - The role of carers in the Trust,
   - A Dementia Care lay reference group,
   - A Head and Neck cancer centralisation lay reference group.

   This work will support the emerging Equality Delivery System in the coming year.

All of this work has been used to inform the development of Patient Experience Action Plans. Some of the themes emerging from these plans are reflected in our objectives for 2011/12 (see page 28).

Review of 2010/11

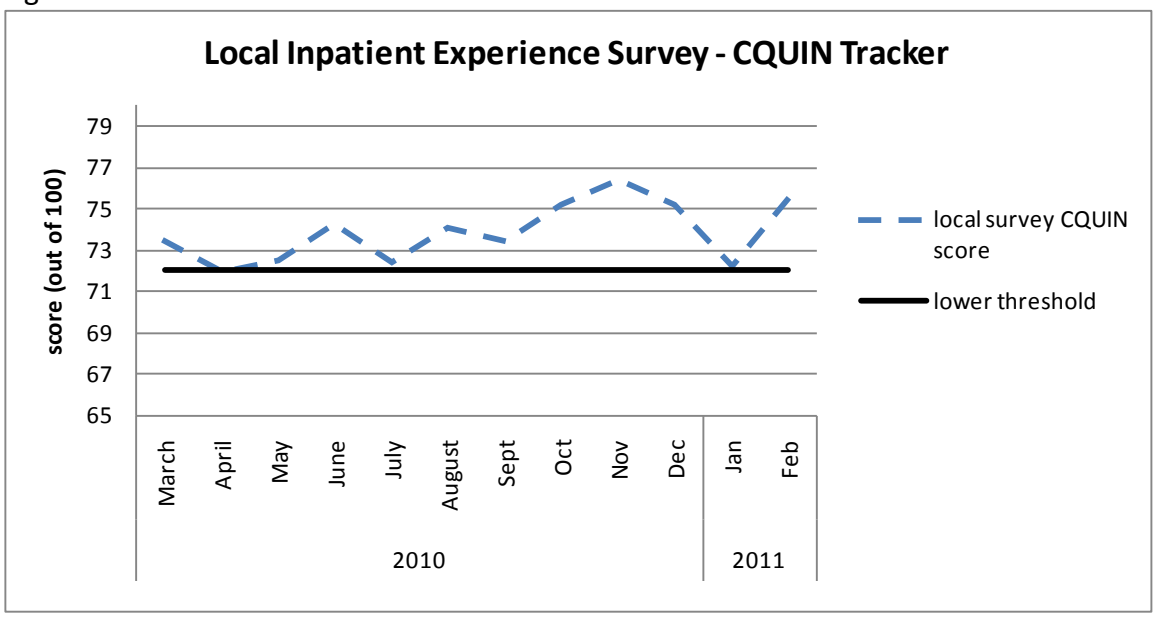
National Patient Experience CQUIN

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 p42 for more information). A national CQUIN measure was set for all NHS providers in 2010/11, based on the results of the annual National Inpatient Survey. The CQUIN consists 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?

The Trust was set a target for improvement of 73.0 points, which we were disappointed not to achieve: the National Inpatient Survey seeks the views of patients seen during the month of July each year, i.e. relatively early in the financial year for the Trust to bring about improvements which could influence the CQUIN. The Trust Board tracked the progress of this indicator throughout 2010/11 using much more robust data from our own monthly inpatient survey. Figure 2 shows that there were signs of improvement through the autumn of 2010, followed by a dip in reported patient experience which may reflect the early onset of winter pressures including Norovirus. The reader will note that performance improved in February 2011.

Figure 2

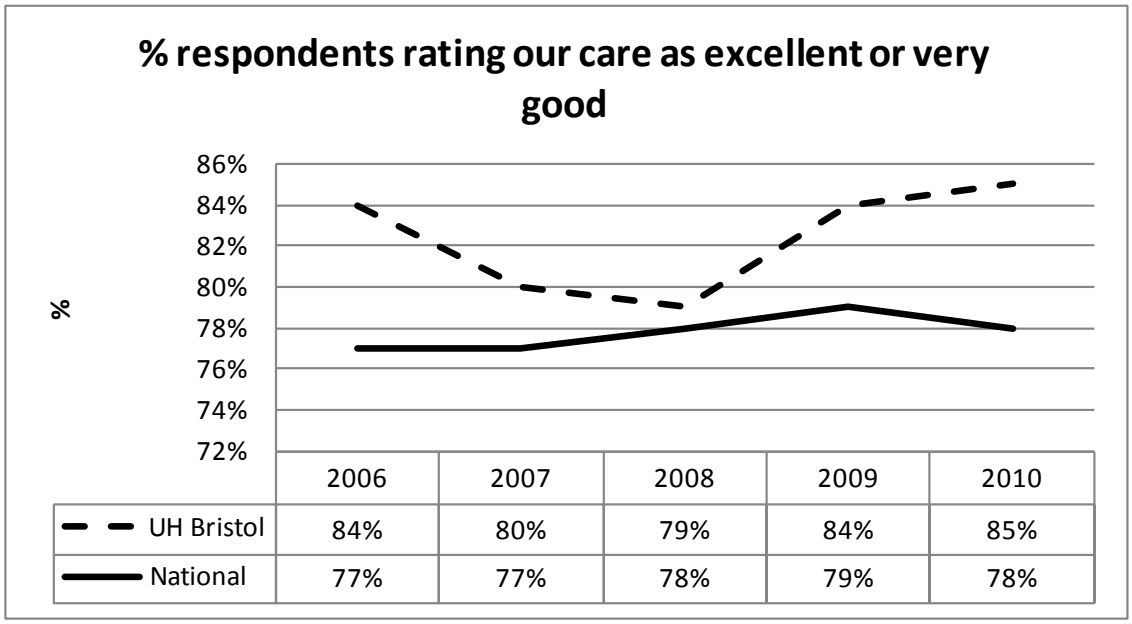


Source: UH Bristol monthly survey (inpatients aged 12+ excluding maternity)

Overall patient rating of care

According to data derived from the 2010/11 National Inpatient Survey (patients who were seen in our hospitals during July 2010), **85% of patients rated the care they received in our hospitals as either 'Excellent' or 'Very good'**[6].

Figure 3



Source: National Inpatient Survey

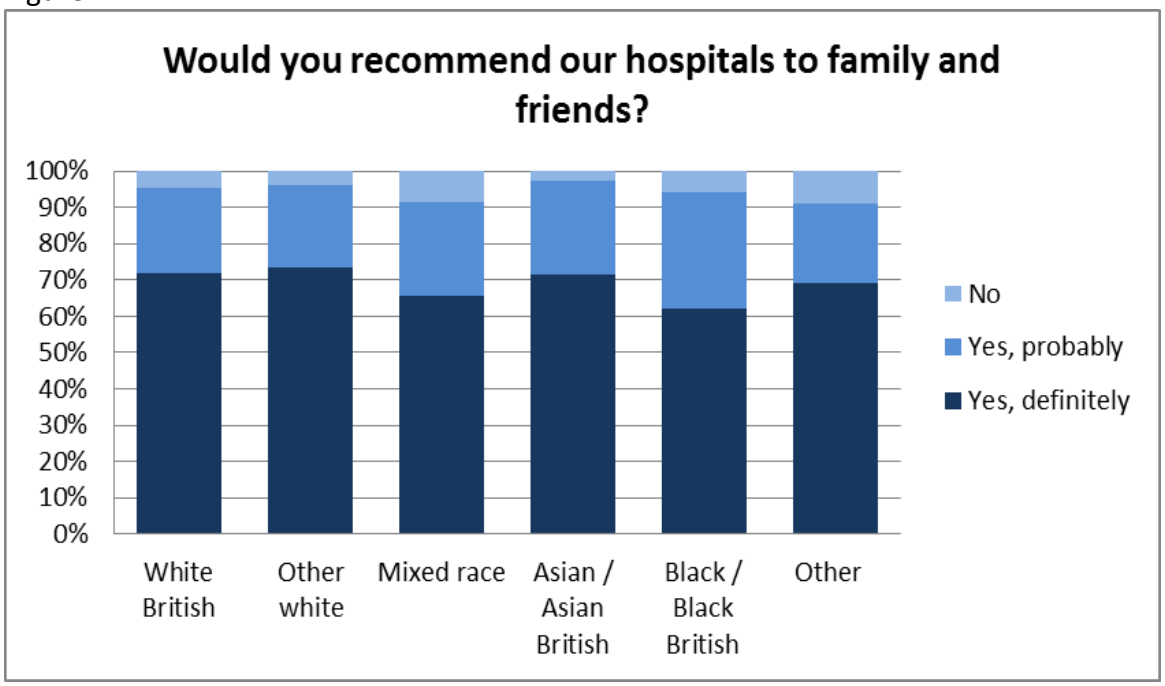
'Would you recommend us?'

This is one of the questions we ask in our monthly inpatient survey. During 2010/11, 10,224 patients answered this question. **73% of respondents said they 'definitely' would recommend us** and a further 23% said they 'probably' would. Figure 4 shows responses to this question analysed by ethnicity. This gives a flavour of how we hope to present patient experience findings in the future.

The data should be read with a note of caution due to relatively low numbers of non-'White British' respondents and other demographic factors may lie behind these results (for example, we know that the 'White British patients in our survey tend to be older than patients in the other categories, and that older people tend to express greater satisfaction with the care they receive). This data is therefore a starting point for further discussion and investigation. Whilst we recognise that people don't *want* to be hospital, we would of course aspire to a position where no patients would say that they would not recommend us.

[6] The officially reported figure in the Care Quality Commission National Inpatient Survey report was '82' – please note that is a score, not a percentage. The data equated to 85% of patients.

Figure 4



Source: Monthly UH Bristol postal survey (inpatients aged 12+ and parents of 0-11 year olds; excludes maternity)

Complaints

Complaints are another important source of information telling us about the experiences of patients and those who care for them. In May 2010, the Trust's Patient Advice and Liaison Service (PALS) and Complaints Department merged to become the 'Patient Support and Complaints Team'. The procedures used by the previous departments have been reviewed and improved so complaints are now managed in more a consistent and effective way.

The total number of complaints received by the Trust in 2010/11 was 1,532: an average of 128 complaints per month. This represents an improvement compared to 2009/10 when the monthly average was 157 complaints[7].

Complaints legislation introduced in April 2009 requires all complaints to have an individually agreed response time, based upon their nature and complexity. The Trust's average response time for complaints is 25 working days (as required under the previous legalisation), with longer timescales negotiated for more complex complaints, particularly those covering more than one organisation.

In 2010/11, the average number of complainants who remained dissatisfied with the response to their complaint was four per month. All such cases were reinvestigated by the Trust. A small proportion of complainants remained dissatisfied with our response and contacted the Parliamentary and Health Service Ombudsman (PHSO) for

[7] Please note that data quoted in the 2009/10 Quality Report was, for historic reasons, based on a 13 month reporting period – which is why a comparison of monthly rates is provided here, rather than a comparison of full-year data.

independent review and consideration; however no further investigations were subsequently requested by the PHSO during 2010/11.

Privacy and dignity (including elimination of mixed sex accommodation)

In 2010/11, **86% of inpatients[8] told us that they were always treated with respect and dignity on the ward**; 79%[9] said that they were always given enough privacy when discussing their treatment or condition[10].

Whilst many patients continue to tell us that the care they receive in the Trust is 'excellent' or 'very good', we can and must strive to ensure excellence in all aspects of patient care. Ensuring patients' privacy, and respecting their dignity, is of great importance to the Trust and a top priority for all staff on a daily basis. The specific issue of same sex hospital accommodation has again rightly been highlighted by the Trust's Governors for inclusion in this year's Quality Report.

The Trust's Privacy and Dignity Group has continued to progress work in all areas to improve the patient experience. Achievements during the last year include:

- A review and re-launch of the End of Life Policy to ensure that the person who has died is afforded dignity in death, from how the body is cared for and prepared, to how their possessions are handed back to their friends/relatives,
- A Last Offices box, funded by the League of Friends of the Bristol Royal Infirmary, is now available on every ward, ensuring that staff have all the resources they need to perform last offices. This includes the relevant policies and paperwork to help staff perform this important aspect of care to the best of their ability,
- "Do Not Enter" signs on wards across the Trust, to ensure that staff think about privacy and dignity before entering closed curtains. This work has been supported by our suppliers of disposable curtains.

The Privacy and Dignity Group is currently looking at the design of a hospital property bag to be used to return property to relatives after their loved one has died. Approximately 1,500 patients die each year in the Trust: we want to ensure that the way in which property is returned conveys respect for the person who has died, and for their family. Once the design has been completed and costed, the plan is to apply for charitable funding to meet the cost of the bags.

In order to raise the profile of the work of the Group, twice yearly study days have been held, which have been very well received by staff. In 2010 the group held drop-in days called "Making Dignity Our Priority – Care of the Person who has Died". Approximately 100 staff attended these practical and interactive events. In 2011, drop-in days called "Make a Patient's Day" will be aimed at non clinical staff such as Porters, Housekeeper and Ward Clerks, all of whom make valuable contributions to maintaining patients' privacy and dignity.

[8] 86% of 8,631 patients who responded to this question
[9] 79% of 8,603 patients who responded to this question
[10] Source: Trust Monthly survey (inpatients aged 12+ excluding maternity; March 2010 - January 2011)

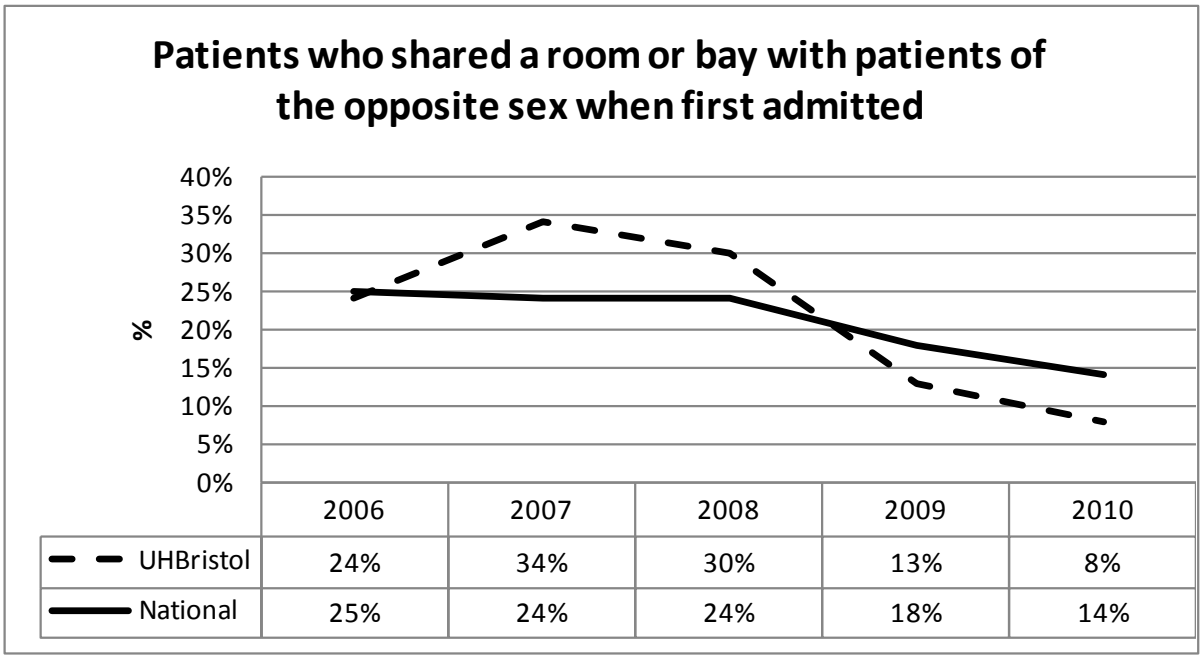
In November 2010, a change in national standards created an expectation that all NHS trusts eliminate mixed sex accommodation. The Trust was required to carry out a detailed assessment against this new, more stringent standard, with a view to making a formal declaration regarding compliance. On 31st March 2011, the Trust Board concluded that the Trust was non-compliant based on the following areas of concern:

- Lack of fixed segregation screens on the observation unit in the Adult Accident and Emergency Department. This requirement was an addition to the previous guidance.
- Bed capacity on the Medical Assessment Unit (MAU). This Unit does support same sex accommodation, but segregation cannot be maintained due to operational pressures. Bed capacity needs to be expanded in this respect. The number of notified breaches where patients shared sleeping accommodation within the MAU between April 2010 and January 2011 was 104.

The Trust has developed an action plan in respect of MAU and the A&E Observation Unit. **There are currently 17 beds in MAU: the Trust has committed to expanding capacity to 25 beds**, enabling the Trust to manage the operational pressures and eliminate mixed sex accommodation. The Trust Board has agreed this action, with a completion date of 1st August 2011. The Observation Unit requires fixed screens to be installed between patients: this work will be completed by 1st June 2011.

Figure 5 draws upon data from the annual National Inpatient Survey and demonstrates how patient experience of mixed-sex accommodation has improved during the last five years.

Figure 5



	2006	2007	2008	2009	2010
UHBristol	24%	34%	30%	13%	8%
National	25%	24%	24%	18%	14%

Source: National Inpatient Survey

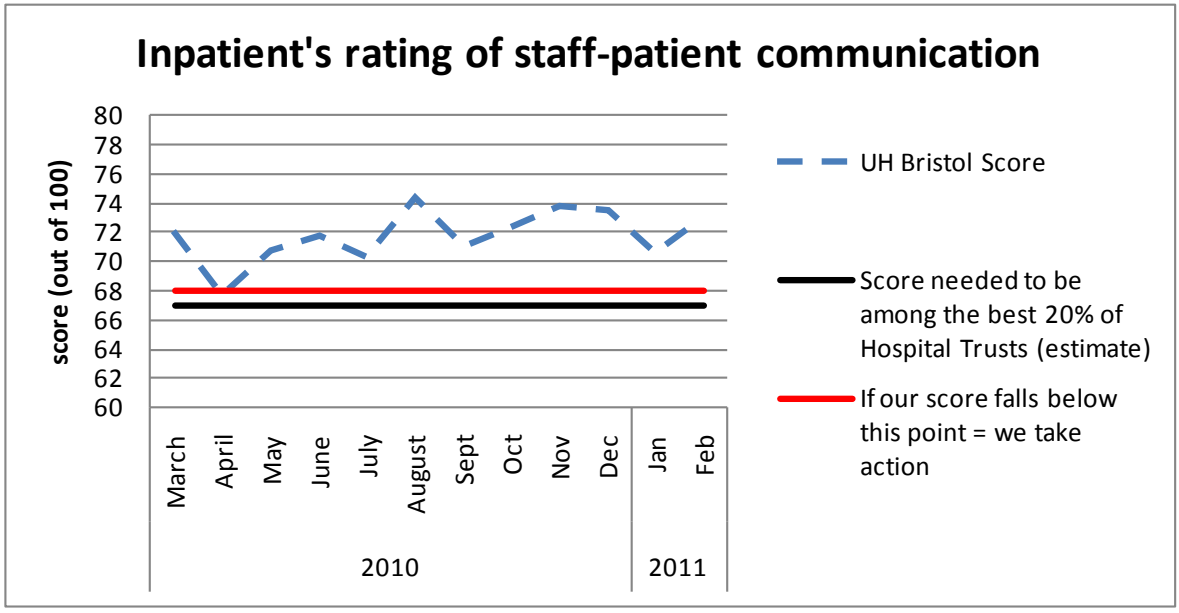
Staff-patient communications

Our Non-Executive Directors and Governors were keen to retain a section of the Quality Report which focuses on the quality of communication between staff and patients. The indicator shown in Figure 6 consists of a 'basket' of four questions which form part of our monthly inpatient survey. The questions are:

- Did a member of staff explain how you could expect to feel after the operation or procedure?
- Do you feel you were kept well informed about your expected date of discharge from hospital?
- 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?

This indicator is reported to the Board each month. A statistical threshold has been set, below which the Board will expect to see intervention. Our rating dipped below that threshold in April 2010; however the dashboard was not in place at this point in time (data has since been populated retrospectively) so the Board did not request any specific intervention at this point. The data returned to 'norm' the following month.

Figure 6



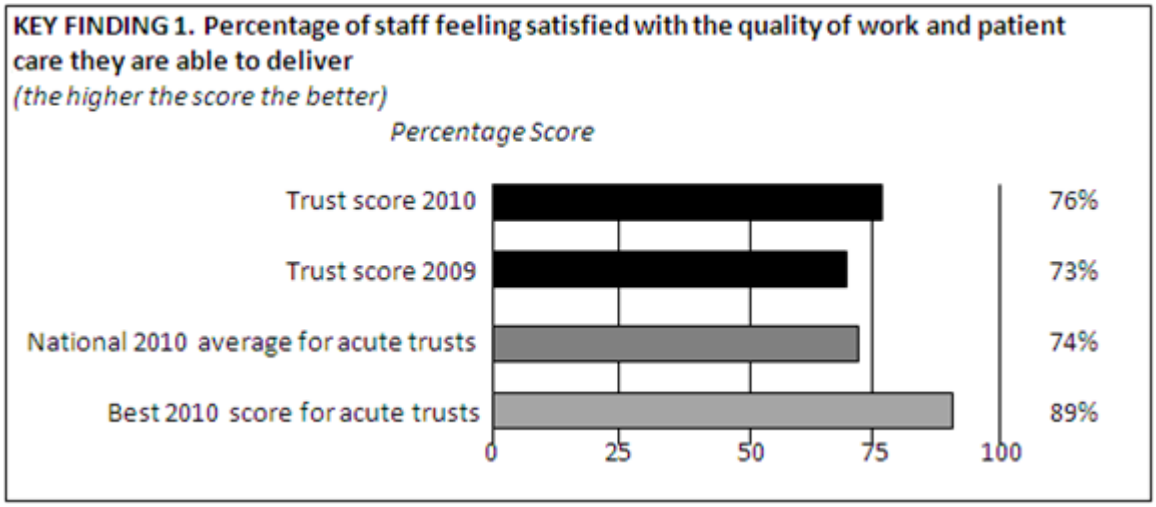
Source: UH Bristol monthly survey (inpatients aged 12+ excluding maternity)

National Staff Survey 2010

Published research is increasingly pointing to the relationship between staff and patient satisfaction. Put simply, a happy, supported, trained workforce is more likely to deliver care which is safe, effective and which patients rate highly. Trusts are encouraged by the Department of Health to include in their Quality Reports data from specific indicators (questions) which appear in the annual National Staff Survey. These indicators

demonstrate how quality of care within the Trust is viewed by its workforce. Relevant results from the 2010 survey are presented below. Questionnaires were sent to a random sample of 1,500 staff across the Trust. 59% of staff responded (an improvement from 56% in 2009).

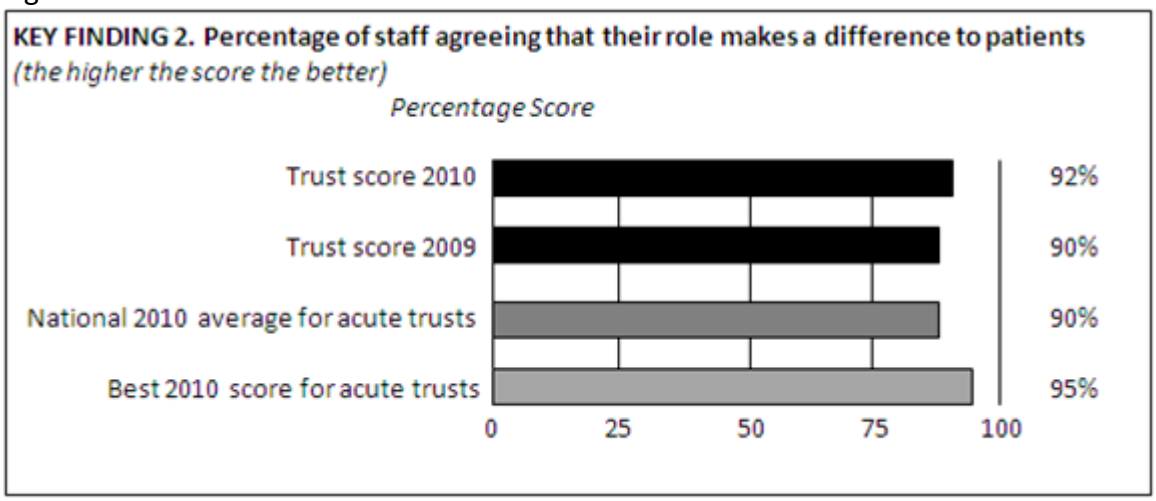
Figure 7



Source: National Staff Survey 2010

76% of staff agreed with at least two of the following three statements: that they are satisfied with the quality of care they give to patients; that they are able to deliver the patient care they aspire to and that they are able to their job to a standard they are personally pleased with. The Trust's score was average when compared with trusts of a similar type and equated to a 3% increase on the previous year.

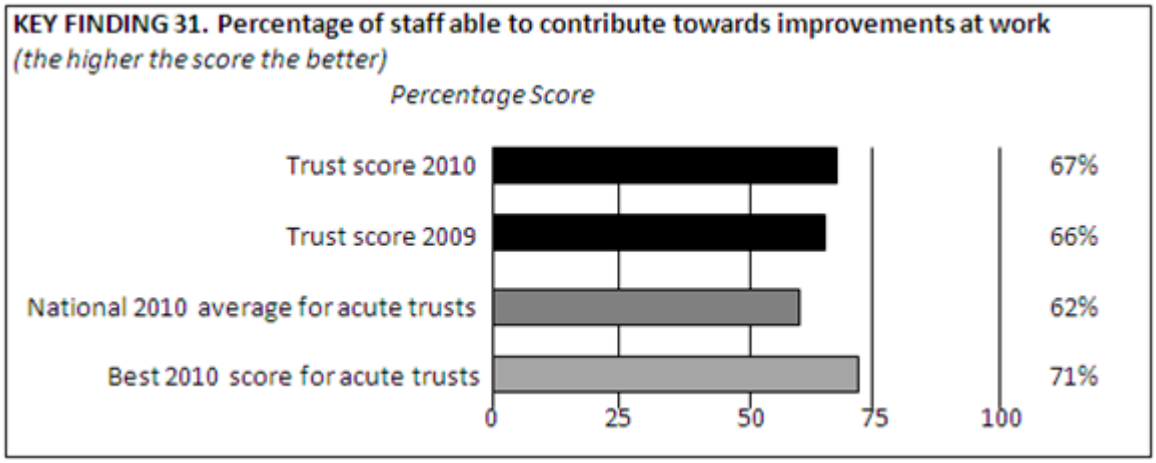
Figure 8



Source: National Staff Survey 2010

92% of staff agreed that their role makes a difference to patients. This score was in the highest (best) 20% of NHS trusts of a similar type: a 2% increase compared to 2009.

Figure 9



Source: National Staff Survey 2010

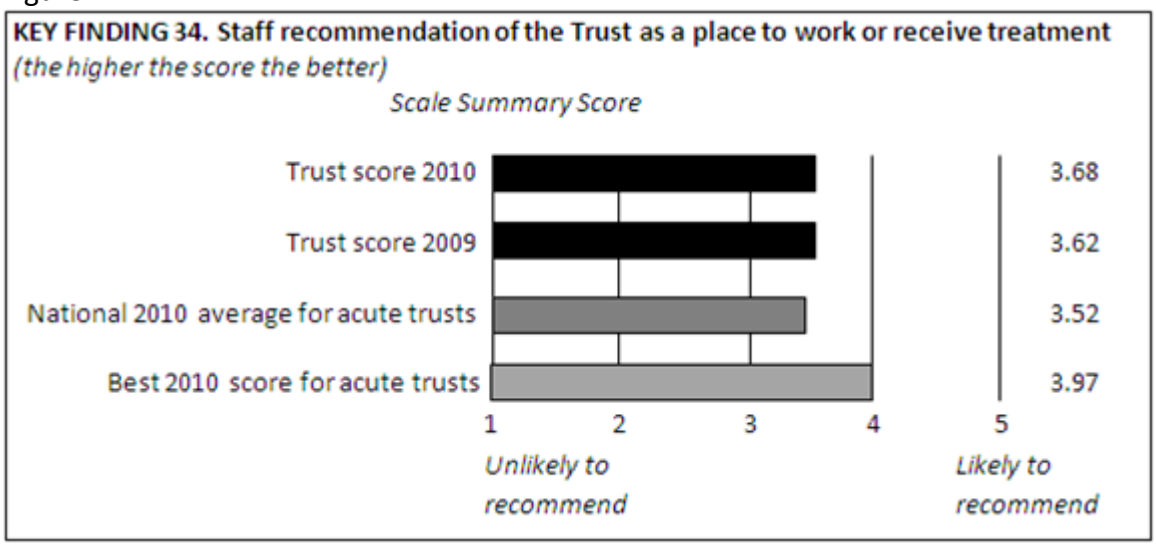
67% of staff agreed with at least two of the following three statements: that they are able to make suggestions to improve the work of their team; that there are frequent opportunities for them to show initiative in their role and that they are able to make improvements at work. This score was in the highest (best) 20% of NHS trusts of a similar type: a 1% increase compared to 2009.

Figure 10

Source: National Staff Survey 2010

Staff were asked how satisfied they were with various aspects of their job including: recognition for good work; support from their immediate manager and colleagues; freedom to choose methods of working; amount of responsibility; opportunities to use their skills and the extent to which the Trust values their work. The Trust's score of 3.59 was in the highest (best) 20% when compared with trusts of a similar type: a statistically significant increase since 2009, when the Trust scored 3.56.

Figure 11



Source: National Staff Survey 2010

Finally, staff were asked whether or not they thought care of patients and service users was the Trust's top priority, whether or not they would recommend the Trust to others as a place to work and whether they would be happy with the standard of care provided by the Trust if a friend or relative needed treatment. The Trust's score of 3.68 was in the highest (best) 20% when compared with trusts of a similar type: a statistically significant increase since 2009, when the Trust scored 3.62.

Objectives for 2011/12

1. We will persevere with our strategy for obtaining systematic feedback from inpatients and extend the core methodologies into Outpatient services (i.e. postal surveys, clinic-based surveys and comments cards)
2. We will create a range of opportunities for carer feedback and engagement, with a particular focus on carers of patients with dementia
3. We will achieve measurable reductions in patient-reported hospital noise at night
4. We will ensure that patients who need assistance at mealtimes receive this
5. We will review the provision of ward-based patient information ensuring that this meets our patients' needs
6. We will develop customer care training for staff in response to what our patients tell us matters to them.

Objectives 3, 4 and 5 have resulted from an analysis of inpatient feedback in 2010/11. Objective 6 has been requested by our Governors. The Chief Nurse will be the Executive Director responsible for achieving these objectives. Progress will be measured by the Trust's Clinical Quality Group, and by the Quality and Outcomes sub-committee of the Board.

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 objectives for 2010/11

Objective 5
We wanted to meet the requirements of the proposed NICE Quality Standard for Dementia

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

We said we would…
Meet the requirements of the proposed NICE Quality Standard for Dementia.

How did we do?
The NICE Quality Standard for Dementia was published in June 2010. The Trust is collaborating within the South West Dementia Partnership to drive through the necessary changes to clinical practice to meet the standards set out by NICE.

There are three statements within the Quality Standard which are of particular relevance to the Trust:

Statement 1 - People with dementia receive care from staff who have been appropriately trained in dementia care.
The Trust currently partially meets this standard. Staff have access to training in 'Safeguarding Adults' (Health professionals), Dementia awareness (healthcare assistants) and online eLearning, as well as the University of West of England postgraduate module on Dementia Care. However, we recognise that training provision is insufficient and not all staff take up these opportunities. The Trust is currently working with North Bristol NHS Trust on a shared Dementia Training Strategy, to include a mandatory training session for all staff, starting in April 2012.

Statement 5 - People with dementia, while they still have capacity, and their carer/s, will have discussed and made decisions about the use of advance statements; advance decisions to refuse treatment; Lasting Power of Attorney; Preferred Priorities of Care.

Again, the Trust partially meets this standard. The Trust has appropriate policies and protocols in place to support these issues, which are also addressed via patient safety updates and corporate induction for all staff, plus Level 2 Safeguarding Adults training. As of April 2011, 40.9% of eligible staff had received Level 2 Safeguarding Adults training. We are committed to improving this position: our target is to achieve 80% compliance by 31st October 2011.

Statement 8 - People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health.

The Trust meets this standard. As a result of an enlarged multidisciplinary team that supports both of the acute trusts in Bristol, there is now increased access to the Older Adult Mental Health Team, including a Consultant Psychiatrist.

The first National Audit of Dementia Care in General Hospitals took place in 2010. The Trust participated fully in the organisational and clinical phases of this audit, the results of which are being used as key measures to track implementation of the NICE Quality Standard across the South West region.

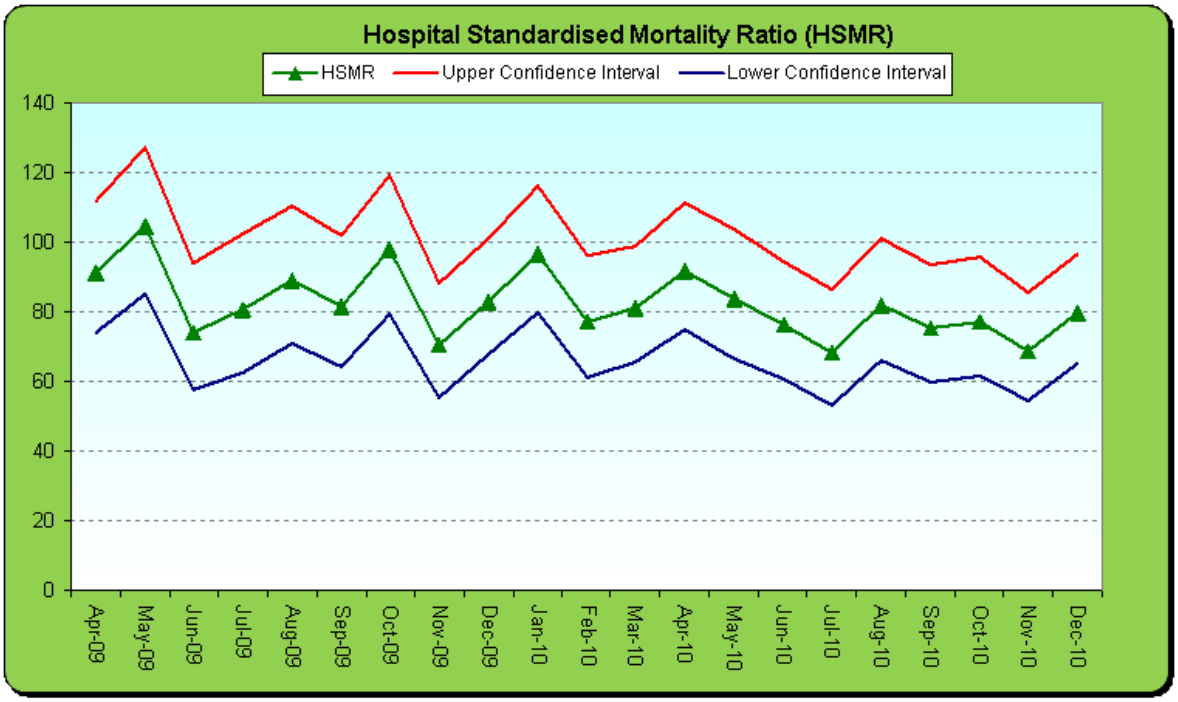
Review of 2010/11

Hospital Standardised Mortality Ratio

The Hospital Standardised Mortality Ratio is a calculation used to monitor death rates in hospitals. 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 excellent 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. The data is also scrutinised by the Care Quality Commission, who issue alerts to individual trusts if unexpectedly high mortality figures are detected (see page 46). It should be noted that the HSMR does not provide definitive answers: rather it poses questions which Trusts have a duty to investigate.

University Hospitals Bristol continues to have a low overall HSMR and was listed in the Dr Foster *Hospital Guide 2010* as having 'lower than expected' HSMR. The same report listed the Trust as having 'lower than expected' mortality for an indicator which covers a 'basket' of five specific conditions which contribute to the HSMR: heart attacks, stroke, pneumonia, congestive heart failure and broken hips.

Figure 12



Source: Imperial College London – derived from HES data

In simple terms, HSMR compares the number of actual deaths with the number of expected deaths. The 'expected' measure is a prediction based on complex statistical modelling which takes into account factors such as age, co-morbidity and social deprivation. In figure 12, the upper and lower confidence intervals describe the level of statistical doubt associated with this model. The graph is saying that we can be 95% confident that the 'true' HSMR lies somewhere between the intervals.

Adult Cardiac Surgery Outcomes

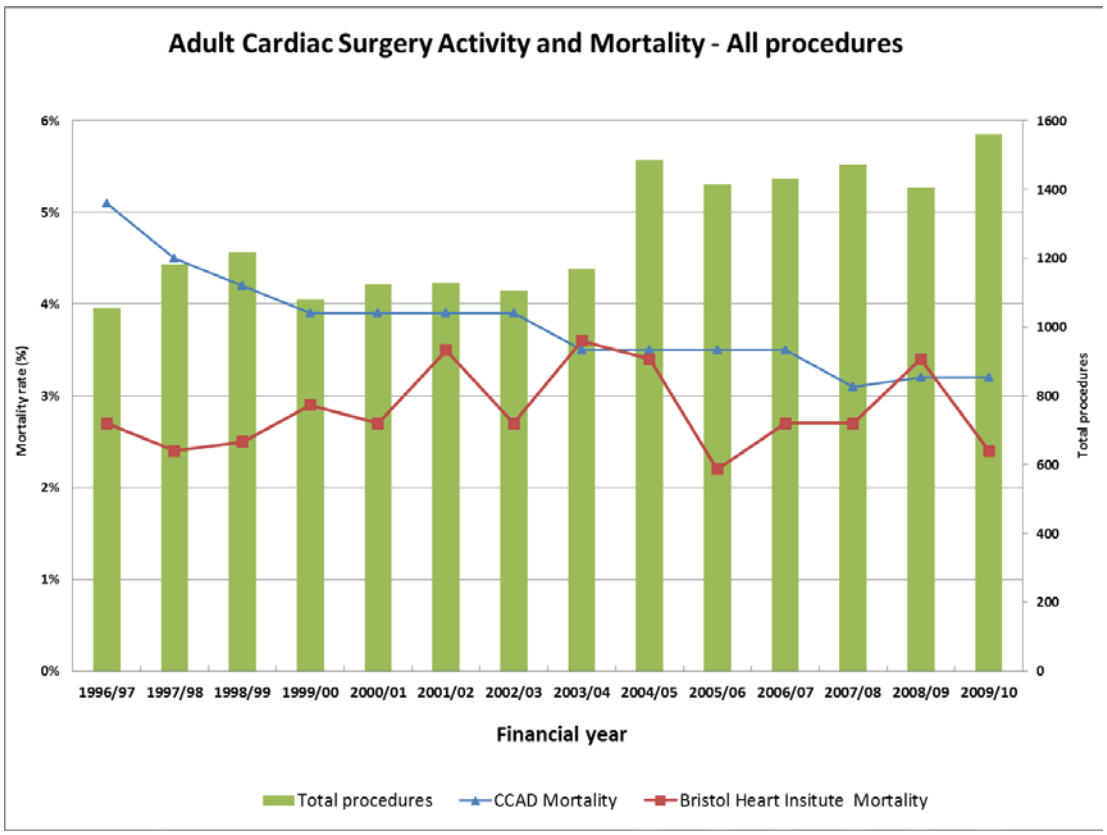
The Trust has maintained a comprehensive cardiac surgery database for the past 15 years, enabling comparison of outcomes for patients undergoing adult cardiac surgery against national and international benchmarks.

In 2009/10, for the first time, the Bristol Heart Institute performed in excess of 1,500 adult heart surgeries, making it 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 in the 'Key Publications' section – visit www.uhbristol.nhs.uk

Figure 13 below shows a pattern of increasing levels of surgical activity, and **a combined mortality rate which is below the national average**. Please note that benchmarked mortality data is available one year in arrears. This is to enable the national CCAD

(Central Cardiac Audit Database) team to perform its comparative analysis of data across the NHS. The latest data shown in Figure 13 is therefore for the year 2009/10.

Figure 13



Source: Central Cardiac Audit Database / Patient Analysis Tracking System

Cataract Surgery Outcomes

Cataract surgery is the most frequently performed surgical procedure at the Bristol Eye Hospital, with approximately 5,000 cases each year. The Trust carries out an annual audit to monitor overall visual acuity outcomes and surgical complication rates. It should be noted that the figures quoted here are provisional.

In 2010/11, 4,590 cataract operations were carried out. 60.6% of procedures were on “first eyes” and 39.4% on “second eyes” (second eyes are where the patient has already had cataract surgery on one eye). Table 3, below, shows a number of key outcome measures for 2010 compared with Trust data from previous years, and a UK benchmarking study.

Table 3

	UH Bristol 2010	UH Bristol 2009	UH Bristol 2008	UK EPR[11] study (published 2009)
Day cases	98.2%	98.4%	97%	
Pre-operative visual acuity[12] of 6/12 or better	39.1%	41%	42%	63%
Surgery performed under general anaesthetic (as opposed to local anaesthetic)	4.4%	4%	5.5%	
Post-operative visual acuity of 6/12 or better (compared to pre-operative visual acuity, i.e. a measure of success)	82.7%	86%	92%	92%
Posterior capsule rupture*	2.3% (1.91 – 2.79%)	1.7%	2.2%	1.9%
Dropped nucleus*	0.4% (0.26 - 0.65%)	0.1%	0.24%	0.2%
Post-op cystoid macular oedema*	1%	1.6%	5.3%	0.6%

* denotes complications associated with Cataract Surgery

In summary, state-of-the-art cataract surgery (i.e. predominantly day-case phacoemulsification procedures under local anaesthesia) is being practiced at the Bristol Eye Hospital. Visual outcomes scores for 2010 are slightly lower than previously, whilst rates of posterior capsule rupture and dropped nucleus are slightly higher. This is likely to reflect the fact that our clinicians are seeing more complex cases and associated co-morbidity as an increasing proportion of lower-risk cases are now treated at the Independent Sector Treatment Centre[13]. It is important to note the higher percentage of patients with ocular co-pathology being operated upon (39.9% compared to 36% in 2009, 31% in 2008, 30% in 2007 and 15% in the national EPR study).

Oesophageal Cancer Outcomes

The oesophago-gastric surgical unit at the Bristol Royal Infirmary comprises a team of six surgeons providing expertise in the local and tertiary care of benign and malignant upper Gastro-Intestinal diseases. Oesophagectomy is a long and complex operation that typically lasts between five and seven hours and it is associated with considerable risks of postoperative mortality and morbidity.

[11] Electronic Patient Record

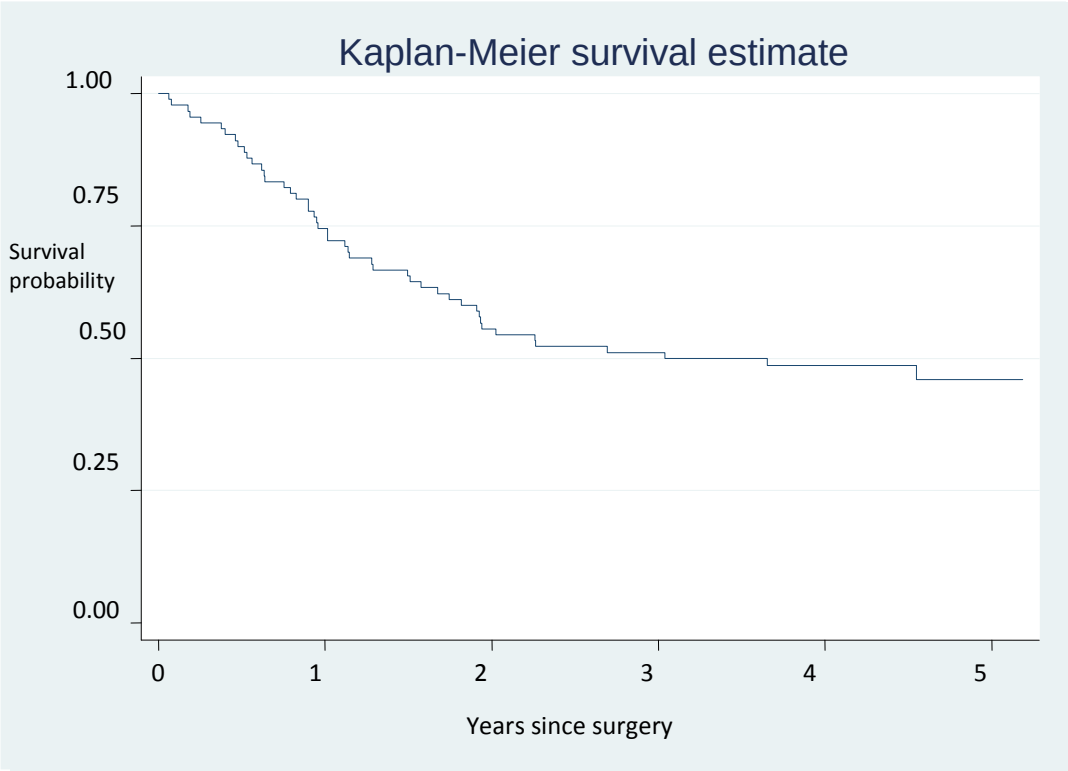
[12] Visual acuity is acuteness or clarity of vision

[13] ISTCs are private-sector owned treatment centres contracted within the NHS to treat NHS patients free at the point of use, like any other NHS hospital

The main purpose of undergoing oesophagectomy for cancer is to optimise long term cure rates. These have historically been poor, with many centres and studies showing five year survival figures of less than 25%. In Bristol, we have followed up the long term survival of patients undergoing oesophagectomy in 2006 and 2007 and found that almost 50% were alive five years after their surgery. Currently, long term survival data is not available from the national oesophago-gastric audit, but our figures are comparable to those achieved from international centres of excellence.

Figure 14

Five-year survival of patients selected for planned oesophagectomy at University Hospitals Bristol between 2006 and 2007



90 patients were scheduled for surgery in 2006 and 2007

Source: local database

Patient Reported Outcome Measures (PROMs)

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.

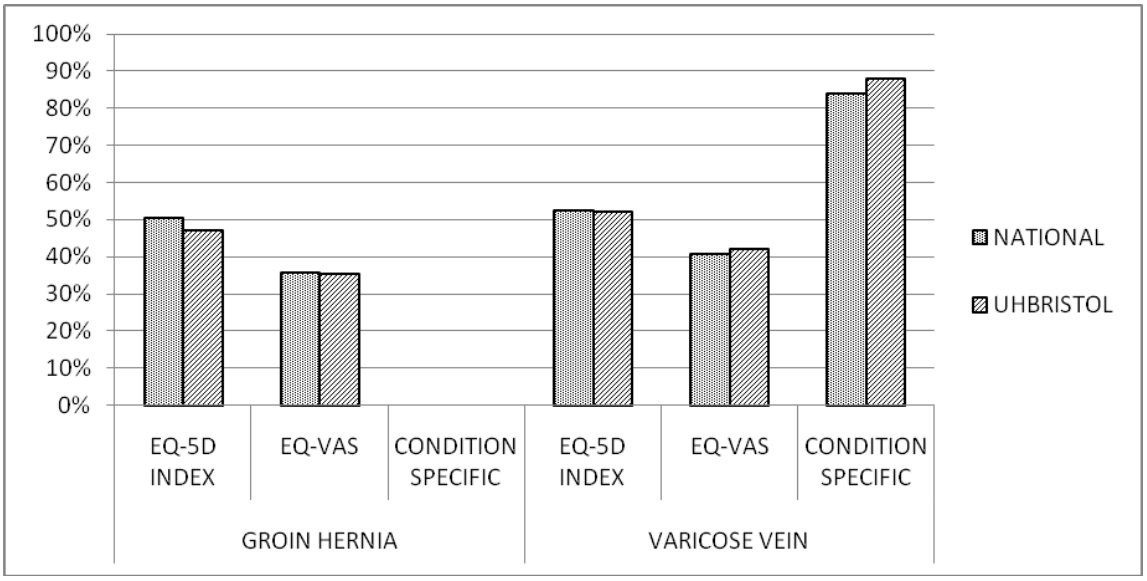
PROMs comprise questionnaires completed by patients before and after surgery to record their health status. Outcomes are measured in three ways: a tool called the 'EQ-5D index' asks patients questions about things like mobility, activities and pain levels; patients also rate their health on a scale of 0-100 using a 'visual analogue scale' and

finally (in the case of varicose veins) patients are asked questions about the specific condition for which they are having surgery.

In September 2010, the Department of Health published the first post-operative scores from the PROMs programme, updates of which are now made available on a regular basis. Data for the period April 2009 – July 2010 (see Figure 15) indicates that patient-reported outcomes for patients treated by University Hospitals Bristol are similar to those reported across the NHS. The graph shows that more than four out of five patients reported positive outcomes relating to their varicose vein surgery, although only around half of patients reported improvements to their general quality of life as a result (i.e. using the two EQ-5D measures). Results for individual trusts should be read with caution as the numbers of patients is relatively small with wide margins of statistical error associated with the data: for example, for the Groin Hernia EQ-5D index, of 19,338 patients in England who completed the PROM, 125 were patients of University Hospitals Bristol.

Figure 15

Percentage of scores that improved for each procedure and scoring mechanism
National scores compared to University Hospitals Bristol: April 2009 - July 2010



Source: Health and Social Care Information Centre

Objectives for 2011/12

The Trust's goal is to maintain it's 'lower than expected mortality' rating for headline HSMR[14]. We have identified four specific areas where we would like to see progress in 2010/11:

[14] The HSMR will be replaced at some point during 2011/12 be a new measure called 'SHMI' – the Summary Hospital-level Mortality Indicator.

1. One year survival rates for colorectal, breast and lung cancer patients – in particular, we will implement the recommendations of *Improving Outcomes: a strategy for cancer* (Department of Health, 2011),
2. Achieving improvements in Dr Foster rating for stroke care – in particular, we will establish a specialist stroke unit: our target is that 90% of patients who suffer a stroke will spend 90% of their care in a specialist unit,
3. Increasing the proportion of spontaneous vaginal births,
4. Dementia care - implementing our action plan in response to the NICE Quality Standard for Dementia, and delivering the following specific actions related to agreed standards of dementia care within the South West region:

    - Introduce "This is Me" document across the Trust,
    - Define and implement the Dementia Champion role across the Trust,
    - Develop and implement a minimising ward move policy for patients with dementia,
    - Identify communal areas used by patients with dementia and ensure appropriate signage is in place,
    - Install clocks and calendars in all ward areas,
    - Review current dementia training.

The first two themes - cancer survival and improving recovery from stroke - reflect priorities set out in the NHS Outcomes Framework 2011/12; the third is a local CQUIN target agreed with our commissioners; whilst the fourth theme links to both.

The Medical Director will be the Executive Director responsible for achieving these objectives. Progress will be measured by the Trust's Clinical Quality Group and by the Quality and Outcomes sub-committee of the Board.

PERFORMANCE AGAINST KEY NATIONAL PRIORITIES

Summary of performance against national access standards

Whilst the Trust faced challenges in meeting all the national access standards in each quarter of 2010/11, overall, there was a marked improvement in performance relative to the previous year (see Table 4). The Trust continued to meet the target reductions in levels of MRSA (*Meticillin Resistant Staphylococcus Aureus*) bacteraemias and C diff (*Clostridium difficile)* infections, achieving not only the national but also local 'stretch' targets (i.e. even more demanding aspirations set by the Trust). Key national waiting time standards for the Accident and Emergency maximum wait within four hours (95% standard), cancer and 18-week Referral to Treatment Times (RTT) were also achieved for the year as a whole.

The consistency of performance across quarters also improved, although the Trust failed to achieve the 95% A&E four-hour standard in the fourth quarter of the year. All of the cancer standards were achieved in quarters 2 and 3, with one standard (2-week wait for symptomatic breast patients – cancer not initially suspected) not being achieved in quarter 1 and one standard (62-day wait for treatment for patients referred from a screening programme), not being achieved in quarter 4. The 18-week RTT standards for admitted and non-admitted patients were achieved in each quarter of the year. The standard for screening elective patients for MRSA failed to be achieved in full in the first two quarters of the year. However, following corrective action being taken to improve the frequency of monitoring of levels of screening, the 100% standard was achieved in the second half of the year, along with the screening of Emergency patients, which came into effect in quarter 4 2010/11.

Year-on-year improvements were also seen in a number of other access standards, including the target time spent on a stroke unit; reperfusion[15] times for patients suffering a heart attack; and non-smoking rates of mothers at the time of delivery. Four of the six new standards relating to access for patients with learning disabilities had already been met at the start of the year. Compliance with the remaining two standards was achieved at the end of the second quarter of 2010/11.

Despite improvements in 2010/11 compared to previous years, the Trust did not meet national standards for minimising the number of operations cancelled at the last minute for non-clinical reasons, nor for re-admitting patients whose operations were cancelled within 28 days. This was mainly due to the sustained increase in emergency demand, with bed availability being the major cause of cancellations on the day.

Full details of the Trust's performance in 2010/11 compared with 2009/10 are set out in Table 4, which shows cumulative year-to-date performance. Further commentary regarding the 18 week RTT, Accident and Emergency 4 hour wait, cancer and cancelled operations targets is provided in Appendix B of this Quality Report.

[15] Reperfusion is the restoration of blood flow to an organ or tissue

Table 4 – Performance against national standards

National standard	2010/11 Target	2009/10	2010/11		Notes
A&E maximum wait of 4 hour	98%	**98.0%**	**96.6%**	↓	
MRSA Bloodstream Cases Against Trajectory	Trajectory	**15**	**5**	↓	
C.diff Infections Against Trajectory	Trajectory	**100**	**94**	↓	
Cancer - 2 Week wait (urgent GP referral)	93%	**93.7%**	**95.6%**	↑	
Cancer – 2 Week wait (symptomatic breast cancer not initially suspected)	93%	**46.9%**	**93.3%**	↑	Target met in 3 quarters in 2010/11 (not Q1)
Cancer - 31 Day Diagnosis To Treatment (First treatment)	96%	**96.3%**	**98.1%**	↑	Target me in every quarter in 2010/11
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94%	**92.6%**	**95.5%**	↑	Target me in every quarter in 2010/11
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	98%	**99.6%**	**99.8%**	↑	Target met in every quarter in 2010/11
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	94%	**/**	**99.6%**		Target came in 1st Jan 2011
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	**80.9%**	**86.1%**	↑	Target met in every quarter in 2010/11
Cancer 62 Day Referral To Treatment (Screenings)	90%	**86.3%**	**90.8%**	↑	Target met in 3 quarters in 2010/11 (not Q4)
Cancer 62 Day Referral To Treatment (Upgrades)	Not published	**95.3%**	**96.2%**	↑	Target met in every quarter in 2010/11
Referral To Treatment Admitted Under 18 Weeks	90%	**90.5%**	**93.0%**	↑	Target met in every quarter in 2010/11
Referral To Treatment Non Admitted Under 18 Weeks	95%	**97.5%**	**98.3%**	↑	Target met in every quarter in 2010/11
GUM Offer Of Appointment Within 48 Hours	98%	**100%**	**100%**	→	
Number of Last Minute Cancelled Operations	0.80%	**1.1%**	**1.3%**	↑	
28 Day Readmissions	95%	**92.3%**	**91.0%**	↓	
Data Quality on Ethnic Group	85%	**88.8%**	**94.8%**	↑	
60 Minute Thrombolysis Call To Needle Time	68%	**100%**	**100%**	→	
Primary PCI - 150 Minutes Call To Balloon Time	75%	**69.6%**	**78.7%**	↑	Target as per 2009/10 Operating Framework
Delayed Transfers Of Care (Acute)	3.50%	**1.0%**	**1.5%**	↑	
Rapid Access Chest Pain 2 Week Wait	98%	**100%**	**100%**	→	
Infant Health - Mothers Who Are Not Smokers At Delivery	87.9%	**87.9%**	**89.1%**	↑	
Infant Health - Mothers Initiating Breastfeeding	71%	**76.3%**	**76.3%**	↓	
Stroke Care	76.2-78.1%	**69.8%**	**78.5%**	↑	Quarterly target as per PCT contact
High Risk TIA Patients Starting Treatment Within 24 Hours	52.9%	**58.9%**	**66.1%**	↑	Quarterly target as per PCT contact
MRSA Emergency Screening	90% (Q4)		**91.3%**		Target as agreed with the Primary Care Trust
MRSA Elective Screening	100%		**99.4%**		Achieved 100% standard in Q3 and Q4.

Achieved Under-achieved Failed

Quality Report Annex A - Statements of assurance from the Board

1. Review of services

During 2010/11, University Hospitals Bristol NHS Foundation Trust provided clinical services in 63 [16] specialties via five clinical Divisions (i.e. Medicine; Surgery Head & Neck Services; Women's & Children's Services; Diagnostics and Therapy; and Specialised Services).

During 2010/11, the Trust Board has reviewed selected high-level quality indicators (e.g. infection control, HSMR) as part of monthly performance reporting. The Trust also receives information relating to the review of quality of services in all specialties via, for example, the Clinical Audit Annual Report. The income generated by University Hospitals Bristol NHS Foundation Trust services reviewed in 2010/11 therefore, in these terms, represents 100% of the total income generated from the provision of NHS services by the Trust for 2010/11.

2. Participation in clinical audits and national confidential enquiries

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

During 2010/11, 48 national clinical audits and seven national confidential enquiries related to covered NHS services that University Hospitals Bristol NHS Foundation Trust provides.

During that period University Hospitals Bristol NHS Foundation Trust participated in 81% (39/48) national clinical audits and 100% (7/7) national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2010/11 are as follows:

Title of audit	Eligible	Participated
Peri- and Neo-natal		
Neonatal intensive and special care (NNAP)	Yes	Yes
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	No
Paediatric asthma (British Thoracic Society)	Yes	Yes

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

Paediatric fever (College of Emergency Medicine)	Yes	Yes
Childhood epilepsy (RCPCH National Childhood Epilepsy Audit)	Yes	Yes
Paediatric intensive care (PICANet)	Yes	Yes
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	Yes	Yes
Diabetes (RCPCH National Paediatric Diabetes Audit)	Yes	Yes
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	No
Adult community acquired pneumonia (British Thoracic Society)	Yes	No
Non-invasive ventilation (NIV) - adults (British Thoracic Society)	Yes	No
Pleural procedures (British Thoracic Society)	Yes	No
Cardiac arrest (National Cardiac Arrest Audit)	Yes	No
Vital signs in majors (College of Emergency Medicine)	Yes	Yes
Adult critical care (ICNARC Case Mix Programme)	Yes	Yes
Potential donor audit (NHS Blood & Transplant)	Yes	Yes
Long term conditions		
Diabetes (National Diabetes Audit)	Yes	Yes
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes
Chronic pain (National Pain Audit)	Yes	Yes
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	Yes
Parkinson's disease (National Parkinson's Audit)	Yes	No
COPD (British Thoracic Society/European Audit)	Yes	Yes
Adult asthma (British Thoracic Society)	Yes	No
Bronchiectasis (British Thoracic Society)	Yes	No
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes
Elective surgery (National PROMs Programme)	Yes	Yes
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	Yes	Yes
Liver transplantation (NHSBT UK Transplant Registry)	No	N/A
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	Yes
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes
Carotid interventions (Carotid Intervention Audit)	Yes	Yes
CABG and valvular surgery (Adult cardiac surgery audit)	Yes	Yes
Cardiovascular disease		
National Clinical Audit of Management of Familial Hypercholesterolaemia	Yes	Yes
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes
Heart failure (Heart Failure Audit)	Yes	Yes
Pulmonary hypertension (Pulmonary Hypertension Audit)	No	N/A
Acute stroke (SINAP)	Yes	No
Stroke care (National Sentinel Stroke Audit)	Yes	Yes
Renal disease		
Renal replacement therapy (Renal Registry)	Yes	Yes
Renal transplantation (NHSBT UK Transplant Registry)	Yes	Yes
Patient transport (National Kidney Care Audit)	Yes	Yes
Renal colic (College of Emergency Medicine)	Yes	Yes
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	Yes
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes
Head & neck cancer (DAHNO)	Yes	Yes

Trauma		
Hip fracture (National Hip Fracture Database)	Yes	Yes
Severe trauma (Trauma Audit & Research Network)	Yes	No
Falls and non-hip fractures (National Falls & Bone Health Audit)	Yes	Yes
Psychological conditions		
Depression & anxiety (National Audit of Psychological Therapies)	No	N/A
Prescribing in mental health services (POMH)	No	N/A
National Audit of Schizophrenia (NAS)	No	N/A
Blood transfusion		
O negative blood use (National Comparative Audit of Blood Transfusion)	Yes	No
Platelet use (National Comparative Audit of Blood Transfusion)	Yes	Yes
National Confidential Enquires		
Parental Nutrition (NCEPOD)	Yes	Yes
Surgery in the Elderly (NCEPOD)	Yes	Yes
Peri-operative care (NCEPOD)	Yes	Yes
Surgery in Children (NCEPOD)	Yes	Yes
Cardiac Arrest Procedures (NCEPOD)	Yes	Yes
Cosmetic Surgery (NCEPOD)	No	N/A
National maternal and perinatal mortality surveillance (CMACE)	Yes	Yes
Child mortality surveillance (CMACE)	Yes	Yes

The Trust did not participate in ten relevant national clinical audits in 2010/11. The reasons for this are set out below:

- British Thoracic Society audit programme (five of the audits within this programme) – resources have been identified within the specialty, however participation in every BTS audit was not possible due to sheer volume. The BTS audit programme for 2011/12 has yet to be announced – the Trust is committed to participating where resources allow.
- Cardiac arrest (National Cardiac Arrest Audit) – no funding available during 2010/11. The Trust has now registered and participation will commence June 2011.
- Parkinson's disease (National Parkinson's Audit) – clinical staff were not aware of this national audit. Participation has been agreed for next round (to commence 2012).
- Acute stroke (SINAP) – the Trust is already participating in the National Sentinel Audit for stroke and has prioritised this as there are insufficient resources to enable participation in studies. On-going discussions with Clinical Lead for stroke as to future participation by the Trust.
- Severe trauma (Trauma Audit & Research Network) – no funding available during 2010/11. Participation for 2011/12 is under discussion as a result of the centralisation of specialist paediatric services and the Trust's role as a Regional Trauma Centre.
- O Negative blood use (National Comparative Audit of Blood Transfusion) – the Trust did not have a Transfusion Lead in post during the audit period. A Lead has since been appointed and participation in the future National Comparative Audit programme confirmed for 2011/12.

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 2010/11 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.

Title of audit	% Cases Submitted
Peri- and Neo-natal	
Neonatal intensive and special care (NNAP)	753*
Children	
Paediatric asthma (British Thoracic Society)	13*
Paediatric fever (College of Emergency Medicine)	100% (50/50)
Paediatric intensive care (PICANet)	561*
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	100% (977/977)
Acute care	
Vital signs in majors (College of Emergency Medicine)	100% (50/50)
Adult critical care (ICNARC Case Mix Programme)	100% (982/982)
Potential donor audit (NHS Blood & Transplant)	100%
Long term conditions	
Diabetes (National Diabetes Audit)	359*
Elective procedures	
Hip, knee and ankle replacements (National Joint Registry)	27% (5/18)
Elective surgery (National PROMs Programme)	83%
Coronary angioplasty (NICOR Adult cardiac interventions audit)	100% (989/989)
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	100% (302/302)
Carotid interventions (Carotid Intervention Audit)	98% (48/49)
CABG and valvular surgery (Adult cardiac surgery audit)	100% (1567/1567)
Cardiovascular disease	
National Clinical Audit of Management of Familial Hypercholesterolaemia	100% (40/40)
Acute Myocardial Infarction & other ACS (MINAP)	100% (817/817)
Heart failure (Heart Failure Audit)	52% (159/307)
Stroke care (National Sentinel Stroke Audit)	100% (62/62)
Renal disease	
Patient transport (National Kidney Care Audit)	100% (62/62)
Renal colic (College of Emergency Medicine)	100% (50/50)
Cancer	
Lung cancer (National Lung Cancer Audit)	59% (107/180)
Bowel cancer (National Bowel Cancer Audit Programme)	157*
Head & neck cancer (DAHNO)	>89%
Trauma	
Hip fracture (National Hip Fracture Database)	46% (162/350)
Falls and non-hip fractures (National Falls & Bone Health Audit)	66% (40/60)
Blood transfusion	
Platelet use (National Comparative Audit of Blood Transfusion)	100%
National Confidential Enquiries	
Parental Nutrition (NCEPOD)	81% (44/54)
Surgery in the Elderly (NCEPOD)	86% (12/14)
Peri-operative care (NCEPOD)	100% (6/6)

Surgery in Children (NCEPOD)	100% (22/22)
Cardiac Arrest Procedures (NCEPOD)	N/A
National maternal and perinatal mortality surveillance (CMACE)	Neonatal deaths: 37 (all reported) CMACE[17] has closed and at the time of writing, the Trust does not have access to Maternal and Stillbirth death statistics
Child mortality surveillance (CMACE)	Child Deaths: 33 (all reported)

* not possible to establish baseline from HES data

The reports of 18 national clinical audits were reviewed by the provider in 2010/11 and University Hospital Bristol NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National cancer audits

- Data is now being entered 'live' onto the Cancer Register at multidisciplinary team (MDT) meetings.
- Lead clinicians are to meet with the National Cancer Team to explore how to make better use of the Cancer Register and to improve the quality of the data submitted.
- Local reports are run on a frequent basis to help ensure data validity.
- The Trust will be exploring new approaches to data collection including the use of portable devices to capture data at 'point of care'.
- The results of national audits are now included within the national 'peer review process'; actions are agreed within specific cancer group annual reports.

National cardiac audits

- A dedicated data manager has been appointed to improve process, coordinate data submissions and improve data quality.
- Data is now being entered at the 'point of care' by clinical staff through web based data systems.
- Local audit is being conducted to enable further investigation into areas of concern.

National audits of older people, including dementia[18]

- A joint 'Dementia Steering Group' has been set up with colleagues from North Bristol Trust. A local group has also been established.
- A training strategy is being developed to identifying the key skills for people working with patients with dementia.
- The Trust is planning to adopt the *'This is me'* leaflet developed by the Alzheimer's Society.
- The Trust has implemented guidance and recommendations around the management of constipation in older adults.

[17] CMACE – the national Centre for Maternal and Child Enquiries – ceased to exist on 1st April 2011. CMACE's work will be taken forward by a new consortium awarded by the National Patient Safety Agency

[18] We recognise that dementia is not confined to elderly patients

Neonatal intensive and special care (NNAP)

- Additional support is now being provided to the multi-disciplinary team to help enable fully validated and complete data submission.

Potential donor audit (NHS Blood and Transplant)

- Relevant Trust policy and guidelines have been updated.
- Donor committee meetings have been established and a 'workspace' for committee minutes and relevant information has been created.
- Staff awareness has been raised by attaching organ donation information to staff payslips. Information was widely disseminated and the process of organ donation was promoted during transplant week.
- Organ Donation funds have been distributed to critical care area as part organ donation task force recommendations.

The reports of 160 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2010/11. During 2010/11, summary outcomes and actions reports from these audits were reviewed by the Trust's Governance and Risk Management Committee (an Executive sub-committee of the Trust Board). Full details of the changes and benefits of these projects will be published in the 2010/11 Clinical Audit Annual Report. This will be available via the Trust's website in July 2011.

3. Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by University Hospitals Bristol in the period 1st April 2010 to 31st March 2011 that were recruited during that period to participate in research approved by a research ethics committee was 8,836.

4. CQUIN framework (Commissioning for Quality and Innovation)

The amount of potential income in 2010/11 for quality improvement and innovation goals was £5.61 million, based on 2010/11 actual outturn. This potential income was conditional upon achieving key national patient access targets in full.

It is currently forecast that associated payment in 2010/11 will be £1.361 million, although final validation by commissioners is not yet available.

An explanation of the factors contributing to the failure to earn more than the 24% of potential CQUIN rewards is provided at the end of this section. One key factor has been the inclusion of the gateway, which has served as a barrier to full clinical and divisional engagement, given that there is no certainty that achievement of individual CQUIN goals will then attract the relevant CQUIN reward. Additionally, the failure to meet the Cancelled Operations gateway standard reduced payments by 10%.

A proportion of University Hospitals Bristol Foundation Trust's income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between

University Hospitals Bristol 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. Further details of the agreed goals for 2010/11 and for 2011/12 are available electronically at http://www.uhbristol.nhs.uk/who-we-are-and-what-we-do/how-we-are-doing.html

During 2010/11, the Trust was required to meet a number of gateway standards before being eligible for CQUIN financial rewards. The mandatory standards consisted of the national cancer standards, A&E 4-hour maximum wait, and 18-week Referral to Treatment Times. Achievement of a further three gateway standards (MRSA trajectory, 6-week diagnostic wait and the national last-minute cancelled operations standard) determined the scale of the reward. The Trust has achieved all of the CQUIN gateway standards, with the exception of last minute cancelled operations. This is in contrast to 2009/10, when a number of the mandatory gateways failed to be achieved.

The CQUIN goals were chosen to reflect both national and local priorities. Eighteen goals were agreed, including two nationally specified goals - Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE), and Improve responsiveness to personal needs of patients. The Trust has achieved six of the eighteen goals in full and two in part, as follows:

- Reduction in medication errors;
- Reduction in Hospital acquired pressure ulcers;
- Increased use of WHO surgical checklist;
- Reduction of MRSA bloodstream cases (Infection control);
- Improved outcomes for adult and paediatric bone marrow transplants;
- Improved outcomes in paediatric cardiac surgery – readmissions and mortality;
- Improved outcomes in neonatal care – total refusals (part);
- Smoking cessation – referrals to cessation service (part).

Unfortunately, whilst spot audits have shown that the Trust is achieving the national VTE CQUIN, problems with data capture in 2010/11 have prevented us evidencing this. These issues will be rectified from April 2011 with the introduction of an electronic system for the data capture of VTE risk assessments.

Six of the CQUIN goals related to productivity indicators, including average length of stay, new to follow-up ratio and emergency readmissions, accounting for £2.24 million potential rewards. These targets, which were always known to be extremely challenging for the Trust, were not achieved. Other CQUINs which are expected not to be achieved are Smoking cessation training, GP discharge summaries, Emergency care 30 minute assessment and Improved outcomes in neonatal care (transfers out). A new electronic system for discharge letters has been rolled out across the Trust through 2010/11; however, experience from other providers has shown that such systems can take a number of years to become fully embedded. It is anticipated that there will be sustained progress on this next year, when this will again be a CQUIN. The emergency care assessment within 30 minutes CQUIN has been impacted by the increased level of Accident and Emergency attendances across the Trust, particularly over the winter months. The Trust had raised concerns about the deliverability in full of the Neonatal

CQUIN at the outset, given that commissioners had not agreed investment in increased cot capacity to the level proposed, and therefore achievement was always in doubt.

(Also see page 20 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 and its current registration status is 'registered without compliance conditions'. The Care Quality Commission has not taken enforcement action against University Hospitals Bristol during 2010/11.

As part of the process of registering with the CQC, the Trust declared non-compliance with four of the CQC's 16 key quality and safety standards (called 'Outcomes'). These were Outcome 5 (Meeting nutrition needs – see page 14), Outcome 10 (Safety and suitability of premises – we recognised the need to bring fire safety at St Michael's Hospital up to the highest standards[19]); Outcome 14 (Supporting Staff – for example, we recognised that we needed to improve the proportion of staff who were having an appraisal every 12 months) and Outcome 21 (Records – for example, we recognised that we needed to introduce clear guidance for our staff about how long different sorts of records should be kept for). The issues identified by the Trust which led to this decision had been addressed by year-end. The Trust has yet to receive a periodic Planned Review, however in October 2010 the CQC made an unannounced inspection of Outcome 5, the findings of which are described elsewhere in this Quality Report.

During 2010/11, the Trust received one Outlier Alert 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. In July 2010, we received an Alert for Percutaneous Coronary Intervention (PCI, coronary angioplasty). The Trust reviewed data for all patients who had received a coronary procedure in its catheter labs between May 2009 and May 2010. Following robust analysis, the Trust was able to confirm an increase in mortality associated with emergency PCI, as a result of higher risk patients being treated. Case-mix adjusted outcomes were found to be equal to, or better than, national figures. The Trust has requested that the national 'flagging' system be refined.

6. Data quality

University Hospitals Bristol NHS Foundation Trust submitted records during 2010/11 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:

[19] Upgraded fire detection and alarm system and improvements to fire compartmentation – issues addressed by April 2010

- Which included the patient's valid NHS number was: 99.1% for admitted patient care; 99.6% for outpatient care; and 94.9% for accident and emergency care. (Improved scores on 2009/10 for admitted and A&E. Same as 2009/10 for outpatients)
- Which included the patient's valid General Practice code was: 100% for admitted patient care; 99.8% for outpatient care; and 100% for accident and emergency care.

(Data source: NHS Information Centre, SUS Data Quality Dashboard, April 10 – December 2010 as at Month 9 inclusion date)

The Trust's score for 2010/11 for Information Quality and Records Management using the Information Governance Toolkit is 65% and graded Red. The score was 82% in 2009/10. This year's toolkit represents a substantial change with regard to the need to upload evidence and a strengthening of the requirements. The previous RAG (Red-Amber-Green) rating, which related to the overall percentage score, has been removed. It is now necessary to achieve level 2 against all 45 requirements in order to be rated green. University Hospitals Bristol was assessed at Level 1 on three requirements, which has resulted in the red rating. The first of these requirements relates to Information Governance Training: the Trust has added Information Governance to the list of statutory and mandatory training and is preparing a communications strategy to raise staff's awareness of this training and achieve Level 2. The second requirement relates to confidentiality audits: a schedule of audits is being communicated to staff, and checks performed to ensure that staff are conforming to policy. A third requirement was automatically rated red as a consequence of first two issues.

The Trust was not subject to the Payment by Results clinical coding audit during the reporting period (10/11) by the Audit Commission; however an external audit was arranged by the Trust which covered 1,080 sets of notes across a range of specialties. The error rates reported in this audit for the period October 2010 for diagnoses and treatment coding were:

- Primary procedures coded incorrectly: 9.9%
- Primary diagnoses coded incorrectly: 9.4%

This would equate with a Level 2 score in the Information Governance Toolkit (8-505) - an improvement on the Level 1 score in 2009/10.

Quality Report Annex B - Additional information

Extended narrative about national access targets

18 weeks

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 2010/11. The 90% and 95% standard were achieved in all except two national specialties each quarter. In so doing the Trust met the 18-week RTT standard in Monitor's original 2010/11 Compliance Framework, before the requirement was removed. The new median and 95th percentile standards for RTT were also achieved every month, from their introduction in the latter half of 2010.

A&E 4-hour maximum wait

The Trust achieved the four-hour maximum wait from arrival in an Emergency Department to discharge, admissions or transfer, for over 95% of patients during the year, but failed to achieve the standard in quarter 4. There was a 5% increase in emergency admissions into the Trust during the year (6% for the Bristol Royal Infirmary) compared with 2009/10. The Trust cared for a large number of seasonal flu cases during December 2010 and January 2011, which put additional pressure on bed availability and facilities to isolate patients. Levels of *norovirus* within the community remained a challenge for the Trust, with wards having to be closed in the last quarter of the year, during which the 95% standard failed to be achieved. The Trust's improvement plans for 2011/12 will focus on expansion of adult Medical Assessment Unit (MAU) facilities, enhancements to emergency care pathways to reduce admissions and lengths of stay, and ways of improving the Trust's responsiveness to meet fluctuations in levels of emergency demand. Work is also underway to assess the Trust's position against the new A&E quality of care indicators, and to understand what improvements need to be made to best serve our patients' needs.

Cancer

Significant advances were made in achieving the national cancer standards during 2010/11, building on the improvement work undertaken in the latter half of 2009/10. Across the year as a whole, every standard was achieved. As a result, the gateway for CQUIN rewards was met. A performance notice was issued to the Trust by NHS Bristol in relation to the breast 2-week wait standard, following a poor period of performance in the first quarter of the year. However, the 93% standard was achieved in quarters 2-4, with the strong performance in the last quarter in particular enabling the standard to be achieved for the year as a whole.

To consolidate the achievements against the cancer standards, the Trust will continue to carry-out quarterly reviews of the reasons why the cancer standards were not met for individual patients. This will shape our improvement plan for next year. Being a specialist provider of cancer treatment, the Trust receives many complex cases each year. These patients are often managed across a number providers (hospitals and other facilities) and may require more tests to diagnose and treat their cancer, which can introduce delays. Due to the nature of the specialist surgery undertaken for these patients, the Trust continues to experience a growing demand for Intensive Therapy

Unit (ITU) beds. The Trust will therefore continue to focus on ways of minimising delays to cancer patient pathways which are within the control of the Trust, and expansion of its adult ITU facilities, to ensure the cancer waiting times standards continue to be met despite the inevitable challenges that our patient group brings.

Cancelled operations

During 2010/11, the Trust cancelled 1.3% of operations on the day of the procedure for non-clinical reasons. This was a slight increase compared to 2009/10 when 1.1% were cancelled. During the second quarter, the Trust received a performance notice from NHS Bristol in this respect. A refreshed action plan was agreed in response. Bed pressures remained the leading causes of last-minute cancellations of surgery (accounting for 41% of cases). This reflected the continued heightened demand for beds for emergency admissions during the year. Improving bed availability through actions to improve patient flow remains a key focus in 2011/12 to ensure improvements are realised against this important indicator of both patient experience and service efficiency.

Board engagement with Quality

Every public meeting of the Trust Board begins with consideration of a patient's story: both for organisational learning and as a reminder to the Board of whom the Trust exists to serve. Randomly selected patient comment cards are also displayed at every public Board meeting.

In our Quality Report for 2009/10, we said that we would be developing to use of quality 'dashboards' at Trust Board level and within our clinical Divisions. We also said that we would be establishing a new Board committee to oversee matters of Quality.

A quality dashboard was introduced as part of the monthly Board quality report in April 2010, comprising a range of quality metrics presented under the three domains of patient safety, clinical outcomes and patient experience. The metrics were chosen following a quality away day in late 2009 attended by representatives from our Governors and Non-Executive Directors, as well as key clinicians and managers from across the Trust.

The dashboard has been developed and quality metrics have been added to and refined, resulting in a total of 51 metrics by the end of 2010/11. The quality dashboard and report is a key tool for the Board to understand, scrutinise and challenge the quality of service provision and as such supports compliance with Monitor's Quality Governance Framework.

Where data is available at divisional level, the core quality metrics have been replicated in dashboards for the four inpatient clinical Divisions of Medicine, Surgery Head and Neck, Specialised Services, and Women and Children for use by their divisional Boards. Divisions have added locally selected metrics reflecting key quality priorities for their patient groups e.g. the Division of Women and Children have a maternity dashboard containing specific quality indicators for maternity services.

In 2011/12, the quality dashboards will be further developed to reflect the emerging quality priorities from internal intelligence, commissioning contracts and the overarching quality indicators in the NHS Outcomes Framework 2011/12.

The Trust Board undertook a technical review of Corporate Governance beginning in November 2010, shortly after the arrival of the newly appointed Trust Secretary. The review assessed the Trust's compliance with the Monitor Foundation Trust Code of Governance whilst undertaking a wider review of the risk and safety management provisions within service Divisions. Following consideration of a range of proposals by the Trust Secretary by the Audit and Assurance Committee, the Trust Board of Directors resolved to establish new committee arrangements at a meeting of the Board on 18th March 2011. The new committee structure includes a Quality and Outcomes Scrutiny Committee. This Non-Executive Committee of the Trust Board will assess current-state performance, particularly with regard to the quality of services and the patient experience.

Major incident response

During 2010/11, the Trust was unfortunate enough to have the opportunity to test its operational response to a major internal incident. Following a flood, caused by a burst pipe, power was lost to many areas in the Queens Building of the Bristol Royal Infirmary for eight hours. Whilst around half of the building was supported by emergency generator power during this time, many services were unable to operate. North Bristol NHS Trust provided superb support during this time, as did our own front line staff. No patient or staff member suffered harm during the incident and although 288 patients had either an outpatient appointment or operation cancelled, more than 50% were re-booked within 24 hours and all within a week of the incident. This was testament to the professionalism of our staff and the robust nature of our emergency planning.

As with every major incident, there were things for the Trust to learn. An action plan has been developed with clear, timed improvements that will enable us to minimise the impact of such an event even further in the future.

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. During 2010/11, a never event occurred in the Trust when a patient was injected intravenously with 1 ml of strong potassium chloride in error. Fortunately, the mistake was identified immediately and remedial action was taken which meant that the patient did not receive any of the drug and came to no harm. Immediate further preventative measures were put in place and a thorough root cause analysis investigation conducted.

Prior to the incident occurring, the Trust had put in place the systems and controls required by the National Patient Safety Alert *Potassium Chloride Concentrate Solution*, published in 2002, but in this instance, the guidance was not followed. Learning from

the incident has been significant for the clinical area where the error occurred and has been shared - and is continuing to be shared - throughout the Trust and the local health community.

Quality Report Annex C – Assurance statements from 'third parties'

Statement from the Membership Council of the University Hospitals Bristol NHS Foundation Trust

"Quality Reports are a tool for public accountability and quality improvement and therefore the Governors welcome the opportunity to comment on these accounts.

FORMAT AND READABILITY

A group of Governors from the Quality Working Group were invited to discuss how the format of the Quality Report could be revised to make it a more readable document. We wanted the document to have: a logical flow; topics included set in context; a clear indication about sample sizes where applicable and one version that would suit all. We believe that through the immense amount of work by Chris Swonnell and his team, this is what we now have.

SAFETY

We are reassured by the further reduction in healthcare-acquired infection which is key to people having confidence in the system of care and are pleased by the efforts being made to improve procedures by the Trust to reduce the rate of infection incidences. We note that the Trust achieved all the targets set by the Department of Health and NHS Bristol for 2010/2011. We were pleased to see that the Trust has fully implemented, and monitored, its policy for antibiotic prescribing.

We were concerned by the level of medication errors and welcome the steps that are being taken to minimise the risk to patient safety. We note there are regular multidisciplinary reviews of reported incidents with a view to reducing errors and a programme in place for learning from mistakes.

We were pleased to see the measures the Trust has undertaken in the prevention of Venous Thromboembolism, which is a significant cause of mortality and moreover can cause long term disability and chronic ill health. We would like to see all adult patients risk assessed as soon as possible after admission – we note there was 96.1% compliance in February 2011. However we are aware that many patients experience difficulties with wearing anti-embolic stockings once discharged.

We saw the number of patients with Trust-acquired pressures ulcers as disappointingly high and would welcome improved measures to prevent occurrence. We note there is training for staff. We are assured that the team led by the Chief Nurse will improve this crucial aspect of care.

We were concerned with the escalated number of falls reported from September - December 2010 and hope that the implementation of specific staff training will improve this. We note the number of falls within Medicine is above average.

Histopathology
The Governors have read with great interest the Histopathology Review. We note there have been media concerns with histopathology services across North Bristol Trust and University Hospitals Bristol. We welcome the closer partnership with North Bristol NHS Trust and the appointment of a joint director of histopathology services.

Nutritional Care
We had concerns that patients were not given the help they needed at mealtimes resulting in poor nutrition, compromising their ability to fight infection and recover from illness. We are pleased to see measures have been put in place especially protected mealtimes.

Adverse Event Rate
We were pleased to see a low adverse event rate has been sustained during 2010/2011.

EXPERIENCE
As Governors, we welcome the emphasis on patient and public involvement in service improvement. The use of regular postal surveys of discharged patients; the use of electronic hand-held survey devices; and the use of comment cards on the wards allow both patients and relatives to give "real" feedback about hospital care. We are pleased to see how comments can be immediately used to both praise staff and if necessary to improve aspects of care. We acknowledge the importance of completed cards at Trust Board and Membership Council meetings. We welcome the use of Focus Groups and the on-going commitment to working with groups such as RNIB, Action for Blind Bristol; The Bristol Physical Action Chain; the council of Bristol Mosques; The Alzheimer's Society; UBAX Somali women forum; Bristol Carers Organisations and Bristol and South Gloucestershire Local Involvement Networks (Links).

National Patient Experience CQUIN
We note the Trust did not achieve the national CQUIN measure 2010/2011 which to us indicates negative patient experience based on the five set questions. In contrast, according to the 2010/2011 National Inpatient Survey 85% of patients rated the care they received as either "Good" or "Excellent".

Complaints
We are reassured by the fact that the number of complaints is falling and that 95% were resolved within agreed timescales.

Privacy and Dignity (including elimination of mixed sex accommodation)
We note that in 2010/2011, 86% of inpatients believed they were always treated with respect and dignity. We value the work being done by the Trust's Privacy and Dignity Group including a review and re-launch of the End of Life Policy. We are aware that on the 31st March the Trust was non-compliant in the elimination of mixed sex accommodation but are aware of plans with agreed action and completion by 1st August 2011.

Staff-patient communications
We were pleased to see improvements in areas where effective communication is so important.

EFFECTIVENESS
Report on Trust objective for 2010/2011
We acknowledge the proposal by the Trust to meet the requirements of the proposed NICE Quality Standard for Dementia. We note the immense amount of commitment and work to achieve this standard.

Review of 2010/2011

It is reassuring to note outcomes for HSMR, Cardiac surgery, Cataract surgery and Oesophageal cancer. However we are concerned that national cancer standards are not being met. We note that some delays are due to complexity of surgery and therefore need for intensive care beds post-surgery. We are assured that the Trust will continue to focus on minimising delays to cancer patient pathways to ensure that cancer waiting times standards will be met. We are aware of delays in A&E and cancelled operations due to pressures on beds but are assured that there are plans to improve efficiency in these areas.

Finally we are pleased to note the introduction of the Quality dashboard as a key tool for the Board to understand, scrutinise and challenge the quality of service provision."

Statement from Bristol Local Involvement Network

We are pleased to see that the format of this year's Quality Report document has improved from that of last year, resulting in a much more readable and accessible document. It contains clear information on the work the Trust has been doing over the past year which will be useful for further research by LINk and other organisations such as the Joint Strategic Needs Assessment.

We congratulate both UHB and NBT on their Working Partnership agreement and we will be interested in seeing how this will evolve to the benefit of patients in the Greater Bristol Area. In particular, we note that as a result of the Histopathology review the Trusts have a joint action plan for future working. However, although it is noted in the Quality Report that both Trusts are acting on recommendations made by the review panel, we are aware that there is an issue regarding when patients are given their results and we therefore look forward to an early resolution of this.

During 2010, Bristol LINk was invited to make a number of visits to the BRI and Bristol General Hospital to investigate nutritional care at UHB and we were assured of the policies and procedures in place for a good standard of care particularly to the more vulnerable patients. In general, we agree with Care Quality Commission's concerns, one of which is over protected meal times which are designed to allow patients to eat meals without interruption and benefits their recuperation. We would like to see these

become standard where possible and observed by all staff particularly medical clinicians.

Although the Trust is making a committed effort to reduce the number of falls, we feel from the statistics that there is still a high number of falls recorded for 2010 with no indication of how serious these were and what sort of harm they caused to the patients. We compliment the Trust on reducing infections during hospital stays and putting in place improved procedures. However, from a lay point of view, we feel that quoting infections per bed days is not easy to follow. We would expect that, as a result of the current emphasis on hand washing procedures and the higher percentage of staff now taking infection control training, there will be continued improvements.

It is disappointing to see that the Trust did not meet the National Patient Experience CQUIN target. We feel it would have been useful to have the reasons why this was not met. We note that the Trust feel they have followed this up with more robust data from their own inpatient survey and have confidence this shows signs of improvement, although we are not sure this is indicated clearly by figure 2. We look forward to the results of future work planned by the Trust to capture improved feedback and data on patient experience during 2011/12.

It would have been useful to see the range of complaints received by the Trust so that we have some measure of their seriousness. However, we are aware that the procedures in place to process complaints have led to an improvement in the time taken to effect satisfactory resolution.

We note that work still needs to be done to reducing the number of high risk medication errors. Although the number of incidents resulting in major or catastrophic harm has not increased, and the numbers of incidents that result in moderate or greater harm have been reduced, we feel that the latter figures still seem high.

It is clear by the traffic lights that there is still work to be done in reducing Venous Thromboembolism (VTE). We would like to see an improvement in the uptake of qualitative audits by trainee medical staff in the coming year particularly as the reduction is a Trust objective for 2011/12.

We notice that the Trust has achieved a reduction in acquired pressure ulcers in 2010/11. However we would expect to see this further reduced and the policies put in place that indicate basic nursing practice are adhered to.

It is reassuring to see the efforts being made with regard to privacy and dignity particularly end of life care and consideration given to bereaved families. In addition, we note that, as a result of the more stringent requirements with regard to providing single-sex accommodation, the Trust has an action plan to improve the patient areas in the MAU and A&E Observation Unit, and the work is expected to be completed later this year. This will be of great benefit to patients at a time that could be potentially distressful during their period of assessment.

We note that work to meet the NICE Quality Standard for Dementia is on-going, with joint working with North Bristol NHS Trust, to improve training of staff in dementia

awareness and safeguarding in particular. We look forward to a successful report on this for 2011/12.

One further objective for 2011/12 is to establish a specialist stroke unit. Bristol LINk visited the stroke unit recently and, although we were very impressed by the dedication and work done by the staff, the current accommodation has limitations with the danger of it being split up with recovering patients having to be accommodated elsewhere. We look forward to seeing the Trust's plans for improvement.

The pressure on bed demand especially over winter has clearly had an impact on the number of cancelled operations and re-admissions. We hope that the Trust can work on plans to be more responsive to fluctuations in demand at critical times of the year and that safe discharge procedures are in place to avoid bed-blocking.

We believe that there is now a robust relationship between Bristol LINk and UHB. A Joint Working Protocol has been established with Enter and View visits taking place throughout the year. There is a greater sharing of information and willingness of the Trust to listen to LINk concerns. We would expect this to be on-going during the transition period resulting from the change from LINk to HealthWatch in 2012.

Although we have used this opportunity to comment on areas of concern, we acknowledge that the Trust continues its work to provide a good in- and outpatient service for its patients.

Statement from South Gloucestershire Local Involvement Network

1. INTRODUCTION

1.1 This document contains the LINk's comments and questions on the UH Bristol Quality Report 2010/11. The LINk would like to thank the Trust and its Patient and Public Involvement Lead, Tony Watkin for the opportunity to review the document at a workshop with Tony and members of Bristol LINk on 4th May 2011.

1.2 Priorities set by South Gloucestershire LINk in its work plan included the reduction in hospital infections, control of hospital acquired thrombosis (VTE) and the improvement of standards of nutrition and hydration. The LINk is pleased to note the improvements in all three and that continued improvement remains an on-going target. The Link is also pleased with the improvement in the user friendliness and less jargon in this year's Quality Reports.

1.3 The information on Histopathology is based on the draft Quality Reports received and the LINk has had no opportunity to read or revise this information prior to the deadline to submit the Quality Reports.

2. SAFETY

2.1 The LINk welcomes the Trust's commitment to patient safety and its report on priorities and progress.

2.2 It would be helpful to know to what extent the Trust involves patients and the public in prioritising objectives.

2.3 Falls

2.3.1 We note the report on falls and would like to be kept informed of the Trust's achievement in reducing the number of them. However, we acknowledge that not all falls will be prevented

2.4 Histopathology

2.4.1 The LINk welcomes the appointment of the Joint Director of Histopathology Services.

2.4.2 It is stated that the two Bristol Trusts have accepted the Inquiry recommendations in full. However, according to the Consolidated Histopathology Plan approved by UH Bristol and North Bristol NHS Trust, both Trusts have decided not to implement one of the Inquiry's recommendations.

2.4.3 Recommendation 7.6 says "**Where a patient's care is going to be discussed at a multidisciplinary team meeting, patients should not be given information contained in histopathology reports until the reports have been considered by the multidisciplinary team.**

The Trusts' response is "**UH Bristol and North Bristol Trust Medical Directors and Pathology Teams cannot implement this recommendation as it will jeopardise the existing gold standard service provided to patients by "one stop" services".**

The LINk would like more information about the definition of a "gold standard one stop service" and would like to see evidence that they are acknowledged to be national best practice.

2.4.4 South Gloucestershire LINk's request for a public forum to discuss concerns about the extent to which the Inquiry was "exhaustive" has not been accepted by the Trust.

2.4.5 The LINk does not believe that the issues can be satisfactorily addressed in Trust meetings at which members of the public have no right of debate or reply. Focus groups with patients to explore their expectations of histopathology cannot be deemed a response to public dissatisfaction with the conduct and outcome of the Inquiry and the implications for public confidence in the safety of current

and future services.

2.4.6 The LINk would welcome constructive discussions with the Trust to try to resolve these issues.

2.5 Nutritional Care

2.5.1 The LINk would like more information about assessments of nutritional screening and care planning. Do GPs perform any assessment before patients are referred to hospital? Are carers asked for information?

2.5.2 Are patients awaiting surgery monitored for adequate hydration? If surgery is delayed due to unforeseen circumstances, are protocols in place to ensure that they don't become dehydrated?

3. EXPERIENCE

3.1 Admissions

3.1.1 How does the Trust ensure that patients are assessed before and during admission to ensure that appropriate support is available for their needs?

3.1.2 How are co-morbidities identified and how is appropriate care and support delivered?

3.1.3 To what extent are carers/personal assistants and relatives involved in the planning?

3.2 Discharge Planning

3.2.1 The LINk would like more information about the Trust's discharge planning and the involvement of consultants.

3.2.2 How does the Trust identify whether patients have unplanned care after discharge?

3.2.3 How is the information used to improve the discharge process?

3.2.4 To what extent are patient notes used by staff to assess and understand patients' discharge needs?

3.2.5 To what extent are carers/personal assistants and relatives involved in the planning?

3.3 Focus Groups

3.3.1 It would be helpful to know more about "Opinion finders" and "Hear Say" events.

3.3.2 The Trust mentions a pro-active approach to working with local organisations and communities. It would be useful to see a summary of one or two specific examples.

3.4 Complaints

3.3.1 How does performance compare with other Trusts?

3.3.2 Is there any analysis of trends and seriousness of complaints to enable lessons to be learned?

3.5 Mixed sex accommodation

3.5.1 Is this only an issue for the Medical Assessment Unit or are there other wards with mixed-sex accommodation? If so, how is the Trust dealing with this?

3.6 End of Life

3.6.1 Are relatives, carers and close friends involved with the patient in preparation for death, for example, Advance Directives?

3.6.2 What is the Trust's policy for broaching the subject of organ donation?

4. EFFECTIVENESS

4.1 How often is mandatory Safeguarding Adults training run?

4.2 Hospital Standardised Mortality Ratio (HMSR) – are there plans to extend this to other conditions?

5. GENERAL COMMENTS

5.1 The Partnership Agreement with NBT is mentioned. What does that actually mean for patients whose pathway crosses both Trusts? How does the patient know which Trust takes the lead role in his/her care?

5.2 The LINk would like more information on the Trust's management of the patient pathway between Health and Social Care.

5.3 It would be useful to have a summary on the work of Avon Breast Screening in the Quality Report.

5.4 Some specific examples of work the Governors have undertaken with the Trust would be informative.

5.5 Objectives for 2011/12 – these appear to be aims rather than objectives. It would be more meaningful if they were re-worded as measurable objectives.

5.6 The “traffic light” system for reporting progress is helpful.

Statement from South Gloucestershire Health Scrutiny Select Committee

	Details / Comments
Local Authority	South Gloucestershire Council
Official Title of the OSC	Health Scrutiny Select Committee
Do the provider’s priorities match those of the public?	Alison Moon, Chief Nurse and Mark Callaway, Deputy Medical Director presented UH Bristol’s Draft Quality Report (QA) for 2010-11 to the Select Committee on 20th April 2011. The Committee is satisfied that in the development of the QA UH Bristol has paid due regard to issues raised by the public. The Committee welcomes the Trust introducing its own monthly patient survey, patients receiving comment cards and the Trust’s Governors undertaking interviews with patients on wards using hand held electronic devices. In response to a question UH Bristol confirmed the patient surveys / cards would also be available in other languages. The Committee welcomes the objective around dementia care, particularly UH Bristol’s on-going commitment to meeting the eight common standards of care, and commissioners now including these standards in contracts with healthcare providers.
Do you believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to Quality Reports?	The Committee asks that UH Bristol consider including details of the Bristol Histopathology Inquiry in the QA, covering the outcome of the Inquiry and the steps being taken by the Trust, and neighbouring North Bristol NHS Trust, to address the recommendations in the report.
Has the provider demonstrated they have involved patients and the public in the production of the Quality Report?	Yes, please refer to the first response above.
Any comment on issues the OSC is involved in locally?	Problems with access and car parking at the Bristol Royal Infirmary and the Children’s Hospital are often raised with councillors and parking would be even more difficult once new building work commenced. However, the Committee noted that the Trust would be reducing staff car parking in order to maximise the number of patient spaces during the building work. It would also be promoting its free bus shuttle

	service from Cabot's Circus car park to the health campus.
Any other Comments	
Your contact details: • Committee • Chairman • Scrutiny Contact	Health Scrutiny Select Committee South Gloucestershire Council Councillor Sandra Grant, Chair Claire Rees, Democratic Services Officer 01454 864116 claire.rees@southglos.gov.uk

Statement from Bristol City Council Health and Adult Social Care Scrutiny Commission

	Details / Comments
Local Authority	Bristol City Council
Official Title of the OSC	Health and Adult Social Care Scrutiny Commission
Does a providers priorities match those of the public?	Members supported the objectives set by UHB for 2011/12 and in particular a commitment to Patient Safety at the heart of everything the Trust does.
Do you believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to Quality Reports?	Members did not feel there were any significant omissions and that the Quality Report was a very comprehensive document, which was also easy to read and understand. The Commission supported the objectives for 2011/12 and in particular the focus on Patient Safety being central to everything that the Trust wishes to achieve as a provider. Members welcomed the rigorous reporting mechanisms in relation to Patient Safety and the processes for escalating any issues of concern. Members also welcomed the inclusion of Falls Prevention and Pressure Ulcers as objectives for 2011/12 and the practical steps in particular being taken to prevent Falls. Members also noted the overall reduction in MRSA and that the Trust had performed well in this area. Some concerns were raised about hospital re-admissions and discharges and members noted the Trusts commitment to work with all partners to ensure improved outcomes in this area.
Has the provider demonstrated they have involved patients and the public in the production of the Quality Report?	Members welcomed involvement in the Quality Report and discussions at their meeting in March 2011 on the draft priorities for 2011/12. The priorities are supported by the Commission. The Commission noted the use of patient feedback in assessing priorities for the Trust and also the commitment and plan to eliminate mixed sex accommodation.
Any comment on issues the OSC is involved in locally?	The Commission has been involved with the Trust in relation to the Histopathology Inquiry and actions arising from that Inquiry. The Committee and Trust have agreed a quarterly monitoring process to

	review progress against actions and provide assurances against the Action Plan.
Any other Comments	None
Your contact details: • Committee • Chairman • Scrutiny Contact	Shana Johnson Scrutiny Co-ordinator Bristol Health and Adult Social Care Scrutiny Commission Chair: Cllr Lesley Alexander Shana.Johnson@bristol.gov.uk

Statement from NHS Bristol

NHS Bristol has taken the opportunity to review the Quality Report prepared by University Hospital Bristol Foundation Trust for 2010/11. NHS Bristol have had discussions with University Hospital Bristol Foundation Trust on the content of their Quality Report, the majority of these suggestions have been included. The priorities for 2011/12 have been developed in partnership and NHS Bristol endorses the proposals set out in the Quality Report

NHS Bristol and University Hospital Bristol Foundation Trust have continued to work together on their shared vision of a comprehensive quality framework to ensure patients receive high quality health care. This includes nationally mandated quality indicators alongside locally agreed quality improvement targets. The national NHS contract and Commissioning for Quality and Innovation (CQUIN) scheme reflect the quality areas both organisation agree priorities to drive forward the quality agenda for 2011-12.

Throughout the year University Hospital Bristol Foundation Trust has provided assurance to NHS Bristol and associate PCTs through the monthly Clinical Quality Review Group on the quality of services, covering the key quality domains of safety, effectiveness and experience of care. Remedial plans have been put in place when performance has occasionally fallen below expectations and learning shared wherever possible

Through the quality framework for 2010/11 University Hospital Bristol Foundation Trust have been seen to improve the safety, effectiveness and patient experience of their services across a wide range of specialities. NHS Bristol commends University Hospital Bristol Foundation Trust on the significant reduction in health care acquired infections in 2010-11. This reflects the commitment of staff within the trust to reduce these infections.

NHS Bristol is working closely with University Hospital Bristol Foundation Trust to implement the joint action for Bristol that was produce in December 2010 following an Independent Enquiry into the Histopathology services.

NHS Bristol can confirm that we consider that the Quality Report contains accurate information in relation to the quality of services they provide to the residents of Bristol and beyond.

The accuracy of the data has been checked and concords with the data and information that has been supplied by them during the year.

Deborah Evans
Chief Executive
NHS Bristol

Date: 15 May 2011

Quality Report Annex D – Statement of Directors' Responsibilities

2010/11 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 20**10** to May 20**11;**

  Papers relating to Quality reported to the Board over the period April 20**10** to May 20**11;**

  Feedback from the commissioners dated 15/05/11

  Feedback from governors dated 09/05/2011;

  Feedback from Bristol LINk dated 17/05/2011;

  Feedback from South Gloucestershire LINk dated 19/05/2011;

  The trust's complaints data as reported to the Board for the period April 20**10** to March 20**11.**

  The 2010 National Inpatient Survey received 05/04/2011;

  The 2010 National Staff Survey received 28/02/2011;

  The Head of Internal Audit's annual opinion over the trust's control environment dated 01/06/2011;

  Care Quality Commission quality and risk profile received 17/04/2011;

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with 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/annualreportingmanual)).

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
26 May 2011

Robert Woolley, Chief Executive
26 May 2011

Quality Report Annex E – External audit opinion

Independent Assurance Report to the Membership Council of University Hospitals Bristol NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Membership Council of University Hospitals Bristol NHS Foundation Trust to perform an independent assurance engagement in respect of the content of University Hospitals Bristol NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter

I read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I become aware of any material omissions.

Respective responsibilities of the Directors and auditor

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

I read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 2010 to May 2011;
- papers relating to Quality reported to the Board over the period April 2010 to May 2011;
- feedback from the Commissioners dated 15 May 2011;
- feedback from the Lead Governor dated 9 May 2011;
- feedback from LINks dated 17 May and 19 May 2011;
- the Trust's annual complaints data as reported to the Board for the period April 2010 to May 2011;
- the 2010 national patient survey dated 5 April 2011;
- the 2011 national staff survey dated 28 February 2011;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 1 June 2011; and
- Care Quality Commission quality and risk profiles dated 17 April 2011.

I considered the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Membership Council of University Hospitals Bristol NHS Foundation Trust as a body, to assist the Membership Council in

reporting University Hospitals Bristol NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Membership Council to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Membership Council as a body and University Hospitals Bristol NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). My limited assurance procedures included:

- making enquiries of management;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents listed previously.

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

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Wayne Rickard
Officer of the Audit Commission

3-4 Blenheim Court
Matford Business Park
Lustleigh Close
Exeter
Devon
EX2 8PW

4 June 2011

University Hospitals Bristol NHS
NHS Foundation Trust

Accounts for the year ended 31 March 2011

Paul Mapson
Director of Finance CPFA

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 2011

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31st March 2011 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, 03 June 2011

Statement of Comprehensive Income for the year ended 31 March 2011

	Note	Year ended 31 March 2011 £'000	Restated Year ended 31 March 2010 £'000
OPERATING INCOME			
Income from activities	3	393,085	375,081
Other operating income	4	113,535	110,561
TOTAL OPERATING INCOME		**506,620**	**485,642**
Operating expenses (Restated)	5-6	(485,914)	(484,878)
OPERATING SURPLUS		**20,706**	**764**
FINANCE COSTS			
Finance income	9.1	296	209
Finance costs	9.2	(435)	(459)
Finance expense unwinding discount on provisions	18	(9)	(7)
Public dividend capital dividends payable		(8,519)	(9,588)
Net finance costs		**(8,667)**	**(9,845)**
SURPLUS (DEFICIT) FOR THE YEAR/PERIOD		**12,039**	**(9,081)**
OTHER COMPREHENSIVE INCOME/(EXPENDITURE)			
Revaluation losses on property plant and equipment (Restated)		(3,671)	(55,699)
Revaluation gains		4,216	-
Revaluation losses on intangible assets		-	-
Receipt of donated assets		5,759	248
Depreciation /impairment/disposal of donated assets		(1,255)	(1,397)
Other recognised gains and (losses)		47	-
Other reserve movements		-	-
TOTAL COMPREHENSIVE INCOME/(EXPENDITURE) FOR THE PERIOD/YEAR		**17,135**	**(65,929)**

Please note:

a) All income and expenditure is derived from continuing operations.

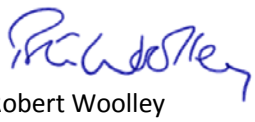
b) The notes on pages 6 to 55 form part of these Accounts.

c) Refer to Note 9.4 for the basis of the restatement

Statement of Financial Position as at 31 March 2011

	Note	31 March 2011 £'000	31 March 2010 £'000
NON CURRENT ASSETS			
Intangible assets	10	3,083	2,129
Property, plant and equipment	11	292,207	284,415
TOTAL NON CURRENT ASSETS		**295,290**	**286,544**
CURRENT ASSETS			
Inventories	12	7,029	5,782
Trade and other receivables	13	20,063	24,798
Other financial assets	14.1	146	146
Assets Held for Sale	14.2	1,470	-
Cash and cash equivalents	19	53,015	41,231
TOTAL CURRENT ASSETS		**81,723**	**71,957**
CURRENT LIABILITIES			
Trade and other payables	15	(39,546)	(34,980)
Borrowings and bank overdrafts	17	(164)	(3,530)
Provisions	18	(784)	(625)
Tax Payable	15	(6,948)	(6,432)
Other liabilities	16	(12,270)	(12,574)
TOTAL CURRENT LIABILITIES		**(59,712)**	**(58,141)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**317,301**	**300,360**
NON CURRENT LIABILITIES			
Trade and other payables	15	-	-
Borrowings	17	(6,142)	(6,306)
Provisions	18	(256)	(286)
TOTAL NON CURRENT LIABILITIES		**(6,398)**	**(6,592)**
TOTAL ASSETS EMPLOYED		**310,903**	**293,768**
TAXPAYERS' EQUITY			
Public dividend capital		191,011	191,011
Revaluation reserve		71,416	71,685
Donated asset reserve		12,984	10,847
Other reserves		85	85
Income and expenditure reserve		35,407	20,140
TOTAL TAXPAYERS' EQUITY		**310,903**	**293,768**

The accounts on pages 2 to 55 were approved by the Board on 03 June 2011 and signed on its behalf by:



Robert Woolley
Chief Executive, 03 June 2011

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2011

Changes in Taxpayers' equity in the current year	Public Dividend Capital £000	Revaluation Reserve £000	Donated Asset Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	Total £000
Taxpayer's Equity at 01 April 2010	191,011	71,685	10,847	85	20,140	293,768
Surplus (deficit) for the period	-	-	-	-	12,039	12,039
Revaluation/impairment gains and losses on property plant and equipment and intangible assets		2,912	(2,367)	-	-	545
Movement in donated assets reserve	-	-	4,525	-	-	4,525
Public dividend capital received	-	-	-	-	-	-
Asset disposals	-	-	(21)	-	-	(21)
Public dividend capital repaid	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	47	47
Other transfers between reserves		(3,181)	-		3,181	-
Taxpayers' Equity at 31 March 2011	**191,011**	**71,416**	**12,984**	**85**	**35,407**	**310,903**

Changes in Taxpayers' equity in the previous year	Public Dividend Capital £000	Restated Revaluation Reserve £000	Donated Asset Reserve £000	Other Reserves £000	Restated Income & Expenditure Reserve £000	Total £000
Taxpayer's Equity at 01 April 2009	183,958	122,443	13,302	85	32,856	352,644
Surplus for the period (Restated)	-	-	-	-	(9,081)	(9,081)
Revaluation/impairment gains and losses on property plant and equipment and intangible assets (Restated)	-	(54,393)	(1,306)	-	-	(55,699)
Movement in donated assets reserve	-	-	(1,149)	-	-	(1,149)
Public dividend capital received	7,053	-	-	-	-	7,053
Public dividend capital repaid	-	-	-	-	-	-
Other recognised gains and losses	-	(4,336)	-	-	4,336	-
Other transfers between reserves (Restated)	-	7,971	-	-	(7,971)	-
Taxpayers' Equity at 31 March 2010	**191,011**	**71,685**	**10,847**	**85**	**20,140**	**293,768**

Please note:

a) The restatements relate to a change in accounting policy in respect of impairments – see Note 9.4.

b) 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 Year Ended 31st March 2011

	Note	Year ended 31 March 2011	Restated Year ended 31 March 2010
		£000	£000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus from continuing operations		20,706	764
OPERATING SURPLUS		**20,706**	**764**
NON CASH INCOME AND EXPENDITURE			
Depreciation and amortisation	10-11	17,372	17,592
Impairments	11	3,256	20,531
Reversal of impairment		(1,473)	-
Transfer from donated asset reserve		(1,235)	(1,371)
Movements in balances			
(Increase)/decrease in trade and other receivables	13	4,709	(3,388)
(Increase)/decrease in other assets	14	-	147
(Increase)/decrease in inventories	12	(1,247)	(158)
Increase/(decrease) in trade and other payables	15	5,033	(1,092)
Increase/(decrease) in other liabilities	16	(304)	(1,465)
Increase/(decrease) in provisions	18	129	289
Other movements in operating cash flows		480	67
NET CASH GENERATED FROM OPERATIONS		**47,426**	**31,917**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		299	217
Purchase of property, plant and equipment	11	(22,404)	(24,335)
Purchase of intangible assets	10	(1,094)	(13)
Sales of property, plant and equipment		-	-
NET CASH USED IN INVESTING ACTIVITIES		**(23,199)**	**(24,131)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		-	7,053
Public dividend capital repaid		-	-
Loans repaid		-	-
Capital element of finance lease rental payments		(140)	(116)
Interest paid		-	-
Interest element of finance leases		(435)	(459)
PDC dividends paid		(8,478)	(9,611)
Cash flows from other financial activities		-	(133)
NET CASH GENERATED USED IN FINANCING ACTIVITIES		**(9,053)**	**(3,266)**
INCREASE IN CASH AND CASH EQUIVALENTS		**15,174**	**4,520**
***CASH AND CASH EQUIVALENTS AT START OF YEAR**	19	**37,841**	**33,321**
***CASH AND CASH EQUIVALENTS AT END OF YEAR**	19	**53,015**	**37,841**

*Bank overdrafts are included as part of cash and cash equivalents for cash flow reporting purposes

Notes to the Accounts

1. Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *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 2010/11* 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 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

Short term - employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements.

An assessment of annual leave owing to staff at 31st March 2011 has been calculated using a sample of 400 staff across all divisions and all staff groups. As staff have personal annual leave years, the number of hours taken has been compared with the pro-rated allocation of hours to the 31st March. The average annual leave owed to staff groups in the sample has been used to calculate the total number of hours owed to all staff in post in March 2011. 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 is provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably.

Where a significant asset, for example a building, includes a number of components with different economic lives, then these components are treated as separate assets within the buildings classification and depreciated over their own useful economic lives.

Measurement (Valuation)
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value.

Land and buildings
All land and buildings are revalued using professional valuations every five years and in addition 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.

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 when they are brought into use.

Other assets
Assets with estimated economic lives of less than 10 years are considered to be short life assets. These are held at depreciated historical cost which is considered to be an appropriate proxy for current value.

Assets with estimated economic lives of more than 10 years are considered to be medium/long life assets. These are initially recorded at cost and then their values are updated annually using appropriate indices to reflect fair value (net current replacement cost).

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful 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 and residual interests in 'off-balance sheet' (Statement of Financial Position) PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining useful life of the asset as assessed by the NHS Foundation Trust's professional valuers. Leaseholds are depreciated over the primary lease term. Other items of property, plant and equipment are depreciated on a straight line basis over their estimated remaining useful lives, as assessed by the Trust. The remaining maximum and minimum economic lives of property, plant and equipment assets held by the Trust are as follows

Asset Type	**Minimum Life**	**Maximum Life**
Buildings excluding dwellings	6 years	44 years
Dwellings	13 years	35 years
Medical Equipment	5 years	10 years
Plant and machinery	1 year	9 years
Transport equipment	1 year	6 years
Information technology	1 year	6 years
Furniture and fittings	1 year	5 years

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 will transfer 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 as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

1.6 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised where they have a cost in excess of £5,000, where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated intangible assets
Internally generated intangible assets such as goodwill, brands, customer lists and similar items are not capitalised. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets (except for emission allowances – see note below) are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value.

Intangible assets with estimated economic lives of less than 10 years are considered to be short life assets. These are held at amortised historical cost which is considered to be an appropriate proxy for fair value. Intangible assets with estimated economic lives of more than 10 years are considered to be medium/long life assets. These are initially recorded at cost and then their values are updated annually using appropriate indices to reflect fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Allowances granted under the EU green house gas emission scheme are held at fair value. Changes to fair value are recognised in the Statement of Comprehensive Income as an item of "other comprehensive income", except for impairments which are recognised in operating income.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits (except for emission allowances – see below).
The remaining maximum and minimum economic lives of intangible assets held by the Trust are as follows:

Asset Type	Minimum Life	Maximum Life
Software (purchased)	1 year	4 years
Other (purchased)	1 year	1 year

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.

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 valuation techniques including using recent arm's length market transactions between knowledgeable, willing parties if available, reference to the current fair value of another instrument that is substantially the same, discounted cash flow analysis and option pricing models. If there is a valuation technique commonly used by market participants to price the instrument and that technique has been demonstrated to provide reliable estimates of market prices, the Trust will use this technique.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of

Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision. The allowance/provision is then used to write down the carrying amount of the financial asset, at the appropriate time, which is determined by the Trust on a case by case basis.

1.10 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to 'finance costs' in the Statement of Comprehensive Income.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.11 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 18.3.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 22.1 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 22.2, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the NHS Foundation Trust's predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is 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 period ended 31 March 2011.

1.16 Financial Risk

IFRS 7," Financial Instruments: Disclosures", requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities (see note 27).

The Trust's activities expose it to a variety of financial risks: market risk (including interest rate risk, and foreign exchange risk), and credit risk. The 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 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 period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

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. University Hospitals Bristol is also required to comply and remain within the Prudential Borrowing Limit which is set by Monitor. For 2010/11 this was set at £109.4m. This represents maximum long-term borrowing of £71.9m and an approved working capital facility of up to £37.5m. A Working Capital Facility of £37.5m was put in place for two years from 1 September 2010. Therefore the Trust has little exposure to liquidity risk.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in note 28 to the accounts, in accordance with the requirements of HM Treasury's *Financial Reporting Manual*.

Notes to the Accounts

a. **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 is compiled directly from the losses and compensations register which reports on a cash basis with the exception of provisions for future losses.

b. 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 7 Financial Instruments: Disclosures - amendment Transfers of financial assets	October 2010	Effective date of 2012/13 but not yet adopted by the EU.
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.
IAS 12 Income Taxes amendment	December 2010	Effective date of 2012/13 but not yet adopted by the EU.
IAS 24 (Revised) 'Related Party Disclosures'	November 2009	2011/12
IFRIC 14 The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction	November 2009	2011/12
IFRIC 19 'Extinguishing financial liabilities with Equity Instruments'	November 2009	2011/12

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 period of initial application is not known at this stage.

1.18 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.

b) Holiday Pay Accrual (see 1.3)

c) Revaluation

Indexation is used in the 2010/11 Accounts, based on indices provided to the Trust by the District Valuer. The District Valuer is an expert, therefore a high degree of reliance on an expert.

d) Impairment

Impairments are based on the District Valuer revaluations 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.

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. Note: 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.

1.19 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.

Notes to the Accounts

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.

	Healthcare £000	Skills for Health £000	Total £000
Year ended 31 March 2011			
Income	475,007	31,613	506,620
Retained surplus (deficit) for year	12,027	12	12,039
Net assets at 31 March 2011	310,903	-	310,903
Year ended 31 March 2010			
Income	453,280	32,362	485,642
Retained surplus (deficit) for year	(4,309)	17	(4,292)
Net assets at 31 March 2010	293,768	-	293,768

Notes to the Accounts

3. Income

3.1 Income from activities

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Acute trusts:		
Elective income	81,894	86,244
Non elective income	103,531	106,049
Outpatient income	61,215	51,823
Accident and emergency income	11,240	10,115
Other NHS Clinical income *	127,834	118,823
All Trusts:		
Private patients	2,524	1,915
Other non-protected clinical income	4,847	112
TOTAL	393,085	375,081

*Significant items comprise:	£000	£000
Critical care bed days	31,866	31,526
'Payment by results' exclusions	23,024	15,008
Bone marrow transplants	8,093	9,815
Excess bed days	9,302	8,339
Radiotherapy Inpatient Treatments		7,717
		7,821
Diagnostic imaging	1,605	6,528
Direct access	7,084	4,569
Regular day and night attenders	2,744	2,626
'At cost' contracts	10,917	2,232

3.2 Income by type

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Income from activities		
NHS Foundation Trusts	17	14
NHS Trusts	60	774
Strategic Health Authorities	514	-
Primary Care Trusts	380,094	361,916
Department of Health	-	178
Non-NHS Private Patients	2,521	1,915
Non-NHS Overseas Patients	289	105
NHS Injury Scheme	819	796
Other**	8,771	9,383
Total	393,085	375,081

**Significant items comprise:	£000	£000
Territorial Bodies (Health Commission Wales)	8,371	8,333
Bodies outside of Whole of Government Accounts	297	944

Notes to the Accounts

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, £381.3m (2010 £366.1m) is mandatory and £11.8m (2010 £9.0m) is non-mandatory.

3.4 Private patient cap

Section 44 of the 2006 Act requires that the proportion of private patient income to total patient related income should not exceed the proportion that was achieved whilst the body was an NHS trust in 2002/03, which was 1.1%.

	Year ended 31 March 2011	Year ended 31 March 2010
	£000	£000
Private patient income	2,820	1,915
Total patient income	393,085	375,081
Proportion	0.7%	0.5%

The Trust's private patient cap was not exceeded in the year ended 31 March 2011 or the prior year ended 31 March 2010.

4. Other operating income

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Research and development	10,917	8,614
Education training and research	39,706	39,357
Charitable and other contributions to expenditure	686	953
Transfers from the donated asset reserve	1,235	1,370
Non-patient care services to other bodies	44,854	49,325
Reversal of impairment of property, plant, and equipment	1,473	-
Other*	14,664	10,942
TOTAL	113,535	110,561

*The 'Other' category above comprises mainly:	£000	£000
Distinction awards granted from the Department of Health	3,555	3,614
Patient transport	1,738	2,058
Income generation	4,760	1,958
Rental income from operating leases	901	831
Catering	824	819
Staff accommodation rentals	454	452

The Trust's income includes an element that might be classified as 'commercial' and might be subject to corporation tax in future years. This income totals £3.793m and comprises mainly of the operations of the Medical Equipment Management Organisation (£1.332m), Pharmacy income (£1.605m) and car park receipts (£0.856m).

Notes to the Accounts

4.1 Operating lease income

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Rents recognised as income	901	831
TOTAL	901	831

4.2 Future minimum lease payments due to the Trust

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Future minimum lease payments due		
- not later than one year	237	153
- later than one year but not later than five years	497	422
- later than five years	427	78
TOTAL	1,161	653

Notes to the Accounts

5. Operating Expenses

5.1 Operating expenses comprise:

	Year ended 31 March 2011 £000	Restated Year ended 31 March 2010 £000
Services from other NHS Foundation Trusts	429	373
Services from NHS Trusts	3,206	7,095
Services from other NHS bodies	3,529	3,244
Purchase of healthcare from non NHS bodies	821	1,493
Executive directors costs	1,099	1,111
Non executive directors costs	152	160
Staff costs	304,644	293,548
Drug costs	41,095	33,622
Supplies and services:		
- Clinical	49,844	47,140
- General	7,343	6,930
Establishment	5,933	7,557
Transport	608	333
Premises	14,226	15,396
Bad debts	691	2,075
Depreciation of property plant and equipment	16,775	17,003
Amortisation of intangible assets	597	589
Impairment of property plant and equipment (Restated)	3,256	20,531
Impairment of intangible fixed assets	-	-
Auditor's remuneration;		
- Audit services – statutory audit	61	58
- Other services	29	46
Clinical negligence	6,505	6,236
Loss on disposal of property, plant & equipment	480	64
Other*	24,591	20,274
TOTAL	485,914	484,878

*Other expenditure includes the following:	£000	£000
External contractors	2,243	8,381
Training, courses and conferences	10,510	6,840
Research costs	1,343	964
Contributions to early retirement upon redundancy	1,251	n/a
Services from Non-NHS Bodies	1,836	n/a
Pre- Employment Scheme	1,217	n/a

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

Notes to the Accounts

5.2 Operating Leases

Operating expenses include:

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Operating lease payments	978	796
	978	796

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 2011 £000	Year ended 31 March 2010 £000
Not later than one year	681	785
Later than one year but not later than five years	1,517	1,831
Later than five years	3,296	3,712
TOTAL	5,494	6,328

The Trust leases various equipment and buildings and the most significant are 78 – 100 St Michael's Hill (includes Car Park) which has an annual charge of £233k and expires in June 2030. The old Bristol Children's Hospital and associated premises at St. Michaels Hill Bristol were sold to the University of Bristol on 28 February 2002. The Trust continues to occupy the following areas of the hospital and the premises at St. Michael's Hill under 'peppercorn' operating leases with the University of Bristol.

Premises	Lease Term	Termination Date
Residential Family Accommodation Royal Fort Road, Bristol	25 years	28 February 2027

6. Staff Costs and Numbers

6.1 Staff Costs:

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Salaries & wages	251,875	241,951
Social security costs	20,284	20,123
Employer contributions to NHS Pension Scheme	27,910	27,356
Agency contract staff	5,674	5,739
TOTAL	305,743	295,169

In 2010-11, the Trust made £114k (2009-10, £125k) contributions to the NHS Pension Scheme in respect of executive directors.

Notes to the Accounts

6.2 Average Number of Employees

	Year ended 31 March 2011 Number	Year ended 31 March 2010 Number
Medical and dental staff	936	917
Ambulance staff	-	-
Administration and estate staff	1,703	1,626
Healthcare assistant & other support staff	694	757
Nursing, midwifery & health visiting staff	2,593	2,567
Nursing, midwifery & health visiting learners	6	7
Scientific, therapeutic and technical staff	1,130	1,059
Social care staff	-	-
Bank and agency staff	402	444
TOTAL	7,464	7,377

Numbers are expressed as average whole time equivalents for the period.

6.3 Employee Benefits

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

6.4 Management Costs

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Management costs	18,509	18,065
Income	506,620	485,642
Percentage of Income	3.7%	3.7%

Analysis	2010/11			2009/10		
	University Hospitals Bristol	Skills for Health	Totals	University Hospitals Bristol	Skills for Health	Totals
	£'000	£'000	£'000	£'000	£'000	£'000
Management costs	17,068	1,441	18,509	16,645	1,420	18,065
Income	475,007	31,613	506,620	453,280	32,362	485,642
Percentage of Income	3.6	4.6	3.7	3.7	4.4	3.7

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 2011 there were 11 (2010: 8) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill-health retirements will be £0.49m (2010: £0.45m). 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	9 (2)	11 (7)	20 (9)
£10,000 - £25,000	10 (1)	14 (1)	24 (2)
£25,001 - £50,000	3 (1)	9 (-)	12 (1)
£50,001 - £100,000	5 (-)	4 (-)	9 (-)
£100,001 - £150,000	2 (-)	4 (-)	6 (-)
£150,001 - £200,000	- (-)	5 (-)	5 (-)
Total number of exit packages by type	**29 (4)**	**47 (8)**	**76 (12)**
Total resources cost	**£913,984 (£59,552)**	**£2,247,918 (£32,508)**	**£3,161,902 (£92,060)**

Analysis by Segment	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	19 (2)	42 (-)	61 (2)
Total resources cost	£563,083 (£17,224)	£2,195,733 (£nil)	£2,758,816 (£17,224)
Healthcare			
Total number of exit packages by type	10 (2)	5 (8)	15 (10)
Total resources cost	£350,901 (£42,328)	£52,185 (£32,508)	£403,086 (£74,836)

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. No Directors received a staff exit package as noted in Note 6.7.

Comparative figures for 2009/10 are shown in brackets.

Notes to the Accounts

6.7 Directors Remuneration

Salaries and Allowances	12 Months to 31 March 2011	12 Months to 31 March 2010
	Salary	Salary
	(bands of £5000) £000	(bands of £5000) £000
Chair		
John Savage	50-54	50-54
Executive Directors		
Robert Woolley, Chief Executive (from 23 December 2009)	170-174	35-39
Robert Woolley, Director of Corporate Development (until 22 December 2009)	n/a	85-89
Paul Mapson, Director of Finance	135-139	120-124
Steve Aumayer, Director of Workforce and Organisational Development (from 6 July 2009)	110-114	80-84
Alison Moon, Chief Nurse and Director of Governance (from 13 July 2009)	110-114	80-84
Deborah Lee, Director of Strategic Development on secondment from 17 May 2010 (substantive from 4 February 2011)	94-99	n/a
Jane Luker, Acting Medical Director (from 1 October 2010)	74-79	n/a
Jim O'Connell, Acting Chief Operating Officer (from 21 February 2011, seconded)	15-19	n/a
Tony Ranzetta, Acting Chief Operating Officer (from 1 August 2010 to 20 February 2011)	110-114	n/a
Irene Gray, Chief Operating Officer (until 31 July 2010)	35-39	110-114
Jonathan Sheffield, Medical Director (until 30 September 2010)	90-94	190-194
Graham Rich, Chief Executive (Until 22 December 2009)	n/a	120-124
Alex Nestor, Acting Director of Workforce and Organisational Development (from 3 November 2008 until 5 July 2009)	n/a	20-24
Patricia Fields, Acting Chief Nurse (from 23 March 2009 until 12 July 2009)	n/a	25-29
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	10-14	10-14
Paul May	10-14	10-14
John Moore (from 1 January 2011)	0-4	n/a
Patsy Hudson (until 31 May 2009)	n/a	0-4
Sarah Blackburn (from 1 June 2009 until 31 March 2010)	0-4	10-14

No Directors received any other remuneration or benefits in kind during either period. No Directors received any Exit packages during either period. Aggregate salary cost for 2010/11 was £1,045k (2009/10, £1,033k). The aggregate employer contribution to the pension scheme was £105k (2009/10, £123k). The total number of Directors to whom benefits are accruing under defined benefit schemes is 6 (2009/10, 7).

Notes to the Accounts

Pension Benefits for the year ended 31 March 2011

Name and title	Real increase in pension at age 60 at 31 March 2011 (bands of £2,500)	Real increase in lump sum at age 60 at 31 March 2011 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real Increase in Cash Equivalent Transfer Value £000	Employer funded contribution to growth in CETV £000
Robert Woolley, (Chief Executive)	0-2.4	5.0-7.4	30-34	100-104	608	590	(13)	(9)
Paul Mapson, Director of Finance	2.5-4.9	7.5-9.9	50-54	160-164	1,117	1,089	(31)	(21)
Steve Aumayer, Director of Workforce and Organisational Development (from 6 July 2009)	0-2.4	nil	0-4	nil	41	29	10	7
Alison Moon, Chief Nurse and Director of Governance (from 13 July 2009)	0-2.4	2.5-4.9	35-39	105-109	552	571	(49)	(34)
Deborah Lee, Director of Strategic Development On secondment from 17 May 2010 (substantive from 4 February 2011)	0-2.4	2.5-4.9	15-19	45-49	243	241	(9)	(6)
Jane Luker, Acting Medical Director (from 1 October 2010)	5.0-7.4	15.0-17.4	45-49	145-149	896	803	25	18
Jim O'Connell, Acting Chief Operating Officer (from 21 February 2011)**	n/a	n/a	35-39	110-114	555	n/a	n/a	n/a
Tony Ranzetta, Acting Chief Operating Officer (from 1 August 2010 to 20 February 2011) *	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Irene Gray, Chief Operating Officer (until 31 July 2010)	(0-2.4)	(5.0-7.4)	50-54	150-154	n/a	1,124	n/a	n/a
Jonathan Sheffield, Medical Director (until 30 September 2010)	0-2.4	0-2.4	75-79	235-239	1,487	1,547	(71)	(50)

* Tony Ranzetta was employed via an agency.

** Jim O'Connell is seconded from South Central Strategic Health Authority. The figures for the movement in pension values are not available.

Pension Benefits for the year ended 31 March 2010

Name and title	Real increase in pension at age 60 at 31 March 2010	Real increase in lump sum at age 60 at 31 March 2010	Total accrued pension at age 60 at 31 March 2010	Lump sum at age 60 related to accrued pension at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real Increase in Cash Equivalent Transfer Value	Employer funded contribution to growth in CETV
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Robert Woolley, Director of Corporate Development (until 22 December 2009, then acting Chief Executive)	2.5-4.9	10-12.4	30-34	90-94	590	476	91	63
Jonathan Sheffield, Medical Director	5-7.4	17.5-19.9	70-74	220-224	1,547	1,285	198	138
Paul Mapson, Director of Finance	(0-2.4)	(0-2.4)	45-49	145-149	1,089	988	52	36
Irene Gray, Chief Operating Officer	(0-2.4)	(0-2.4)	50-54	150-154	1,124	1,032	41	29
Steve Aumayer, Director of Workforce and Organisational Development (from 6 July 2009)	2.5-4.9	n/a	0-4	n/a	29	n/a	29	21
Alison Moon, Chief Nurse (from 13 July 2009)	2.5-4.9	10-12.4	30-34	95-99	571	431	85	59
Graham Rich, Chief Executive (until 22 December 2009)	0-2.4	2.5-4.9	45-49	145-149	907	791	76	53
Alex Nestor, Acting Director of Workforce and Organisational Development (until 3 July 2009)	0-2.4	0-2.4	15-19	50-54	237	178	13	9
Patricia Fields, Acting Chief Nurse (until 12 July 2009)	0-2.4	2.5-4.9	35-39	110-114	939	757	41	28

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

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

Notes to the Accounts

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. In some cases, the real increase in the CETVs show a significant difference, when comparing this year's values with last year's. This difference is due to a change in the factors used to calculate CETVs, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for CETV's (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine cash equivalent transfer values (CETV) from Public Sector Pension Schemes came into force on 13 October 2008.

Employer funded contribution to growth in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme, or arrangement) and uses common market valuation factors for the start and end of the period.

Robert Woolley
Chief Executive, 03 June 2011

Notes to the Accounts

7. Better Payment Practice Code

7.1 Measure of Compliance

	Year ended 31 March 2011		Year ended 31 March 2010	
	Number	Value £000	Number	Value £000
Total Non NHS trade invoices paid in the period	147,973	152,223	170,846	151,010
Total Non NHS trade invoices paid within target	132,096	133,608	154,304	134,740
Percentage of Non NHS trade invoices paid within target	89.3%	87.8%	90.3%	89.2%
Total NHS trade invoices paid in the period	4,445	58,133	4,129	55,306
Total NHS trade invoices paid within target	4,061	54,506	3,533	48,878
Percentage of NHS trade invoices paid within target	91.4%	93.8%	85.6%	88.4%

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 (2010: £0.001m) arising from claims made under this legislation. No other compensation was paid to cover debt recovery cost under this legislation.

8. Loss on Disposal of Fixed Assets

The loss on the disposal of fixed assets of £0.480m (2010: loss of £0.064m) related exclusively to non-protected assets. There were no protected assets disposed of during the period.

9. Finance

9.1 Finance Income

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Interest on loans and receivables	296	165
Other	-	44
TOTAL	296	209

9.2 Finance costs

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Finance leases	435	459
TOTAL	435	459

9.3 Impairment

Net impairment of property plant and equipment and intangibles

	Year ended 31 March 2011 £000	Restated Year ended 31 March 2010 £000
Changes in market price	1,057	83,156
Loss or damage from normal operations (donated)	2,614	-
Loss or damage from normal operations (purchased)	3,256	20,532
Reversal of impairments	(1,473)	-
TOTAL	5,454	103,688

Impairments occur when the carrying amount of property, plant and equipment are reviewed by the District Valuer on application of indices or external valuation. This review is undertaken annually through a revaluation to ensure assets reflect the fair value, when they are brought into use, or assets are identified as assets held for sale. The impairments relate to the following:

Property, plant and equipment	£000
Bristol Oncology Hospital	915
St Michaels	1,699
Queens Building	644
Bristol General Hospital	1,760
Terrell Street	1,129
Horfield Road Houses	780
Total	**6,927**

Of the total impairments arising during the year £3.671m (2010: £83.156m Restated) was charged to the revaluation and donated asset reserves and £3.256m (2010: £20.532m Restated) was charged to the operating expenses within the Statement of Comprehensive Income. The reversal of impairments of £1.473m is credited to other comprehensive income.

9.4 Restatement of Prior Year Impairments

There has been a change in accounting policy in respect of the treatment of impairments arising from consumption of economic benefit or service potential. HM Treasury have adopted a divergence from IAS 36 whereby an impairment loss arising from a clear consumption of economic benefits or service potential is recognised in operating expenses. However, to ensure Foundation Trust reserves are in the same position as if IAS 36 applied, an amount should be transferred from the revaluation reserve to the income and expenditure reserve. This transfer is the lower of:

(i) the amount of the impairment loss charged to expenses or
(ii) the balance on the revaluation reserve in respect of the asset

In 2009/10 there were two impairments relating to consumption of economic benefit which were originally charged to the revaluation reserve. The 2009/10 comparative figures have been restated to reflect the change in accounting policy.

Bristol Heart Institute – the building was brought into use during 2009/10. The impairment of £4.165m was originally charged £2.966m to the revaluation reserve and £1.199m to operating expenses. These have been restated to reflect an additional charge to operating expenses of £2.966m and a corresponding transfer between the revaluation and income and expenditure reserves.

IM&T / Joint Boiler House– the building was brought into use during 2009/10. The impairment of £3.478m was originally charged £1.823m to the revaluation reserve and £1.655m to operating expenses.

These have been restated to reflect an additional charge to operating expenses of £1.823m and a corresponding transfer between the revaluation and income and expenditure reserves.

In 2008/09 there was an impairment relating to the Milne Centre of £1.208m which was charged to the revaluation reserve. As the divergence from IAS36 also includes a transfer between reserves this adjustment has a net nil impact on the 2009/10 opening balance of the income and expenditure reserve.

10. Intangible assets

	Software licences £000	Other £000	Total £000
Cost at 1 April 2010	3,029	428	3,457
Additions	1,416	178	1,594
Disposals	-	(174)	(174)
Fair value adjustment	-	131	131
Cost at 31 March 2011	**4,445**	**563**	**5,008**
Accumulated amortisation at 1 April 2010	1,267	61	1,328
Impairments	-	-	-
Charged during the year	597	-	597
Disposals	-	-	-
Accumulated amortisation at 31 March 2011	**1,864**	**61**	**1,925**
Net book value at 31 March 2010			
Purchased	1,762	-	1,762
Donated	-	-	-
Funded from Government Grant	-	367	367
Restated net book value at 31 March 2010	**1,762**	**367**	**2,129**
Net book value at 31 March 2011			
Purchased	2,581	-	2,581
Donated	-	-	-
Funded from Government Grant	-	502	502
Total net book value at 31 March 2011	**2,581**	**502**	**3,083**

Other intangibles assets are emission allowances granted under the EU Emissions Trading Scheme. These allowances are held at fair value.

11. Property, plant and equipment

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation at 1 April 2010	29,680	200,802	6,038	10,297	88,712	430	15,337	2,261	353,557
Additions – purchased	-	1,917	-	16,532	3,923	73	1,948	2	24,395
Additions – donated	-	3,399	-	-	299	-	6	-	3,704
Impairments	(435)	(6,250)	(943)	-	-	-	-	-	(7,628)
Reclassifications	-	7,646	65	(10,182)	1,375	-	697	8	(391)
Revaluations	144	5,574	135	-	-	-	-	-	5,853
Transferred to assets held for sale	(610)	-	(860)	-	-	-	-	-	(1,470)
Disposals	-	-	-	-	(22,585)	-	(2,482)	(38)	(25,105)
At 31 March 2011	**28,779**	**213,088**	**4,435**	**16,647**	**71,724**	**503**	**15,506**	**2,233**	**352,915**
Accumulated depreciation at 1 April 2010	-	-	-	-	58,414	155	9,146	1,427	69,142
Charged during the year	-	8,495	308	-	6,090	62	1,586	234	16,775
Impairments	-	(600)	(102)	-	-	-	-	-	(702)
Reversal of Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluations	-	179	(63)	-	-	-	-	-	116
Disposals	-	-	-	-	(22,103)	-	(2,482)	(38)	(24,623)
At 31 March 2011	**-**	**8,074**	**143**	**-**	**42,401**	**217**	**8,250**	**1,623**	**60,708**
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**
Net book value at 31 March 2010									
Purchased	29,680	187,595	6,038	10,297	27,389	275	6,191	729	268,194
Donated	-	7,833	-	-	2,909	-	-	105	10,847
Finance leases	-	5,374	-	-	-	-	-	-	5,374
Total at 31 March 2010	**29,680**	**200,802**	**6,038**	**10,297**	**30,298**	**275**	**6,191**	**834**	**284,415**

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 2010/11 the value of these assets has been estimated by using valuation indices for the year provided by the District Valuer. Revaluation gains on indexation total £4.449m in the current year.

Land and dwellings was transferred from property, plant and equipment to assets held for sale amount to £1.470m. See note 14.2 for further details regarding assets held for sale.

Depreciation expense of £16.775m has been charged to operating expenses (note 5) within the Statement of Comprehensive Income

The Bristol Dental Hospital buildings are owned by the University of Bristol. The Trust's ongoing access to the healthcare facilities provided by the hospital and future economic benefits from the Trust's capital investment in the hospital have been confirmed by the University of Bristol in a Memorandum of Understanding.

11.1 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 2011 £000	Year ended 31March 2010 £000
Cost or valuation at 1 April	5,374	6,802
Impairments charged to revaluation reserve	-	(1,428)
Revaluations	896	-
Cost or valuation at 31 March	**6,270**	**5,374**
Accumulated depreciation at 1 April	-	303
Provided during the year	330	330
Revaluation surplus	-	(633)
Accumulated depreciation at 31 March	**330**	**-**
Net Book Value at 31 March	**5,940**	**5,374**

11.2 Net book value of land building and dwellings

The net book value of land, buildings and dwellings comprises:

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Freehold	232,134	231,146
Long leasehold	5,940	5,374
TOTAL	238,074	236,520

11.3 Protected and non-protected assets

Details of value of property, plant and equipment which are protected/non-protected are as follows:

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Protected assets	196,975	191,920
Non protected assets	95,232	92,495
TOTAL	292,207	284,415

11.4 Net book value of land building and dwellings – where the Trust is the lessor

The Trust leases out certain buildings or parts of buildings under operating leases. The carrying amount of buildings leased out in part, or their entirety was as follows:

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Cost	2,257	623
Depreciation	(71)	-
Net book value	2,186	623
Depreciation charged for the year	71	32

12 Inventories

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Raw materials and consumables	7,029	5,782
TOTAL	**7,029**	**5,782**
Inventories recognised as an expense in the year	76,207	68,211
Impairments	-	-
TOTAL	**76,207**	**68,211**

Notes to the Accounts

13. Trade and Other Receivables

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Amount falling due within one year:		
NHS receivables	11,888	16,314
Other receivables	9,801	8,766
Provision for impaired receivables	(3,568)	(3,111)
PDC receivable	-	23
Prepayments	1,579	1,179
Accrued income	363	1,627
Total falling due within one year:	**20,063**	**24,798**
Amount falling due after one year		
Other receivables	-	-
Provision for impaired receivables	-	-
Total falling due after one year	**-**	**-**

Provision for irrecoverable debts (impairment of receivables):	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Balance at start of year (period)	**3,111**	**1,364**
New Provisions	1,378	2,719
Utilised in year	(234)	(328)
Reversed in year	(687)	(644)
Balance at end of year (period)	**3,568**	**3,111**

Ageing of impaired receivables	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
By up to three months	1,873	1,556
By three to six months	531	590
By more than six months	1,164	965
TOTAL	**3,568**	**3,111**

Ageing of non-impaired receivables past their due date	£000	£000
By up to three months	1,258	7,994
By three to six months	2,132	1,203
By more than six months	284	510
Total	**3,674**	**9,707**

14. Other assets

14.1 Other financial assets

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Amount falling due within one year	146	146
TOTAL	**146**	**146**

14.2 Assets Held for Sale

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Assets Held for Sale	1,470	-
TOTAL	**1,470**	**-**

The assets held for sale relate to Rose Cottage, Horfield Road Houses and 56 Alfred Hill following the approval of the Finance Committee. The completion date for the transactions is expected by December 2011.

15. Trade and Other Payables

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Amount falling due within one year:		
NHS payables	10,927	12,217
Capital payables	1,911	1,880
Other payables	18,295	11,313
Accruals	15,361	16,002
TOTAL	**46,494**	**41,412**
Amounts falling due after one year:		
Loans	-	-
TOTAL	**-**	**-**

Outstanding pension contributions of £3.542m (2009-10 £3.529m) are included within the NHS payables totals and £6.854m for PAYE (£3.923m) and National Insurance (£2.931m) has been included in Other payables.

16. Other liabilities

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Amount falling due within one year:		
Deferred income	12,240	12,207
Deferred government grants	30	367
TOTAL	**12,270**	**12,574**

17. Borrowings

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
17.1 Amount falling due within one year:		
Bank overdrafts	-	3,390
Finance lease obligations	164	140
TOTAL	**164**	**3,530**
17.2 Amounts falling due after one year:		
Finance lease obligations	6,142	6,306
TOTAL	**6,142**	**6,306**

17.3 Finance Lease Obligations

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Payable:		
Not later than one year	575	575
Later than one year but not later than five years	2,300	2,300
Later than five years	7,140	7,715
Sub-Total	**10,015**	**10,590**
Less finance charges allocated to future periods	(3,709)	(4,144)
Net Obligation	**6,306**	**6,446**

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 2011 £000	Year ended 31 March 2010 £000
Payable:		
Not later than one year	164	140
Later than one year but not later than five years	898	802
Later than five years	5,244	5,504
Net Obligation	**6,306**	**6,446**

17.5 Finance Lease Commitments

There are no finance lease commitments at 31 March 2011 (31 March 2010 Nil)

18. Provisions for Liabilities and Charges

	Legal Claims £000	Other £000	Total £000
At 1 April 2010	627	284	911
Arising during the period	125	257	382
Utilised during the period	(146)	-	(146)
Reversed unused	(116)	-	(116)
Unwinding of discount	9	-	9
Market value adjustment	-	-	-
At 31 March 2011	**499**	**541**	**1,040**
At 1 April 2009	519	103	622
Arising during the period	224	153	377
Utilised during the period	(83)	-	(83)
Reversed unused	(40)	(40)	(80)
Unwinding of discount	7	-	7
Market value adjustment	-	68	68
At 31 March 2010	**627**	**284**	**911**

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	243	541	784
Later than one year but not later than five years	98	-	98
Later than five years	158	-	158
Total	**499**	**541**	**1040**

18.1 Legal Claims

The provision for legal claims at 31 March 2011 includes the following:

a) Provision for Staff Injuries
A staff injuries provision of £0.283m, (2010: £0.301m) in respect of staff injury allowances payable to the NHS Pensions Agency.

b) Provision for Liabilities to Third Parties
A provisions for liabilities to third parties of £0.217m (2010: £0.286m) 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 2011 of £0.540m (2010: £0.284m) relate to the charge for carbon emissions under the EU Emissions Scheme. This provision is stated at market value.

18.3 Clinical Negligence

The NHS Litigation Authority has included a £50.224m provision, in its accounts (2010: £42.78m) in respect of clinical negligence liabilities of the Trust.

19. Cash and cash equivalents

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Cash with the government banking service	52,876	41,177
Commercial cash at bank & in hand	139	54
Total cash and cash equivalents	**53,015**	**41,231**

The Trust's bank overdraft forms an integral part of cash management and therefore for the purposes of the cash flow statement it has been included within cash and cash equivalents as follows:

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Total cash and cash equivalents	53,015	41,231
Bank overdraft	-	(3,390)
Total cash and cash equivalents	**53,015**	**37,841**

Notes to the Accounts

20. Capital Commitments

The Trust has issued Project Management Instructions to the value of £2m with Laing O'Rourke for enabling works on the BRI Redevelopment Project. (2010: £nil).

21. Post-Statement of Financial Position (SoFP) Events

University Hospitals Bristol has secured an offer of 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. Take up of the loan is subject to approval by the Trust Board of the Full Business Case for the BRI Redevelopment project and completion of the Monitor due diligence process. The Full Business Case for the Centralisation of Specialist Paediatrics was approved by the Board in March 2011. The loan is available for staged drawdown in 2012/13 and 2013/14.

Skills for Health entered into a three month consultation exercise on 13th April 2011 with its staff regarding a major restructure of the organisation. Depending upon the outcome of the consultation exercise the preliminary assessment is that this is likely to involve the removal of 73.65 whole time equivalents from the funded structure which will result in a significant number of redundant posts which in turn will result in redundancy and superannuation costs being incurred during the 2011/12 financial year. The estimated costs and timing of the cash outflow cannot be determined at this stage.

22. Contingencies

22.1 Contingent Assets

The Trust has no contingent assets at 31 March 2011 (2010: £nil).

22.2 Contingent Liabilities

Contingent liabilities at 31 March 2011 comprise:

Bristol Education Centre Reviewable Rent
The Trust pays an annual rent of £0.575m for the lease of the Bristol Education Centre. In addition, an annual "reviewable" rent, equal to 5% of the Market Rental Value of the premises is payable (currently £0.034m per annum). This rent is reviewed periodically in accordance with the lease terms. This was last reviewed in August 2008 and the next review is due in August 2013 (2013/14). The Market Rental Value of the premises over the remaining period of the lease and hence the Trust's financial liability cannot be determined with any certainty.

Equal Pay Claims
The NHS Litigation Authority is co-ordinating a national approach to the litigation of equal pay claims and is providing advice to the Trust. The likely outcome of these claims and hence the Trusts financial liability, if any, cannot be determined until these claims are resolved.

Other Contingencies
The Trust has contingent liabilities in relation to any new claims arising under the NHS Litigation Authority's "Liability to Third Parties" and "Property Expenses" schemes. The contingent liability will be limited to the Trust's excess for each new claim.

23. Prudential Borrowing Code

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

a) the maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's compliance framework determines one of the ratios and therefore can impact on the long term borrowing limit.
b) the amount of any working capital facility approved by Monitor.

Further information on the Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

At the 31 March 2011 the Trust's Prudential Borrowing Limit was £109.40m (2010: £131.35m). This represents maximum long term borrowing of £71.90m (2010: £99.60m) and an approved working capital facility of £37.50m (2010: £31.75m). At 31 March 2011 the Trust had £6.306m (2010: £6.446m) outstanding for long term borrowings, and had utilised £nil (2010: £nil) funds from its working capital facility.

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

Financial ratio	Actual ratios year ended 31 March 2011	Approved PBL ratios year ended 31 March 2011	Actual ratios year ended 31 March 2010	Approved PBL ratios year ended 31 March 2010
Minimum dividend cover	4.9x	>1	4.1x	>1x
Minimum interest cover	95x	>3	84x	>3x
Minimum Debt service cover	72x	>2x	67x	>2x
Maximum debt service to revenue	0.1%	<2.5%	0.1%	<2.5%

At 31 March 2011 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 or parties related to them has undertaken any material transactions with the University Hospitals Bristol NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. Entities where income or expenditure, or outstanding balances as at 31 March 2011, exceeded £500,000 are listed below.

Notes to the Accounts

	31 March 2011 £m		2010/11 £m		2009/10 £m	
	Receivables	Payables	Income	Expenditure	Income	Expenditure
Avon and Wiltshire Mental Health Partnership NHS Trust			0.89		0.88	
NHS Bath and North East Somerset			13.18		12.76	
NHS Birmingham East and North			0.87		0.73	
NHS Bristol	4.14		255.01	0.51	249.49	0.96
Central Manchester University Hospitals NHS Foundation Trust			0.82		0.64	
NHS Cornwall and the Isles of Scilly			1.14		1.22	
NHS Devon			2.10		2.26	
NHS Dorset			0.79		0.83	
NHS Gloucestershire	0.95		8.96		7.14	
Great Western Ambulance Service NHS trust				0.72	0.80	1.84
NHS Hampshire			0.83		1.01	
Health Commission Wales			6.65		10.22	
Health Protection Agency		0.55	0.62	3.06		2.68
NHS Blood and Transplant				6.43		6.20
NHS Litigation authority				6.50		6.24
NHS Purchasing and Supply Agency				9.32		10.15
North Bristol NHS Trust	1.40	1.21	3.35	1.38	3.22	3.85
NHS Business Service Authority Pension Division		3.55		43.11		41.58
NHS North Somerset	0.95		44.39		42.57	
North West SHA			7.88		5.75	2.10
Pennine Acute Hospitals NHS Trust				0.56		0.84
Royal United Hospitals Bath Trust					0.90	
NHS Somerset			15.14		15.69	
NHS South Gloucestershire	1.24		34.48		32.48	
South West SHA			0.58		38.43	
NHS Swindon			1.95		2.62	
Taunton and Somerset NHS Foundation Trust					0.92	
Weston Area Health NHS Trust			1.11		0.93	
NHS South East Essex			0.69			
NHS Wiltshire			7.10		6.64	
Yorkshire and the Humber SHA					1.01	
East Lancashire NHS Trust				0.54		
Royal Liverpool and Broadgreen University Hospital				0.68		
NHS Liverpool				0.73		
Department of Health		1.26	39.40	2.74		

In addition the Trust has had a number of material transactions with other Government Departments and other central and local government bodies. Most of these transactions have been with:

	31 March 2011 £m		2010/11 £m		2009/10 £m	
	Receivables	Payables	Income	Expenditure	Income	Expenditure
HM Revenue and Customs	-	6.85	-	72.45	-	75.94
University of Bristol	-	-	3.94	6.82	2.91	6.13

Grand Appeal and Above and Beyond

Two of the Trust's Board members serve as Trustees; one for Above and Beyond and one for Grand Appeal. The Trust has received capital payments from a number of charitable funds, including Above and Beyond Charities. The transactions relating to Above and Beyond are receipts of donated assets (£531k) income (£2.6m) expenditure (£741k) and receivables (£1.5m). There were transactions relating to the Grand Appeal on income (£159k) and receivables (£5k). The Audited Accounts of Above and Beyond Charities can be obtained from:

Above and Beyond Charities,
The Abbot's House,
Blackfriars,
Bristol, BS1 2NZ

25. Private Finance Transactions

At 31 March 2011 the Trust has no PFI schemes (2010: none).

26. Pooled Budget Projects

The Trust is party to a Pooled Budget arrangement with Bristol North PCT, Bristol South & West PCT, North Bristol NHS Trust, Bristol City Council, North Somerset Council and South Gloucestershire Council for the management and prevention of delayed discharges from hospitals. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006. The Pool is hosted by the Councils. The Trust makes no contribution to the Pooled Fund but receives income in the form of reimbursement payments which are paid where the level of delayed discharge exceeds an agreed threshold and it serves a Section 2 Notice and Section 5(3) Notice on the Council. For the year ended 31 March 2011 the total income amounted to £0.033m (2010: £0.01m).

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

27. Financial Instruments

27.1 Financial Instruments by currency

Financial Assets	**31 March 2011**	**31 March 2010**
	£000	**£000**
Currency		
Denominated in Sterling	71,645	64,973
TOTAL	**71,645**	**64,973**

	31 March 2011	**31 March 2010**
Financial Liabilities		
Currency	**£000**	**£000**
Denominated in Sterling	43,921	42,742
TOTAL	**43,921**	**42,742**

The Trust has negligible foreign currency income or expenditure.

Notes to the Accounts

27.2 Financial instruments by category

Financial assets per Statement of Financial Position	31 March 2011 £000	31 March 2010 £000
Loans and receivables:		
NHS debtors	11,888	16,314
Other debtors	9,801	8,912
Other financial assets	146	-
Accrued income	363	1,627
Provision for irrecoverable debts	(3,568)	(3,111)
Cash at bank and in hand	53,015	41,231
Total	**71,645**	**64,973**

Loans and receivables are held at amortised cost.

Financial liabilities per Statement of Financial Position	31 March 2011 £000	31 March 2010 £000
Financial Liabilities at amortised cost:		
Bank overdraft	-	3,390
NHS creditors	10,927	12,329
Capital creditors	1,911	1,880
Other creditors	11,329	4,761
Accruals	15,361	16,002
Finance lease obligations	4,393	4,380
Total at 31 March	**43,921**	**42,742**

The process for how the Trusts manage risk associated with financial instruments is set out in section 1.16 Financial Risk of the Accounting Policies.

27.3 Fair Values

At 31 March 2011 and 31 March 2010 there was no significant difference between the fair value and the carrying value of any of the Trust's financial instruments.

27.4 Maturity of financial assets

At 31 March 2011 and 31 March 2010 all financial assets were due within one year.

27.5 Maturity of financial liabilities

	Year ended 31 March 2011 £000	Year ended 31 March2010 £000
Less than one year	39,687	38,497
In more than one year but not more than two years	175	153
In more than two years but not more than five years	617	554
In more than five years	3,442	3,538
Total	**43,921**	**42,742**

Notes to the Accounts

28. Third Party Assets

At 31 March 2011 the Trust held £nil (2010: £nil) cash at bank and in hand which relates to moneys held by the Trust on behalf of patients.

29. Intra-Government Balances

At 31 March 2011	Receivables: amounts falling due within one year	Receivables: amounts falling due after more than one year	Payables: amounts falling due within one year	Payables: amounts falling due after more than one year
	£000	£000	£000	£000
Foundation Trusts and NHS Trusts	2,462	-	3,825	-
Department of Health	-	-	1,263	-
Strategic Health Authority	319	-	14	-
Primary Care Trusts	9,107	-	932	-
NHS WGA bodies	-	-	5,065	-
TOTAL NHS	**11,888**	**-**	**11,099**	**-**
Other WGA bodies	-	-	9	-
TOTAL at 31 March 2011	**11,888**	**-**	**11,108**	**-**

At 31 March 2010	Receivables: amounts falling due within one year £000	Receivables: amounts falling due after more than one year £000	Payables: amounts falling due within one year £000	Payables: amounts falling due after more than one year £000
Foundation Trusts and NHS Trusts	2,965	-	4,077	-
Department of Health	170	-	-	-
Strategic Health Authority	300	-	32	-
Primary Care Trusts	12,779	-	3,295	-
RAB Special Health Authorities	29	-	811	-
NHS WGA bodies	71	-	4,002	-
TOTAL NHS	**16,314**	**-**	**12,217**	**-**
Other WGA bodies	28	-	-	-
TOTAL at 31 March 2010	**16,342**	**-**	**12,217**	**-**

30. Losses and Special Payments

There were 496 cases of losses and special payments totalling £0.247m paid during the period ended 31 March 2011 (2010: 483 cases totalling £0.10m).

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

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

Under the NHS Act 2006, Monitor has directed University Hospitals Bristol NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the accounts direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Bristol NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.
In preparing the accounts, the accounting officer is required to comply with the requirements of the NHS Foundation Trust 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
- 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, 03 June 2011

1. Statement on internal control

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 University Hospitals Bristol 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 2011 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Leadership

The Trust Board of Directors is accountable for ensuring that risk is effectively addressed throughout the Trust's operations. Responsibility for the management of risk is delegated to the Chief Executive who discharged this duty through the formal Executive management and Board committee structures established for the purpose.

The Chief Executive chaired the Governance and Risk Management Committee of the Board which consisted of Executive Directors, specialist risk advisers and risk management leads drawn from across the Trust. This Committee was supported by a number of risk management sub-committees which address areas of risk from a specialist point of view. For the management of clinical risk and patient safety, these included the Clinical Risk Assurance Committee, the Clinical Effectiveness Committee and the Clinical Audit Committee. The Clinical Risk Assurance Committee, chaired by the Medical Director, reported regularly to the Governance and Risk Management Committee on its activities and assessments of clinical risk.

Minutes of the meetings of the Governance and Risk Management Committee were routinely reported to the Audit and Assurance Committee which assessed the systems and processes of risk management for suitability. In the 2010/11 financial year, minutes of the Governance and Risk Management Committee were also reported to the Trust Board of Directors, with an additional report established in the latter half of the year by the Committee Chairs on the activities of both the Governance and Risk Management Committee and the Audit and Assurance Committee. This receipt of Committee Chairs' reports further ensured that risk and risk management activities were effectively reported and considered in the Boardroom.

In undertaking its role and function as a scrutiny and monitoring Committee of the Board, the Audit and Assurance Committee received both the corporate risk register and the Board Assurance Framework document and considered these on behalf of the Board in the periods between their direct reporting to the Board.
The maintenance and use of divisional risk registers was embedded as a risk management practice within Trust Services and clinical divisions, and exceptions were reported to the Board through the Governance and Risk

Management Committee. Divisions reported in full on their divisional risk register to the Governance and Risk Management Committee on a rotational basis.

The corporate risk register was reviewed by the Trust Board each quarter, and integrated quality and performance reports were considered by the Trust Board of Directors at each public meeting throughout the year.

Risk Management

Divisions have continued to standardise and strengthen their risk management arrangements during the course of 2010/11. This has included embedding the use of divisional risk registers and developing appropriately trained and experienced risk leads and risk assessors. Divisional risk registers reflect the status of risks associated with achieving the divisions' objectives and include the risks associated with the provision of clinical services, including clinical, operational, financial, and compliance risk.

Risk management and patient safety specialists from within the Trust have worked with the Chief Nurse to ensure that the risk management infrastructure is continually developed and fit for purpose, for example, the standardised use of the Trust's central risk registry. There has been continued work in 2010/11 to ensure that risk registers are maintained and kept up to date, reported to the appropriate groups and that senior managers are trained in their use. Additionally, the Trust utilises the services of independent risk advisers to undertake audits or conduct specialist risk training as and when appropriate.

There is a comprehensive single incident reporting scheme for both clinical and non-clinical incidents, which has been highly commended by the NHS Litigation Authority in both its design and application. All incidents are assessed and those of a more serious nature are subject to a full investigation and root cause analysis and appropriate action plans are produced to minimise the risk of a similar incident occurring again. This has included external review of incidents occurring in the Trust.

The Trust places significant emphasis on learning from good practice both from within and outside the Trust. This includes learning points identified through the investigation of incidents, complaints and claims, which are considered by the relevant committees to identify trends and ensure that learning is undertaken in a joint review group which reports to the Governance and Risk Management Committee and the clinical divisions. In addition the Trust, through national groups such as the Association of Litigation and Risk Managers (ALARM), shares details of good practice in all areas of risk management. The Trust is a member of the regional Network of Governance and Risk Managers which also shares details of good practice in risk management. The Trust continues to participate in the South West Quality and Patient Safety Initiative.

The Trust takes all complaints seriously and through the Senior Nurse for Complaints, under the direction of the Chief Nurse, and in conjunction with divisions, investigates and responds to all complaints in accordance with the requirements of the NHS complaints procedure and works closely with Patient Advisory and Liaison Services. The Trust responds to all legal claims appropriately and in accordance with NHS Litigation Authority guidance. Risk management issues identified through the complaints or litigation process are addressed through the appropriate committee of the Trust.

Training

The Trust presents regular risk awareness training starting with corporate induction and continued through more detailed training in clinical and non-clinical areas. Where appropriate, risk assessment training, including root cause analysis training, is provided to key members of staff. A risk management training matrix is maintained for all staff.

The Risk and Control Framework

Risk Management Strategy

The Trust Board of Directors sets the appetite of the Trust for the tolerance of risk during its regular meetings and the meetings of the principal Board committees concerned with risk. The Board's position with regards to risk to patients is summarised by the Chairman in a statement drawn from the minutes of the Board in which he summarised the Board's position as having "no tolerance for any form of harm to patients".
The Risk Management Strategy sets out the Trust Board of Directors' approach to discharging its responsibility for the effective management of risk, and aims to establish and maintain a culture where everyone has a responsibility for the proactive identification and addressing of potential risk. The Strategy is reviewed in accordance with the procedural document review schedules, and was most recently considered by the Governance and Risk Management Committee on behalf of the Trust Board of Directors on 10 February 2011. It is available to the public on the Trust web site at www.uhbristol.nhs.uk/keypublications.html.

Risk Management System

Systems for the management of risk are considered to be embedded throughout the organisation. Operations of the Trust seek to ensure that potential risks are identified and managed proactively. The identification, categorisation, scoring and mitigation of risks are captured in the risk registers which are considered by the specialist advisory committees reporting to the Governance and Risk Management Committee and the Trust Board of Directors.

The Trust management executive strove to continually improve its own performance in all areas and in terms of risk management this was undertaken through assessments, audits and inspections with detailed action plans produced to address areas where performance could be improved. The corporate risk register is now central to the overall system of risk management being applied to both 'high level' corporate risks as well as high risks identified within and by the divisions. This register was reviewed and updated routinely during 2010/11.

A 'live' data-capture facility enabled the risks entered by divisions to be cross-referenced to the Trust Board of Directors' Board Assurance Framework document; this document associates risks with corporate objectives, and outlines the status of management and risk-mitigation actions to minimise their impact on the achievement of objectives.

The system described was further refined in 2010/11 with the corporate risk register and Board Assurance Framework document becoming standing items on the Trust management executive's regular meeting agenda in addition to their regular presence on the agendas of Board committees.

Risk Profile

Among the corporate risks under particular scrutiny in the coming year will be, firstly, delivery of financial plans in support of the Trust's capital investment programme. This will be managed through a focus on sustainable cost reduction resulting from major service redesign across the Trust but particularly in the emergency inpatient pathway and in outpatient services, with in-year mitigation plans in place to cover any non-recurrent shortfall.
Secondly, the Trust will continue to ensure full implementation of the action plan in response to the 2010 Independent Inquiry into Histopathology Services at the Trust, to address the weaknesses in working practices identified in the Inquiry report, and it will continue to report progress publicly to ensure that confidence in the Trust's services is maintained.

Board Assurance Framework

The Trust Board of Directors derives its assurances as to its own efficacy from a number of sources, including the regular reports presented by the Trust management executive, the monitoring and scrutiny conducted by Board committees (and the subsequent reports by Board committee Chairs), the regular constructive challenge and holding to account by Non-Executive Directors in the boardroom, interaction with the Membership Council and Governors, and the formal assessment of the Board's own performance.

In addition, the Board has adopted the regular receipt of a Board Assurance Framework document which sets out the Trust management executive's progress in achieving the organisational objectives of the Board of Directors agreed at the beginning of each financial year (or end of the previous year). With the aims, objectives and progress clearly set out alongside any known risks and mitigating actions taken, the Board Assurance Framework document provides Directors with a clear picture of the health of the Board's agenda at any particular time. Any gaps in controls and evidence of progress are addressed through appropriate action plans which are monitored either by the Board, or by the Board's committees. In particular, the Governance and Risk Management Committee and the Audit and Assurance Committee considered the majority of the key elements on behalf of the Trust Board. This on-going monitoring and scrutiny further contributed to the Board's sense of assurance regarding any identified gaps in assurance.

In addition to the Board Assurance Framework document, the Board received a Quarterly corporate objectives (Annual Plan) progress report from the Director of Strategic Development. Together these two reports were considered formally on five occasions by the Trust Board of Directors in the 2010/11 period, and the Board Assurance Framework document was scrutinised by the Audit and Assurance Committee on behalf of the Board on four additional occasions. The Board resolved at its March 2011 public meeting to consolidate the quarterly corporate objectives progress report and the quarterly Board Assurance Framework Report into one regular progress report in 2011/12.

Care Quality Commission Registration

The Trust Board of Directors received an update to the Trust's position regarding the Care Quality Commission (CQC) Outcomes Framework at its public meeting in March 2011. At this point, the Trust remained registered with the Care Quality Commission with no restrictions or limitations.

The report confirmed the outcomes currently declared non-compliant with the CQC were Outcomes 5 (Nutrition), 14 (Supporting Staff) and 21 (Records).

The Board noted assurance that considerable progress had been made in respect of Outcomes 5 and 14, but that further data was being sought to confirm sustained progress.

Involvement of Public Stakeholders

The Trust Membership Council of Governors continued to develop its interaction with the Trust Board of Directors in this reporting period, with a regular attendance of Governors at meetings of the Trust Board of Directors and a complementary attendance of Executive Directors at meetings of the Membership Council. Additionally, the Membership Council has established and effectively run its three groups for strategy, membership, and quality. Each of these groups has been attended by relevant Executive Directors and other senior managers of the Trust to ensure on-going dialogue and collaboration between Governors and the most senior managers of the Trust. These interactions were in addition to the formal joint meetings of the Membership Council and the Trust Board of Directors. In addition, the Chairman hosted regular informal meetings of the Membership Council and the Trust Board of Directors during which Governors and Directors exchanged views and ideas in a spirit of openness and accountability. This engagement has gone a long way to

ensuring trust and cooperation between the two governing bodies of University Hospitals Bristol NHS Foundation Trust.

The Trust has also continued to build on previous public and patient involvement mechanisms and works actively with a number of groups involving patient and public representatives in the design and planning of its services. There has been significant engagement of the general public, voluntary organisations, staff, local involvement networks, Overview and Scrutiny Committees as well as participation in the planning of a number of services and priorities for the Trust's redevelopment schemes. 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 Trust staff, Governors, members and the public in this reporting period.

Information Governance

The Trust is a data controller as defined by the Data Protection Act of 1998 and takes its responsibility for the security of personal and corporate data very seriously. We remain compliant with the Data Protection Act 1998 and the Freedom of Information Act 2000.

We continued to demonstrate our commitment to ensuring the security and integrity of that information and maintained our focus on the risks associated with loss of data, fully implementing software to manage and monitor the use of removable and portable devices to preclude serious data incidents.

The Information Governance Steering 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 eight of the Information Governance Toolkit, we declared and published our out-turn position as at 31 March 2011 of 65%, compared to 82% in 2009/10. I note that this out-turn position appears to indicate a deterioration in our performance this year, but we are assured that it is not significantly out of alignment with other Trusts in the region. This year's Information Governance Toolkit represents a substantial change with regard to the methodology for demonstrating compliance combined with a significant increase in the standards demanded by the Toolkit. Additionally, the methodology for calculating the Trust's risk rating in relation to the Toolkit has changed with a requirement for the Trust to achieve level 2 for all 45 requirements. At the point of out-turn, there were three indicators out of 45 at level 1 which resulted in a red-rating calculated by the Information Governance Toolkit.

Action plans are in place to address this shortfall in 2011/12 and will be reviewed by the Information Governance Steering Group, chaired by the Medical Director. A structure has been developed to support information risk-ownership within the Trust, in line with the requirements of the Information Governance Toolkit.

Climate Change

The Trust has in place a carbon reduction delivery plan and reinforces it with a spend-to-save investment programme of energy related measures across its estate. We are now developing a wider sustainability plan to draw all of the activities of the Trust into this initiative, including the development of models of care, procurement and travel. Waste minimisation and management is already included in the plan and this year has seen a major roll out of dry mix recycling across the Trust.

We continue to work with our partners in the Avon Health Executive Resilience Group to ensure our obligations with regard to emergency preparedness and those 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.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all obligations in respect of the NHS Pension 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.

Measures are in place to ensure that all of the Trust's obligations under equality, diversity and human rights legislation are complied with. Implementation of the Single Equality Scheme and action plan is monitored on a six monthly basis by the Trust Board.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Trust Board of Directors has adopted 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 and formalising these arrangements in 2009 as the Making Our Hospitals Better programme with revised governance arrangements agreed in September 2010.

The Transformation Programme Board was established in January 2011 to lead, oversee and coordinate the programme of change and service improvement to effect improvements in quality, productivity and economic efficiency across the Trust. The Transformation Programme Board 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 Executive Group 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.

Over a similar time period, a wider programme approach to cost savings has been developed in the form of a cash releasing efficiency savings programme which has been monitored routinely by the Audit and Assurance Committee and the Trust Board of Directors. Divisional Review meetings were held six-monthly, and monthly financial and operational reviews continue to be undertaken with divisions. These review meetings focus on issues relating to performance targets, human resources and finance, including cash releasing efficiency savings.

The Internal Auditor has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Audit and Assurance Committee. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Audit Standards. Where scope for improvement was identified during an internal audit review, appropriate recommendations were made and action plans were agreed for implementation.

Internal audit reviews of the Trust's Estate's service have provided limited assurance, particularly as to the system for its planned maintenance programme. I will take these findings into account when considering the management of this function during 2011/12.

At the end of the year, I requested a rapid review of current arrangements, best practice and recommendations for programme enhancements to be made for the forthcoming year, including the management and reporting arrangements for the transformation and savings programmes. Subsequent to the recommendations of this review, I have sanctioned an approach which includes the application of programme management

methodologies to this programme which is in accordance with the standards set out by the Office of Government Commerce in its Managing Successful Programmes guidance.

Review of Effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. The Head of Internal Audit opinion I have received is that 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, I note that there are some areas where scope for improvement has been identified in the consistency of application of the system, and action plans have been drawn up to address these. 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 and Assurance Committee and the Governance and Risk Management Committee and have established a plan to address any weaknesses and ensure continuous improvement of the system.

The Trust Board of Directors and I derived assurances during the course of the year from a range of sources, including the reporting cycle of the Trust Executive, the Board Assurance Framework document, the corporate risk register, the work of the Governance and Risk Management Committee, the work of the Audit and Assurance Committee, and a number of external sources including the Trust Governors and Membership Council and direct patient and public involvement through the use of hand-held survey devices.

I have also received assurances as a result of inspections, audits and reviews by a number of national and professional bodies. The Trust participates in nationally organised bench-marking programmes. Importantly the Trust achieved Level III compliance with the maternity risk management standards under the National Health Service Litigation Authority in 2011. The Trust is working diligently to achieve Level II compliance with the National Health Service Litigation Authority acute general standards. We also continue to enjoy the highest level Practice Plus status under the Improving Working Lives scheme.

The overall effectiveness of the Assurance Framework is assessed by the Governance and Risk Management Committee and the Audit and Assurance Committee who report to the Board. Other committees assess specific areas of the Assurance Framework and through the Executive Directors, approve improvement plans. The overall effectiveness of the Assurance Framework and its ability to support the system of internal control is reviewed as part of the work of internal audit.

In addition to seeking its assurances from the existing infrastructure described, the Trust Board of Directors undertook a detailed review of its corporate governance provisions to assess compliance with the Foundation Trust Code of Governance. This review, conducted by the Trust Secretary, was further supported by two additional audits and a review of the Trust Executive's management arrangements, including the provisions for risk management, which I commissioned. The first of the two additional audits, a High-level Divisional Governance Review, is due to conclude at the end of April 2011 and set out to assess the arrangements in place in divisions to discharge their accountability to me for the management of risk and safety, and for the quality of service and clinical outcomes.

The Safety and Risk Review, which is the second of the two additional audits I have commissioned to provide additional assurance on the standards of patient safety and risk management within the Trust's divisions through an independent qualitative review, is also due to conclude at the end of April 2011.

My review of executive management arrangements, which runs in parallel to the Board's review of Corporate Governance, is also due to conclude at the end of April 2011.

The Board's review of corporate governance indicated areas where the Board could establish clearer lines of accountability, particularly with regards to risk management, and has resulted in the Board decommissioning the Governance and Risk Management Committee, and establishing the new Quality and Outcomes Committee which will meet for the first time in April.

Responsibility for risk management previously held by the Governance and Risk Management Committee is now delegated directly to me as Chief Executive and I have established a risk management group to be supported by additional specialist groups for addressing risk in four key areas. The Trust Board of Directors retains responsibility for ensuring the appropriate management of risk, and in particular will address strategic risk at Board level. The Trust management executive has also established a Clinical Quality Group to manage and ensure the quality and safety of the Trust's clinical services.
These revised 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, and will be assessed for efficacy later in the year by an internal audit.

Annual 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 in the NHS Foundation Trust Annual Reporting Manual. The process of producing the Annual Quality Report on behalf of the Trust Board of Directors is overseen by the Chief Nurse.

In preparing the Annual Quality Report, the Board took into consideration detailed comments on the draft Report from Non-executive Directors (via the Audit and Assurance Committee), our Governors (including formal discussion at the Membership Council), each of the Heads of Division, our commissioners (NHS Bristol), the Health Overview and Scrutiny Committees of Bristol and South Gloucestershire Local Authorities, Local Involvement Networks for Bristol and South Gloucestershire (in a facilitated workshop), and from our auditor (the Audit Commission). Feedback from these partners has also helped us to ensure the readability, balance and accuracy of the final version of the Quality Report. Our commissioners have confirmed that the accuracy of the data presented in the quality account concords with the data and information they have available and that there are robust arrangements in place to monitor and review the quality of services in the Trust.

Additionally, the Trust has put a number of processes in place to assure the Board that the Quality Report presents a balanced view, and that there are appropriate controls in place to ensure the accuracy of data. Based on these assurances, the Board considers that the narrative of the Quality Report represents a fair and balanced view and interpretation of the data upon which it is based, and that the data is accurate and up to date, and is consistent with other data published by the Trust during the year, for example in monthly quality reports to the Trust Board of Directors.

The Trust has processes in place to ensure that accurate and up to date data is consistently used to support effective reporting and decision making, and is subject to a system of internal control and validation. Internal and external reporting requirements have been critically assessed and data provision is reviewed regularly. This is achieved through both internal and external audit; an example is the Audit Commission Payment by Results Assurance Clinical Coding Audit, the results of which are published in the Trust's Quality Report. Data is used to populate a monthly Quality and Performance Report to the trust Board of Directors which is reviewed by the Executive Team and the Trust Board and is subjected to appropriate levels of challenge. This means that the Trust Board of Directors is able to track data trends throughout the reporting year and can evidence consistency

with the narrative and metrics reported in the annual Quality Report. In the 2010/11 reporting year, the Trust Board of Directors also received a detailed half-year progress report on the Trust's quality objectives.

As set out under "
Information Governance" on page 51 of this report, the Trust has an Information Governance Management System Policy which incorporates procedures and protocols for ensuring data quality which is overseen by the Information Governance Management Group, reporting to the Trust Management Executive.

During the 2010/11 reporting year, the Trust built on its existing data quality arrangements and processes in a number of key areas, including:

- Establishing the Quality Intelligence Group, with a membership including medical, nursing, risk, performance and information personnel, to take lead responsibility for reviewing clinical services data. The Group is chaired by the Trust's Medical Director, and systematically reviews national benchmarking and data quality across all clinical specialities.
- Extending the scope of audits of clinical record keeping, as addressed by the Assurance of Record Keeping Group, to a wider range of data items.

In addition to these developments, the Trust has used a suite of reports to monitor and improve data quality during the year. These include daily data quality reports derived from a variety of sources, but chiefly the Patient Administration System made available via the information and performance data warehouse. These reports are utilised by operational staff throughout the Trust who are fully supported to ensure that they have the knowledge, competencies and capacity for their roles in relation to data quality. Managers monitor staff competencies and development needs through the appraisal and supervision process, and ensure that staff have access to appropriate training and developmental opportunities. The Trust has put training programmes in place to ensure that staff have the capacity and skills for effective collection, recording and analysis of data. Training is provided to all staff using the Patient Administration System and the Integrated Healthcare System, and support materials are available through the intranet. The requirements for data quality skills are clearly set out in the Trust's standard job description template which is used for all job descriptions.

The Trust Board of Directors drew upon additional external assurance that it met the standards set-out by Monitor through the Audit Commission's review of the 2010/11 Quality Report. As part of this review, three performance indicators were checked. These checks focused on whether the figures reported were relevant and reliable, and whether they were calculated according to the correct definitions and guidance. Two of the three performance indicators selected this year were mandated by Monitor. These were Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemias and Cancer 62-day wait. A further indicator, adult mortality rate following cardiac surgery, was selected for review by the Trust's Governors. In all three instances the Audit Commission concluded the data for these three indicators could be substantiated.

Conclusion

I conclude that no significant internal control issues have been identified and where the systems of corporate governance and risk management could be enhanced, the Trust Board of Directors has approved appropriate actions as outlined in the body of this statement on internal control.

Robert Woolley
Chief Executive, 03 June 2011

Independent auditor's report to the Board of Governors of University Hospital Bristol NHS Foundation Trust

I have audited the financial statements of University Hospital Bristol NHS Foundation Trust for the year ended 31 March 2011 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on page 69 and 70 and
- the table of pension benefits of senior managers and related narrative notes on pages 71 and 73.

This report is made solely to the Board of Governors of University Hospitals Bristol NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work has been undertaken so that I might state to the Board of Governors those matters I am required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

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 Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of affairs of University Hospitals Bristol NHS Foundation Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Certificate

I certify that I have completed the audit of the accounts of University Hospitals Bristol NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Wayne Rickard
Officer of the Audit Commission

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3 June 2011