University Hospitals Bristol NHS
NHS Foundation Trust

Annual Report and Accounts 2013-2014

University Hospitals Bristol NHS Foundation Trust

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

1. Chairman's Statement

Welcome to the Annual Report and Accounts, including the Quality Report, for University Hospitals Bristol NHS Foundation Trust for the year from 1 April 2013 to 31 March 2014.

It has once again been a momentous year for the whole of the NHS with challenges to work through in a variety of areas.

1.1 Quality of care

The focus on the quality of care the NHS provides to patients rightly continued in the wake of the publication of three significant reports - the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC (the 'Francis Report'); the Keogh Review by Professor Sir Bruce Keogh, NHS England Medical Director, and the Berwick Report by Professor Don Berwick. Here at University Hospitals Bristol NHS Foundation Trust (UH Bristol) we reviewed all of Robert Francis' recommendations, and the other two reports, to consider what further improvements we can make to ensure that the interest of the patient is at the centre of all we do.

We did this with a detailed self-examination of the Trust's system of governance and shared Trust values, by considering the Francis Report's recommendations for acute Trusts and assessing ourselves against those and with a qualitative analysis of information derived from discussions with Trust staff as well as from other forms of feedback from staff and patients. As a result, we identified a number of themes for us to address including perceived variation in attitudes to openness and sharing across the Trust, listening and learning more effectively throughout the Trust and making the process of change easier and more usual.

1.2 Changes in the structure of the NHS

On 1 April 2013 Clinical Commissioning Groups (CCGs) replaced Primary Care Trusts as the lead commissioner for services such as ours. At a strategic level, the CCGs are focussed on a clinical Z\view of the decisions that underpin the commissioning process but, on a practical level, local relationships and ways of working have changed and we welcome the change in emphasis these changes have brought.

The Health and Social Care Act 2012 also expanded the role of the Council of Governors, and this is something that we invested a significant effort in preparing for to ensure that we were ready not only to fulfil our duty of equipping our governors with the skills and knowledge they need, but also enabling them to fulfil their new statutory duties to hold the non-executive directors to account for the performance of the Board, and to represent the interests of the members, and the interests of the public.

1.3 The financial challenge coupled with growing demand for services

Much has been written about the overall financial challenge faced by the NHS, coupled with the increased demand for NHS services. We know that austerity within public services will continue and, even although health spending is protected, this does not account for increases in health costs caused by things such as the advances in treatments and drug costs and the growing demand from a burgeoning elderly population. This Trust is not immune from these pressures – our savings target for 2013/14 was £21 million - and we are working hard to transform our services in response to these pressures.

1.4 The local perspective

As a university hospitals trust in the centre of Bristol, with a key role in the delivery of education and training, research and development, and district and tertiary health services, University Hospitals Bristol plays an important role in Bristol and the surrounding areas. Central to how we perform, are the values we adhere and work to, our strategy as an organisation, our governance structure and the way in which we approach the challenges of the future.

1.5 Shared values

As an organisation, we embrace the Nolan principles and public service values, as well as having our own. In 2012, we rolled out 'Living the values' training to ensure that as well as setting out our values we are also doing all we can to embed them throughout the Trust. Our values are part of the shared language within the Trust and also play a prominent role in each staff members' annual appraisal.

1.6 Strategy

During 2013/14 we have engaged with governors, staff, services and partners to develop a draft strategy that will take us up to 2020 – and we are now in the process of gathering feedback on it.

We have over 8,000 staff who delivery more than 100 different clinical services across nine different sites. With services from the neonatal intensive care unit to care of the elderly, we offer care to the people of Bristol and the South West from the very beginning of life to its later stages. We're one of the country's largest acute NHS Trusts with an annual income of half a billion pounds.

Our Mission as a Trust is to improve the health of the people we serve by delivering exceptional care, teaching and research every day.

Our Vision is for Bristol, and our hospitals, to be among the best and safest places in the country to receive care.

We want to be characterised by:

- High quality individual care, delivered with compassion;
- A safe, friendly and modern environment;
- Employing the best and helping all our staff fulfil their potential;
- Pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation and;
- Providing leadership to the networks we are part of, for the benefit of the region and people we serve.

The basic challenge for organisations like ours is responding to the challenge of maintaining and developing the quality of our services by managing with fewer available resources. This requires three main approaches:

- Optimising the productivity and operational efficiency of our systems, processes and staff;
- Transforming the way in which we deliver care through service and workforce redesign;
- Making strategic choices that directly address the challenge.

This annual report will provide information about how we responded in 2013/14.

1.7 Governance

The primary and central role of the Trust Board of Directors is to govern the Trust, putting patients, staff and the public first, and to be accountable for its actions and inactions. We have seen this reinforced with the provisions of the Health and Social Care Act 2012 and the implications of the Companies Act 2006 for directors. Without a recognisable and pervasive 'tone at the top', the organisation will have no direction, and will remain 'valueless'. It is imperative therefore that I maintain a balanced, diverse and fully focussed Board.

We took a more lateral approach to succession planning for the Board in 2013/14, searching for candidates beyond our immediate boundaries and as a result, I am delighted to welcome four new directors and two observers to the Board. Alison Ryan and David Armstrong joined as Non-executive Directors; Jill Youds and Julian Dennis were recruited as Non-executive Observers (non-voting); and, Sue Donaldson and Carolyn Mills were appointed as voting Executive Directors to the portfolios of Director Workforce and Organisational Development and Chief Nurse respectively. We made these appointments to complement and augment the skills of existing directors and I'm pleased to say we had a large number of applicants of unprecedented quality, giving us the opportunity to be highly selective.

Biographies of the members of the Board, and of our two Non-executive Observers are provided at Appendix A – Biographies of Members of the Trust Board of Directors on page 91 of this report.

I am reassured that the combination of the refreshed Trust Board of Directors with sound management systems of internal control that we are taking our ability to govern to a new level. I am further reassured by the Internal Auditor's[1] statement that "Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives… we highlight the Trust's continued emphasis on the control environment and the *very proactive approach that the Trust has taken over the year* over its response to internal audit work and the clearance of internal audit recommendations."

The Chief Executive's Annual Governance Statement in the Annual Accounts (Appendix D) provides details of our systems of internal control and quality management arrangements.

1.8 Transforming Care

Our ambition to continually improve in this increasingly challenging environment means we have to deliver change across all areas of our hospitals. We have chosen to bring this work together under a common, overarching programme – Transforming Care. The programme is based on the belief that redesigning services to give the best care to patients is the route to making taxpayers' resources go further, and that clinical teams across the Trust are best placed to identify opportunities for improvement and to lead the changes.

2013/14 has been an important year for University Hospitals NHS Foundation Trust. As we move into a new and equally challenging year, I would like to thank the staff, members, governors, charities and volunteers who have worked together to deliver improvements in quality of care, new facilities and transformed services that contribute towards our overarching mission to improve the

[1] The Internal Audit service for University Hospitals Bristol NHS Foundation Trust is provided by the Audit South West Consortium, who provides Internal Audit services to a number of Foundation Trusts in the South West, in accordance with Public Sector Internal Audit Standards.
A three year Internal Audit strategy, prepared by the Director of Audit, is in place covering the core areas of governance, assurance and risk management, finance, IT, workforce management, quality and safety, operational services, performance and procurement. The strategy incorporates an annual Internal Audit Plan agreed by the Audit Committee based on the Trust's Assurance Framework and Risk Register and risk areas highlighted by the Audit Committee, Chief Executive and Executive Directors.

health of the people we serve by delivering exceptional care, teaching and research every day and our vision for Bristol, and our hospitals, to be among the best and safest places in the country to receive care.

John Savage CBE

Chairman,

28 May 2014

2. Chief Executive's Foreword

The NHS is undergoing unprecedented change at a time when the challenges facing acute hospital trusts are becoming more arduous. The increasingly complex needs of patients, major changes in the way our services are commissioned, a reduction in income in real terms and the increasing expectations of patients and tax payers who pay for NHS services, who want higher quality, personalised care, delivered closer to their home, at times convenient to them, mean that we must have a robust response. As these challenges get tougher, so our resolve to respond to the demands of our patients must get stronger.

In this national context which, John Savage, our Chairman has set out, our Transforming Care programme provides a strategy for improving services. This strategy is founded on driving up clinical quality, improving the flow of patients through hospital and redesigning our services, in order to deliver sustainable best value to the public purse and remain true to our mission.

2.1 Delivering best care

Delivering the very best care that we can is central to our mission to improve the health of the people we serve by delivering exceptional care, teaching and research every day and our vision, for both Bristol and our hospitals, to be among the best and safest places in the country to receive care. Furthermore, we believe that providing the best care, we will also provide efficient services that deliver best value for the NHS and the taxpayer.

One of our key initiatives for delivering best care is our adult patient safety programme. I am delighted to report excellent progress towards completing and sustaining a number of safety improvements. Progress within the programme is measured using a five point scale and our external assessors have just confirmed we are edging closer to the maximum score of 5.0, having moved from 3.5 in April 2013 to 4.5 in November 2013 and maintained this level for the last two quarters. This five year improvement programme aims to reduce mortality by 15% and adverse events (harm directly attributed to an unplanned event) by 30% by October 2014. We have already achieved over 15% reduction in mortality and are well on our way to reducing our adverse event rate thanks to a huge amount of work by clinical staff to implement safety improvement measures and to embed them in the daily care of our patients.

Our focus on the quality of our services and the safety of patients is unrelenting. Caring for a million people every year, it is imperative that we use all the information at our fingertips so that we can make improvements where these are necessary. During 2013/14, Dr Foster Intelligence released mortality data for the period July 2012 to June 2013, which showed that University Hospitals Bristol delivers effective care. For that period, we have a lower than expected hospital standardised mortality ratio (HSMR) and emergency weekday HSMR. In other categories (emergency weekend HSMR and death in low risk diagnosis groups), we are performing within the expected range. Very simply put, this indicates that our patients overall do well and this is testament to the care that clinical staff are giving every day.

In addition, the Care Quality Commission assessed the Trust in October 2013 and gave us the lowest risk rating in its first Intelligence Monitoring Report, confirming our strong safety profile. The Trust achieved an overall risk score of 3 out of a possible 162. Just 37 of the 161 acute and specialist trusts included in the report achieved this rating and only three other trusts in the South West.

Quality of care and patient safety in the NHS has rightly been a national focus following the events at Mid Staffordshire NHS Trust and it is essential that we critically examine processes and how we

work. Over the summer of 2013 we asked staff for their views on what we could do to always put our patients first. The information they gave us formed the basis of our continuing efforts to ensure we have a supportive and safety-conscious culture across the Trust, as recommended by the Francis Report.

The Trust's response to the Francis Report sets out our interpretation of the information we gained and the conclusions we reached following a searching self-examination. It also sets out the work that is already taking place and the work that is planned to ensure that our culture of quality, openness and learning is further enhanced. Finally, it includes our commitment to continue to improve care for patients, undertake the work identified through the Transforming Care programme and continue to critically self-evaluate our performance and behaviour through enhanced staff engagement, so that any further opportunities for learning may be identified.

During 2013/14 we opened new facilities where we had identified we could improve services to patients. In June actress Lynda Bellingham helped us celebrate the opening of the new midwifery-led birthing unit at St Michael's Hospital.

We also opened the Bristol Gamma Knife Centre at the Bristol Haematology and Oncology Centre. The new facility is the first of its kind outside London and the North of England and will transform care for patients in our region with acoustic neuroma, meningioma, pituitary tumours, brain metastases, trigeminal neuralgia and vascular abnormalities, many of whom currently need to travel to Sheffield for this treatment.

Finally, we welcomed our new Chief Nurse, Carolyn Mills and new Director of Workforce and Organisational Development, Sue Donaldson to the Trust. I'd like to thank Helen Morgan and Claire Buchanan for all their hard work and dedication as acting directors in the interim.

2.2 Improving patient flow

Improving patient flow is a fundamental part of our Transforming Care programme, alongside delivering best care. This is because moving patients on in a clinically appropriate but timely manner is critical to our ability to do the work we are contracted to do and maintain our reputation as a provider of planned and specialist care. During 2013/14, our work to improve patient flow was fundamental as we coped with operational pressures that had a negative impact on patient flow and on the experience of our patients.

During the year we introduced a number of new systems and ways of working to improve patient care. We opened a discharge lounge on level 5 of the Bristol Royal Infirmary (BRI), next to the entrance to the Bristol Heart Institute (BHI). Its purpose was to improve patient flow through our hospitals by taking around 150 patients a week from wards in the BRI and BHI. This facility is pivotal to our work to increase the early discharge of patients from our wards to ensure that new patients needing a bed can be admitted to the right ward, from the onset of their care.

We also opened an Older Persons Admissions Unit to improve care for older patients with acute needs and to help the flow of patients through our hospitals. The 38 bedded unit has been created in response to this growing need. Over the past two years approximately 45 more older people per month (between ages of 75 and 89) have been admitted to the BRI. For patients aged 90 plus the increase over the same period has been 100 patients per month. Patients being cared for on unit are assessed on admission by specialists in elderly care and are supported by social workers, occupational therapists, physiotherapists and pharmacists. In addition to improving outcomes for older patients and reducing the amount of time they need to spend in hospital, this model of care should reduce the number of inappropriate patient transfers, which is important for those patients with dementia.

Of course, moving patients who are medically fit for discharge into appropriate environments is essential and this year we looked at out-of-hospital capacity both in nursing homes and in other settings to help us with operational pressures. Working with our partners we secured funding from the Bristol Clinical Commissioning Group and top-level sign-up from Bristol Community Health and Social Services for this extra capacity.

We had an opportunity to share our work more widely when Earl Howe, Parliamentary Under Secretary of State for Quality at the Department of Health, visited Bristol. We discussed our patient flow work with both the Minister and our commissioners and showed them round the adult Emergency Department and the new discharge lounge as well as the new BRI ward block.

2.3 Delivering best value

I am pleased to report that the Trust maintained a healthy financial position and a strong balance sheet for the financial year ended 31 March 2014. We were particularly pleased to achieve an income and expenditure surplus of £6.188m before technical items, efficiency savings of £16.855m, a healthy cash position of £47.535m and a strong balance sheet resulting in a Continuity of Services risk rating of 4. The surplus we have made allowed us to continue our significant investment in the future of health care in Bristol with expenditure on capital schemes in 2013/14 totalling £64.986m

Good financial management and strong governance provide the foundation for the delivery of high quality health services and the contribution of staff in these areas should be celebrated. I am delighted that our finance director Paul Mapson has received the Lifetime Achievement Award from the South West Branch of the Healthcare Financial Management Association (HFMA), the professional body for health and social care finance staff. At the same awards, the Student Award was won by Patrick O'Brien in recognition of his success in obtaining the highest mark of the 4,764 candidates who took the Chartered Institute of Management Accounts (CIMA) Financial Strategy paper last November. Congratulations to both on their awards.

2.4 Renewing our hospitals

With this programme of work we aim to provide facilities that match our high quality services and, as a Trust, we have made financial surpluses each year to enable us to make these vital investments in our infrastructure. As the year has progressed, visitors, patients and staff cannot have failed to notice the progress as buildings have emerged and new facilities have opened to patients.

One of the most noticeable changes from the outside has been the opening of the new Welcome Centre, which has transformed the entrance to the BRI by providing a bright, spacious area for the benefit of patients, visitors and staff. Facilities include an outpatient booking service, patient support and complaints service, smart new reception and waiting area, and retail outlets. We know how important first impressions are and we hope that this new entrance into our hospitals will better reflect the high quality of care and services we provide within the hospital. It has been made possible through our partnership with Capita who worked with us to develop the proposal which will be entirely funded though income we will receive from our retail partners.

We have long recognised that the external appearance of the Bristol Royal Infirmary is not one that reflects the quality of care provided within. Once voted "one of the ugliest buildings in Bristol", we got Bristol talking when we embarked upon a project to dramatically improve the building's appearance. At the end of 2012, we selected six international artists and architects to develop concept designs for the redevelopment of the front of the BRI and encouraged comment on them. Three designs were shortlisted and a winning design chosen – "Veil" by Nieto Sobejano, the Madrid-based architectural firm. The chosen design was further developed and submitted for

planning permission at the end of 2013 with the aim of delivering a visible result over the next twelve months.

The redevelopment of the BRI continued at pace throughout the year and the focus is moving now from the development and fit out of the new extension at the rear of the Queen's Building, to how it will work as a hospital providing excellent quality care. Staff are working together to plan the delivery of services and ensure we are prepared as the new facilities open later this year.

The £16 million redevelopment of the Bristol Haematology and Oncology Centre continued throughout the year and some new facilities are now open to patients. The new haematology day unit and the region's first adult bone marrow transplant unit have both opened. This unit will enable seriously ill patients who often require very long and intensive courses of treatment to have all their care delivered in one place.. The dedicated unit for teenagers and young adults with cancer has now opened to much acclaim. Work to replace the two radiotherapy bunkers is now complete which will enable us to offer the most up to date treatment available from November 2014 this year when new state of the art radiotherapy equipment is installed.

It has long been our aim to centralise all specialist paediatric services at the Bristol Royal Hospital for Children and work continued in 2013/14. After years of working together to plan this move, including extending, reconfiguring and equipping the children's hospital, familiarisation and induction for transferring staff and rehearsing how new and changed services will operate, the Trust welcomed new colleagues from specialist paediatric services at North Bristol Trust to the children's hospital and to University Hospitals Bristol in early May 2014. It is also my pleasure to share the news that the children's hospital has become a paediatric major trauma centre serving both the Peninsula and Severn Trauma Networks.

None of these developments would be possible without the support of our charitable partners – Above & Beyond, The Grand Appeal, Friends of the BHOC and the Teenage Cancer Trust. We were highly gratified and impressed as they launched innovative and high profile fundraising appeals and we celebrated with them as they reached fundraising milestones.

Finally, renewing our hospitals is not only about big capital investments. This programme also looks at smaller investments we can make to improve the environment for patients and staff - like the £230,000 we received from the Department of Health to improve the efficiency of the ventilation system in the BRI Queen's Building.

2.5 Building capability

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

We simplified essential training across the Trust to make it easier for staff in all areas to understand what essential training they need to do and to keep up to date.

The Trust welcomed Sue Donaldson as director of Workforce and Organisational Development. Sue was director of workforce at Oxford University Hospitals NHS Trust and has a wealth of senior NHS experience as a director in both hospital and commissioner organisations.

We made a second important appointment, this time in the vital area of medical education. Consultant anaesthetist Dr Rebecca Aspinall was appointed to the role of Director of Medical Education for the Trust. Rebecca has a long standing interest in medical education, is a former Foundation Programme Director and last year won a Recognising Success Award for Excellence in Teaching, Learning and Research for her work to transform training and education in very practical ways for junior doctors, focusing on patient safety.

Part of building capability is also recognising and celebrating successes and, for the second year, the Trust held its Recognising Success Awards programme, generously sponsored by Above & Beyond. Recognising success is one of the Trust's values - it is there because in the complex, multi-faceted work of our hospitals, it is critical that we all know what good looks like and we take the time and trouble to acknowledge those individuals and teams who go the extra mile for patients or for each other. Recognising success is also about sharing the learning to see if the same recipe for success can be applied to other areas.

2.6 Leading in partnership

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

As part of this we continued our work with our healthcare partners in this area to identify what changes are needed to ensure that hospital services deliver high quality, safe and accessible care to patients for the long term. The Bristol Acute Services Review began by only looking at hospital services but the clear message we received from clinical staff was that the scope of the review needed to be expanded. In line with our ambition to lead in partnership, we agreed this change with the three local clinical commissioning groups. The review undertook detailed analysis of eleven specialities across University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust, a review of the whole urgent and emergency care pathway in Bristol, North Somerset and South Gloucestershire and consideration of options for addressing the significant financial challenges ahead.

University Hospitals Bristol NHS Foundation Trust is playing a leading role in research. During the year it was announced that the Trust would host both the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in the West of England and the new West of England NIHR Clinical Research Network. As we know, research today will provide more effective treatments for patients tomorrow, so I am delighted that the Trust is playing this important leadership role.

Our clinical colleagues are also taking on national roles. Dr Jackie Cornish has been made National Clinical Director for Children and Young People and Transition to Adulthood and Professor Jonathan Benger has been made National Clinical Director for Urgent Care. These appointments are a recognition of the professional standing of the two individuals but they also reflect very positively on the Trust - the Board offered many congratulations to them both.

Of course the Trust also plays a major role in the life of Bristol and you cannot have been in the city last summer without noticing Gromit Unleashed.The much-anticipated public arts trail saw 80 individually decorated giant sculptures of the much-loved Aardman character populate the city for ten weeks. After the trail closed the sculptures were auctioned to the highest bidders in aid of Wallace & Gromit's Grand Appeal, which has pledged to raise an initial £3.5 million for the Bristol Royal Hospital for Children. This really was a tremendous event and it was humbling to see the

extent to which individuals and families from far and wide pulled together to support the children's hospital.

Last year was also a difficult one for the paediatric congenital heart service at the children's hospital as a number of families expressed public concerns about their experience of the service. During 2013/14, it was announced by NHS England that they would invite Sir Ian Kennedy to work with these concerned families to conduct an independent review into children's cardiac services in Bristol. We hope that this independent review will restore their confidence in the service by demonstrating that their concerns have been understood by the Trust, and importantly, acted upon.

Finally, I would like to end by paying tribute to the staff at the Trust. Significantly, in the final week of the financial year, we considered the continuing operational pressure on the Trust and what our response should be. We concluded that we need a step-change in the way we deliver services and all adult areas embarked on a focussed week of action. In all areas there was a concerted effort to solve problems and provide the highest quality care and, even although adult services were under the same or similar demand as before, our performance, and the quality of care we delivered to patients improved. This could not have happened without the dedication and sheer hard work of clinical and non-clinical staff across the Trust and I thank them warmly for it.

I hereby confirm that the Annual Report and Accounts, including the Strategic Report and the Directors' Report were approved as a true and fair account of the Trust's business for the reporting period 1 April 2013 to 31 March 2014 at a meeting of the Trust Board of Directors on 28 May 2014.

Robert Woolley

Chief Executive,

28 May 2014

3. Strategic Report

The Trust's accounts at Appendix D – Annual Accounts 2013/14 – including the 'Annual Governance Statement' have been prepared under a direction issue by Monitor under the National Health Service Act 2006. The further details provided in this 'Strategic Report' are intended to provide accessible context for the Accounts.

3.1 Principal Activities of the Trust

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

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

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

As a University Teaching Trust, we also place great importance on teaching and research. The Trust has strong links with both of the city's universities and teaches students from medicine, nursing and other professions allied to health. Research is a core aspect of our activity and has an increasingly important role in the Trust's business. The Trust is a full member of Bristol Health Partners, and of the West of England Academic Health Science Network, and also hosts the recently established Collaboration for Leadership in Applied Health Research for the West of England.

University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of hospitals in the heart of Bristol, a vibrant and culturally diverse city.

We have over 8,000 staff who deliver over 100 different clinical services across nine different sites. With services from the neonatal intensive care unit to care of the elderly, we provide care to the people of Bristol and the South West from the very beginning of life to its later stages. We're one of the country's largest acute NHS Trusts with an annual income of half a billion pounds.

We have recently renewed our mission and vision which we express as:

Our mission as a Trust is to improve the health of the people we serve by delivering exceptional care, teaching and research every day.

Our vision is for Bristol, and our hospitals, to be among the best and safest places in the country to receive care. We want to be characterised by:

- High quality individual care, delivered with compassion;
- A safe, friendly and modern environment;
- Employing the best and helping all our staff fulfil their potential;

- Pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation;
- Providing leadership to the networks we are part of, for the benefit of the region and people we serve.

Our strategic intent is to provide excellent local, regional and tertiary services, and maximising the mutual benefit to our patients that comes from providing this range of services.

Our focus for development remains our specialist portfolio and we aim to expand this portfolio where we have the potential to deliver exceptional, affordable healthcare.

As a University Teaching Trust, delivering the benefits that flow from combing teaching, research and care delivery will remain our key advantage. In order to retain this advantage, it is essential that we recruit, develop and retain exceptionally talented and engaged people.

We will do whatever it takes to deliver exceptional healthcare to the people we serve and this includes working in partnership where it supports delivery of our goals, divesting or out sourcing services that others are better placed to provide and delivering new services where patients will be better served.

The Trust's role in community service provision will be focused upon supporting our partners to meet the needs of our patients in a timely way; however, where our patients' needs are not being met, the Trust will provide or directly commission such services.

Our patients – past, present and future - their families, and their representatives, will be central to the way we design, deliver and evaluate our services. The success of our vision to provide "High quality individual care, delivered with compassion" will be judged by them.

3.2 Our Business Plan

Over the next two years, our priority is to address the specific challenges that we face as an organisation, and we will focus on the successful implementation of a revised operating model across the Trust that will deliver the following benefits:

- Improvement of the consistency with which we deliver elective care and a significant reduction in the cancellation of planned care;
- Implementations of the findings of a trust wide review of the provision of critical care. This will allow us to further improve the consistency with which we deliver planned care and reduce cancellations of planned surgery because of the unavailability of critical care beds;
- Eliminating a large number of cancer pathway delays and deliver planned activity;
- Restoring our Accident and Emergency performance through delivery of reduced bed occupancy in the emergency care beds;
- Reduction in the number of patients remaining in hospitals after the point at which they no longer require hospital care. This is fundamental to Trust performance in the next two years and we plan to achieve this improvement via the following specific initiatives:
  - The establishment of an integrated discharge hub, co-locating professionals from acute services, social care and community providers, and re-designing discharge processes and practices to support rapid assessment and care planning for patients who no longer require acute care;

- Rapid commissioning of additional out of hospital transitional care beds to assist with the discharge of patients who no longer require hospital care but for whom discharge is delayed for whatever reason;
- Establishment of an Early Supported Discharge (ESD) function to enable those patients who are "homeward bound" to be discharged earlier – this will replicate the model we already operate for stroke patients;
- Revision of our approach to weekend discharge with the aim of significantly increasing the proportion of patients with a predicted weekend discharge who go on to be discharged;
- Successfully transfer specialist paediatric and cleft services from North Bristol NHS Trust (NBT) to University Hospitals Bristol NHS Foundation Trust and transfer out vascular services and breast screening. Successfully commissioning and opening of the Bristol Royal Infirmary redevelopment, including decommissioning of the then redundant estate;
- Go further to deliver our vision of truly effective staff engagement; our National Staff Survey results for staff engagement show small improvements on last year and we exceed the sector average but we recognise this as an area where our success rests upon us excelling in this domain; as such our new Director of Workforce and Organisational Development has signalled this as one of her early priorities;
- Implement a new approach to working with patients, our Members and the wider public;
- Continue to deliver a financial surplus for the next two years and unlock the £15m disinvestment assumed in the current plans for the Better Care Fund.

3.3 Business Review

(a) Our Performance in 2013/14 (an overview of regulatory risk ratings)

In the 2013/14 Annual Plan, risks to compliance with the Accident and Emergency 4-hour standard, the *Clostridium difficile* (C. diff) quarterly trajectory and the Referral to Treatment Time (RTT) Non-admitted standard were declared. This gave the Trust an Annual risk rating of Amber-Red. The Trust held an Amber-Red Governance Risk Rating during the first two quarters of the year. Following the introduction of the new Risk Assessment Framework, which came into effect on the 1st October 2013, the Trust achieved a Green rating in quarter 3.

Disappointingly, the Trust triggered the criteria for potential escalation in quarter 4, with a Service Performance Score of 5.0 and repeated failure against three standards (C. diff, A&E 4-hours and RTT non-admitted standard). At the time of this report the Trust is awaiting the outcome of this anticipated escalation.

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

	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Financial Risk Rating	3	3	4	4	3
Governance Risk Rating	AMBER-GREEN	AMBER-RED	AMBER-RED	RED (over-ride)	AMBER-RED

	Annual Plan 2013/14	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Financial/Continuity of Service Risk Rating	3	3	4	4	4
Governance Risk Rating	AMBER-RED	AMBER-RED	AMBER-RED	GREEN	*Monitor Confirmation Awaited**
Standards declared at risk/not met	A&E 4-hours RTT Non-admitted *Clostridium difficile*	A&E 4-hours *Clostridium difficile*	*Clostridium difficile* *RTT Non-admitted* *62-day GP standard*	A&E 4-hours *Clostridium difficile* *RTT Non-admitted*	A&E 4-hours *Clostridium difficile* *RTT Non-admitted* *62-day GP standard* *31-day first definitive*

**At the time of the report the Trust is holding a GREEN rating against the Risk Assessment Framework. Following the submission of the quarter 4 2013/14 declaration Monitor has requested further information to understand repeated failure against the A&E 4-hour, RTT Non-admitted and 62-day GP Cancer Standards, which will inform the published rating for quarter 4.*

(b) Review of quarterly performance

As part of the 2013/14 Annual Plan the Trust declared the Accident & Emergency 4-hour maximum wait 95% standard to be at risk of not being achieved. As in 2012/13, performance was below the national standard in Quarters 1, 3 and 4. Despite the failure to achieve the 4-hour standard in these three quarters, there have been some demonstrable improvements in key aspects of patient flow, including a 54% reduction in ambulance hand-over delays (December to March), a 23% reduction in last-minute cancellations of operations (October to February), and a 25% reduction in the number of bed-days patients spent outlying from their correct specialty ward (October to February), compared with the same period last year. The Trust also achieved each of the A&E clinical quality indicators, in particular showing an improvement in performance against the Time to Initial Assessment for patients arriving by ambulance.

During each month in 2013/14, the level of ambulance arrivals was significantly higher than the same month in the previous year, averaging a 10% increase year-on-year. However, the level of emergency admissions remained similar to that in

previous years within the BRI, which is thought to be a result of the Ambulatory Care Unit being able to manage appropriate patients without an admission to hospital. Although the number of emergency admissions did not increase, the proportion of over 75 year olds being admitted rose during the winter of 2012/13 and remained at these levels into quarter 1 2013/14. A further 8% increase on the 2012/13 winter levels was experienced during the winter of 2013/14. Older patients often have more complex health conditions and need more intensive medical input before they can leave hospital. This steep rise in the age of patients being admitted to hospital was a main contributor to the dip in performance in each quarter in 2013/14.

In the Bristol Royal Hospital for Children the increased level of ambulance arrivals was associated with an increase in emergency admissions via the Emergency Department, with levels increasing by an average of 39% across November and December 2013, relative to the same period in the previous year. This level of increase in emergency admissions is exceptional and resulted in record high levels of admissions. This was due to the high levels of respiratory illness in the community, which mirrored the national picture. This led to significant bed pressures, which heavily contributed to the failure to achieve the 4-hour standard in quarter 3 at a Trust level.

The Senior Leadership Team has developed the Operating Model for 2014/15. This consists of seven projects aimed at improving the efficiency with which the Trust operates. This programme of work focuses on a range of initiatives aimed at improving patient flow, including the creation of a Discharge Hub by the co-location of ourselves with Bristol City Council and Bristol Community Health, to promote better ways of working between the three organisations responsible for managing patients with complex health needs, the commissioning of more out of hospital beds, establishing early supported discharge pathways, and a Trust-wide review of critical care. This work programme will not only help to reduce extended stays in hospital and demand for beds, especially from elderly patients that have the most complex of care needs, but it will also help to improve quality of care and patient experience. Reducing pressure on beds will also improve flow through the front door of the hospital, and in so doing support the Trust in recovering performance against the 4-hour target.

Performance against six of the eight key national cancer waiting times standards remained strong in 2013/14, with full achievement of these six standards in every quarter of the year. The 62-day wait from GP referral with a suspected cancer to treatment failed to be achieved in quarter 2 and Quarter 4. This was due to a combination of high volumes of the more ‘unavoidable’ causes of breaches of standard, such as late referrals from other providers, clinical complexity, and patient choice to delay diagnostics and treatments, but also some more avoidable causes of breaches, such as elective cancellations due to critical care capacity, delays in outpatients for certain specialties and delays to admitted diagnostic procedures being booked due to capacity constraints. Unlike in 2013/14, the 62-day standard for screening referred patients was, however, achieved in each quarter. This follows the sustained reduction in waiting times for specialist screening practitioner appointments (SSP), and colonoscopy diagnostic procedures as a result of work undertaken to reduce delays in the latter half of 2012/13.

Following the transfer-out of the high performing breast and urology cancer services, and the transfer in of the head & neck cancer service at the end of 2012/13, the Trust

now has a more complex portfolio of cancer services. In combination with increasing levels of breaches due to late referral by other providers, mainly for lung cancer surgery, medical deferral and patient choice to delay pathways, consistent achievement of the 62-day standard will require performance significantly above the national average in most tumour sites. A Rapid Improvement Group was established at the end of quarter 2 in order to effect improvements in those pathways for which breach analysis had identified avoidable causes of breaches. Improvements in performance were demonstrated in quarter 3, across a range of tumour sites. However, there was deterioration in performance during quarter 4. This was primarily due to a further increase in the number and proportion of breaches attributed to unavoidable reasons, increasing from 49% in quarter 2 to 69% in quarter 4. Further improvement work will be undertaken in 2014/15, using the information gained from the monthly review of the causes of breaches, and learning from other organisations obtained from telephone interviews conducted with better performing equivalent providers. This will include work with other providers on improvements that can be made to the pathways of patients referred to the Trust for lung, cancer surgery, to improve the timelines for referral.

The Trust achieved an 18-week Referral to Treatment Time (RTT) for over 90% of admitted patients, in every month in 2013/14. In addition, the Trust achieved the target for incomplete pathways, with over 92% of patients waiting less than 18 weeks at each month-end. The Trust achieved the 95% RTT non-admitted pathways standard in quarter, but failed the standard in quarters 2, 3 and 4. The RTT non-admitted standard was flagged in the Annual Plan as at risk of being failed for two quarters, in advance of the transfer of the head & neck services from North Bristol NHS Trust. However, due to a rise in demand from GP referrals, which was in addition to the challenges posed by the waiting times of patients transferring to the Trust at the start of the year, the RTT non-admitted standard was failed in a third quarter. During quarter 4, work was undertaken to re-assess the level of capacity required to meet this new level of demand. Target waiting times for new outpatient appointments have also been reviewed, from which weekly activity plans have been generated. These plans will be enacted during quarters 1 and 2 in 2014/15, following which the non-admitted standard is expected to be achieved again from the start of quarter 3.

The C. diff annual objective was flagged as a risk in the 2013/14 Annual Plan due to Monitor's flat profiling of cases over quarter, which conflicts with the strong seasonal pattern of cases the Trust has experienced over recent years. The C. diff quarterly cumulative trajectory was failed in each quarter of 2013/14, with the annual objective being narrowly missed. However, overall the Trust achieved a 21% reduction in cases, reporting 38 cases in total in 2013/14, compared with 48 in 2012/13. Although the Department of Health target of zero MRSA (Meticillin Resistant Staphylococcus Aureus) bacteraemias was not achieved in 2013/14, material reductions in the number of cases were also realised, from the 10 reported in 2012/13 to one confirmed case in 2013/14[2].

[2] Although two MRSA bacteraemias were formally reported in 2013/14, one was a contaminated sample, with the patient being confirmed as negative for MRSA on repeated testing.

(c) Annual Performance against national access standards

During 2013/14, the Trust cancelled 1.01% of operations on the day of the procedure for non-clinical reasons. This represents an improvement on 2012/13 when 1.13% of procedures were cancelled. This improvement was primarily due to a reduction in cancellations due to the lack of a ward bed being available, and reflects the significant programme of work on improving patient flow, implemented during the year. However, the lack of a ward bed resulted in higher levels of cancellations in January and February 2014 in particular. The lack of a critical care bed also resulted in a high level of cancellations relative to that seen in previous years. The programme of work developed to support the 2014/15 Operating Model should further improve both ward and critical care bed availability in 2014/15 and reduce the last-minute cancellation rate. This should also help the Trust readmit patients within 28 days of their operation being cancelled, as achievement of this standard is very dependent upon the level of cancellation of operations at any point in time.

During quarter 3, the Trust received a performance notice from Bristol Clinical Commissioning Group (CCG). This made reference to the failure to achieve the RTT, 4-hour and cancer standards, as outlined in the summary above, but also the failure to consistently meet the standard of 99% of diagnostic tests being carried-out within six weeks. Significant improvements in performance have been realised in 2013/14, with performance against the 6-week standard increasing from 89.7% in 2012/13 to 98.5% in 2013/14. This was a result of service capacity for gastrointestinal endoscopies being increased to meet the higher level of demand. Following further work to increase capacity in services such as cardiac stress echo scanning and cardiac MRI, which have also seen a significant recent growth in demand, the 99% standard was achieved for quarter 3 2013/14 as a whole, and again in February and March. Further work is being undertaken to ensure a more consistent performance against the standard in 2014/15.

In 2013/14, the Trust reported further improvements in the percentage of mothers initiating breast feeding, from 80.6% to 81.6%. Improvements were also reported in the Door to Balloon 90 minute reperfusion standard. The Door to Balloon time measures the time from the arrival of the patient in the Trust through to the time when the reperfusion treatment commences (i.e. balloon inflation in the blood vessel). During the year, 93.0% of patients received reperfusion within the 90 minute standard, compared with 92.4% in 2012/13. The Call to Balloon times 150 minute standard, measures the time from the call for professional help through to the commencement of reperfusion treatment. As in 2012/13, the Trust failed to meet the 90% local stretch target. However this continued to reflect the time it took for the patient to get to the hospital (Call to Door time), rather than the time from arrival to treatment.

The table below sets out annual performance against key national standards in 2012/13 and 2013/14. Requirements are shown as per the Monitor Compliance and Risk Assessment Frameworks, along with the NHS Constitution.

National Standard	Target	2012/13	2013/14
A&E maximum wait of 4 hours	95%	Not achieved	Not achieved
MRSA bloodstream cases against trajectory	Trajectory	Not achieved	Not achieved
Clostridium Difficile infections against trajectory	Trajectory	Achieved	Not achieved
Cancer – 2-week wait (urgent GP referral)	93%	Achieved	Achieved
Cancer – 2-week wait (symptomatic breast cancer not initially suspected)	93%	Achieved	Achieved
Cancer – 31-day diagnosis to treatment (First treatment)	96%	Achieved	Achieved
Cancer – 31-day diagnosis to treatment (subsequent surgery)	94%	Achieved	Achieved
Cancer – 31-day diagnosis to treatment (subsequent drug therapy)	98%	Achieved	Achieved
Cancer – 31-day diagnosis to treatment (subsequent radiotherapy)	94%	Achieved	Achieved
Cancer – 62-day referral to treatment (urgent GP referral)	85%	Not achieved	Not achieved
Cancer – 62-day referral to treatment (screenings)	90%	Not achieved	Achieved
18 weeks referral to treatment - admitted pathways	90%	Achieved	Achieved
18 weeks referral to treatment - non admitted pathways	95%	Achieved	Not achieved
18 weeks referral to treatment – incomplete pathways	92%	Achieved	Achieved
GUM offer of appointment within 48 Hours	98%	Achieved	Achieved
Number of last minute cancelled operations	0.80%	Not achieved	Not achieved
28 day readmissions	95%	Not achieved	Not achieved
Primary PCI – 90 minutes door to balloon time	90%	Achieved	Achieved
Diagnostic waits of 6 weeks	99%	Not achieved	Not achieved

(d) Contractual performance

As part of the 2013/14 contract with the co-ordinating commissioner, Bristol Clinical Commissioning Group, which included NHS England and all South West Clinical Commissioning Groups in the South West, the Trust committed to the achievement of a number of 'stretch targets' under the Commissioning for Quality and Innovation scheme (CQUIN). Financial rewards were attached to achievement of CQUIN targets (potential rewards of over £10 million if achieved in full), and there were a number of national penalties for non-achievement of key national standards such as C diff,

18-week Referral to Treatment Time standards, Accident and Emergency 4-hour maximum wait and Cancer standards.

In line with national guidance, in order to qualify for CQUIN payments in 2013/14, the Trust had to satisfy at least 50 per cent of the pre-qualification criteria applicable to the Trust, namely demonstrating that plans/trajectories were in place for: Intra-operative fluid management, International and commercial activity, Digital First, and Carers for people with dementia. Commissioners confirmed that the Trust had met these criteria. The CQUIN targets included quality improvement indicators, ranging from the national safety thermometer and dementia measures; to system-wide CQUINs for patient flow and end of life measures; and local goals on high impact innovations, cancer treatment summaries and deteriorating patient; and specialised goals including quality dashboards and paediatric intensive care measures.

For 2013/14 the Trust expects to achieve 19 of the CQUIN standards in full and eight in part, as follows, subject to commissioner confirmation. This level of achievement attracts an estimated financial value of £9.092 million (based on the contract plan), which reflects 88% of the funds available. Details of the CQUIN schemes are shown in the table overleaf;

Type	CQUIN detail	Threshold for achievement (and period on which payment is based)	Performance	Achieved
National	Friends and Family Test: Phased expansion	Full implementation	Implementation achieved	Yes
	Friends and Family Test: Increased response rate	≥20% increase (Q4) - 15% entry threshold	24.70%	Yes
	Friends and Family Test: Improved performance on staff test	Increase on 2012/13	2012/13: 3.66 2013/14: 3.76	Yes
	NHS Safety Thermometer: Improvement Goal (pressure ulcers)	≥15% reduction = 50% Q1/2 (25 per month) ≥15% reduction = 50% Q3/4 (25 per month)	Q1: 49 (16.3 per month) Q2: 65 (21.7 per month) Q3: 45 (15 per month) Q4: 39 (13 per month)	Yes
	Dementia: Case finding (FAIR)	>90% all 3 measures, any 3 consecutive months	No measure achieved for any 3 month period	No
	Dementia: Clinical leadership	Named clinicians Delivery of training program	Reports submitted showing compliance	Yes
	Dementia: Carers support	Monthly carer survey 4 carer events in year	Poor returns on carer questionnaire 3 of 4 carer events held	No
	VTE Risk Assessment	>95% = 25% Q1/Q2 >95% = 25% Q3/Q4 MUST also achieve RCA 25% Q3/Q4	Q1: 97.1% Q2: 97.5% Q3: 98.2% Q4: 98.6%	Yes
	VTE Root Cause Analyses	≥90% (Q3/Q4) MUST also achieve Assessment	Q3: 100% Q4: 100%	Yes

Type	CQUIN detail	Threshold for achievement (and period on which payment is based)	Performance	Achieved
High Impact Innovations	HII: Intra Operative Fluid Management	408 (Full Year)	427	Yes
	HII: Digital First	1. Appointments reminder system: Purchase a system and increase reminders to 30% of patient appointments (c. 178,500) in 2013/14 measured at Q4. 2. Telephone pre-operative assessments: Currently 1 specialty; increase to another 2 specialties in 2013/14 for clinically suitable patients. 3. Remote post-surgical follow-ups: Not currently conducted. Plan for 2013/14 to agree and test out for one cohort of clinically suitable post-op patients; agree plan to increase service provision if suitable in 2014/15. 4. Remote follow-ups: 12 remote follow-up services confirmed in baseline, but not currently recorded in a robust manner. Aim for 2013/14 is for all existing well established services to be on a system where activity can be recorded. Also, increase non face-to-face follow-ups in 1-2 specialties where clinicians willing to trial. 5. Remote test results: Aim in 2013/14 for sexual health clinic to deliver negative test results by SMS where appropriate.	All 5 elements achieved	Yes
System wide	Patient Flow (adults) - reduction in OBDs for >14 day spells	≤30.8% achievement (Q4) = 50% reward ≤30.6% achievement (Q4) = 75% reward ≤30.4% achievement (Q4) = 90% reward ≤30.2% achievement (Q4) = 100% reward	30.50%	75% achieved
	End of Life Care preferred place of death	Full implementation	Reports submitted showing compliance	Yes
Locally determined non-specialised CQUINs	System flow measures - % discharges before midday	≥25% achievement (Q4) = 50% reward ≥29% achievement (Q4) = 75% reward ≥33% achievement (Q4) = 100% reward	30.80%	75% achieved
	Nutrition & Dietetics: Food chart review	≥90% achievement= 100% reward ≥85% achievement= 50% reward	87.70%	50% achieved
	Nutrition & Dietetics: Nutritional Assessments/Dietetic review	≥85% (Q4)	91.90%	Yes

Type	CQUIN detail	Threshold for achievement (and period on which payment is based)	Performance	Achieved
	Reduction in Medication errors to improve patient safety: Medication reconciliation	Group 1: ≥95% all wards (Q1 - Q4) AND Group 2: ≥85% (Q2 - Q4)	Group 1: 99.4% Group 2: 94.1%	Yes
	Reduction in Medication errors to improve patient safety: Missed Doses	≤2.25% (Full year)	1.91%	Yes
	Cancer Treatment Summaries	≥70% (Q4)	81.50%	Yes
	Enhanced Recovery Programme: Discharge	≥45% (Q4)	30.50%	No
	Enhanced Recovery Programme: Theatres - Pre-Operative Assessment Clinic / Surgical Admissions Suite & Staggered Start – BRI and St Michael's (excluding Day Case)	Part 1: ≥80% (Q4) Part 2: ≥80% (Q4) Part 3: ≥70% (Q4)	Part 1: 87.5% Part 2: 90.5% Part 3: 77.6%	Yes
	Enhanced Recovery Programme: Pathway rollout – Expansion to Vascular, Maxillary Facial Surgery and General Gynaecology	Part 1: ≥30% (Q4) Part 2: ≥30% (Q4) Part 3: ≥75% (Q4) All three targets achieved = 100% award Two targets achieved = 50% CQUIN award One target achieved = 25% CQUIN award	Part 1: 26.2% Part 2: 66.7% Part 3: 96.0%	Yes
	Enhanced Recovery Programme: Pathway rollout – Thoracic Surgery	≥95% (Full year)	98.20%	Yes
	Enhanced Recovery Programme: Pathway rollout – Lower GI Cancer	≥92% (Q4)	100%	Yes
	Deteriorating patient: EWS	≥95% (Q4)	99.00%	Yes
	Deteriorating patient: SBAR	70% (Q3) 80% (Q4)	Q3: 82.9% Q4: 90.5%	Yes
	Adult Learning Disability	≥58% (Q4)	92.60%	Yes
	Children's Learning Disability	≥90% (Q4)	95.90%	Yes
	Inpatient Diabetes specialist nurse	SHN: ≥39% (Full year) Med/SS: ≥22% (Q3/Q4)	SHN (Full year): 42% Med/SS (Q3): 26.3% Med/SS (Q4): 28.5%	Yes

Type	CQUIN detail	Threshold for achievement (and period on which payment is based)	Performance	Achieved
Specialised	Quality Dashboards	Quarterly submission of databooks	All databooks submitted	Yes
	Neonatal - Breastfeeding	≥35.8% (Full year)	40.70%	Yes
	PICU - Minimise the number of patients accidentally extubated	≥90% (Full year)	100%	Yes
	PICU - Prevention of unplanned readmissions to PICU within 48 hours	<0.91% (Quarterly)	0.70%	Yes
	Transition	Milestones (Quarterly)	Reports submitted showing compliance	Yes
	BMT - Donor acquisition measures	Data submission on 4 measures (Quarterly)	All data submitted quarterly	Yes
	Cardiac - Inpatient waits 7 days	Q2: ≥64% Q3: ≥67% Q4: ≥70%	Q2: 46.9% Q3: 73.8% Q4: 83.2%	75% achievement
	Cardiology - Access to cath lab within 24 hours	≥40% (Q4)	48.30%	Yes
	Radiotherapy – increased access to IGRT	Milestones (Quarterly) Q2: 10% Q3: 30% Q4: 50%	Milestones (Quarterly) Q2 – 10.25% Q3 – 98.7% Q4 – 96.4%	Yes
	Haemophilia – joint score	≥50% (Q4)	76.80%	Yes

Alongside the quality incentive scheme, the Trust was exposed to a series of financial sanctions where performance fell short of the contracted standards. In 2013/14 the Trust incurred financial penalties of £1.06 million due to the non-achievement of certain national quality standards, including specialty level referral to treatment waits, ambulance handover delays, c diff, emergency department 4-hour wait, and cancer 62-day referral to treatment. Recovery plans to address these areas of poor performance are in place with the aim of delivering care to the contracted standards throughout 2014/15.

(e) Financial performance

The key highlights for University Hospitals Bristol NHS Foundation Trust's financial performance during 2013/14 include:

- Delivery of an income and expenditure surplus of £6.188m before the technical adjustments of asset revaluation impairment (net loss of £12.713m) and income and depreciation of donated assets (net gain of £0.650m) to give a reported income and expenditure deficit of £5.875m for the year;
- A Continuity of Services risk rating of '4';
- An EBITDA (earnings before interest, tax and depreciation/impairments) of £35.168m (6.46%);
- Achievement of cash releasing efficiency savings of £16.885m;
- Expenditure on capital schemes of £64.986m;
- A healthy cash position of £47.535m and a strong Balance Sheet.

The results for 2013/14 confirm we have delivered the sixth year of our financial strategy as a Foundation Trust.

In summary, a good result for 2013/14 but with a lot of work to be done in 2014/15, particularly on the delivery of managing service level agreement activity and the savings / service transformation programme to ensure the Trust's strategic objectives are still progressed.

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

University Hospitals Bristol reported a surplus before technical items, of £6.188m for the year. The out-turn position is £0.272m better than the Annual Plan surplus for the year.

Items	Plan for Year	Actual Year ended 31 March 2014	Variance Favourable / (Adverse)
	£ 'm	£ 'm	£ 'm
Operating Income	537.371	544.716	7.345
Operating Expenses	(500.651)	(509.548)	(8.897)
EBITDA	**36.720**	**35.168**	**(1.552)**
Depreciation	(18.710)	(17.872)	0.838
Profit (Loss) on Asset Disposals	-	(0.110)	(0.110)
Trust Debt Remuneration	(9.803)	(9.289)	0.514
Interest Receivable	0.050	0.145	0.095
Interest Payable - Loans	(1.954)	(1.484)	0.470
Interest Payable - Leases	(0.387)	(0.370)	0.017
Net Surplus before technical adjustments	**5.916**	**6.188**	**0.272**
Depreciation - Donated Assets	(0.860)	(0.851)	0.009
Donations	2.250	1.501	(0.749)
Impairments	(3.030)	(20.523)	(17.493)
Impairment Reversals	1.886	7.810	5.924
Net Surplus for Year	**6.162**	**(5.875)**	**(12.037)**

(ii) Cash releasing efficiency saving (CRES) plans

The Trust achieved cash releasing efficiency savings of £16.885m in 2013/14. Income generation schemes contributed £2.116m. Reductions in pay costs of £5.950m were achieved and a further £8.819m was saved on supplies and services.

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

The Trust has a healthy statement of financial position which shows net working capital of £15.513m. The increase over the year reflects the draw-down of the balance of the loan from the Independent Foundation Trust Financing Facility and by slippage in the Capital Programme.

(iv) Cash flow

The Trust ended the year with a cash balance of £47.535m. The cash flow statement in the Annual Accounts shows a £12.417m increase in cash over the year. This is due to the following factors:

	£ 'm
Net cash flow from operating activities	30.760
Net cash flows from investing and other financing activities	(1.143)
Capital expenditure	(57.597)
Loans received from the Foundation Trust Financing Facility	50.000
Public Dividend Capital dividend payment	(9.603)
Increase in cash balance 2013/14	**12.417**

(v) Better payment practice code

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

	Year ended 31 March 2014	
Items	**Number**	**Value £ 'm**
Total non-NHS trade invoices paid in the period	167,561	225.243
Total non-NHS trade invoices paid within target	149,423	200.144
Percentage of non-NHS trade invoices paid within target	89.2%	88.9%
Total NHS trade invoices paid in the period	4,159	54.266
Total NHS trade invoices paid within target	3,363	49.418
Percentage of NHS trade invoices paid within target	80.9%	91.1%

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

No payments were made from claims made under the Late Payment of Commercial Debts (Interest) Act 1998 in 2013/14 (2012/13: £nil). No other compensation was paid to cover debt recovery cost under this legislation.

(vi) Capital

The Trust incurred capital expenditure of £64.986m. The table that follows shows a breakdown of funding and expenditure on major schemes.

	Year Ended 31 March 2014		
	Plan	**Actual**	**Variance** Favourable/ (Adverse)
	£ '000	£ '000	£ '000
Sources of Funding			
Public Dividend Capital	490	490	-
Donations	1,199	1,199	-
Capital Grants	75	75	-
Retained Depreciation	17,959	17,871	(88)
Sale of Property	700	-	(700)
Prudential Borrowing	50,000	50,000	-
Cash balances	5,026	(4,649)	(9,675)
Total Funding	**75,449**	**64,986**	**(10,463)**
Expenditure			
Strategic Schemes	(54,608)	(49,487)	5,121
Medical Equipment	(9,425)	(5,353)	4,072
Information Technology	(4,144)	(2,763)	1,381
Roll Over Schemes	(2,331)	(1,719)	612
Operational / Other	(12,379)	(5,664)	6,715
Anticipated Slippage	7,438	-	(7,438)
Total Expenditure	**(75,449)**	**(64,986)**	**10,463**

The Trust has drawn down the balance of £50m of the £70m loan in 2013/14 from the Independent Foundation Trust Financing Facility to support the Trust's Medium Term Capital Programme 2013/14 to 2017/18.

The variance from plan of £10.463m is attributable to slippage on the capital programme into 2014/15 (£10.210m) and lower than planned spend in 2013/14 (£0.253m).

(vii) Financial risk rating

Financial risk is assessed by Monitor's continuity of services risk rating. This was introduced for use from October 2013. A rating of '4' reflects the lowest level of financial risk i.e. no evident concerns and a rating of '1' the greatest, i.e. a significant level of financial risk. The continuity of services risk rating incorporates two common measures of financial robustness:

- Capital Service Cover - the degree to which the Trust's generated income covers its financing obligations, and
- Liquidity - days of operating costs held in cash or cash-equivalent forms.

The continuity of services risk rating aims to identify whether the financial situation of a provider of Commissioner Requested Services could place these key NHS services at risk. 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	31 March 2014	
	Metric Performance	Rating
Capital Service Cover	3.04	4
Liquidity	2.71	4
Overall rating	**4 (actual weighted score = 4.0)**	

The above table shows the Trust's overall continuity of services risk rating is 4, and the weighted continuity of services risk score is 4.0.

University Hospitals Bristol's activities are incurred under legally binding contracts with Commissioners which are financed from resources voted annually by Parliament. The Trust also has the potential to finance its capital expenditure from external sources such as the Independent Trust Financing Facility. 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.

(viii) Financial outlook

We are planning to achieve the following for 2014/15:

- A planned surplus of £5.8m;
- A planned cash balance at the year-end of £46.6m;
- A savings programme of £20.9m;
- A capital programme of £57.6m;
- A Continuity of Services risk rating of 4.

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

- Support for the Capital Programme to undertake major schemes of improvement;
- Management of substantial strategic change in Bristol over the next few years;

Maintenance of a strong on-going trading position which allows for management of potential downside scenarios in future years.
To achieve the planned surplus the following are required:

- Delivery of the planned savings for 2014/15;
- Conversion of non-recurring savings from 2013/14, into recurring savings;
- Continued maintenance of strict cost control;
- Delivery of National Performance targets and in particular the avoidance of Service Level Agreement fines;
- Delivery of clinical performance within agreed Contract Limiters to avoid non-payment of activity by Commissioners;
- Proper recording and coding of activity leading to full income recovery;
- Achievement of significant clinical service improvement in a planned and effective manner using lean methodology to enable the delivery of savings;
- Delivery of 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:

- Over-performance on Commissioner Service Level Agreements is becoming inevitably difficult to sustain in preparation for the implementation of the Better Care Fund in 2015/16;
- Pressures on spending and delivery of savings programme are intensifying and firm control is required to avoid the Trust's current financial position and its medium term plans being undermined;
- Pressure on the commitments to improve the scope of services at a time of financial constraint requires careful management.

(ix) Financing Implications of Significant Changes in Trust Objectives

The Trust's Long Term Financial Plan includes the financial implications of the Trust's major strategic capital schemes, the full impact of these schemes will not be felt until the financial year 2015/16. There have been no other material changes to the Trust's objectives or activities in the period 2013/14.

(f) Environmental impact and sustainability

The Trust has developed a sustainability action plan to draw all of the environmental activities of the Trust under the Big Green Scheme, including the development of sustainable models of care, procurement and travel. We continue to work in partnership with the University of Bristol to encourage and recognise staff through the Green Impact awards scheme in the NHS.

Our spend-to-save investment programme to reduce our energy consumption across the estate has focussed on improving the efficiency and control of heating, lighting and cooling.

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

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

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

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

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

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

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

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

(i) Cost of energy

The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal. We reduced our gas consumption, and despite increasing electricity use our expenditure has decreased by 5.6% in 2013/14.

We have put plans in place to reduce carbon emissions and improve our environmental sustainability. Over the next five years we expect to make considerable savings as a result of these measures.

(ii) Waste

We recycle 211 tonnes of our waste each year, which is 25% of the total domestic waste we produce. We plan to continue increasing the amount we recycle.

(iii) Energy consumption

Our total energy consumption has decreased by 3%during the year, from 91,668 MWh to 88,176 MWh. 20% of our electricity is generated by our on-site combined heat and power generation. 25% of the electricity we purchase is generated from renewable sources.

(iv) Carbon emissions

Greenhouse gas emissions from energy used have reduced by 38 % tonnes this year.

(v) Water consumption

Our water consumption has increased by 17,775 % cubic meters in the recent financial year.

(g) Human rights, social and community issues/matters

Our services affect people and the diverse community we serve in many different ways. We particularly value and actively seek contributions from our stakeholders, made at the various engagement and involvement events which help us understand and improve the patient experience and specific services. Some examples during 2013/14 are:

- The annual "Up the Pace" event for children and young people who have a pacemaker. Fifty-nine people attended the day, which involved information workshops and discussion sessions aimed at developing the service;
- A workshop was held with service-users and other stakeholders, as part of an ongoing project to improve emergency care for patients who self-harm;
- Two lay members were recruited to the Trust's End of Life Steering Group.

In addition the Trust is working with Neighbourhood Forums, private and third sector partners across south Bristol to promote a broader health and well-being agenda in this part of the city and to facilitate a process whereby local people are actively engaged in conversations about the strategic direction of the Trust.

The Trust has been working with other local healthcare providers to directly recruit volunteers from across Bristol, North Somerset and South Gloucestershire to help to improve the health of local communities. The Trust supported the initiative to provide free training to volunteers who want to understand how the local NHS is tackling health inequalities.

The Trust has established and respected relations with local faith communities. Dignity and respect includes respect for our patient's spiritual and religious beliefs and values. Our chaplaincy department provides for patients, relatives and staff a 24 hour service for spiritual and pastoral support. The chaplaincy department serves those of faith and none. In order to meet the challenges of a city centre group of

hospitals within a multi faith and multi-cultural community, the chaplaincy has formed productive links with leaders of various faith communities within the city of Bristol. Our links with the Bristol Multi Faith Forum and other faith communities has enabled us to build a strong foundation that meets the spiritual needs of our patients no matter ~~of~~ their faith, position or cultural heritage. We have also worked with colleagues from various faith communities within the city to provide an integrated approach to the very sensitive area of baby and infant loss.

The Trust has a significant work experience and schools programme. Our future depends upon attracting young people to the wide range of careers on offer in the NHS and increasing awareness about how many different roles there are. After all, we are not just about doctors and nurses. Work experience placements are one way in which we can offer school students the chance to experience healthcare.

The Trust's work experience programme here at the University Hospitals Bristol successfully continues with over 240 students from local schools and colleges being placed across the Trust over the last year.

All students are interviewed in order to fully understand their personal aims for their placement and to ensure their time with us is curriculum based, structured, and offers a wide range of activities across the very many different healthcare settings we have.

Through this, close links have been maintained with local schools who fully appreciate the extensive programmes we offer. This is further supported through attendance at school career fairs and offering mock interviews, allowing students to practice in a safe environment their first taste of being interviewed!

The highly successful visits to schools from our own team of anaesthetists continue, delivering science lessons to classrooms of students, opening up the eyes of young people and enthusing them in this subject, by showing them that science based careers can be hugely interesting, challenging and rewarding. Equally it's encouraging pupils to aspire to a fulfilling career achieved by hard work and a commitment to succeed in examinations.

Furthermore, visits to the Simulation Centre take place, allowing students to have a better idea of how hospitals work and the role we play within them. These visits encourage students/pupils to re-enact real-life situations and shows how the Trust develops and encourages multidisciplinary teamwork, communication, and decision making skills along with leadership.

The whole schools programme relies heavily on the good will of staff from right across the Trust, who open their doors and give their time to host students and widen their access into the world of healthcare and the NHS.

(h) Breakdown of the Number of Male and Female Directors

Whilst we do not believe that diversity in the Boardroom is adequately represented solely by a consideration of gender, we are required to provide a breakdown of the numbers of female and male directors in this report.

Of the seven Executive Directors, four are male and three are female. Of the eleven Non-executive Directors, four are female and seven are male. 45% of very senior

managers (Agenda for Change band 9 and above) are female, compared with 77% of all staff at University Hospitals Bristol NHS Foundation Trust.

3.4 Statement of Going Concern

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

4. Directors' Report

This report is presented in accordance with the Monitor NHS Foundation Trust Annual Reporting Manual 2013/14 published in March 2013 which includes guidance and regulations for the Directors' Report, Quality Report and Annual Accounts. For the purpose of the Accounts, the directors are responsible for preparing the accounts on a true and fair basis and in particular to:

- observe the Accounts direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed and disclose and explain any material departures in the financial statements; and,
- prepare the financial statements on a going concern basis.

The directors have prepared this Annual Report on the basis that it is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.

4.1 Directors of the Trust

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

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

Non-executive Directors	Executive Directors
John Savage – Chairman	Robert Woolley – Chief Executive
Emma Woollett – Vice Chair	Paul Mapson – Director of Finance and Information
Iain Fairbairn – Senior Independent Director	Carolyn Mills – Chief Nurse
Kelvin Blake – Non-executive Director	Sue Donaldson – Director of Workforce and Organisational Development
Lisa Gardner – Non-executive Director	Deborah Lee – Director of Strategic Development and Deputy Chief Executive
Anthony (Guy) Orpen – Non-executive Director	Sean O'Kelly – Medical Director
John Moore – Non-executive Director	James Rimmer – Chief Operating Officer
Alison Ryan – Non-executive Director	
David Armstrong – Non-executive Director	

Biographies of the members of the Board, and of our two Non-executive Observers are provided at Appendix A – Biographies of Members of the Trust Board of Directors on page 91 of this report.

4.2 Independence of the Non-executive Directors

The Trust Board of Directors has formally assessed the independence[3] of the Non-executive Directors and considers all of its current Non-executive Directors to be independent in that notwithstanding their known relationships with other organisations[4], there are no circumstances that are likely to affect their judgement that cannot be addressed through the provisions of the Foundation Trust Code of Governance as evidenced through their declarations of interest and the on-going scrutiny and monitoring by the Trust Secretary.

4.3 Statement as to Disclosure to Auditors

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

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

4.4 An overview of quality

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

The Trust's commitment to providing the highest quality of patient care can be summed up in the following highlights from the 2013/14 Quality Report, which is included in full at Appendix C. The Quality Report includes a review of progress against quality objectives for 2013/14 and details of agreed quality objectives for 2014/15. The structure of the Quality Report addresses each of the three core dimensions of quality in turn, and incorporates guidance issued by the Department of Health and Monitor.

(a) Patient safety

In 2013/14, 94.1 % of patients received harm-free care as measured by the NHS Safety Thermometer, and 97.2% of patients did not acquire any new 'harms', i.e. pressure ulcers, falls, urinary tract infections or venous thrombo-embolisms (VTEs), following admission to hospital. 97.7 % of UH Bristol inpatients received a VTE risk assessment upon admission to hospital, which compares favourably with the national average of 95.6%.

[3] As defined in the Foundation Trust Code of Governance provisions

[4] Including the University of Bristol (Guy Orpen) and Above & Beyond (Lisa Gardner and Emma Woollett)

We continue to promote proactive reporting of patient safety incidents and are encouraged that in 2013/14 we achieved a further annual reduction in the proportion of medication errors which result in moderate or greater harm to patients.

We are also pleased to report only two MRSA bacteraemia in 2013/14 (compared to 10 in 2012/13) and another annual reduction in C diff cases (37 compared to 48 last year) although we were disappointed not to have achieved our challenging C diff national target (35 cases). Our focus on infection prevention and control training continues, with a strong emphasis on IV line care management.

(b) Patient experience

In 2013/14, we implemented the NHS Friends and Family Test in inpatient, emergency and maternity services. We are pleased to have achieved a 20%+ overall response rate for the inpatient and emergency department surveys and delighted that our patient-reported scores are significantly better than the national average.

We have continued to run our own monthly post-discharge patient survey alongside the Friends and Family Test. We are once again pleased to report that 97% of patients (aged 12 and over) rated the care they received in our hospitals as excellent, very good or good. We are also encouraged that we succeeded in sustaining last year's excellent patient-reported scores for treating people with kindness and understanding: something which goes to the heart of our organisational values.

One of our areas of focus in 2013/14 was to improve patient-reported experience in maternity services. We have run patient experience workshops for newly recruited midwives so that they understand the impact their role has on patient experience, and we were delighted to open our new midwifery-led unit at St Michael's Hospital. Improvements in patient experience were reflected in some excellent scores in the 2013 national maternity survey.

(c) Clinical effectiveness

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

Provisional adult cardiac surgery data for 2013/14 shows the Trust's mortality rate to be better than the national average.

Last year we said that we would re-double our efforts to ensure that at least 90% of stroke patients spend at least 90% of their time on a dedicated stroke ward. In 2013/14 we made important improvements (84.5% in 2013/14 compared to 79.3% in 2012/13), achieving the national standard of 80% but falling short of our own target of 90%. The Quality Report describes the ongoing steps we are taking to protect beds on our dedicated stroke unit to enable direct admissions.

Elsewhere, we have improved care and support for patients with diabetes, dementia and learning disabilities and have made significant strides towards achieving the best practice tariff for treating patients with hip fractures.

(d) Objectives for 2014/15

We applied a different approach this year in determining our annual quality objectives. In recent years, we have set ourselves a large number of goals, many of which we have achieved. In some cases, objectives have been continued from one year to the next as part of continuous improvement. This year we felt that these recurring objectives should be seen as "business as usual" and that we should instead focus on a much smaller number of objectives that have the potential to genuinely transform patient care. Following a public consultation event in January 2014, we have agreed five objectives:

- Reducing numbers of cancelled operations;
- Minimising patient moves between wards;
- Ensuring patients are treated on the right ward for their clinical condition;
- Improving the efficiency and experience of patient discharge;
- Renewing the Trust's approach to patient and public partnership.

4.5 Management Costs[5]

	Year ended 31 March 2014 £ '000	Year ended 31 March 2013 £ '000
Management costs	17,310	17,480
Income	544,716	528,209
Percentage of Income	3.2%	3.3%

(i) Retirements due to ill health

During the year ended 31 March 2014 there were 12 (2012/13: 5) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill-health retirements will be £0.904m (2012/13: £0.147m). The cost of these ill health retirements will be borne by the NHS Business Services Authority – Pensions Division.

(ii) Policies on counter-fraud and corruption

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

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

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

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

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

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

Work is carried out across the four key areas of counter fraud activity:

- Strategic governance;
- Inform and involve;
- Prevent and deter; and,
- Hold to account.

(iii) External audit

University Hospitals Bristol NHS Foundation Trust's External Auditors are PricewaterhouseCoopers (PwC). The audit fee in relation to the statutory audit of the Trust for the year ended 31 March 2014 was £50,050 (excluding VAT). The audit fee in relation to the quality accounts was £8,100 (excluding VAT).

4.6 Research and innovation

Research at University Hospitals Bristol NHS Foundation Trust is underpinned by our collaborative working both across Bristol and the wider West of England region. Local collaborations continue with the Universities of Bristol and the West of England and our NHS partners; this has been facilitated greatly by the joint Research Directorship of North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust since 2010. As an organisation committed to working in partnership through Bristol Health Partners we have seen a number of successes over the last year, which include the award of a National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and the hosting of the Local Clinical Research Network.

Our work to build stronger relationships with our regional partners over the last few years was recognised by the successful CLAHRC west bid. We were awarded £9 million by the Department of Health and the collaboration involves 19 organisations throughout the West of England. CLAHRC started on 1 January 2014, and funding is for five years. Much of the work of the CLAHRC will be to work with new and established Health Integration Teams (HIT), a concept conceived by Bristol Health Partners (BHP). BHP has approved a number of HIT led by University Hospitals Bristol NHS Foundation Trust, the aim of the HITs being to assess and redesign clinical service delivery across the region and generate research evidence for changes to those services. HITs based at the Trust include: Child Injury Prevention and Injury Care (CIPIC); Retinal Outreach, Integration and Research (RENOIR); Improving Care in Self-Harm (STITCH). Together with our two Biomedical Research Units in Cardiovascular Disease and Nutrition we now have a strong long-term research infrastructure to support a wide range of research across Bristol and the West of England. CLAHRC West aims to provide research and evidence to underpin the best care of patients

throughout the region, working with the West of England Academic Health Science Network (WEAHSN) to translate and support the implementation of research into practice.

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

The National Institute for Health Research (NIHR) regional networks underwent a major reorganisation last year, and the Trust was successful in its bid to host the new West of England Local Clinical Research Network (LCRN), which commenced on April 1st 2014. The new network, which draws together the topic and comprehensive networks, is led by Stephen Falk as Clinical Director, and Mary Perkins as Chief Operating Officer. We now enter a transition year of consolidation and a new focus on delivering best value with the funds we receive from the NIHR.

An increasing number of clinical staff at the Trust have been successful in leading grant applications to deliver research. The total value of our NIHR grant income continues to increase year on year, from £14,509 million (2011/12), £21,590 million (2012/13) and £25,006 million (2013/4), comprising our two BRUs and 22 NIHR project or programme grants. These include three new NIHR grants starting recruitment in 2013/14 (Professor John Sparrow's Cataract Surgery programme grant; Professor Sarah Hewlett's Health Technology Assessment (HTA) funded trial of how to reduce fatigue in rheumatoid arthritis, and Dr Richard Brindle's research for patient benefit grant comparing antibiotic treatments for cellulitis. New grants awarded in 2013/14 were Professor Jane Blazeby's HTA funded trial of surgical dressings; Professor Alastair Poole's i4i grant on development of a novel clinical platelet function analyser; Professor Jonathan Benger's programme development grant on out of hospital cardiac arrest – totalling an additional £1.03 million. In addition, Dr Robin Holmes (Medical Physics) and Mr Valentino Oriolo (Specialised Services) were awarded highly competitive NIHR Fellowships (post-doctoral and doctoral, respectively).

Recognising that our workforce underpins research delivery, our Research Matron has focussed on identifying and sharing best practice and developing materials to support the development of research nurses, allied health professionals and administrators. Within the national arena, she has worked with a small group of peers across England to develop and pilot a novel training course for Research Nurses which we expect will be adopted by the NIHR and used nationally.

We are committed to improving the quality of the research we do by involving patients, their carers and the public in research, and patient input into grant applications and ongoing research has increased during the last year. We have celebrated the impact of research on the clinical services the NHS provides and showcased some of the research we host by marking International Clinical Trials Day for the last two years and through symposia where our researchers present their findings to the local research community. Alongside these activities we have aimed to increase opportunities for patients to take part in research, supporting the NIHR's "it's ok to ask" campaign and launching a dedicated section of our website for patients and the public.

Our performance in opening trials and recruiting to them has improved during 2013/14. Our researchers recruited 7,796 patients into NIHR portfolio studies, representing a 10% increase in weighted recruitment on the previous year and the Trust remains the highest recruiting trust in the local research network. Our researchers have been working closely with the research management team to open our trials more quickly, making research available to our patients more widely. The performance metrics describing how quickly we can open new trials, and which we report to the Department of Health, place us in the top rankings of the large research active acute Trusts in England. Professor Wynick, as Director of Research, has continued to lead nationally on initiatives around the research performance benchmarks with other major teaching trusts and the Department of Health.

We have maintained a significant level of income through collaborative and contract commercial trials, generating approximately £1.6 million in 2013/14; this level of activity is expected to continue into 2014/15. We have increased the number of contract commercial trials opened, from 40 new studies in 2012/13 to 61 in 2013/14, and new specialties are becoming involved for the first time. Having earned a reputation as an effective industry partner, we are increasingly being asked to act as the lead site for contract commercial trials in the UK and are quick to set them up, recruiting the first worldwide patient to a number of trials. Nationally, we contribute to improving and standardising systems for setting up commercial research through the Commercial Research Manager's involvement in the NIHR CRN Industry Costing Group.

We have continued to improve facilities for research, with the new Cardiovascular Research Unit, based in the Bristol Heart Institute, nearing completion. This will host researchers and provide space for patient consent adjacent to our cardiac MR facilities. Within the BRI redevelopment, plans for the physical integration and co-location of the research units of the Divisions of Medicine and Surgery, Head and Neck, have progressed to the finalisation of detailed drawings; the new joint facility in the King Edward Building is expected to open in 2015.

4.7 Workforce Overview

As a university hospitals trust and regional tertiary referral centre, we are an ambitious health care provider. We are equally ambitious in recruiting and retaining the most talented, passionate and committed individuals to help in our continuous drive for health care excellence.

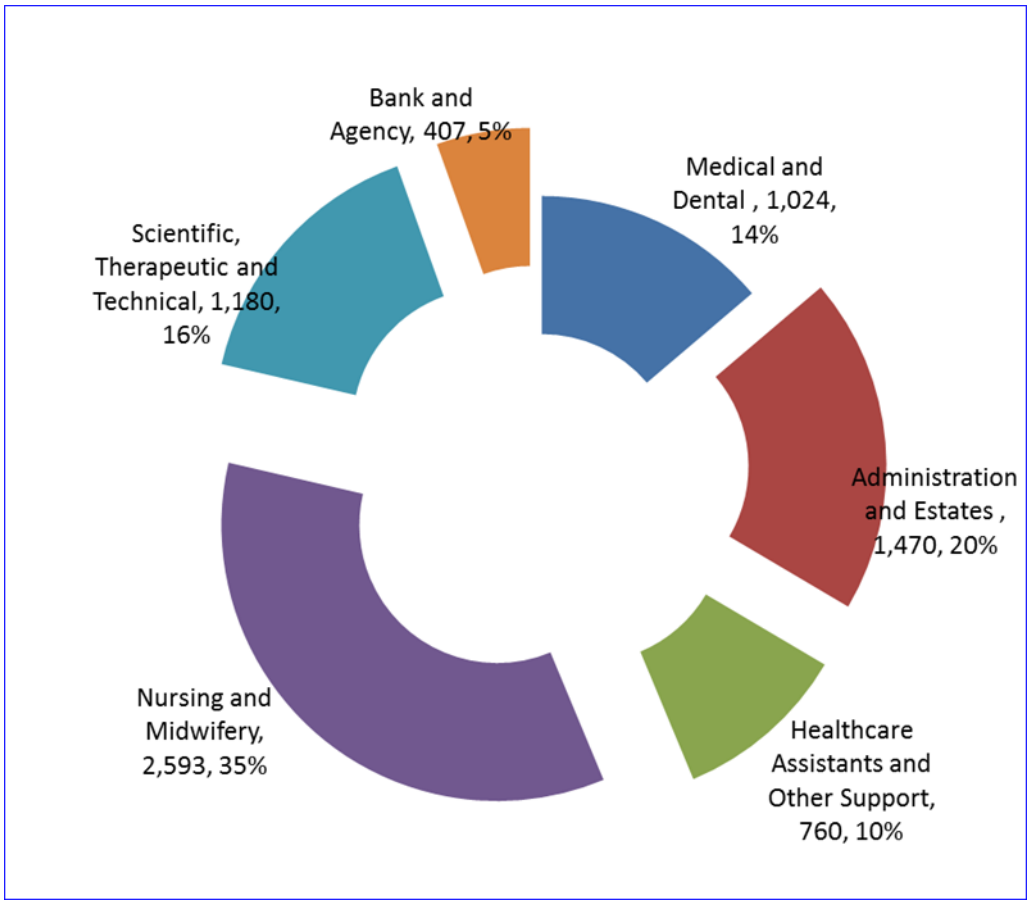
We recognise our workforce is our most valuable asset and through the delivery of our Workforce Strategy we aim to be an Employer of Choice – building a workforce culture of engagement, leadership and harmony - through our Trust values, a fair pay and reward system, and an innovative research and development environment.

(a) Workforce Profile

The Trust is one of the largest employers in the Avon area with 8,370 staff, which equates to a monthly average of 7,027 Full Time Equivalent (FTE) during 2013/14. In addition, a monthly average of 407 FTE bank and agency staff were used during the year.

The breakdown by staff by occupational group is summarised in the table and graphic below.

Staff group	Full-time Equivalent
Medical and Dental	1024
Administration and Estates	1470
Healthcare Assistants and Other Support	760
Nursing and Midwifery	2593
Scientific, Therapeutic and Technical	1180
Bank and Agency	407
Grand Total	7434



4.8 Teaching and Learning

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

The aim of the Teaching and Learning Strategy is to:

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

As one of the UK's leading teaching hospital trusts, closely linked to academic institutions locally, nationally and worldwide, we have an extremely successful history of developing clinical skills and careers. The Trust supports a range of under graduate programmes such as medical, dental, nursing and healthcare scientists, and positively encourages post graduate study and research for nursing, Allied Health Care Professionals, Health Care Scientists, medical and dental staff, with active continuous professional development programmes that include simulation training programmes, workshops, conferences, seminars and e-Learning to keep professionals up to date with the latest clinical developments and patient safety matters. Through the Qualifications Credit Framework, and apprentice schemes, the Trust offers a wide range of training and learning opportunities for non-clinical members of staff, along with extensive continuous professional development to encourage internal succession for staff across all disciplines alongside our commitment to delivering a quality Induction and Essential Training as the foundation for new starters joining the organisation.

Strong partnerships exist with Health Education Southwest Postgraduate Medical Education, Local Education and Training Board (LETB), University of Bristol and University of West of England, City of Bristol College, North Bristol NHS Trust and other NHS organisations. Further education partnerships are being strengthened, including collaborative working with the clinical commissioning groups and with the newly formed Bristol Health Partners. We value these partnerships highly and will continue to develop them as part of our governance structure and partnership working arrangements and to consolidate our efforts to build on our aim of lifelong learning.

4.9 Engaging with our staff

The Trust is transforming the care it delivers--building health care services which are driven by quality and excellence. This requires a set of common Trust values and behaviours which are transparent across the Trust.

The Trust values act as an invaluable guide about what is important and how we are expected to behave towards patients, relatives, carers, visitors and each other. The values are embedded at recruitment and induction stages and within the subsequent leadership and management development programs that staff would access. Commencing in May 2012, Living the Values training for all staff has been rolled out, with 5,036 staff having been trained.

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

The design of the leadership and management development programmes builds on the foundation of the values training to ensure our transformational leadership agenda supports leaders to use the platform of the values to influence real cultural change within their areas for the benefit of their teams and the patients.

The Trust recognises that staff engagement and involvement is fundamental to successfully working to a common set of values and behaviours.

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

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

4.10 NHS staff survey

The National Staff Survey was undertaken by Quality Health for the Trust between September 2013 and December 2013.

Questionnaires were sent to a random sample of 850 staff across the Trust. 439 staff took part in this survey, and the report arising from the survey highlights this year's key findings and notes the position of the Trust in terms of its local performance and the Trust's relative position to other acute Trusts nationally.

The Trust has achieved and sustained an overall staff engagement score that is better than average compared with Trusts of a similar type. Staff recommendation of the Trust as a place to work, or receive treatment, also remains better than average by comparison with all acute Trusts.

However, overall trends relating to the staff survey, show that staff perception of their experiences of working for the Trust has deteriorated in a number of areas in the past 12 months.

(a) Key areas of improvement

The Trust recognises that it needs to continuously engage and listen to its workforce and seek to respond to suggested areas for improvement. From the feedback it has received, the Trust is responding by implementing an improvement plan.

The proposed key priority areas for improvement are:

- % suffering work-related stress in last 12 months;
- % feeling satisfied with the quality of work and patient care they are able to deliver;
- % witnessing potentially harmful errors, near misses or incidents in last month;
- % saying hand washing materials are always available;
- % experiencing harassment, bullying or abuse from staff in last 12 months.

The Trust has already planned focused time to discuss new ways of tackling these issues. These actions will be included in the Trust's Staff Engagement action plans.

The Staff Family and Friends test will be implemented in 2014. This test, which has been developed by NHS England, offers all staff the opportunity to feed back their views of the Trust by answering the following two questions: (i) How likely are you to recommend the Trust to friends and family if they needed care or treatment?, and (ii) How likely are you to recommend the Trust to friends and family as a place to work?

4.11 Communication with staff

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

(a) Key trust meetings

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.

(b) Staff magazine

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

(c) Acknowledging excellence and recognising success

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

- Recognising Success Awards – An annual awards ceremony and celebration dinner which recognises exceptional performance and achievements of staff in support of the Trust's vision, values and goals. This was run in 2012 and 2013 and a further event is being planned for November 2014;

- Divisional schemes – Some divisions have implemented their own Awards for Excellence. These encourage nominations and give awards to teams or individual members of staff in recognition and appreciation of teamwork and commitment which improve services for patients and staff;
- Facilities and Estates have a Recognition Award for Excellence scheme – encouraging nominations for people in the division who have achieved something special in terms of their service delivery towards patients, Trust staff and/or visitors or have overcome adversity or pressures/demands within the division, which is believed to deserve being recognised as being out of the ordinary;
- Celebration of Service Awards – each year the Trust celebrates the service of staff that have reached 30 years' service with the Trust – in recent years this ceremony has been part of the Annual Members Meeting. In 2013 this became part of the Recognising Success Award event;
- International Nurses' Day – held annually in May. Each year the Trust celebrates this by holding an event for our nurses;
- Vocational Education Award Ceremony – This is run twice yearly and celebrates the achievements of staff that have completed a qualification credit framework in both non-clinical and clinical departments within the Trust. Staff are presented with their certificates of achievement and the event is usually hosted by Emma Woollett, Non-executive Director and Vice Chair.

(d) Tackling harassment and bullying

The Trust Board undertakes to ensure that:

- Harassment or bullying of any definition by any member of staff towards either patients or members of staff will not be tolerated;
- All members of staff have the right to work within an environment which is free from harassment or bullying;
- All allegations of either harassment or bullying will be investigated within the timescales set down in the Tackling Bullying and Harassment Policy and Procedure, and steps taken to eradicate all incidents;
- Anyone using this policy and procedure, without malice, may do so in the full knowledge that the Trust will not tolerate reprisal action by other staff or managers.

During 2013/4 a task and finish group worked on a number of areas around tackling harassment and bullying in the Trust. In addition to strengthening the existing policy and procedure, the group focused on:

- Creating a diagnostic toolkit to address concerns in areas where bullying/ harassment/ inappropriate behaviour is known or strongly suspected but no formal complaint has been made. This toolkit is now included in policy directions and is in use in divisions;
- Communications for all staff involving raising concerns about harassment and bullying and sources of support – this has included information in 'Newsbeat', and via posters; a refreshed web page with details of how to access support, an electronic bullying/harassment diary and details of how to access support;

- Specifically targeted information for junior doctors on how to raise concerns and sources of support available.

The Trust has a confidential Harassment and Bullying Advisors' Service which is available to any member of staff who believes they have been subjected to harassment or bullying in the workplace. The advisers can also provide support and advice to anybody who has been or who has witnessed another person being subjected to harassment or bullying or who has been accused of harassment and/or bullying.

The advisors have been trained to support staff. They will listen to issues, talk through problems, explain the options available and the Trust's policy and procedure on tackling harassment and bullying and direct employees to other areas of support that may be helpful.

Medical trainees have access to a mentor who can give advice and offer support on any issues (including harassment and bullying) which may adversely affect medical trainees' ability to undertake their work.

4.12 Statement of approach to equality and diversity

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

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

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

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

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

The Equality Act requires the Trust to publish its equality objectives. The following objectives for the Trust have been published on the Trust's website.

- We become an acknowledged regional leader in equality and diversity outcomes both for our patients and staff. (This includes specific commitments to staff training, to patient satisfaction levels and to mitigating differential experiences reported in healthcare);
- We become a national exemplar for the NHS Equality Delivery System.

(b) The NHS Equality Delivery System

A revised version of the NHS Equality Delivery System (EDS2) was introduced in November 2013. Evidence of the Trust's performance across the outcomes of the NHS Equality Delivery System (EDS2) is being collected from a range of sources. Evidence collated to support the Trust's declarations of compliance with the Care Quality Commission's outcomes is useful in demonstrating compliance with elements of the Equality Delivery System 2, as is the Trust's Quality Report. Commitments made by the Trust to the principles of the NHS Constitution are also relevant and have been cited where appropriate.

The Trust continues its equality and diversity engagement by working with other local NHS trusts and the Commissioning Support Unit to ensure a co-ordinated and effective use of time and support from a range of individuals and stakeholders. This includes Healthwatch, the overview and scrutiny committees of local authorities covering the Trust's membership areas, and voluntary sector organisations representing people from protected groups. The Trust has also supported the recruitment of members of the public to assist with the implementation of EDS2 across the healthcare community.

Patient and public involvement activities during 2013/2014 reflect the Trust's commitment to improving patient access and experience. Engagement events have included patient forums, monthly discussion groups, the Community Festival at South Bristol Community Hospital (SBCH), patient experience cards, and events for people with dementia and their carers.

(c) Training and the Equality Act

Information about the Equality Act and wider principles of equality and diversity is included in the Trust Living the Values training, delivered as part of Trust induction and as bespoke sessions.

(d) Equality and diversity in the workplace

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

The Trust is part of 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.

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

The Trust has a well-established Black & Minority Ethnic staff forum, and the Trust is represented at the local NHS Lesbian, Gay, Bisexual and Transgender Group.

(e) Analysis of staff diversity profile

The Trust's Equality and Diversity Report profiling our staff has been updated to reflect information as at January 2014. Some of the key findings from the Trust's Workforce

Monitoring information as at January 2014 is given below. Further information is included in the Public Sector Equality Duties report.

The Trust completes its annual statutory monitoring of equality and diversity in January each year. The outcome of which is published on the Trust's website. For consistency of reporting, this analysis has been summarised in the tables below:

	January 2014	
Gender	**Total**	**%**
Male	1,893	22.83%
Female	6,397	77.17%
TOTAL	8,290	100.00%

	January 2014	
Ethnicity	**Total**	**%**
A - White - British	6,427	77.53%
B - White - Irish	111	1.34%
C - White - Any other White background	470	5.67%
D - Mixed - White & Black Caribbean	34	0.41%
E - Mixed - White & Black African	12	0.14%
F - Mixed - White & Asian	25	0.30%
G - Mixed - Any other mixed background	54	0.65%
H - Asian or Asian British - Indian	355	4.28%
J - Asian or Asian British - Pakistani	35	0.42%
K - Asian or Asian British - Bangladeshi	6	0.07%
L - Asian or Asian British - Any other Asian background	87	1.05%
M - Black or Black British - Caribbean	141	1.70%
N - Black or Black British - African	232	2.80%
P - Black or Black British - Any other Black background	61	0.74%
R – Chinese	42	0.51%
S - Any Other Ethnic Group	181	2.18%
Z - Not Stated	17	0.21%
TOTAL	8,290	100.00%

	January 2014	
Disability	**Total**	**%**
No	7741	93.38%
Not Declared	282	3.40%
Undefined	2	0.02%
Yes	265	3.20%
Total	8290	100.00%

	January 2014	
Age Profile	**Total**	**%**
16 – 20	69	0.83%
21 – 25	756	9.12%
26 – 30	1142	13.78%
31 – 35	1224	14.76%
36 – 40	1073	12.94%
46 – 50	999	12.05%
51 – 55	1017	12.27%
56 – 60	957	11.54%
61 – 65	701	8.46%
Age over 65	275	3.32%
Total	66	0.80%

	January 2014	
Religious Belief	**Total**	**%**
Atheism	907	10.94%
Buddhism	44	0.53%
Christianity	3498	42.20%
Hinduism	96	1.16%
Islam	144	1.74%
Jainism	2	0.02%
Judaism	10	0.12%
Sikhism	490	5.91%
Other	19	0.23%
I do not wish to disclose my religion/belief	3080	37.15%
Total	8,290	100.00%

	January 2014	
Sexual Orientation	**Total**	**%**
Bisexual	30	0.36%
Gay	46	0.55%
Heterosexual	5246	63.28%
I do not wish to disclose my sexual orientation	2933	35.38%
Lesbian	35	0.42%
TOTAL	8,290	100.00%

4.13 Occupational health service

The Trust hosts Avon Partnership NHS Occupational Health Service (APOHS) which provides an integrated occupational health service with the objective of making a positive impact on sickness absence through both healthy working environments and healthy management styles. The service works proactively, through consensus and evidence based practice, to enable staff to achieve and maintain their full employment potential within a safe working environment, thus enhancing the quality of their working lives. These services include: new employee surveillance, immunisations, Health @ Work Advice and referrals, ill health referrals and health and wellbeing support. The APOHS website has been developed (www.apohs.nhs.uk) to support Trust staff, managers and the wider community with advice and support about health and work.

4.14 A safe working environment

The overall strategy for health and safety in the Trust complies with the Health and Safety (Guidance) Document number 65: Successful Health and Safety Management, which is implemented in full as the healthcare model for safety management systems. Health and safety risk assessments, safe systems of work, practices and processes ensure that all key risks to compliance with the legislation have been identified and addressed. Health and safety is integral to the Trust's Risk Management Strategy, from which the five year Health and Safety Action Plan 2013 - 2018 has been developed. Progress against this is subject to annual review and monitored at Trust Health and Safety/Fire Safety Committee. In addition there is the annually reviewed risk management training matrix which identifies needs beyond the essential health and safety training requirements for all staff. It is based on the employee's role for example health and safety for executives/ senior managers or mandatory departmental needs for example Manual Handling Risk Assessors. The annually reviewed Risk Management Training Prospectus and Training Delivery plan include all risk management training programmes. This is monitored by the Human Resources Management Board for compliance each quarter.

(a) Sickness absence

The table below shows sickness for the calendar year ending December 2013. The Trust-wide sickness absence rate was 4.1% and there was an average of 9.2 days lost to absence per full time equivalent member of staff (FTE).

Statistics Produced by the Health and Social care Information Centre Data Warehouse		Figures Converted by DH to Best Estimates of Required Data Items		
Quarterly Sickness Absence Publications	Monthly Workforce Publication			
Average of 12 Months (2013 Calendar Year)	Average FTE 2013	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
4.1%	6,904	1,553,376	63,709	9.2

4.15 Remuneration Report

Details of the remuneration, salaries, allowances and pensions for senior managers of the Trust are set out in full starting at note 6.8 on page 28 of the Annual Accounts attached at "Appendix D – Annual Accounts 2013/14". Accounting policies for pensions and other retirement benefits (which apply to all employees) are also contained in the Annual Accounts at note 1.3 to the accounts.

(a) Remuneration of Executive Directors[6]

The remuneration and allowances, and the other terms and conditions of office of the Executive Directors are determined by the Remuneration Committee which is established by the Board in accordance with Schedule 7 of the NHS Act 2006 (paragraph 18(2)), Schedule 1 of the University Hospitals Bristol NHS Foundation Trust Constitution (paragraph 30.2), and the Monitor NHS Foundation Trust Code of Governance Provision E.2.13. The Committee also reviews the suitability of structures of remuneration for senior management which includes the first layer of management below Board level (in accordance with the Foundation Trust Code of Governance E.2.2.).

The Remuneration Committee consists of not less than three independent Non-executive Directors and the Chairman of the Trust Board of Directors. The Committee is chaired by the Vice Chair of the Trust. Details of membership and attendance are included on page 71.

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

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

[6] Information not subject to audit

foundation trust successfully, but the Trust also avoids paying more than is necessary for this purpose.

The Committee takes into account the ratio relationship between the remuneration of the highest-paid director in the organisation and the median remuneration of the organisation's workforce. This ratio is disclosed in the 'Hutton Review of Fair Pay' set out at note 6.7 on page 27 of the Annual Accounts attached at Appendix D – Annual Accounts 2012/13.

(b) Remuneration of Non-executive Directors[7]

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

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

- four elected public, patient or carer governors;
- two appointed governors, and;
- one elected staff governor.

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

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

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

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

[7] Information not subject to audit

(c) Assessment of performance[8]

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

Executive Directors are assessed by the Chief Executive. The Chairman undertakes the performance review of the Chief Executive and Non-executive Directors. The Chairman is appraised by the Governors' Nominations and Appointments Committee chaired for this purpose by the Senior Independent Director and advised by the Trust Secretary. No element of the Executive and Non-executive Directors' remuneration was performance-related in this accounting period.

(d) Expenses

Members of the Council of Governors and the Trust Board of Directors are entitled to expenses at rates determined by the Trust. Directors' expenses are published on the Trust's website.

Further details relating to the expenses for members of the Council of Governors and the Trust Board of Directors may be obtained on request to the Trust Secretary.

(e) Duration of contracts[9]

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

(f) Early termination liability[10]

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

(g) Review of tax arrangements of public sector appointees[11,12]

(i) Off payroll engagements

This section lists any off-payroll engagements entered into at a cost of more than £220 per day that last for longer than six months, and any off-payroll engagements of board members and/or senior officials with significant financial responsibility, during 2013/14.

[8] Information not subject to audit
[9] Information not subject to audit
[10] Information not subject to audit
[11] In accordance with new reporting requirements published by HM Treasury in PES(2012)17 'Annual Reporting Guidance 2012-13' December 2012
[12] Information not subject to audit

(A) Table 1: All off-payroll engagements as of 31 March 2014, for more than £220 per day and that last for longer than six months

Number of existing arrangements as of 31 March 2014	**2**
Of which…	
No. that have existed for less than one year at time of reporting.	2
No. that have existed for between one and two years at time of reporting.	-
No. that have existed for between two and three years at time of reporting.	-
No. that have existed for between three and four years at time of reporting.	-
No. that have existed for four or more years at time of reporting.	-

The existing off-payroll engagements, outlined above, have all been subject to the Trust's standard process including a HRMC self-employment check, letter of engagement and contract seeking assurance as to the individuals income tax and national insurance obligations.

(B) Table 2: All new off-payroll engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that have reached six months in duration, between 1 April 2013 and 31 March 2014	**4**
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations.	3
No of whom assurance has been requested	3
Of which…	
No. of whom assurance has been received	3
No. of whom assurance has not been received	-

There was one case, that reached six months in duration in early 2013/14, that had been subject to a HMRC self-employment check but a letter of engagement or contract seeking assurance as to the individuals income tax and national insurance obligations had not been sent. The Trust's standard process for off-payroll engagements came into force on 1 April 2013 and as this engagement had commenced prior to this date it continued until its planned completion on 9 August 2013.

(C) Table 3: Any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2013 and 31 March 2014

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-

No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility" during the financial year. The figure includes both off-payroll and on-payroll engagements.	21

(h) Sundry[13]

Please also refer to the notes in the 2013/14 Annual Report at note 6.8-6.11 from page 28 of the Annual Accounts attached at Appendix D to this report in respect of the following:

- Salaries and all pension related benefits;
- Taxable benefits, bonuses and exit packages;
- Pension benefits for the year ended 31 March 2014;
- Pension benefits for the year ended 31 March 2013, and;
- Value of the cash equivalent transfer value at the beginning and end of the financial years.

[13] Information subject to audit

5. NHS Foundation Trust Code of Governance

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

The NHS Foundation Trust Code of Governance (the Code), maintained by Monitor was reissued in December 2013 and further revised in March 2014. The Code sets out an overarching framework for the governance of Foundation Trusts which aims to bring together best practice from a number of recognised references, including the UK Corporate Governance Code (formerly the Combined Code) that sets out standards of good practice in relation to board leadership and effectiveness, remuneration, accountability and relations with shareholders for the private sector.

The Board is committed to the highest standards of good corporate governance and follows an approach that complies with the main and supporting principles of the Code.

This section, the Directors' Report on page 39 (in particular: composition of the Board and the independence of the Non-executive directors; the Remuneration Report; and, the directors' biographies on page 91, combined with the Annual Governance Statement contained in the Annual Accounts), together describe how the Trust applied the principles of the Code during the year.

5.1 Compliance with the Code

The revised Code applies from 1 January 2014 and is based on the principle of 'comply or explain', whilst none of the provisions are mandatory, Monitor recognises that departure from the provisions of the Code may be appropriate where an alternative approach better suits the particular circumstances of the Trust.

Where the Code includes new requirements that have not been complied with for the whole year, it is appropriate to explain that these are new requirements that could not be applied retrospectively.

The Board has considered the extent to which the Trust satisfied the provisions of the Code and for the year ending 31 March 2014 the Board considers that it was fully compliant with the provisions of the Code.

5.2 Trust Board of Directors

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

Following revisions made in December 2013 to increase to complement of Non-executive Directors to eight, the University Hospitals Bristol NHS Foundation Trust Foundation Trust Constitution specifies that the Board of Directors shall comprise:

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

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

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

Appointments to the Board both of Executive and Non-executive Directors in the reporting period meant that the Board was fully constituted by the fourth quarter, whilst utilising the services of two 'acting' Executive directors in the preceding quarters. The Board does not consider that its performance or balance as a whole was significantly impacted during the period of 'acting' arrangements, and considers the quality of the new appointments to have been worth the significant effort put into succession planning and recruitment.

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

There are specific responsibilities delegated to the entire Board, whilst others are delegated to the Chief Executive and other Executive Directors. The 'Schedule of Matters Reserved' includes approval of:

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

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

- enact the strategic direction of the Trust Board of Directors;
- manage risk;
- achieve organisational compliance with the legal and regulatory framework;
- achieve organisational objectives;
- achieve specified standards of quality and performance; and
- operate within, generate and capture evidence of the system of internal control.

(a) Board of Directors – disqualification

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

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

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

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

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

(b) Members of the Trust Board of Directors

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

All of the Non-executive Directors serving on the Trust Board of Directors were considered to be 'independent' as defined in the Foundation Trust Code of Governance when assessed at a meeting of the Board on 14 March 2014. The Board is also committed to reviewing its balance and composition in order to maintain its effectiveness.

Non-executive Directors	Appointment	End of 1st Term of Office	End of 2nd Term of Office	End of 3rd Term of Office
John Savage, CBE – Chairman	01 June 2008[14]	31 May 2011	31 May 2014	31 May 2017
Emma Woollett – Vice Chair	01 June 2008[14]	31 May 2011	31 May 2014	31 May 2016
Iain Fairbairn – Senior Independent Director	01 June 2008[14]	31 May 2011	31 May 2014	
Lisa Gardner – Non-executive Director	01 June 2008	31 May 2011	31 May 2014	31 May 2015

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

Non-executive Directors	Appointment	End of 1st Term of Office	End of 2nd Term of Office	End of 3rd Term of Office
Anthony (Guy) Orpen – Non-executive Director	02 May 2012	01 May 2015		
Paul May – Non-executive Director[15]	01 November 2008[15]	31 October 2011		
Kelvin Blake – Non-executive Director	01 November 2008	31 October 2011	31 October 2014	
John Moore – Non-executive Director	01 January 2011	31 December 2013	31 December 2016	
Alison Ryan - Non-executive Director	28 November 2013	27 November 2016		
David Armstrong – Non-executive Director	28 November 2013	27 November 2016		
*Jill Youds – Non-executive Observer[16]	28 November 2013	27 November 2016		
*Julian Dennis – Non-executive Observer[16]	28 November 2013	27 November 2016		

* These Non-executive Directors were either re-appointed or appointed during 2013/14. The process involved assessment by a Nominations and Appointments Committee. The following considerations were taken into account and matched against a job description and person specification in respect of each re-appointment/appointment:-

- Skills and qualities identified as required
- Composition of the Board mapped against directors
- Statutory and Code of Governance requirements
- Governors' duties in considering re-appointment
- Views of the Chairman and the Council of Governors
- Independence
- Qualifications and experience requirements
- Annual performance appraisals feedback
- Board development feedback
- Refreshment of the Board
- Changes in significant commitments which could be relevant
- Time commitment for the role
- Term of appointment

All Non-executive appointments and re-appointments during the year were approved by the Council of Governors.

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

[15] Paul May retired from the Board at the end of July 2013.

Executive Directors	Appointment	End of Term of Office	Notice Period
Robert Woolley, Chief Executive	08 September 2010[18]	Not applicable	6 months
Paul Mapson, Director of Finance and Information	01 June 2008[16]	Not applicable	6 months
Deborah Lee, Director of Strategic Development	4 February 2011	Not applicable	6 months
Sean O'Kelly, Medical Director	18 April 2011	Not applicable	6 months
James Rimmer, Chief Operating Officer	04 July 2011	Not applicable	6 months
Claire Buchanan, Acting Director of Workforce & Organisational Development	01 May 2012	06 October 2013	6 months
Helen Morgan, Acting Chief Nurse	18 March 2013	05 January 2014	6 months
Sue Donaldson, Director of Workforce and Organisational Development	04 November 2013	Not applicable	6 months
Carolyn Mills, Chief Nurse	06 January 2014	Not applicable	6 months

As recommended by the Local Counter Fraud Service (LCFS) the names of all Trust Directors (Executive and Non-executive are cross-referenced with the Disqualified Directors Register on the Companies House website on an annual basis. It can be confirmed that as at the date of this report, none of the above mentioned Directors appeared on the Disqualified Directors' Register.

Biographies of the Chairman, Chief Executive and Directors are set out on page 91 of this report.

(c) Directors' interests

Members of the Board of Directors are required to disclose details of company directorships or other material interests in companies held which may conflict with their role and management responsibilities at the Trust. The register also contains any significant commitments of the Chairman and any changes to these during the year. The Trust Secretary maintains a register of interests, which is available to members of the public by contacting the Trust Secretariat, contact details are shown on page 98.

(d) Meetings of the Board

The Board met on 12 occasions both in public and in private to discharge the duties described above, and to consider a comprehensive annual cycle of reports and business to be transacted. The Chairman of the Board submitted a report to the Council of Governors at each meeting, highlighting any issues requiring disclosure to the Council of Governors. Attendance at meetings of the Board is set out in the table at Membership and attendance at Board and Committee meetings on page 71 of this report.

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

5.3 Committees of the Trust Board of Directors

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

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

The role, functions and summary activities of the Board's committees are described below. Membership and attendance at Board and Committee meetings is set out on page 71 of this report.

(a) Directors Nominations and Appointments Committee

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

The committee met on two occasions to conduct succession planning and appointed Sue Donaldson and Carolyn Mills to the Board of Directors in this reporting period. The Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure.

(b) Remuneration Committee

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

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

(c) Audit Committee

The primary purpose of the Audit Committee is to provide oversight and scrutiny of the Trust's governance, risk management, internal financial control and all other control processes, including those related to quality and performance. These controls underpin the Trust's Assurance Framework so as to ensure its overall adequacy, robustness and effectiveness. This addresses risks and controls that affect all aspects of the Trust's day to day activity and reporting.

Additional oversight and scrutiny, in particular relating to quality and patient care performance is also provided through the Quality and Outcomes Committee. There

is a direct linkage between the Quality and Outcomes Committee and the Audit Committee through committee membership and exception reporting. Similarly, the Finance Committee also provides financial planning scrutiny and oversight, and again there is a direct linkage between the Finance Committee and Audit Committee through committee membership and exception reporting. The day to day performance management of the Trust's activity, risks and controls is however the responsibility of the Executive.

The Audit Committee consists of four Non-executive Directors and reviews reports from the Internal and External Auditors, plus the Counter Fraud and the Clinical Audit teams. The Committee reviews the effectiveness of systems of governance, risk management and internal control across the whole of the Trust's activities. Three non-Executive Directors serve on both committees, providing the Non-executive Directors with two different perspectives, allowing for comparison or 'triangulation' of related intelligence when considering processes and outcomes. Terms of Reference for both committees are published in the public domain.

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

In particular during 2013/14, the Audit Committee reviewed the adequacy of:

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

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

Additionally during the year, the Audit Committee reviewed the Clinical Audit function and its increased focus on improved patient outcomes and research. The committee also paid particular attention to the executive review of internal controls and consultant job-planning.

(i) Independence and objectivity of the external auditor

In circumstances where the Trust's external auditor provides services which are not related to audit, i.e. 'non-audit services', the Foundation Trust Code of Governance

recommends that the Trust provides "an explanation of how auditor objectivity and independence is safeguarded".

The Audit Committee is aware that the auditor, PwC, provides non-audit services to the Trust, in this year, to the value of £529k. The auditor has declared that they have made enquiries of all PwC teams providing services to the Trust and of those responsible in the UK Firm for compliance matters.

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

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

(ii) Audit Committee Chair's opinion and report

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

- There is a generally adequate framework of control in place to provide reasonable assurance of the achievement of objectives and management of risk;
- Assurances received are sufficiently accurate, reliable and comprehensive to meet the Accountable Officer's needs and to provide reasonable assurance;
- Governance, risk management and internal control arrangements within the Trust include aspects of excellence and there is on-going attention to control improvement where these are considered suitable;
- Financial controls are adequate to provide reasonable assurance against material misstatement or loss, and;

  The quality of both Internal Audit and External Audit over the past year has been satisfactory.

The Committee discharged its role through the year as follows:

- We reviewed the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical);
- We accepted valid evidence that there was an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee. The committee reviewed and approved the internal audit strategy, ensuring that it was consistent with the audit needs of the organisation as

identified in the Assurance Framework. We considered the major findings of internal audit's work (and management's response). The Internal Auditor had unrestricted access to the chair of the committee for confidential discussion;

– We reviewed the work and findings of the external auditor and considered the implications and management's response to their work. The External Auditor had unrestricted access to the chair of the committee for confidential discussion;

– We reviewed the Annual Report and financial statements before submission to the Board;

– We reviewed the findings of other significant assurance functions, both internal and external to the organisation, and considered the implications to the governance of the Trust. This included a regular report from the NHS Counter- Fraud Service;

– Additionally, we specifically reviewed the Trust's whistle-blowing policy, and we sought assurances regarding the control of data used in the Quality Report.

We also examined in detail the following areas of internal control:

– Internal procurement controls;

– Information governance;

– Clinical audit;

– Procurement effectiveness;

– Exception reports (to trust standing orders and standing financial instructions); and,

– E-rostering and Consultant Job Planning.

(iii) Significant judgements

The Trust makes a number of accounting judgements when producing its statutory accounts. Those that are considered significant in terms of the level of estimation are set out below. They form part of the Trust's accounting policies, which have been approved by the Audit Committee.

- Valuation of assets

The District Valuer re-values the Trust's land and buildings every five years on a depreciated replacement cost, Modern Equivalent Asset (MEA) valuation basis using professional standards issued by the Royal Institute of Chartered Surveyors and their own professional judgement. A revaluation took place at 31st March 2014. In line with HM Treasury's Financial Reporting Manual, in intervening years the Trust uses indices provided by the District Valuer and requests interim reviews by them as appropriate.

Plant and equipment is valued using depreciated historical cost as a proxy for fair value.

When new or enhanced land and buildings are brought into use, the District Valuer is asked to provide a professional valuation.

The Audit Committee noted this judgment applied in the 2013/14 annual accounts and considered the methodology used to be appropriate.

- Impairment of assets

When new or enhanced land and buildings are brought into use the District Valuer's formal valuation is compared with the total capitalised scheme cost and the difference is charged as an impairment to the Statement of Comprehensive Income

Plant and equipment impairments are identified following an assessment of whether there is any indication that an asset maybe impaired e.g. obsolescence or physical damage.

The Audit Committee noted this judgment applied in the 2013/14 annual accounts and considered the methodology used to be appropriate.

- Depreciation

Depreciation is calculated from an estimate of the assets' lives. The District Valuer advises on the life of a new or enhanced property when it is brought into use and reassesses all property lives as part of the five year review. Asset lives of new plant and equipment are advised by the Trust manager responsible for them. These are reviewed annually and adjusted as required.

The Audit Committee noted this judgment applied in the 2013/14 annual accounts and considered the methodology used to be appropriate.

(d) Quality and Outcomes Committee

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

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

During the course of the year, the committee met on 11 occasions and considered a set of standard reports as follows:

– The compliance framework monitoring and declaration report;

– The quality and performance report;

– The corporate risk register;

– The histopathology action plan progress report, and;

– The clinical quality group meeting report (including clinical audit).

Additional targeted reviews have included:

– Complaints;

– National and local inpatient and outpatient surveys;

– Results of the annual programme of clinical audit;

– Quality objectives as set out in the annual plan and quality strategy;

– Draft quality report;

– Serious and catastrophic incidents (including key actions arising from root cause analyses); and

– Strategy for care of the elderly.

The Chair of the Committee presents a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board. The Quality and Outcomes Committee is currently in the process of reviewing its Terms of Reference in the light of the Board's new Chairing arrangements and the publication of the Francis Report.

(e) Finance Committee

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

– Control and management of the finances of the Trust;

– Target level of cash releasing efficiency savings and actions to ensure these are achieved;

– Budget setting principles;

– Year-end forecasting;

– Commissioning; and

– Capital planning.

The Finance Committee met on 12 occasions in the course of this reporting period. The Chair of the committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the Board.

(f) Membership and attendance at Board and Committee meetings

The Trust Board of Directors discharged its duties during 2013/14 in 12 private and public meetings, and through the work of its committees. The table below shows the

membership and attendance of Directors at meetings of the Trust Board of Directors and Board committees.

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

	Trust Board of Directors	Directors Nominations & Appointments Committee	Remuneration Committee	Audit Committee	Quality & Outcomes Committee	Finance Committee
Number of meetings	**12**	**2**	**2**	**6**	**11**	**12**
Chairman						
John Savage	C9(12)	2(2)	1(0)	0(0)	8(C7)	6(0)
Chief Executive						
Robert Woolley	12(12)	2(0)	2(0)	4(0)	0(0)	11(12)
Non-executive Directors						
Emma Woollett	9(12) (C3)	C2(2)	2(2) (C2)	0(0)	3(0)	9(12)
Iain Fairbairn	9(12)	2(2)	1(2)	5(5)	1(0)	1(0)
Lisa Gardner	11(12)	2(2)	2(2)	6(6)	0(0)	C12(12)
Paul May	4(4)	2(2)	2(2)	3(3)	C3(3)	1(6)
Kelvin Blake	8(12)	1(2)	2(2)	0(0)	1(0)	7(12)
John Moore	7(12)	1(2)	2(2)	C5(6)	9+C1(11)	0(0)
Anthony (Guy) Orpen	11(12)	2(2)	1(2)	0(0)	0(0)	1(0)
Alison Ryan	3(4)	0(0)	0(0)	0(0)	3(3)	0(0)
David Armstrong	4(4)	0(0)	0(0)	0(0)	0(0)	2(2)
Jill Youds	4(4)	0(0)	0(0)	0(0)	0(0)	2(0)
Julian Dennis	4(4)	0(0)	0(0)	0(0)	0(0)	0(0)
Executive Directors						
Paul Mapson	12(12)	0(0)	0(0)	4(0)	0(0)	12(12)
Deborah Lee	8(12)	0(0)	0(0)	0(0)	0(0)	1(0)
Sean O'Kelly	11(12)	0(0)	0(0)	0(0)	09(11)	0(0)
James Rimmer	11(12)	0(0)	0(0)	0(0)	7(11)	8(12)
Carolyn Mills	3(3)	0(0)	0(0)	0(0)	1(3)	0(0)
Sue Donaldson	5(5)	0(0)	0(0)	0(0)	5(5)	0(0)
Acting Directors						

Helen Morgan	9(12)	0(0)	0(0)	0(0)	10(0)	1(0)
Claire Buchanan	5(7)	0(0)	0(0)	1(0)	0(0)	0(0)

(g) Performance of the Board and Board Committees

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

The Trust Board of Directors undertakes regular assessments of its performance to establish whether it has adequately and effectively discharged its role, functions and duties during the preceding period.

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

The findings of Internal Audit, combined with the Head of Internal Audit Opinion set out in the Annual Governance Statement, support the Board's conclusions as to the efficacy of their performance.

The Board plans to review its performance again in September 2014.

5.4 Council of Governors

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

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

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

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

It is the responsibility of the Board of Directors to:

- set the strategic direction of the organisation within the overall policies and priorities of the government and NHS;
- define its annual and longer term objectives and agree plans to achieve these objectives;

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

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

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

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

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

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

This year, the Council of Governors continued to develop its close working relationship with the Chairman, Directors and Trust Secretary to further develop a mature, challenging and constructive relationship with the Trust Board of Directors. Governors were provided with a programme of development consisting of seminars throughout the year. New governors attended a tailored induction programme.

The Governor Working Groups established in the previous year continued to establish new ways of engagement between governors and directors, and have been hailed as a great improvement over the earlier Foundation Trust years.

Public meetings are now held directly after the quarterly meetings of the Trust Board of Directors at which the Board makes its declarations to Monitor. This allows governors to work closely with the Board on current matters of importance, with the most up to date data and intelligence available at the time. Governors are encouraged to ask challenging

questions and gain immediate responses from the Non-executive Directors and Board as a whole.

(a) Meetings of the Council of Governors

The Council of Governors met on a total of five occasions during 2013/14. This included its four Council of Governors meetings, and the Annual Members' Meeting at which the Annual Report and accounts is presented.

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

Membership and attendance at Council of Governors meetings is set out in the table on page 76 of this report.

The three Governor Working Groups each met six times during the year. Attendance at meetings of the Governor Project Focus Groups is set out in the table on page 79 of this report.

Further comment on the interaction of the Council of Governors and the Trust Board of Directors is provided in the Annual Governance Statement included in Appendix D – Annual Accounts 2013/14.

(b) Governors' Nominations and Appointments Committee

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

(i) Function and Duties

The Committee:

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

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

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

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

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

(F) Gives consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required within the Board of Directors to meet them.

(ii) Meetings

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

(c) Membership and attendance at Council of Governors meetings

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

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

	Council of Governors	Governors' Nominations and Appointments Committee
Number of meetings	4	3
Chairman		
John Savage	C4(4)	C3(3)
Governors		
Public South Gloucestershire		
Pauline Beddoes	2(4)	0(0)
Mary Hodges	0(1)	0(0)
Tony Tanner	3(3)	0(0)
Public North Somerset		
Anne Ford	4(4)	0(0)
Clive Hamilton	4(4)	0(0)
Public Bristol		
Ken Booth	2(4)	0(0)
Glyn Davies	3(3)	0(0)
Heather England	0(1)	0(0)
Brenda Rowe	2(3)	0(0)
Mo Schiller	4(4)	3(3)

	Council of Governors	Governors' Nominations and Appointments Committee
Jade Scott-Blagrove	0(1)	0(0)
Sue Silvey	4(4)	3(3)
Patient Governors from tertiary areas		
Neil Auty	0(1)	0(0)
Mani Chauhan	1(4)	0(0)
Tony Rance	3(3)	0(0)
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire		
Jacob Butterly	1(1)	0(0)
Peter Holt	4(4)	0(0)
Angelo Micciche	2(2)	0(0)
Kylie Murray	0(2)	0(0)
Anne Skinner	3(4)	3(3)
John Steeds	4(4)	3(3)
Elliott Westhoff	2(3)	1(2)
Pam Yabsley	4(4)	2(3)
Carers of patients 16 years and over		
Wendy Gregory	3(4)	1(3)
Sue Milestone	2(3)	0(0)
Garry Williams	1(1)	0(0)
Carers of patients under 16 years		
Philip Mackie	3(4)	3(3)
Lorna Watson	3(4)	0(0)
Staff Non-clinical Healthcare Professional		
Jan Dykes	3(4)	0(0)
Alex Bunn	2(2)	0(0)
Staff Other Clinical Healthcare Professional		
Phil Quirk	0(1)	0(0)
Terrence Flawn	0(3)	0(0)
Staff Medical and Dental		
Louise Newell	0(1)	0(0)
Ian Davies	3(3)	1(2)
Staff Nursing and Midwifery		

	Council of Governors	Governors' Nominations and Appointments Committee
Florene Jordan	4(4)	2(2)
Belinda Cox	0(1)	0(0)
Ben Trumper	3(3)	0(0)
Appointed Governors		
Sylvia Townsend	4(4)	3(3)
Helen Langton	2(2)	0(0)
Tim Peters	3(4)	0(0)
Mark Griffiths	0(2)	0(0)
Partnership organisations		
Jeanette Jones	3(4)	0(3)
Joan Bayliss	4(4)	0(0)
Jessica Burston	0(1)	0(0)
Jane Britton	0(2)	0(0)
Maggie Mickshik	0(2)	0(0)
Jim Petter	0(1)	0(0)
Non-executive Directors		
Emma Woollett	1(0)	0(0)
Paul May	1(0)	0(0)
Lisa Gardner	4(0)	0(0)
John Moore	2(0)	0(0)
Guy Orpen	3(0)	0(0)
Iain Fairbairn	4(0)	2(0)
Kelvin Blake	1(0)	0(0)
Alison Ryan	1(0)	0(0)
David Armstrong	1(0)	0(0)
Julian Dennis (Observer)	1(0)	0(0)
Jill Youds (Observer)	1(0)	0(0)
Executive Directors		
Robert Woolley	4(0)	0(0)
Deborah Lee	2(0)	0(0)
Helen Morgan	3(0)	0(0)
James Rimmer	4(0)	0(0)
Claire Buchannan	2(0)	0(0)

	Council of Governors	Governors' Nominations and Appointments Committee
Sean O'Kelly	4(0)	0(0)
Paul Mapson	2(0)	0(0)
Sue Donaldson	1(0)	0(0)
Carolyn Mills	1(0)	0(0)

(d) Attendance at meetings of the Governor Project Focus Groups

	Annual Plan Project Focus Group	Quality Project Focus Group	Constitution Project Focus Group
Number of meetings	7	5	3
Chairs			
Deborah Lee	C5(7)	C5(5)	0(0)
Charlie Helps	0(0)	0(0)	C3(3)
Governors			
Public South Gloucestershire			
Pauline Beddoes	1(0)	0(0)	0(0)
Mary Hodges	1(0)	0(0)	0(0)
Tony Tanner	3(0)	5(0)	2(0)
Public North Somerset			
Clive Hamilton	6(0)	5(0)	3(0)
Anne Ford	5(0)	0(0)	2(0)
Public Bristol			
Ken Booth	5(0)	1(0)	1(0)
Glyn Davies	2(0)	1(0)	1(0)
Heather England	0(0)	0(0)	0(0)
Brenda Rowe	3(0)	2(0)	2(0)
Mo Schiller	7(0)	5(0)	2(0)
Jade Scott-Blagrove	0(0)	0(0)	0(0)
Sue Silvey	6(0)	5(0)	2+1C(0)
Patient Governors from tertiary areas / Public (Rest of England and Wales)			
Neil Auty	0(0)	0(0)	0(0)
Mani Chauhan	0(0)	0(0)	1(0)
Tony Rance	1(0)	1(0)	2(0)
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire			

	Annual Plan Project Focus Group	Quality Project Focus Group	Constitution Project Focus Group
Jacob Butterly	0(0)	0(0)	0(0)
Peter Holt	5(0)	3(0)	1(0)
Angelo Micciche	2(0)	1(0)	1(0)
Kylie Murray	0(0)	0(0)	0(0)
Anne Skinner	4(0)	4(0)	2(0)
John Steeds	6(0)	5(0)	3(0)
Elliott Westhoff	2(0)	0(0)	1(0)
Pam Yabsley	6(0)	3(0)	1(0)
Carers of patients 16 years and over			
Wendy Gregory	7(0)	2(0)	3(0)
Garry Williams	0(0)	0(0)	0(0)
Sue Milestone	1(0)	1(0)	1(0)
Carers of patients under 16 years			
Philip Mackie	0(0)	0(0)	1(0)
Lorna Watson	0(0)	2(0))	0(0)
Staff Non-clinical Healthcare Professional			
Alex Bunn	0(0)	0(0)	0(0)
Jan Dykes	0(0)	0(0)	1(0)
Staff Other Clinical Healthcare Professional			
Terrence Flawn	0(0)	1(0)	0(0)
Phil Quirk	0(0)	0(0)	0(0)
Staff Medical and Dental			
Louise Newall	0(0)	0(0)	0(0)
Ian Davies	3(0)	1(0)	0(0)
Staff Nursing and Midwifery			
Florene Jordan	0(0)	3(0)	2(0)
Belinda Cox	0(0)	0(0)	0(0)
Ben Trumper	1(0)	0(0)	0(0)
Partnership organisations			
Joan Bayliss,	3(0)	0(0)	1(0)
Jeanette Jones,	0(0)	2(0)	1(0)
Jessica Burston,	0(0)	0(0)	0(0)
Jane Britton,	0(0)	0(0)	0(0)

	Annual Plan Project Focus Group	Quality Project Focus Group	Constitution Project Focus Group
Maggie Mickshik,	0(0)	0(0)	0(0)
Jim Petter	0(0)	0(0)	0(0)
Appointed Governors			
Sylvia Townsend,	0(0)	0(0)	0(0)
Marc Griffiths,	2(0)	1(0)	0(0)
Tim Peters,	0(0)	0(0)	0(0)
Helen Langton,	0(0)	0(0)	0(0)
Non-executive Directors			
Paul May	0(0)	0(0)	0(0)
John Savage	0(0)	0(0)	1(0)
Emma Woollett	0(0)	0(0)	0(0)
Lisa Gardner	0(0)	0(0)	1(0)
John Moore	0(0)	0(0)	0(0)
Guy Orpen	0(0)	0(0)	0(0)
Iain Fairbairn	0(0)	0(0)	0(0)
Alison Ryan	0(0)	0(0)	0(0)
David Armstrong	0(0)	0(0)	0(0)
Julian Dennis (Observer)	0(0)	0(0)	0(0)
Jill Youds (Observer)	0(0)	0(0)	0(0)
Executive Directors			
Robert Woolley	0(0)	0(0)	1(0)
Deborah Lee	5(7)	5(5)	0(0)
Claire Buchannan	0(0)	0(0)	0(0)
Paul Mapson	0(0)	0(0)	1(0)
Sean O'Kelly	0(0)	3(0)	0(0)
James Rimmer	0(0)	0(0)	0(0)
Sue Donaldson	0(0)	0(0)	0(0)
Carolyn Mills	0(0)	0(0)	0(0)

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

Non-executive Directors and the Chair of the Trust are appointed by the Governors at a general meeting of the Council of Governors. The recruitment, selection and interviewing of candidates is overseen by the Governors' Nominations and

Appointments Committee which also makes recommendation to the Council of Governors for the appointment of successful candidates. The Foundation Trust Constitution requires that Non-executive Directors are members of the public or patient constituencies.

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

(f) Business interests

Governors are required to disclose details of company directorships or other material interests which may conflict with their role as Governors. The Trust Secretary maintains a register of interests, which is available to members of the public by contacting the Trust Secretary at the address given on page 98 of this report.

(g) Performance & Development of the Council of Governors

This was a year of consolidation and embedding the changes brought by the Health and Social Care Act 2012. Governors, supported by the Board of Directors and Trust Secretariat undertook a series of structured training and development seminars, and new governors attended a revised induction.

The programme ran throughout the year with sessions presented by a selection of expert speakers and leaders in the field of healthcare governance, law and finance.

The programme includes the following topics:

- Trust induction;
- External influences such as the Francis Report;
- Structure of the Trust and local health economy;
- Strategy, quality, performance & finance;
- External stakeholders and organisations;
- Foundation trust membership;
- Foundation trust network governor training and development programme;
- Media and reputation management, and;
- Integration, mergers and acquisitions.

Each seminar was structured to develop governors' skill in particular areas, including: regulatory compliance, performance, holding to account, 'governance' versus 'management', operational capacity, interpreting statistics and Key Performance Indicators, appraising directors, and, finance.

The Council of Governors will undertake a further self-assessment during 2014/15.

(h) Trust's Constitution

Governors and the Trust Board agreed to revise the Foundation Trust Constitution to allow for more representation from young people on the Council of Governors, giving two extra places. They invited the Youth Council to nominate two people for those positions.

They also agreed a revision to the Foundation Trust Constitution to permit public members from territories outside the Trust's current locality. To do this, the Patient - Tertiary constituency group was deleted and replaced with a group entitled Public - Rest of England and Wales, to encompass non-local members whether or not they had used the Trust's services as a patient.

The complement of Non-executive Directors on the Trust Board of Directors was increased by one (from 7 to 8).

Further work on the Constitution will take place during 2014/15.

5.5 Foundation Trust membership

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

(a) Membership size and variations

The Council of Governors agreed that membership numbers should be maintained during 2013/14, and that the minimum age for membership is seven years of age. Our public and patient membership totalled 11,521 and staff membership was maintained at nearly 100% with only one staff member opting out and our staff membership increased by 914 new members.

The combined public, patient and staff membership as of 31 March 2014 stands at 21,172. The number of members has been maintained by offering membership to patients and their carers in our hospital outpatient areas and members of the public at Trust open events. Membership of the staff constituency is managed on an opt-out basis.

A total of 339 members were removed from the database during routine data maintenance. These will have included members who have moved out of the catchment area or who were deceased. Patient members who were no longer eligible for the patient constituency were switched to the public constituency if they were eligible.

The changes in membership size throughout 2013/14 and estimated growth for 2014/15 are shown in the table below.

	2013/14 (actual)	2014/15 (estimated)
Public constituency		
At year start (1 Apr 2013)	5,903	6,589
New members	930	200
Members leaving	244	200
At year end (31 March 2014)	6,589	6,589
Patient constituency		
At year start (1 Apr 2013)	5,927	4,932
New members	89	100
Members leaving	1,084	100
At year end (31 March 2014)	4,932	4,932
Staff constituency		
At year start (1 Apr 2013)	8,630	9,544
New members	1,776	877
Members leaving	862	762
At year end (31 March 2014)	9,544	9,659

(b) Analysis of current membership

The profile of the Trust's membership at the end of March 2014 is shown in the table below.

Constituency	Number of members	Eligible membership
Public constituency		
Age (years)		
0-16	337	180,150
17-21	605	62,969
22+	5,408	673,069
Unknown	239	0
Ethnicity		
White	5,675	806,242
Mixed	84	21,138
Asian/Asian British	187	32,531
Black/Black British	144	28,584
Other	1	5,072

Constituency	Number of members	Eligible membership
Public constituency		
Unknown	498	22,621
Socio-economic groupings		
AB	1,915	72,696
C1	1,948	91,716
C2	1,307	56,721
D E	1,380	63,324
Unknown	39	631,731
Gender		
Male	2,841	454,969
Female	3,623	461,219
Unknown	125	0
Patient constituency		
Age (years)		
0-16	327	47,783
17-21	254	20,487
22+	4,317	319,343
Staff constituency		
Members	9,544	9.545

(c) Developing a representative and engaged membership

The governor's regularly monitor membership engagement and recruitment activity and performance at the Constitution Project Focus Group.

The governors were concerned that young people were under represented on the Council therefore the governors have increased the appointed governors by two youth council governors. This ensures that the Bristol Royal Hospital for Children's youth council is represented.

Governors agreed that the membership numbers remain the same and recruitment focuses on maintaining the numbers.

(d) Engagement

The Trust Board of Directors proactively supports the involvement of our governors in a wide range of activities within the Trust to assist them in completing their statutory responsibilities and, in particular, for engaging with members.

The focus for engaging members continues through a number of channels, including the activities of the Youth Council which meets each month and provides reports to the Council of Governors. Members are offered opportunities to be involved in

service improvements through our Patient and Public Involvement programme, and our regular Governors' Health Matters events have proved very popular.

Our members have also been engaged through three additional activities:

– Elections: Inviting eligible members to nominate themselves for 14 public, patient and staff seats. Our methods of engagement included meetings and events, personally addressed letters, web marketing and a social media campaign;

– Events: The events in 2014 included three Health Matters events on dementia, strokes and 'Having your say in our Priorities'. There were five election events which included two held in North Somerset.

– Newsletter: Three editions of the newsletter have been posted or emailed to members.

(e) Elections

The nomination process for 14 governor seats started in March 2014 with information events for members. The Trust encourages early engagement of members to enable them to make an informed decision about standing for elections. The outcome of the ballot will be published in May 2014.

(f) Membership commentary and strategy

The Trust has six membership constituencies:

– Public Bristol;

– Public North Somerset;

– Public South Gloucestershire;

– Public rest of England and Wales

– Patient constituency with four groups: Patients from tertiary areas, local patients, carers of patients 16 years and over and carers of patients under 16 years; and staff constituency with four groups: medical and dental, nursing and midwifery, other clinical healthcare professionals and non-clinical healthcare professionals.

The Health and Social Care Act 2012 has given trusts and governors opportunities to amend their own Foundation Trust Constitution. The first amendment will be presented at the Annual Member's Meeting in September 2014. The Constitution Project Focus Group has responsibility for reviewing the Constitution and to make recommendations to the Council of Governors with respect to any amendments that may be considered beneficial. These changes would require approval by the Council of Governors and the Trust Board of Directors.

The agreed priorities include:

– To review the Foundation Trust constituencies and governor ratio;

– To maintain the public and patient membership numbers;

- To maintain staff membership at 95% or higher;
- To continue to engage our members by providing a range of involvement opportunities, including Health Matters events, Trust open days and service improvement opportunities linked with members' special interests and the youth council; and
- To support governors in completing their statutory duties by providing a programme of training and development opportunities.

(i) Public Constituencies

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

(ii) Patient constituency

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

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

(iii) Staff constituency

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

The staff constituency has four groups:

- Medical and dental;
- Nursing and midwifery;
- Other clinical healthcare professionals; and
- Non-clinical healthcare professionals.

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

(g) Governors communication with members

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

Members wishing to communicate with Governors or Directors, or anyone interested in finding out more about membership, should contact the Trust Secretariat at the address given on page 98 of this report.

(h) Governors by constituency – 1 April 2013 to 31 March 2014

Constituency	Name	Tenure	Elected Appointed Partnership
Public Governors			
Public South Gloucestershire	Pauline Beddoes	June 2010 to May 2016	Elected
Public South Gloucestershire	Mary Hodges	June 2010 to May 2013	Elected
Public South Gloucestershire	Tony Tanner	June 2013 to May 2016	Elected
Public North Somerset	Clive Hamilton	June 2011 to May 2014	Elected
Public North Somerset	Anne Ford	June 2008 to May 2014	Elected
Public Bristol	Jade Scott-Blagrove	June 2010 to May 2013	Elected
Public Bristol	Heather England	November 2011 to May 2013	Elected
Public Bristol	Mo Schiller	June 2008 to May 2014	Elected
Public Bristol	Sue Silvey	June 2011 to May 2014	Elected
Public Bristol	Ken Booth	June 2011 to May 2014	Elected
Public Bristol	Brenda Rowe	June 2013 to May 2016	Elected
Public Bristol	Glyn Davies	June 2013 to May 2016	Elected
Patient Governors			
Patient Governors from tertiary areas (who live in the rest of England and Wales) (renamed as Public – rest of England and Wales)	Mani Chauhan	November 2012 to May 2016	Elected
Patient Governors from tertiary areas (who live in the rest of England and Wales) - (renamed as Public – rest of England and Wales)	Neil Auty	June 2010 to May 2013	Elected
Patient Governors from tertiary areas (renamed as Public – rest of England and Wales)	Tony Rance	June 2013 to May 2016	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	Anne Skinner	June 2008 to May 2014	Elected

Constituency	Name	Tenure	Elected Appointed Partnership
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	John Steeds	June 2010 to May 2016	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Kylie Murray	June 2011 to August 2013	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Peter Holt	June 2011 to May 2014	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Pam Yabsley	September 2012 to May 2016	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Angelo Micciche	October 2013 to May 2014	Elected
Local patients Governors who live in Bristol, North Somerset and South Gloucestershire	Elliott Westhoff	June 2013 to May 2016	Elected
Carers of patents 16 years and over	Wendy Gregory	June 2008 to May 2016	Elected
Carers of patents 16 years and over	Garry Williams	June 2010 to May 2013	Elected
Carers of patents 16 years and over	Sue Milestone	June 2013 to May 2016	Elected
Carers of patients under 16 years	Philip Mackie	June 2008 to May 2014	Elected
Carers of patients under 16 years	Lorna Watson	June 2008 to May 2014	Elected
Staff Governors			
Medical and Dental	Louise Newall	June 2011 to May 2013	Elected
Medical and Dental	Ian Davies	June 2013 to May 2014	Elected
Nursing and Midwifery	Florene Jordan	June 2010 to May 2016	Elected
Nursing and Midwifery	Belinda Cox	June 2010 to May 2013	Elected
Nursing and Midwifery	Ben Trumper	June 2013 to May 2016	Elected
Non-clinical Healthcare Professional	Alex Bunn	June 2011 to September 2013	Elected
Non-clinical Healthcare Professional	Jan Dykes	June 2008 to May 2014	Elected
Other Clinical Healthcare Professional	Phil Quirk	June 2010 to May 2013	Elected
Other Clinical Healthcare Professional	Terrence Flawn	June 2013 to May 2016	Elected
Appointed Governors			
University of Bristol	Tim Peters	March 2011 to May 2014	Appointed
University of the West of England	Helen Langton	Oct 2010 to September 2013	Appointed
University of the West of England	Marc Griffiths	Oct 2013 to May 2014	Appointed
Bristol City Council	Sylvia Townsend	June 2009 to May 2014	Appointed

Constituency	Name	Tenure	Elected Appointed Partnership
Partnership organisations			
Avon and Wiltshire Mental Health Trust	Jane Britton	June 2008 to August 2013	Partnership
South Western Ambulance Service NHS Foundation Trust	Jessica Burston	October 2011 to June 2013	Partnership
South Western Ambulance Service NHS Foundation Trust	Jim Petter	December 2013 to May 2014	Partnership
Joint Union Committee	Jeanette Jones	June 2008 to May 2014	Partnership
Community groups	Joan Bayliss	Jan 2011 to May 2014	Partnership
Voluntary groups	Maggie Mickshik	June 2011 to August 2013	Partnership

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

6.1 John Savage – Chairman

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

He was awarded the CBE for service to Business and Regeneration in the 2006 New Year Honours List. He is Canon Treasurer of Bristol Cathedral, Chairman of the Bristol Chamber of Commerce and Initiative, Chairman of Learning Partnership West and Chairman of Destination Bristol. He is the Patron of the Bristol Refugee Rights.

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

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

6.2 Robert Woolley – Chief Executive

Robert has been Chief Executive of University Hospitals Bristol NHS Foundation Trust since 2010. He joined the Trust Board in 2002 and held the Performance Management and then the Corporate Development portfolios, overseeing the expansion of the Bristol Dental Hospital, the construction of the Bristol Heart Institute and the creation of the 10 year plan which committed over £200 million of strategic capital investment. He was project director for the Trust's successful application for Foundation status in 2008.

Robert joined the NHS as a planner at the Royal London Trust in 1992. At Barts and the London NHS Trust, he was head of strategic planning and assistant director for the redevelopment of the Royal London Hospital before taking general management roles in children's services and clinical support services. Robert read English at Lincoln College, Oxford, and holds an MBA with distinction from Bath University.

6.3 Non-executive Directors

(a) Emma Woollett – Vice-Chair

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

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

(b) Lisa Gardner – Non-executive Director

Lisa Gardner was appointed as a Non-executive Director on 1 June 2008. She has acquired a broad range of business experience over more than 20 years; the posts held during that time include finance director of both Aardman Animations Limited and Business West Bristol. She qualified as a chartered accountant in 1992 after gaining a BA Honours degree in accounting and finance at Kingston University. Her current role is as Interim Director of Finance at Above and Beyond, a local charity that raises funds for the Trust's hospitals. Lisa is Chair of the Finance Committee at the Trust and sits on the Audit Committee. She is also a board member at the Watershed's Trust and Trading Companies. She has served as a Parent Governor at Westbury Park Primary School, where she was also Chair of the Finance Committee, was the financial director at Aardman Animations Limited for 11 years and since then has worked in the finance director role at Business West and in the retail industry before returning to practice and freelance work.

(c) Iain Fairbairn – Senior Independent Director

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

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

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

(d) David Armstrong – Non-executive Director

David was appointed as a Non-Executive Director on 28 November 2013. After graduating from Southampton University with First Class Honours in Mathematics and its Applications, David worked in the banking sector before taking up a position as a Systems Engineer with GEC-Marconi in 1983.

During his 30 years in the Aerospace and Defence Sector he worked in a number of Engineering and Project Manager Roles. In 1999 he was appointed as the Alenia Marconi Systems Ltd Business Improvement, ICT and Quality Director and since that time has held board level positions in a number of multi-national Defence Businesses, most recently working for Finmeccanica as UK Vice President of Quality.

He is a Fellow of the Institute of Engineering and Technology and of the Chartered Quality Institute and is a Chartered Engineer and Chartered Quality Professional.

David has also served on a number of policy making committees including Engineering UK's Business and Industry Panel and as a Trustee of the Chartered Quality Institute.

He has recently accepted an appointment to work as Head of Profession at the Chartered Quality Institute where he will be responsible for developing the Profession and raising its profile across academia and the public and private sectors.

(e) Alison Ryan – Non-executive Director

Alison was appointed as a Non-Executive Director on 28 November 2013. Alison is an economist by training and a manager by profession. Since 1985 she has been Chief Executive of a number of voluntary organisations working in the fields of long term illness and disability including mental health. From 1999-2004 she was CEO of the Princess Royal Trust for Carers (now the Carers Trust) and since then she has been CEO of Weldmar Hospicecare Trust which provides specialist palliative care and end of life services for rural Dorset. Alison's Non-executive Director experience includes positions on the boards of Somerset Partnership NHS Trust, NHS Southwest and NHS South of England.

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

(f) Guy Orpen – Non-executive Director

Guy Orpen was appointed as a Non-executive Director of University Hospitals Bristol NHS Foundation Trust on 2 May 2012. He is a graduate of the Universities of Cape Town and Cambridge. He is Pro Vice-Chancellor for Research and Enterprise at the University of Bristol, a role he has held since 2009. In that role has strategic oversight of the University's research and its engagement with society and industry. He chairs the Executive Committee of the UK National Composites Centre, serves on the Board of Bristol Health Partners (the city's academic health sciences collaboration) and the Executive Board of the SetSquared Partnership (for enterprise, with the universities of Bath, Bristol, Exeter, Southampton & Surrey), and is Chair of the Board of the GW4 research alliance with Bath, Exeter and Cardiff Universities. He is a Governor of the Cambridge Crystallographic Data Centre and a member of the Board of the 2015 Company which will deliver the European Green Capital for Bristol in 2015. He has previously served as Head of the School of Chemistry (2001-6) and Dean of the Faculty of Science (2006-9).

(g) Paul May – Non-executive Director

Paul May was appointed as a Non-executive Director of University Hospitals Bristol NHS Foundation Trust on 1 November 2008 and left the Trust on 31 July 2013.

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

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

Paul was the former Chair of the Quality and Outcomes Committee of the Board.

(h) Kelvin Blake – Non-executive Director

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

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

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

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

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

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

(i) John Moore – Non-executive Director

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

Following 12 years international corporate life, and having sold a medium sized business, John has taken a Non-executive Director role with University Hospitals Bristol NHS Foundation Trust, and is a Trustee of various charities, including Education Towards a Future.

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

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

(j) Jill Youds – Non-executive Observer

Jill joined the Trust in November 2013 as Non-Executive Board Observer following a highly successful career in the commercial sector with blue chip organisations such as Virgin Media, where she was an Executive Director, and Lloyds Group. Jill brings her general

business leadership experience to the Trust and her specialist interests include People and Workforce and organisation effectiveness. Jill is an experienced non-executive director in the public and not-for-profit sectors.

(k) Julian Dennis – Non-executive Observer

Julian was appointed as Non-Executive Board Observer on 1 November 2013. A company director and public health scientist, he worked for the Public Health Laboratory Service at Porton Down before joining Thames Water. He was appointed a Director of United Kingdom Water Industry Research Limited in 2003 before joining the board of Wessex Water as Director of Environment and Science in 2004. He is also Visiting Professor of Water Science and Engineering at the University of Bath.

6.4 Executive Directors

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

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

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

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

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

(b) Paul Mapson – Director of Finance and Information

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

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

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

Paul serves on the Finance Committee of the Board.

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

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

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

(d) Helen Morgan – Acting Chief Nurse

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

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

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

(e) Sean O'Kelly – Medical Director

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

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

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

Between 2005 and 2009 Dr O'Kelly also completed a Master of Science degree in Strategic Management at the University of Bristol, chaired the Department of Health National

Steering Group on Cosmetic Surgery Regulation and acted as Honorary Treasurer to the Quality in Healthcare section of the Royal Society of Medicine.

(f) Sue Donaldson – Director of Workforce and Organisational Development

Sue has worked in the NHS since 2004 and has held a number of Director of Workforce roles, these include Cotswold and Vale PCT, Poole NHS Foundation Trust and, most recently, Oxford University Hospitals NHS Trust. Sue started at University Hospitals Bristol in November 2013. Prior to joining the NHS, Sue had an extensive Human Resources and operational career with The Post Office, most notably leading pay, contractual and organisational change programmes.

(g) Carolyn Mills – Chief Nurse

Carolyn is an experienced nurse whose career in the NHS spans 30 years. Carolyn has worked in acute, community and academic sectors. She moved into senior nursing leadership roles in 1998. Between 1998 - 2005, Carolyn held two Assistant Director of Nursing positions, at Hillingdon Hospitals NHS Trust and University College London Hospitals NHS Foundation Trust. Previous to joining University Hospitals Bristol NHS Foundation Trust as Chief Nurse in January 2014, Carolyn was Director of Nursing at Northern Devon Healthcare Trust.

(h) James Rimmer – Chief Operating Officer

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

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

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

7. Appendix B – Contact Details

The Trust Secretariat can be contacted at the following address:

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University Hospitals Bristol NHS
NHS Foundation Trust

Quality Report 2013/14

Contents

Note:

The requirements to report in line with the *2013/14 Detailed Guidance for External Assurance on Quality Reports* published by Monitor have been satisfied as follows:

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Part 2 – Priorities for improvement and statements of assurance from the Board	
Priorities for improvement – plans for 2014/15	Page 47
Statements of assurance from the Board	Page 54

Part 3 – Other information	
Review of quality performance	This information can be found in the reports for the three domains of quality. See pages 6-46
Overview of the quality of care based on performance in 2013/14 against indicators mandated for inclusion in Quality Accounts/ Reports	Page 5
Performance against key national priorities	Page 49

Statement on quality from the Chief Executive

Welcome to this, our sixth annual report describing our quality achievements. Our mission is to provide exceptional healthcare, research and teaching every day. The Quality Report (also known as the Quality Account) is one of the key ways that the Trust demonstrates that its services are safe, clinically effective and that we are providing treatment in a caring and compassionate environment. The report is an open and honest assessment of the last year, its successes and challenges.

Last year we set a large number of quality objectives, the majority of which we achieved. I am particularly pleased to be able to report significant improvements in hospital-acquired healthcare infection (reductions in reported cases of *Clostridium difficile*, MRSA and MSSA) and pressure ulcer prevention. I am also reassured by the Trust's overall mortality rate which continues to be lower than the national average: this means that more patients survive in our care than would normally be expected for the severity of their condition. But there is no room for complacency: there are other aspects of care described in this report where we would have liked to make more progress. For example, despite our concerted efforts, too many patients still say that they were not told about potential side effects of medicines when they were discharged from hospital – an area where we will continue to seek improvements in 2014/15.

Overall, 97% of patients consistently report that the care they receive from us is good, very good or excellent and our monthly scores in the new NHS Friends and Family Test are better than the national average. I am likewise encouraged that 71% of staff, compared to a national average of 62%, say that they would recommend us as a place to work or receive treatment, although our aspiration must be to improve this score further in the future.

Looking ahead to 2014/15, we have taken a different approach to the process of selecting our quality objectives. We began 2014 by hosting an open event where members of the public were able to tell us about the things about hospital care that mattered most to them. At the same time, the Trust has been experiencing unprecedented operational pressures on its services: the number of very sick patients requiring emergency admission to hospital has increased and a higher proportion of them are over 85 years old. This has had a significant impact on the number of beds needed for emergency medical patients and that, in turn, has increased the number of operations cancelled on the day of surgery. Taking all of this into account, we have chosen a set of objectives for 2014/15 which are focused on patient 'flow' through our hospitals and designed to be truly transformational: reducing cancelled appointments, making sure that patients are treated on a ward appropriate to their clinical condition, and eradicating the practice of moving patients out-of-hours for non-clinical reasons. We have also added a fourth objective which is about refreshing our approach to public engagement and involvement, providing continued assurance that when we consult people about changes to services, the process is open and candid and that as an organisation we listen to and act upon people's views and concerns.

In 2013/14, we received three inspections from the Care Quality Commission, each of which highlighted aspects of care that we could improve. You can read more about this in the appendix to this report. Inspections are opportunities for us to learn and also to receive external validation of the high quality of our services, many of which are described in this Quality Report. At the time of writing, we have just received notice that the CQC will be visiting us in September to carry out a comprehensive review of our services and, no doubt, to check that we have made the improvements that we said we would. Going into this inspection, I am pleased to report that University Hospitals Bristol is rated by the CQC as being in a select group of hospitals considered to be at lowest risk of non-compliance with care quality standards.

I would like to thank everyone who has contributed to this year's report, including our governors, commissioners, local councils, and the outgoing Local Involvement Networks. To the best of my knowledge, the information contained in this Quality Report is accurate.

Robert Woolley, Chief Executive

Overview of 2013/14

The University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of general and specialist hospitals, employing around 7,000 w.te. staff and with a turnover of approximately £500m. We are also the major medical research centre in the South West of England. During 2013/14, the Trust provided treatment and care to around 72,000 inpatients[1], 57,000 day cases and 115,000 attenders at our emergency departments[2]. We also provided approximately 447,000 outpatient appointments[3].

Our goal has been that each and every one of these patients should be safe in our care, have an excellent experience of being in our care, and the right clinical outcome: the hallmarks of a quality service. Last year, we set ourselves 16 quality objectives: we are delighted to have fully achieved 11 of these, partly achieved four more and to have made significant improvements in other important aspects of quality which are documented in this report.

In the pages which follow, you will be able to read a detailed account of our performance in 2013/14. Each objective has been assigned a 'traffic light' or 'RAG' rating (Red = not met; Amber = partially met; Green = fully met) to give the reader an idea of the progress we have made. The table below provides an overview.

Table 1

We wanted to…		**How did we get on?**
1	Increase harm free care as measured via the NHS Safety Thermometer	Green
2	Reduce hospital acquired healthcare infections	Green
3	Reduce medication errors	Green
4	Extend medicines reconciliation ('getting the medicines right')	Green
5	Improve the early identification and escalation of care of deteriorating patients	Green
6	Improve levels of nutritional screening and specifically 72 hour nutritional review of patients	Amber
7	Implement the NHS Friends and Family Test	Green
8	Ensure that patients continue to be treated with kindness and understanding on our wards	Green
9	Explain medication side effects to inpatients when they are discharged	Red
10	Focus on improving the experience of maternity patients	Amber
11	Ensure that at least 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke ward	Amber
12	Achieve the best practice tariff for hip fractures (this involves achieving eight indicators including surgery within 36 hours of admission to hospital)	Green
13	Ensure patients with diabetes have improved access to specialist diabetic support	Green
14	Ensure that patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan	Green
15	Continue to implement our dementia action plan	Amber
16	Commence a baseline review of available clinical outcome data	Green

[1] Elective, emergency, maternity and births
[2] Bristol Royal Infirmary, Bristol Royal Hospital for Children, and Bristol Eye Hospital
[3] 145,000 new outpatient attendances; 302,000 follow-up attendances

In February 2012, the Department of Health and Monitor announced a new set of mandatory quality indicators for all Quality Accounts and Quality Reports. The Trust's performance in 2013/14 is summarised in the table below. Where relevant, reference is also made to pages of our Quality Report where related information can be found. The Trust is confident that this data is accurately described in this Quality Report. A Data Quality Framework has been developed by the Trust which encompasses the data sets which underpin each of these indicators and addresses the following dimension of data quality: accuracy, validity, reliability, timeliness, relevance and completeness. The Framework describes the process by which the data is gathered, reported and scrutinised by the Trust. Further details are available upon request. (Comparisons shown are against a benchmark group of all acute trusts with the exception of patient safety incidents where the benchmark group is acute teaching hospitals only).

Table 2

Mandatory indicator	**UH Bristol 2013/14**	**National average 2013/14**	**National best 2013/14**	**National worst 2013/14**	**UH Bristol 2012/13**	**Page ref.**
Venous thromboembolism risk assessment[4]	97.7%	95.6%	100%	80.3%	96.3%	9
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)[5]	17.1	15.0	0.0	30.7	18.4	11
Rate of patient safety incidents per 100 admissions[6]	10.04	7.9	4.9	12.8	8.78	18
Percentage of patient safety incidents resulting in severe harm or death	0.2%	0.4%	0.0%	0.9%	0.8%	18
Responsiveness to inpatients' personal needs	Comparative data for 2012/13: UH Bristol score 72.4; England median 67.4; low 57.4; high 84.4. (Comparative data for 2013/14 will not be available from the Health & Social Care Information Centre until August 2014)					N/A
Percentage of staff who would recommend the provider	71%	64%	89%	40%	71%	32
Summary Hospital-level Mortality Indicator (SHMI) value[7] and banding	95.7 Band 2	100	63.0	118.6	93.6 Band 2	41
Percentage of patient deaths with specialty code of 'Palliative medicine' or diagnosis code of 'Palliative care'[8]	19.4%	20.9%	44.9%	0%	17.6%	N/A
Patient Reported Outcome Measures	Comparative groin hernia data for 2012/13: 70.6% of UH Bristol patients reported an improved EQ-5D score (national average 50.2%); 41.2% of UH Bristol patients reported an improved EQ-VAS score (national average %). Comparative data is not currently available for the full year 2013/14 from the Health & Social Care Information Centre. UH Bristol PROM data for varicose veins does not meet the publication threshold.					44
Emergency readmissions within 28 days of discharge: age 0-15	Comparative data for 2011/12: UH Bristol score 7.8%; England average 10.0%; low 0%; high 47.6%. Comparative data is not currently available for 2012/13 or 2013/14 from the Health & Social Care Information Centre.					45
Emergency readmissions within 28 days of discharge: age 16 or over	Comparative data for 2011/12: UH Bristol score 11.15%; England average 11.45%; low 0%; high 17.15%. Comparative data is not currently available for 2012/13 or 2013/14 from the Health & Social Care Information Centre.					45

[4] Latest nationally published data covers April 2013 – January 2014; UH Bristol score is for full financial year
[5] Latest nationally published data covers April-December 2013
[6] Published (validated) data is for the first six months of the financial year only – NRLS acute trusts group
[7] In-hospital deaths plus deaths within 30 days of discharge: October 2012 – September 2013
[8] Specialty 315, diagnosis Z515: October 2012 – September 2013

PATIENT SAFETY

Our ongoing commitment

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

Objective 1
We wanted to increase harm free care as measured by the NHS Safety Thermometer

GREEN

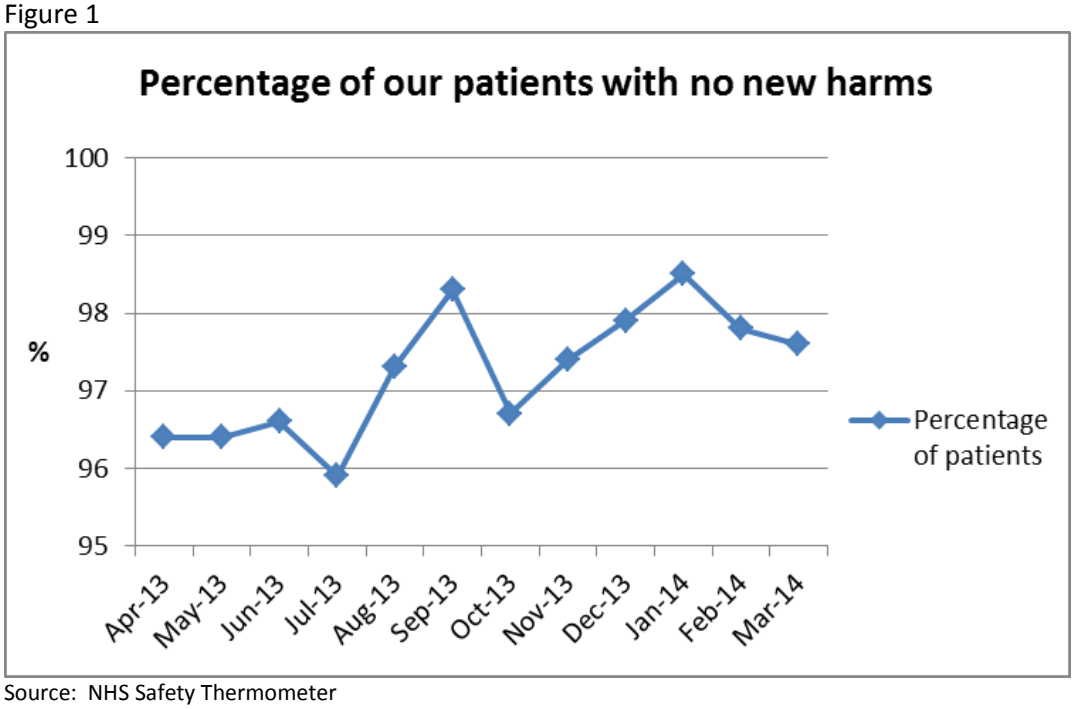
The NHS Safety Thermometer is a national tool used to measure and benchmark the level of harm experienced by patients due to pressure ulcers, falls, venous thromboembolism and catheter associated urinary tract infections. The Safety Thermometer involves conducting monthly point prevalence audits of all eligible inpatients (approximately 750 patients per month) and assessing whether they have experienced any of these four types of harm. The tool measures "new" harm likely to have occurred since the patient was admitted to one of our hospitals and "old" harm likely to have occurred prior to admission. The audits are conducted by front-line nursing staff, providing real-time feedback to the team about areas of good practice and areas for improvement.

Harm Free care
Our chosen measure for this is the percentage of patients with no new harm. For 2013/14, we set an improvement target that by Quarter 4 of 2013/14 at least 97.7% of patients would experience none of the four harms described above. This target was based on the best performing trusts in our acute teaching trust peer group in the final quarter of 2012/13[9] using national NHS Safety Thermometer data[10]. We achieved 98.0%. Our progress in increasing the proportion of patients with no new harm throughout 2013/14 is shown in Figure 1. The improvement in this measure has been largely achieved by the reduction in hospital acquired pressure ulcers from 39 in Quarter 4 2012/13 to 14 in Quarter 4 2013/14. Our Safety Thermometer audits also show that we have reduced the number of falls resulting in patient harm from 42 in Quarter 4 2012/13 to eight in Quarter 4 2013/14.

In 2014/15 we intend to increase our annual target by rebasing it with reference to our improved performance in 2013/14.

[9] This is the same acute teaching trust peer group used by NHS England for benchmarking patient safety incident data submitted to the National Reporting and Learning System. 97.7% was the threshold for the upper quartile.
[10] Source: Health and Social Care Information Centre

Figure 1



Source: NHS Safety Thermometer

Patient falls

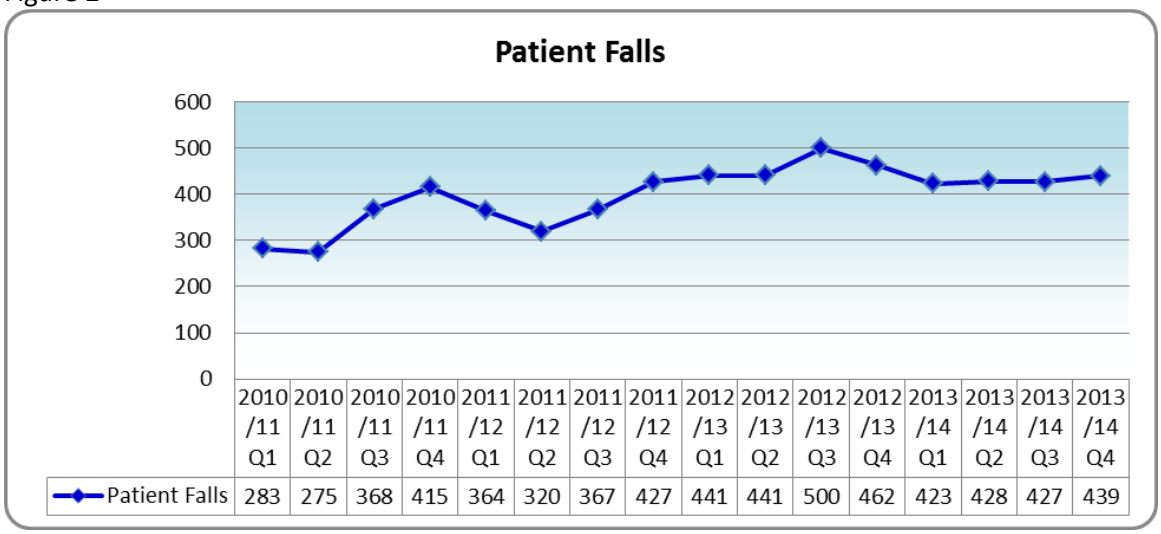
Patient falls are the most commonly reported safety incident in the NHS inpatient setting and occur in all adult clinical areas. Falls in hospital lead to injury in approximately 30% of cases, with up to 5% leading to serious injury. As many as half of all falls involve a degree of cognitive impairment, with 75%[11] of falls occurring in patients aged 65 or over. The number of elderly patients admitted to the Trust is rising steeply. The majority of falls are not witnessed and a significant number occur in the early hours of the morning; not all falls can be prevented. During 2013/14, we developed a method for estimating the impact the age of our patients has on the incidence of inpatient falls and used this to compare the number of expected falls with the number of actual falls.

Our target for 2013/14 was to achieve a total number of reported patient falls of less than the national average of 5.6 per 1000 bed days (National Patient Safety Agency data). We achieved this target in four out of 12 months and an overall rate of 5.7 falls per 1,000 bed days. This compares to two months and a rate of 6.0 in 2012/13. Cases where inpatient falls had a 'major' impact reduced from 17 in 2012/13 to 14 in 2013/14: this was despite a significant rise in the number of 'at risk' patients in the 75 year plus age group being admitted to our hospitals. Further work is required to achieve this target consistently and ensure the level of harm to patients as a result of falls continues to decline.

In 2012, the Royal College of Physicians published 'Fallsafe', an approach to the management and prevention of avoidable falls in hospital. The Trust piloted Fallsafe at the end of 2012 and then implemented the approach across 28 wards during 2013/14. Fallsafe involves educating, inspiring and supporting clinical staff to deliver assessments and interventions through a care bundle approach, supported by a falls assistant project post. Divisions report regularly on their progress to the Trust's Falls Steering Group.

[11] National Patient Safety Agency, 2007 data

Figure 2

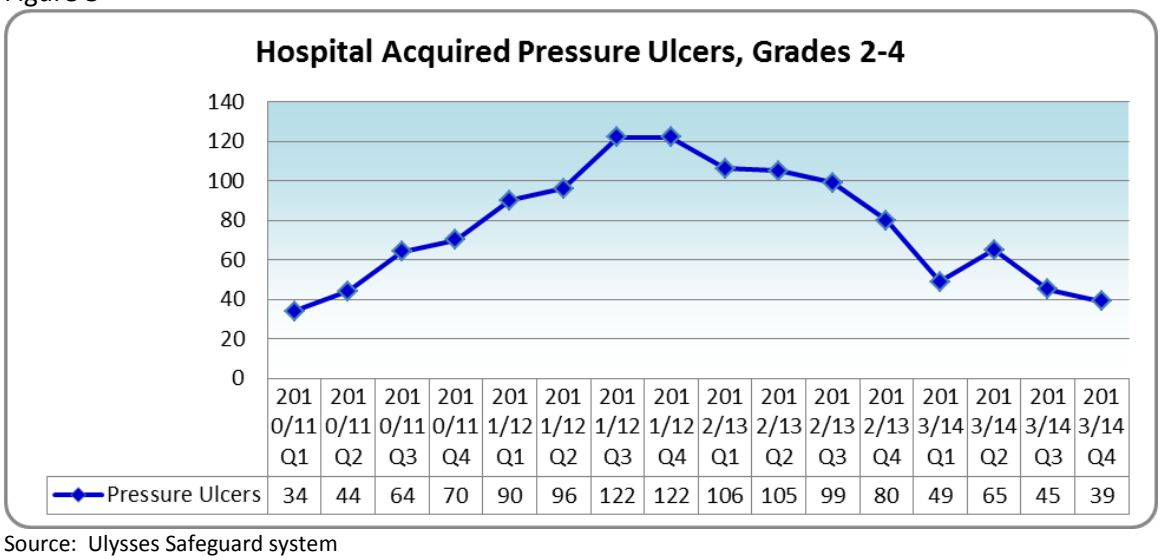


Source: Ulysses Safeguard system

Pressure ulcers

Pressure ulcers range from being small areas of sore or broken skin to more serious skin damage that can lead to life-threatening complications. In 2013/14, a national Commissioning for Quality and Innovation (CQUIN)[12] indicator was mandated for reduction of one of the four types of harm measured by the NHS Safety Thermometer. We agreed a CQUIN target with our commissioners to reduce the number of hospital acquired grade 2-4 pressure ulcers by 15%[13] which equated to no more than 25 grade 2-4 hospital acquired pressure ulcers per month on average during 2013/14. For the purposes of the CQUIN, pressure ulcers were measured as a monthly average in six monthly blocks: we achieved an average of 19 cases per month for the first half of 2013/14 and an average of 14 per month for the second half of the year, i.e. we achieved the CQUIN.

Figure 3



Source: Ulysses Safeguard system

[12] 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

[13] measured through robust incident reporting rather than the point prevalence methodology of the NHS Safety Thermometer.

In 2013/14, we also set an internal Trust target to achieve a total incidence of pressure sores (grades 2-4) of less than 0.651 per 1,000 bed days (based on a percentage reduction of a previous NPSA benchmark): we achieved a rate of 0.656 per 1,000 bed days. This compares with a rate of 1.264 in 2012/13. Examples of actions taken in 2013/14 to achieve this improvement include:

- Monthly review of pressure ulcers and feedback to each division through steering group.
- New wound assessment documentation (to meet requirement of NICE clinical guideline 29).
- New dressing formulary to standardise treatment Trust-wide.
- Launch of monthly formal training for all registered nurses on pressure care and wound assessment; training also provided for nurse assistants.
- New Trust-wide contract for dynamic mattresses, achieving a better specification of dynamic mattress and cost savings at the same time.
- Revised root cause analysis tool for pressure ulcers to enable clearer identification of causes of pressure ulcers, as per external review recommendation.

Additional actions planned for 2014/15 include a review of our contract for topical negative pressure equipment, new static foam mattresses for trolleys in theatres and emergency departments and the development of a pan-Avon dressing formulary to standardise treatment in acute and community setting, achieving cost savings and improved access to dressing treatments.

Venous thromboembolism
(Mandatory indicator)

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: reducing incidence of VTE is a national quality priority within the NHS Outcomes Framework.

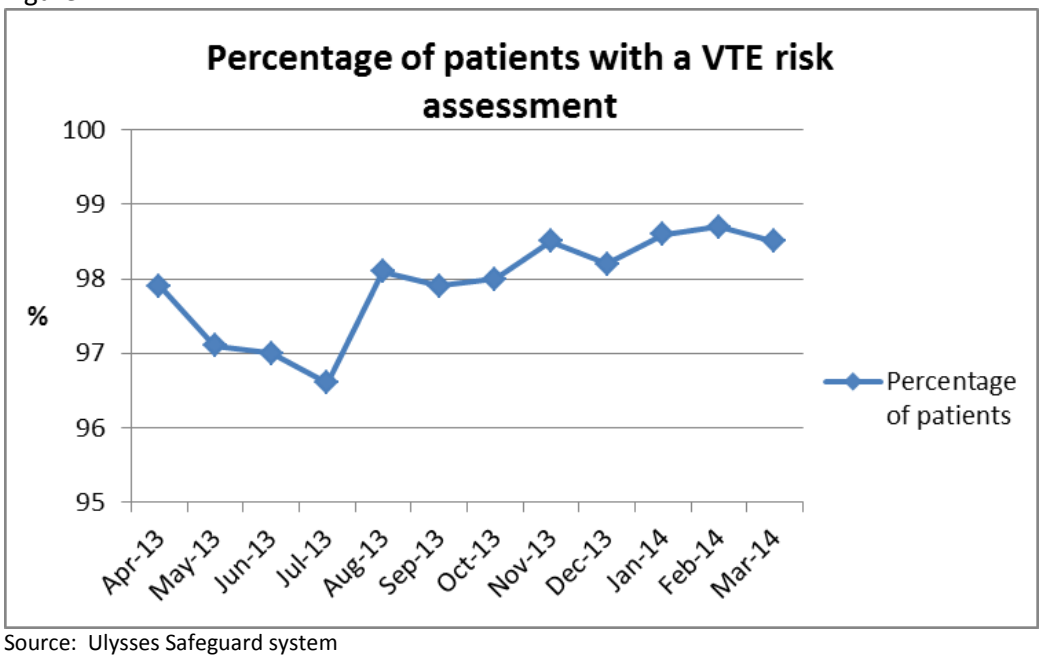
In 2013/14, we wanted to sustain improvements in VTE prevention by continuing to screen patients for risk of VTE and ensuring patients at risk receive appropriate thromboprophylaxis. We achieved a national CQUIN target of 95%+ compliance with VTE risk assessments. The CQUIN was measured quarterly, but in fact the Trust achieved a 95%+ target for VTE risk assessment in every month during 2013/14, as shown in Figure 4. For the year as a whole, 98.0% of inpatients received a risk assessment. This compares with 96.4% in 2012/13.

We also achieved a 90%+ target[14] for appropriate thromboprophylaxis for ten of the 12 months during 2013/14 as shown in Figure 5. For the year as a whole, 93.4% of inpatients identified as being at risk received appropriate thromboprophylaxis. This compares with 94.6% in 2012/13.

The Trust considers its VTE risk assessment data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. Full details of our data quality framework for this indicator are available upon request.

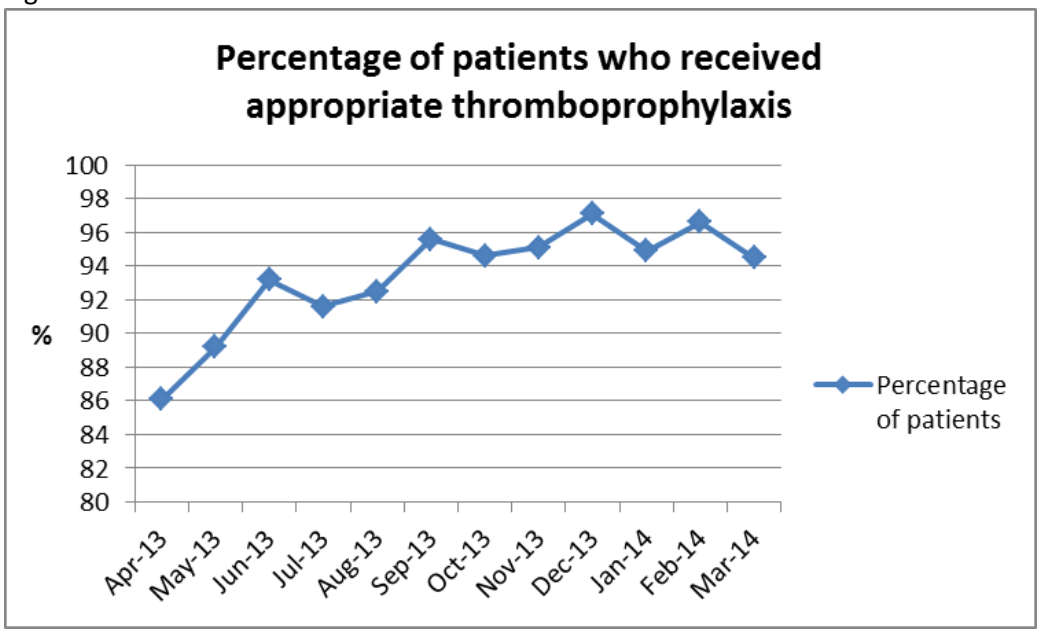
[14] Based on the previous year's CQUIN target

Figure 4



Source: Ulysses Safeguard system

Figure 5



Source: Ulysses Safeguard system

The Trust has taken the following actions in 2013/14 to sustain 95%+ compliance with VTE risk assessments, and so the quality of its services:

- Extending the provision of VTE project nurses to sustain and embed focus on VTE prevention and provide supplementary training by targeting any teams and staff groups where there is evidence of reduced levels of compliance or where, through reported patient safety incidents, patients have been identified as having acquired a VTE in hospital.
- Continuing to focus on VTE prevention training, including induction, update sessions and e-learning.

Also during 2013/14, we agreed with our commissioners details of a nationally mandated CQUIN to investigate hospital associated thrombosis. We agreed to conduct a modified

root cause analysis investigation for at least 90% of all identified hospital associated thrombosis in 2013/14. Root cause analysis enables us to learn from these incidents and take action to help prevent future similar incidents where modifiable factors are identified which have contributed to the incident. There were no modifiable factors identified in the majority patients (39 out of 52) who developed hospital associated thrombosis in quarters 1-3 of 2013/14 i.e. the thromboses were deemed unavoidable. Investigations for those identified in quarter 4 will be completed by the end of May 2014.

Learning from root cause analyses has highlighted the need for additional guidance for continued pharmacological thromboprophylaxis (usually by administration of blood thinning injections) for an extended period following discharge from hospital for additional groups of patients with specific kinds of lower limb fractures. We have also identified the need for more education on the use of anti-embolic stockings and that the use of sequential compression devices[15] may help reduce hospital associated thrombosis in some stroke patients for whom pharmacological thromboprophylaxis is too risky in the early days following a stroke. As a result of this, sequential compression devices are now available on the stroke unit and staff are being trained in their use. They will also be implemented in Ward 200 at South Bristol Community Hospital.

For 2014/15, our goal is to sustain over 95% of patients being risk assessed for VTE, to continue to focus on increasing the proportion of our patients who receive appropriate thromboprophylaxis and to continue our analyses of hospital acquired thrombosis to identify any further opportunities for learning.

Objective 2
We wanted to reduce hospital acquired healthcare infections

GREEN

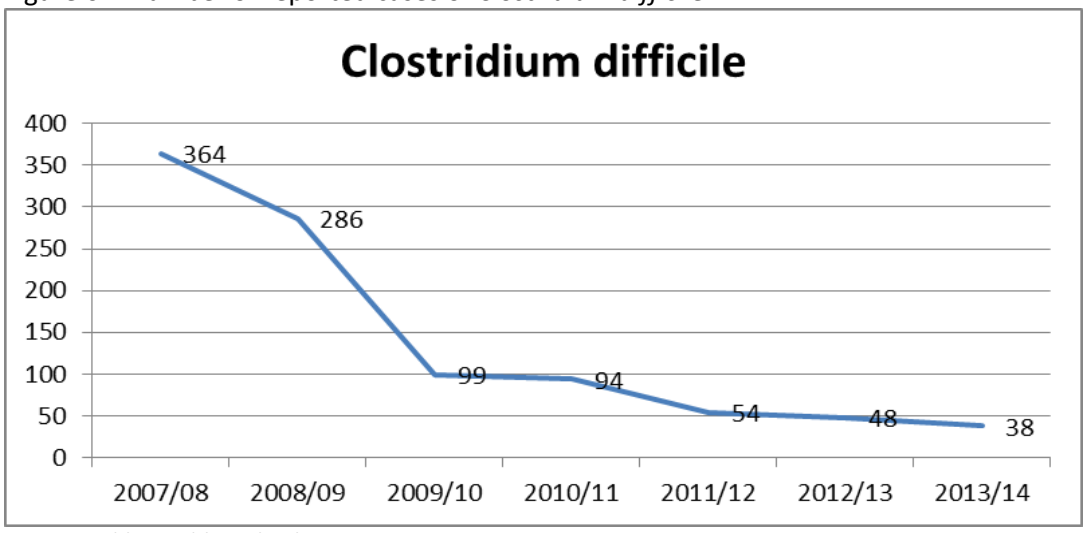
Clostridium difficile
(Mandatory indicator)

The Trust's focus on preventing healthcare acquired infections (HCAIs) is constant and ongoing. In 2013/14, we were disappointed that we exceeded our nationally determined target for *Clostridium difficile* (the Trust reported 38 cases against a target of 35) but nonetheless very pleased to have achieved a 21% reduction in reported cases compared to 2012/13.

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

[15] sequential compression devices involve sending pressure pulses of air into these sleeves (baggy stockings) to stimulate circulation: the devices are for high risk stroke patients only and are used from assessment through to discharge including during rehabilitation

Figure 6 – Number of reported cases of *Clostridium difficile*



Source: Public Health England Data Capture System

The Trust has taken the following actions in 2013/14 to achieve reductions in *Clostridium difficile* infection and so improve the quality of its services:

- Patients continue to be nursed in a separate cohort area and are not admitted back into the general patient population for their duration of stay in hospital.
- Patients are monitored on a daily basis by the infection control team. When patients are discharged, patients' rooms are deep-cleaned. A hydrogen peroxide vapour is used for added assurance of cleaning.
- Antibiotic prescribing is monitored.
- Hand hygiene audits are undertaken each month. If the required standard is not reached, audits are repeated weekly until three consecutive weeks at the required standard are achieved.
- Patients with *Clostridium difficile* are managed by gastro intestinal consultants and an infection control doctor.
- Study sessions have been delivered to general practitioners and nursing home managers to improve community management of *Clostridium difficile.*
- The introduction of Procalcitonin testing of acute admissions, to reduce the antibiotic use and duration of antibiotic treatment.

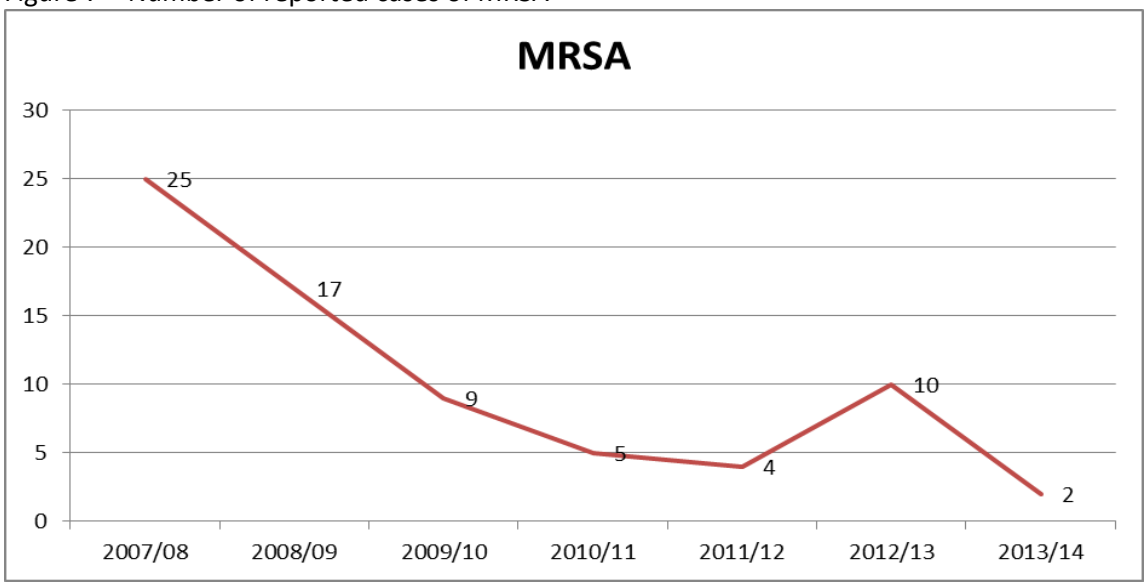
Meticillin resistant *Staphylococcus aureus* (MRSA)

The Trust had two cases of MRSA in 2013/14, which represents a significant improvement compared to 2012/13 (10 cases). Root cause analysis of cases reported in 2012/13 showed there were issues with intravenous (IV) line management and practice. An IV access coordinator post was therefore agreed by the Trust and as a result, we have:

- Established the current level of line management and practice by undertaking clinical shifts and auditing aseptic non touch technique (ANTT) practice across adult areas.
- Made ANTT a part of essential training for all new clinical staff
- Coordinated the setting of Trust-wide care standards regarding vascular access.
- Developed a Trust-wide central line complications protocol.
- Reviewed Trust-wide IV line databases to ensure a consistent approach to data capture.
- Developed and rolled out a Trust-wide IV device selection matrix.
- Reduced blood culture contamination rates.

Neither of the two MRSA cases in 2013/14 was IV line related.

Figure 7 – Number of reported cases of MRSA



Source: Public Health England Data Capture System

Meticillin susceptible *Staphylococcus aureus* (MSSA)
In 2013/14, the Trust recorded 27 cases of MSSA bacteraemia. This was better than our target (29) and an improvement on previous years (36 in 2012/13; 39 in 2011/12). The same actions are in place to reduce MSSA bacteraemia as for MRSA.

Norovirus
In 2013/14, the Trust had a total 47 ward or bay closures (16 and 31 respectively) as a result of norovirus. This compares to 88 closures in 2012/13. The average (mean) length of time for a ward closure was nine days: two days more than 2012/13 but the same level as in 2011/12. We continue to follow national norovirus guidelines and report outbreaks through the Public Health England hospital norovirus outbreak reporting system.

Hand hygiene and antibiotic compliance
We continue to train all staff in infection prevention and control measures. In March 2014, our monthly hand hygiene audit showed 98% compliance. Antibiotic compliance (checking the appropriateness of the antibiotic; whether start and stop dates are recorded; the prescriber's name is legible) is monitored on a monthly basis. In March 2014, the Trust achieved its target of 90% compliance (90.7% of 946 cases audited). The Trust introduced a new antibiotic guideline smartphone app into adult services in February 2014 and we anticipate that the equivalent app for paediatric services will be made available later in 2014.

Objective 3
We wanted to reduce medication errors

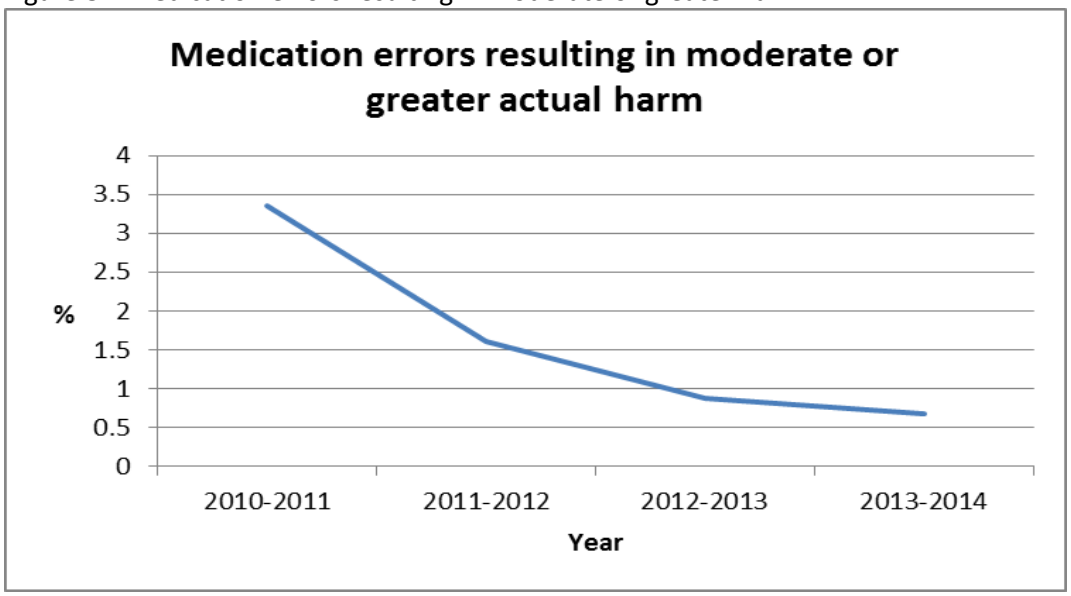
GREEN

In 2013/14, for the third consecutive year, we set ourselves the objective of continuing to drive down levels of medication errors which cause 'moderate', 'major' or 'catastrophic' harm to patients. The reduction of medication errors causing serious harm is a national quality priority within the NHS Outcomes Framework.

Once again, more than 99% of reported medication incidents at our Trust in 2013/14 did not result in major harm to patients (18.4% of incidents were low harm, 61.2% negligible harm (defined as no obvious harm or damage to the patient) and 19.7% were identified as a 'near miss'. Our target was to improve on our 2012/13 performance when 0.88% (14/1,594) of reported medication incidents involved moderate, major or catastrophic harm to patients.

In 2013/14, 0.68% (13/1,910) of medication related incidents resulted in moderate (10/13), major (2/13) or catastrophic (1/13) harm. This represents an improvement on our performance in 2012/13 (0.88%). Changes in 2013/2014 which have contributed to this include a face to face session with all clinical staff at induction on safer medicines management and the successful implementation of a multidisciplinary action plan to reduce omitted doses, along with ongoing work from the learning and feedback from reported incidents.

Figure 8 – Medication errors resulting in moderate or greater harm



Source: Ulysses Safeguard system

In 2014/15, our aim is to comply with the Patient Safety Alert NHS/PSA/D/2014/005 (Improving medication error incident reporting and learning), whilst ensuring the level of moderate or greater harm resulting from medication errors is kept to a minimum.

As in 2012/13, we also set ourselves the goal of reducing omitted doses of critical medicines. This is important to patient safety and quality of care to ensure that the patient receives the maximum benefit from their medicines. From a baseline of 2.59% of patients having a non-purposeful omitted dose (measured by sampling methodology in over 500 patients each month, monitoring the previous three days of treatment), our target was to achieve less than 2.25%. We were successful in reducing the percentage of omitted doses of critical medicines to 1.91% (sampling around 1,000 patients per month) - a 26% reduction, following successful implementation of a multidisciplinary action plan. In 2014/15, our aim is to maintain this low level of omitted doses of critical medicines.

Objective 4

We committed to extend the practise of medicines reconciliation ('getting the medicines right')

GREEN

Medicines reconciliation (locally termed 'getting the medicines right') is a process recommended by NICE[16] which is designed to prevent medication error at hospital admission. Medicines reconciliation involves reviewing and documenting a patient's medicines against the best available sources of information, such as GP records or medicines brought in from home. UK-based evidence indicates that medicines reconciliation is effective in reducing medication errors and resulting patient harm.

In 2013/14, we agreed a CQUIN target with our commissioners to carry out medicines reconciliation within one working day for at least 95% of patients admitted to our hospitals, averaged across identified assessment and cardiac wards. We also committed to extend medicines reconciliation to our oncology, haematology and gynaecology wards, with a target of at least 85% averaged across those areas. Table 3 shows performance by ward and that our targets were achieved.

Table 3

Ward	2012/13			2013/14		
	Number of patients reviewed	Medicines reconciliation carried out within one working day	Aggregate percentage	Number of patients reviewed	Medicines reconciliation carried out within one working day	Aggregate percentage
2	318	95.3%	94.6%	265	99.6%	98.0%
17	140	99.3%		255	98.0%	
CCU	125	97.6%		260	98.5%	
51	120	90.0%		255	96.1%	
52	127	90.6%		265	97.0%	
53	167	93.4%		255	98.8%	
61	0	N/A	N/A	220	94.5%	92.0%
62	0	N/A		189	97.9%	
78	0	N/A		200	83.5%	

Source: ward based audits

In 2014/15, our aim is to maintain coverage in all admissions wards with similar percentages to those achieved in 2013/14. We aim to utilise the national medication safety thermometer risk assessment tool in identified hospital wards to highlight and trend potential medication risks which need to be communicated to primary care clinicians with a view to reducing the incidence and severity of risk. We also aim to evaluate patient re-attendance rates and identify any interventions to mitigate future risk and any common themes.

[16] The National Institute for Health and Clinical Excellence - Patient Safety Guidance Number 1 (December 2007)

Objective 5

We said we would improve the early identification and escalation of care of deteriorating patients

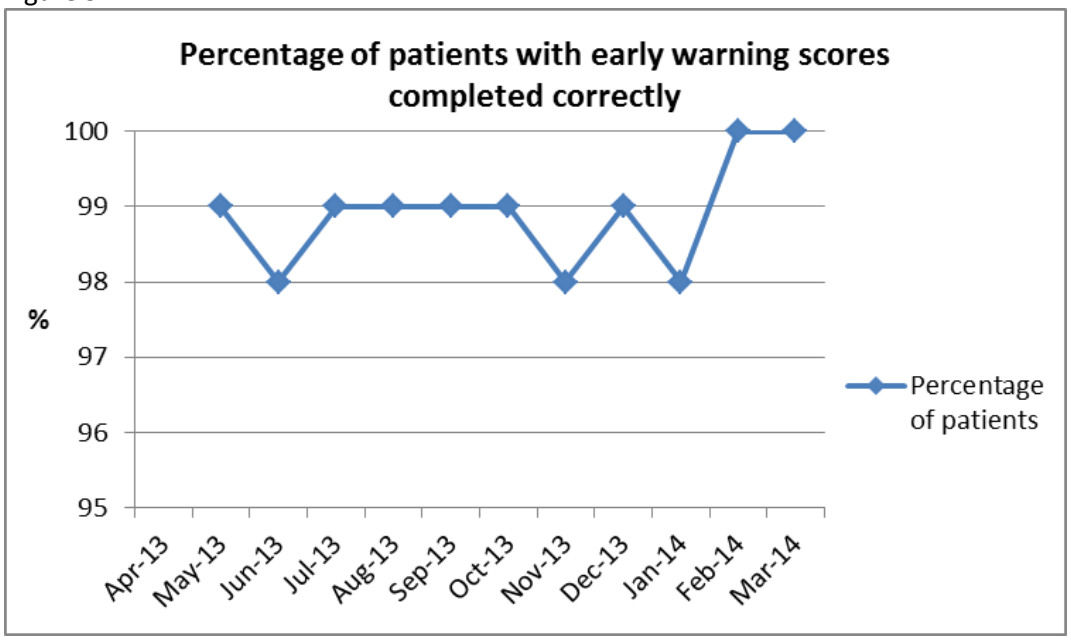
GREEN

As well as using nursing skills and experience to assess the condition of our patients, we also use objective measurements of vital signs, called "observations". This includes, as a minimum, measuring the temperature, pulse, respiration rate and blood pressure of the patient.

These are plotted on our "Bristol Observation Chart" and when individual measurements are outside of the normal parameters, a score is assigned depending on how abnormal they are. The individual scores are then added up to produce an early warning score or "EWS". Generally, the higher the EWS, the more sick the patient is and a pattern of increasing EWS indicates a deteriorating patient. Agreed EWS scores trigger actions by nurses in response to this early warning. A EWS of four is the default point at which a patient is identified as requiring review by a senior nurse or doctor within 15 minutes, known as escalation, although patients with a lower EWS can be escalated if there is additional cause for concern. When this escalation takes place, nurses are required to use a structured communication tool known as "SBAR" (Situation, Background, Assessment and Recommendation) to give the senior nurse or doctor information about the patient in a clear succinct and accurate way so that they can respond promptly as needed.

We agreed a local CQUIN target with our commissioners to ensure that 95% of observations of vital signs were measured correctly and the EWS was correctly calculated, and that the SBAR tool would be used to escalate at least 70% of deteriorating patients with a EWS of four or more in the third quarter of the year, increasing to 80% in the final quarter. Each month, we audited 500-600 patients; in 11 out of 12 months, at least 98% of patients had their early warning scores completed correctly every month (the score for January was 97.8).

Figure 9

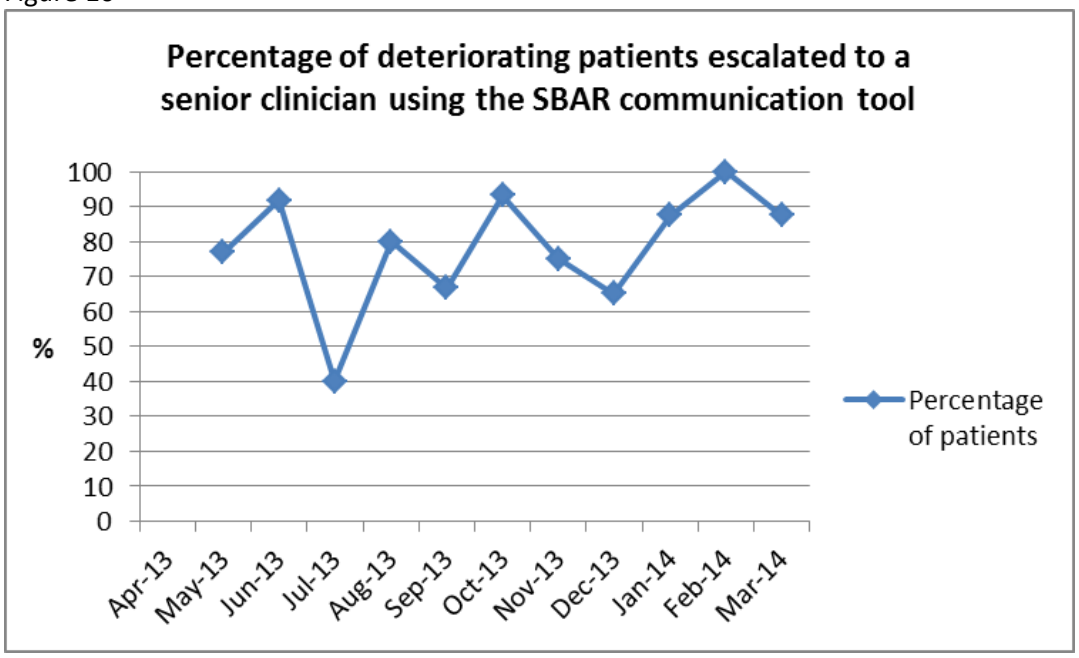


Source: monthly audit

Use of the SBAR communication tool to escalate deteriorating patients for review by a senior clinician has taken time to become established practice. The monthly fluctuations shown in Figure 10 are also due in part to the small numbers deteriorating patients, i.e. small changes in

patient numbers can lead to significant changes in percentage compliance. Figure 10 does however show an overall improvement throughout 2013/14 and we achieved 90.5% for quarter four against our 80% target.

Figure 10



Source: monthly audit

In 2014/15 we aim to sustain the improvements in identifying deterioration and acting on this for the sickest patients, and in addition we will focus on improving responses to less sick patients who may be in earlier stages of deterioration.

Objective 6

We wanted to improve levels of nutritional screening and specifically 72 hour nutritional review of patients

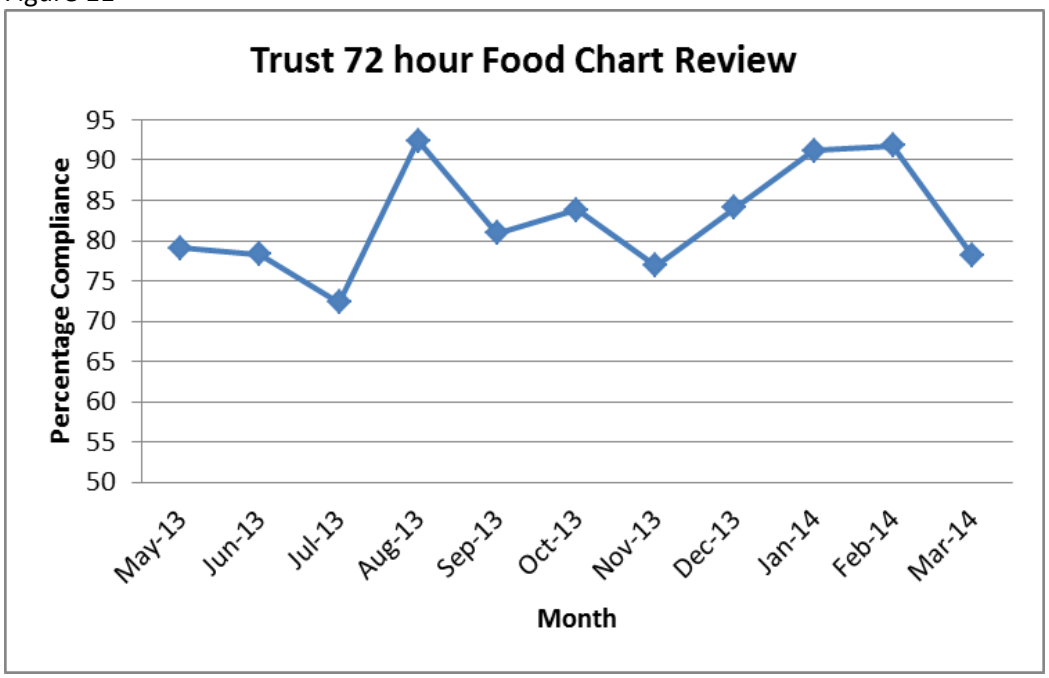
AMBER

In previous Quality Reports, we have explained how we have used feedback from the Care Quality Commission to improve the quality of nutritional care that patients receive, and how we are using volunteer staff to support patients who need help at mealtimes. All patients are screened for risk of malnutrition when they are admitted to hospital. If a patient is identified to be at risk, a number of agreed actions follow, including the requirement to complete a food chart and to formally review this 72 hours after admission. For 2013/14, we agreed a CQUIN target with our commissioners that in the final quarter of the financial year, at least 90% of adult patients who had initially been assessed as being at risk of malnutrition would receive a nutritional review after 72 hours. Performance against this indicator is monitored via the NHS Safety Thermometer; results form part of the supervisory sisters' key performance indicators and are reported to the monthly Nutrition Steering Group. Actions and improvements for wards that are not achieving the required levels of nutritional review are a standing agenda item for the group.

Despite a considerable amount of work at ward level, the CQUIN was not achieved. We met the required target in January and February 2014, but a dip in performance in March pulled our quarterly score down to 87.2%. Nonetheless, Figure 11 points to a positive trend in recent

months and we are focussing on restoring this pattern of improvement at the start of 2014/15. Overall compliance for the period May 2013[17] – March 2014 was 82.5%.

Figure 11



Source: NHS Safety Thermometer

Review of patient safety 2013/14

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

The percentage of reported incidents resulting in severe harm is 0.2% (12 incidents) for the period April-September 2013. This represents a reduction compared both to the previous six months (0.5%, 31 incidents) and the corresponding period in 2012/13 (0.7%, 35 incidents) as reported in our 2012/13 Quality Report. The percentage of reported incidents resulting in death remains at 0%[18] (1 death) for the period April-September 2013. This represents a reduction compared both to the previous six months (0.1%, three deaths) and the corresponding period in 2012/13 (0.1%, four deaths) as reported in our 2012/13 Quality Report, and is below the average rate of our peer group (0.1%). The provisional percentage of reported incidents resulting in severe harm or death was 0.34% (39 severe harm incidents; and 2 potentially avoidable deaths) for 2013/14 as a whole[19]. The Trust considers its incident reporting data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. This framework governs the identification and review of incident data prior to submission to the National Reporting and Learning System (full details are available upon request).

In 2014/15, the Trust intends to take the following actions to continue to reduce harm from avoidable patient safety incidents:

[17] This is when data collection began
[18] technically 0.000166% (1/6012)
[19] Consisting of data for first six months of 2013/14 which has been validated by NRLS, and data for the second six months of the year which is sourced from the Trust's Ulysses Safeguard system

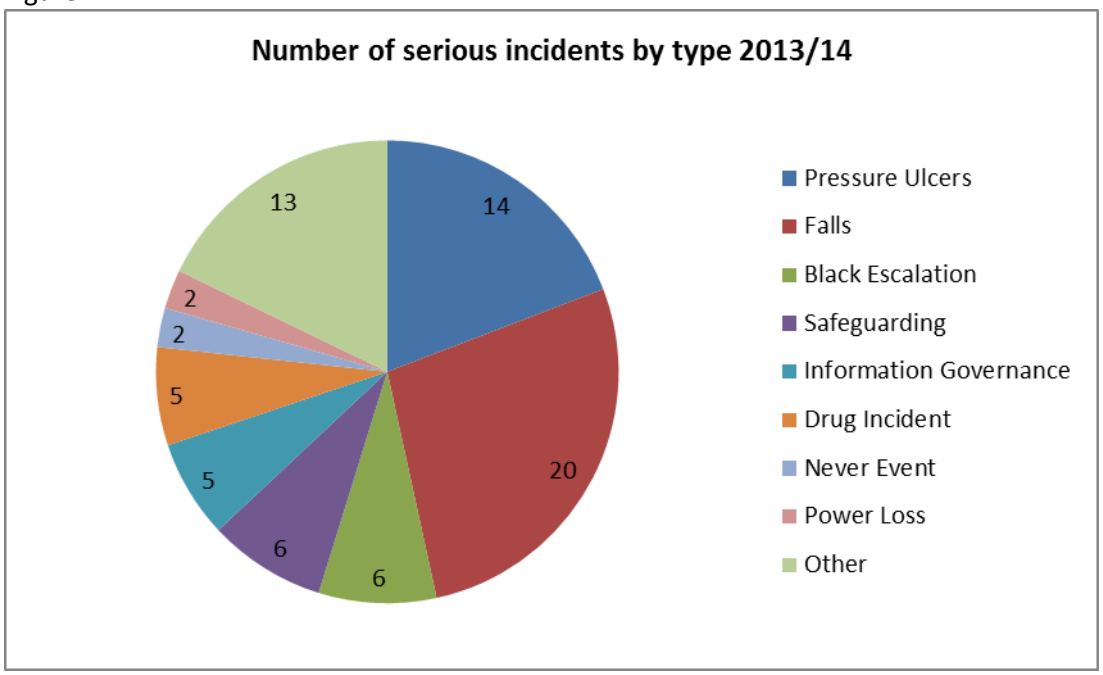
- Complete our five year proactive patient safety improvement programme (renamed Safer Care Southwest) in October 2014 and participate in the safety improvement work of the new regional patient safety collaborative/s.
- Continue to investigate incidents proportionally to their level of harm or risk, and improve how we share learning and taking action across the organisation to reduce the likelihood or impact of the same kind of incident happening again.
- Build on our improvements in 2013/14 for key patient safety issues for the Trust such as reducing the medication errors, reducing inpatient falls and improving the identification of the deteriorating patient and ensuring prompt review by a senior clinician.
- Pilot and, if successful, implement a system for systematic review of adult mortality.[20]

Also see the Trust's quality objectives for 2014/15 on page 47 of this report.

Serious incidents

The purpose of identifying and investigating serious incidents, as with all incidents, is to understand what happened, learn and share lessons and take action to reduce the risk of a recurrence. The decision that an event should be categorised as a serious incident is usually made by an executive director. Throughout 2013/14, the Trust Board was informed of serious incidents via its monthly quality dashboard. The total number of serious incidents reported for the year was 73 compared to 91 in 2012/13. Of the 73 initially reported, five were either downgraded or a downgrade request has been made at the time of writing (April 2014). A breakdown of the themes from these incidents is provided in Figure 12 below.

Figure 12



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

All serious incident investigations have robust action plans which are implemented to reduce the risk of recurrence. Actions taken by the Trust to reduce falls and hospital acquired pressure ulcers are documented elsewhere in this report. Serious incidents are governed by national definitions through NHS England.

Never events

[20] There already exists a well-established Child Death Review Process

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

Two never events occurred in University Hospitals Bristol in 2013/14:

1. A case of wrong site surgery: an emergency procedure was commenced on the wrong side. The mistake was identified shortly after the start of the procedure, remedial action was taken and then the procedure took place on the correct side. The patient came to minor harm; they were informed of the mistake afterwards and a sincere apology was offered. This incident was not prevented by the WHO[21] surgical safety checklist which was completed prior to the procedure starting. The root cause analysis investigation identified, among other things, that making the site of surgery visible within the surgical field after the patient was draped (covered with sterile sheets to reduce the risk of infection during the operation) would probably have prevented this incident. This change in practice will be implemented and a further serious incident panel investigation has been commissioned by the medical director to identify further broader systemic and organisation-wide recommendations.

2. A retained foreign object following emergency surgery: a removable part of a disposable instrument became inadvertently detached during use and was left inside a patient. The patient required a further minor procedure to remove the object. The patient and family were informed of the retained object when its presence was identified and an apology was offered. An immediate action was instigated to ensure all disposable items are included in surgical counts. A serious incident panel investigation was commissioned by the medical director to identify any systemic and organisation-wide learning.

For 2014/15, a proactive Trust-wide review of systems in operating theatres is already underway to identify further risk-reduction actions which can be taken to prevent surgical never events. In February 2014, NHS England published a report of its Never Events Taskforce which was commissioned in response to the recognition that surgical never events are the most commonly reported types of never events. The report identified NHS-wide actions to be taken to with the aim of eradicating surgical never events. Recommendations from the report will form part of the Trust's proactive review, as described above.

NHS England's provisional data for 2013/14 shows that a total of 312 never events occurred in NHS trusts, of which 132 involved a retained foreign object and 89 involved wrong site surgery. At least one never event was reported by 159 NHS trusts, with the maximum number reported by any single trust being eight. Never events are governed by national definitions.

NHS England Patient Safety Alerts

At the end of 2013/14, there were no outstanding alerts relating to University Hospitals Bristol NHS Foundation Trust.

[21] World Health Organisation

PATIENT EXPERIENCE

Our ongoing commitment

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

Report on our patient experience objectives for 2013/14

Objective 7
We were required to implement the Friends and Family Test in adult inpatient, emergency department and maternity services

GREEN

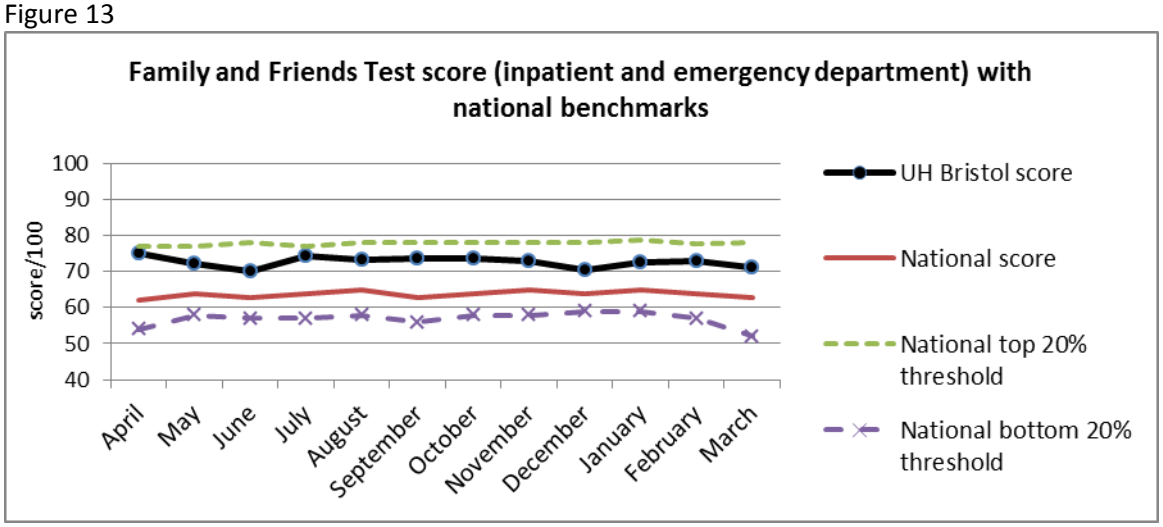
The Friends and Family Test (FFT) is a national survey designed to give patients an opportunity to comment on the care they have received and to help people to make decisions about where they have their NHS treatment in the future. The FFT was launched nationally in adult inpatient and emergency department (ED) services on 1st April 2013, and was subsequently extended to maternity services on 1st October 2013. Patients are asked whether they would recommend the care they received to their friends and family. At University Hospitals Bristol, inpatients and ED patients are given an FFT card as part of their discharge from hospital. In maternity services, women are asked to complete the FFT on up to four occasions in relation to their antenatal community midwifery care, their experience in hospital giving birth and/or on the postnatal ward, and in respect of the postnatal care provided by their community midwife.

In last year's Quality Report, we published "net promoter scores" (the technical term for the scores generated by the FFT question) from our own monthly survey. This year, we are replacing this with the official national FFT data. To date, the Trust's FFT scores in the inpatient and ED elements of the survey have been consistently better than the national average (see Figure 13).

There were two national Commissioning for Quality and Innovation (CQUIN) payments associated with the FFT survey in 2013/14[22]. The Trust met the first element of this CQUIN, having implemented the FFT in adult inpatient wards, emergency departments and maternity services as per the Department of Health's guidance. We also secured half of the value of the second element: although we achieved a 24.6% response rate in the final quarter of the year (against a target of 20%), we had previously underachieved in the first quarter of the year (8.4% against a target of 15%).

[22] Note: there is another element of this CQUIN which is associated with a score in the NHS National Staff Survey

Figure 13



Source: UH Bristol Friends and Family Test survey / NHS England

National benchmarks for the maternity FFT have recently been released: we are achieving above national average scores in the community midwifery and care during birth elements of the survey (see Table 4). The Trust's FFT score relating to care on postnatal maternity wards has fluctuated around the national average, influenced by the relatively low number of responses being collected on the maternity wards at present. The Trust has agreed a set of actions to improve the response rates in these areas.

Table 4: maternity FFT scores

	October	*November*	*December*	*January*	*February*	*March*
UHB antenatal community midwifery score	73	72	66	75	77	65
Overall national score	64	65	63	67	67	Not available
UH Bristolcare during birth score	92	91	68	92	92	86
Overall national score	76	77	75	78	75	Not available
UH Bristol postnatal wards score	50	69	30	76	59	62
Overall national score	65	66	66	65	64	Not available
UH Bristol postnatal community midwifery score	90	80	78	84	82	79
Overall national score	71	72	78	75	75	Not available

In 2014/15, all NHS hospital trusts will be required to be extend the FFT into outpatient and day case care and there will be a new national FFT for staff. The required response rates for the inpatient and emergency department FFT CQUINs will increase in 2014/15. We are developing plans to ensure that all of these targets are achieved.

Objective 8
We wanted to ensure that patients continue to be treated with kindness and understanding on our wards.

GREEN

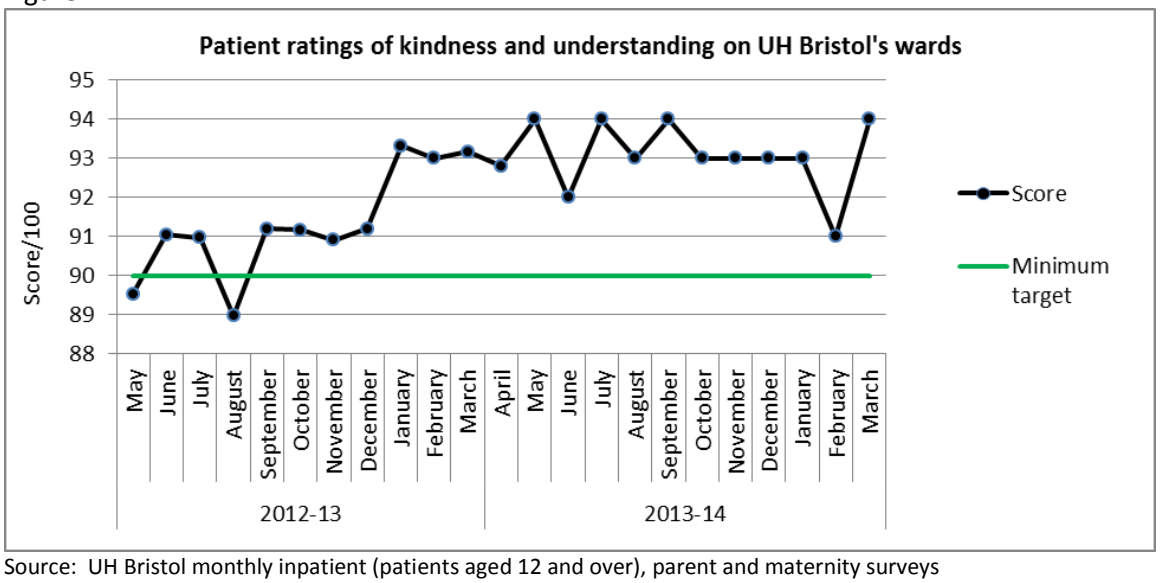
As well as asking patients whether they would recommend us, another important measure of patient experience is whether people feel that they have been treated with kindness and understanding – a hallmark of compassionate care. Last year, we achieved excellent scores on this patient-reported measure and set an objective to sustain this in 2013/14. We are delighted to report that we succeeded: our survey scores have been consistently above 90 points throughout 2013/14 to date (see Figure 14). The Board will continue to monitor our monthly kindness and understanding score in 2014/15.

What patients said in our monthly inpatient survey:

"Every time I've been in the Bristol Royal Infirmary, I have found everyone, from consultants, doctors, nurses, catering staff and even cleaners kind, helpful and polite. I could not fault anyone."

"I had a bad heart attack and had some memory loss, but after the fifth day I started to get back to my old self, all I can think of was how great all the staff in the BRI treated me and made me very at ease. In one of the most scariest and hardest times of my life if it was not for the great care I received and not just medical, I don't think I would be here now, they helped in so many ways I would like to thank everyone of them for their great care and understanding."

Figure 14



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

Objective 9
Explain potential medication side effects to inpatients when they are discharged

RED

Telling patients about the potential side effects of the medications that they are taking away with them from hospital is an important aspect of patient experience and patient safety. Although the Trust's performance is similar to most other NHS trusts, as measured in the national inpatient survey, it is an aspect of care where almost all NHS trusts have considerable scope for improvement.

What patients said in our monthly inpatient survey:

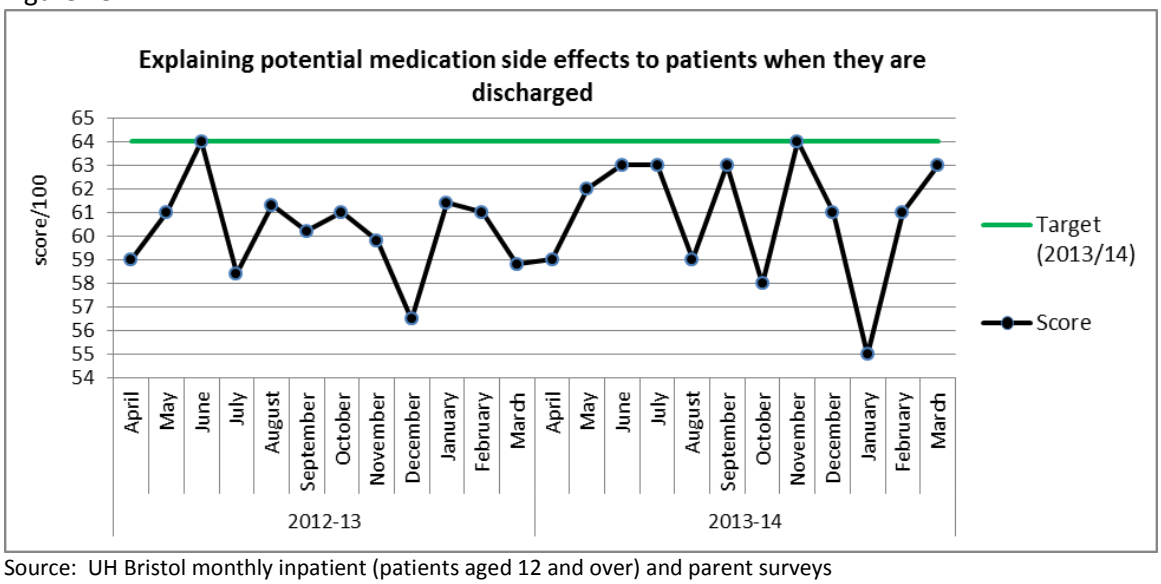
"When I left hospital there was no advice on any side effects or pain issues to be expected."

"Give more explanation of side effects and what you may expect during recovery both whilst in the hospital and when you get home. I had some issues and problems which were normal but would have been less stressful if warned in advance."

Despite our best efforts, our performance in 2013/14 has remained disappointing – albeit still in line with the national average. A new e-tool has also been developed by our pharmacy department to enable ward staff to provide each patient with a tailored list of potential medication side effects for the medication they are leaving hospital with. The system has been successfully piloted on a small number of wards and in the new discharge lounge, and will now be rolled out across the Trust. Informing patients about medication side effects will also form part of the Trust's new inpatient discharge checklist, due to be rolled out in early 2014/15.

Although there was evidence of an improvement in patient experience between May and July 2013, the subsequent data pattern suggests that this improvement was most probably due to natural statistical variation (see Figure 15).

Figure 15



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

Objective 10

We wanted to improve the experience of maternity patients

AMBER

Patient experience ratings on postnatal wards are generally lower than other inpatient wards. This is a national trend which is reflected at University Hospitals Bristol NHS Trust. Since 2012/13, the Trust has made a concerted effort to improve the experience of people who use our maternity service and postnatal care in particular. Developments in 2013/14 have included three projects supported by the Trust's patient experience and involvement team:

- improving the patient experience of women who have an induced labour;
- holding patient experience workshops for newly recruited midwives focussing on how their role impacts on patient experience; and
- identifying and supporting a consultant-level patient experience champion who will lead patient experience and involvement initiatives in postnatal care.

Elsewhere, a new midwifery-led unit has been opened at St Michael's Hospital and antenatal ward staffing is being reconfigured to improve patient experience, especially for induction of labour. Funding has been secured for three band 7 posts to focus on breast feeding and bereavement services. Previously in 2012/13, we ran a series of "Patients at Heart" workshops for maternity staff at St Michael's Hospital, which has contributed to a reduction in complaints.

What patients said in our monthly maternity survey:

"The care I received from staff at St Michael's both during my pregnancy, the birth and post natal 6 day stay was excellent."

"Midwifery Led Unit at St Michael's - excellent care and a wonderful overall experience. Would highly recommend to anyone having a baby."

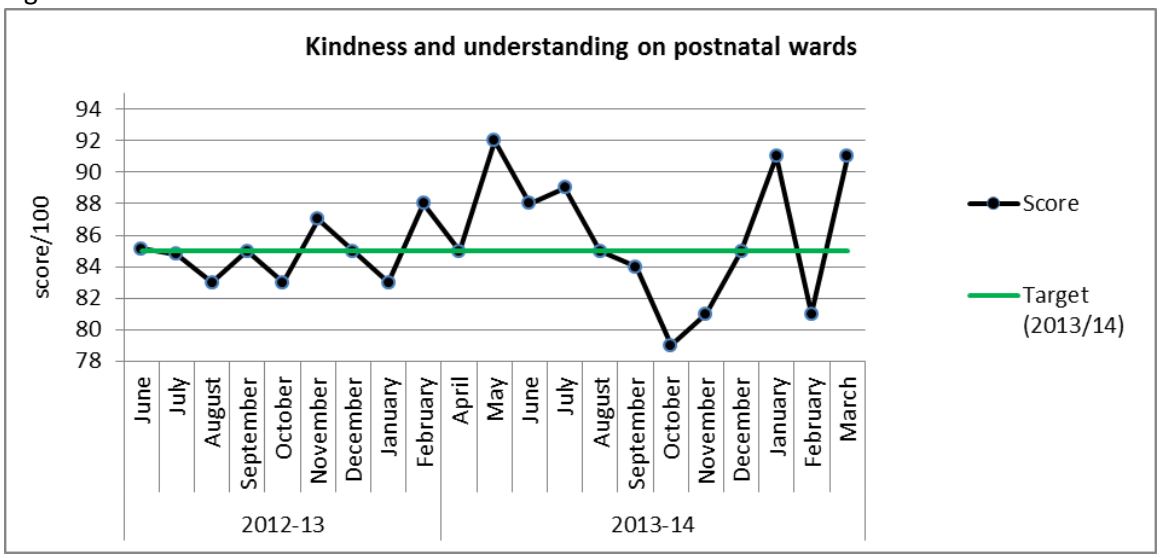
"Faultless care on delivery suite…very caring and personable. Disappointed with ward care."

Our scores in the 2013 national maternity survey were excellent[23]: the Trust was rated as being [statistically significantly] better than the national average, having previously been on the threshold of being in the worst 20% of trusts nationally in 2010. However our own monthly survey of maternity patients has shown fluctuating scores relating to kindness and understanding on postnatal maternity wards (see Figure16). In the third quarter of 2013/14, our score deteriorated during a time of adjustment for the service: postnatal wards were being reconfigured and a number of new midwives were appointed. These changes will have a positive effect on postnatal ward experience and our scores from November 2013 have started to reflect this.

In 2014/15, the maternity service will continue to focus on improving patient experience on the wards by evaluating and acting upon patient feedback. As part of this, our supervisors of midwives will be going onto the wards and into other patient areas to talk to women about their experiences of midwifery and obstetric care. In response to previous patient feedback, we are also planning to introduce the practice of allowing some partners to stay on the wards.

[23] The national maternity survey results reflected the experience of women who gave birth at the Trust in March 2013. The results were released in December 2013.

Figure 16



Source: UH Bristol monthly maternity survey

Review of patient experience 2013/14

Overall patient experience

What patients said in our monthly survey:

"I was taken care of in a manner that was very caring and professional. I did not have a single complaint. They saved my life and took excellent care of me."

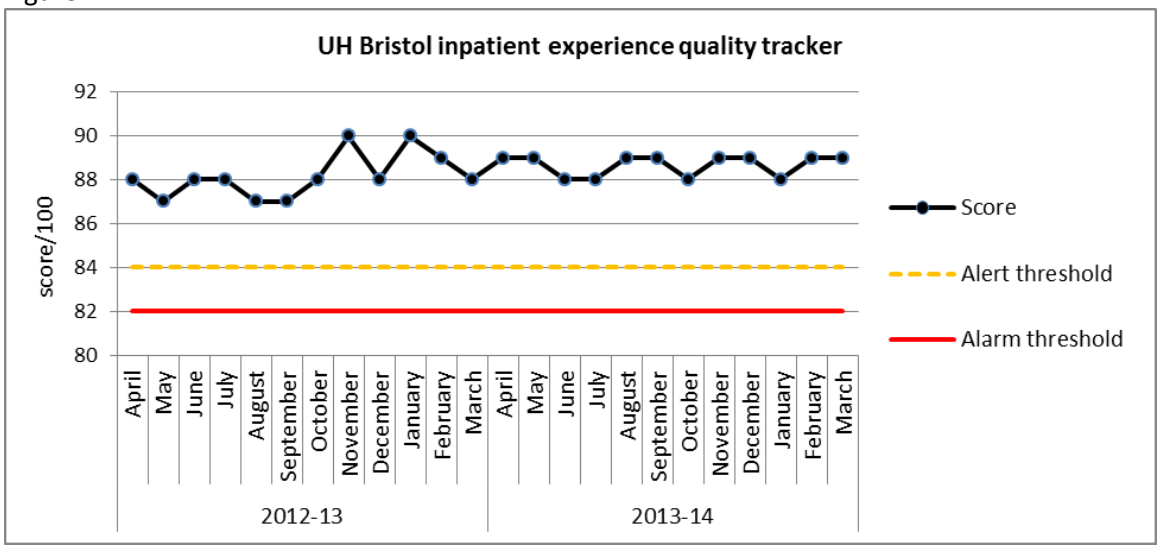
Local patient experience 'tracker' score

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

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

This is a key quality assurance indicator that is reported to our Trust Board each month. If standards were to begin to slip, this would be identified in the survey and actions would be taken to remedy this. Throughout 2013/14, our tracker score has been consistently above our minimum target. The Board will continue to monitor the monthly tracker score in 2014/15.

Figure 17

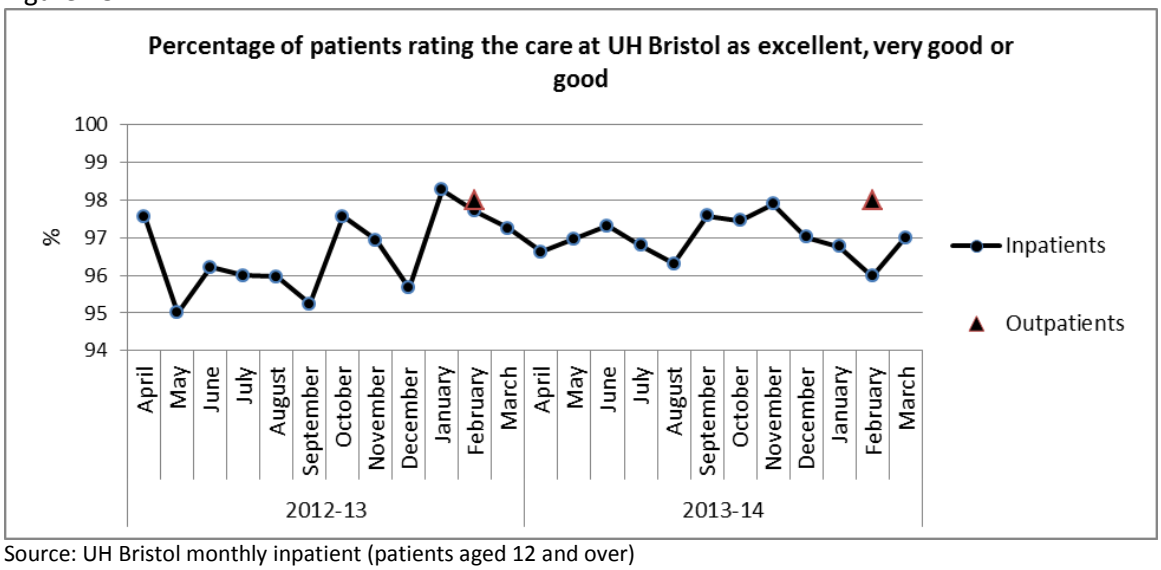


Source: UH Bristol Monthly inpatient survey (patients aged 12 and over)
Note: the alert limit would represent a statistically significant deterioration in the Trust's score, prompting us to take action in response

Overall care ratings

Another way of measuring overall experience of care is to pose that question directly to patients. In 2013/14 (to January 2014), 97% of all survey respondents aged 12 and over rated the care they received at the Trust as excellent, very good, or good (see Figure 18. A similar score (98%[24]) was achieved for outpatient services in the Trust's annual outpatient survey.

Figure 18

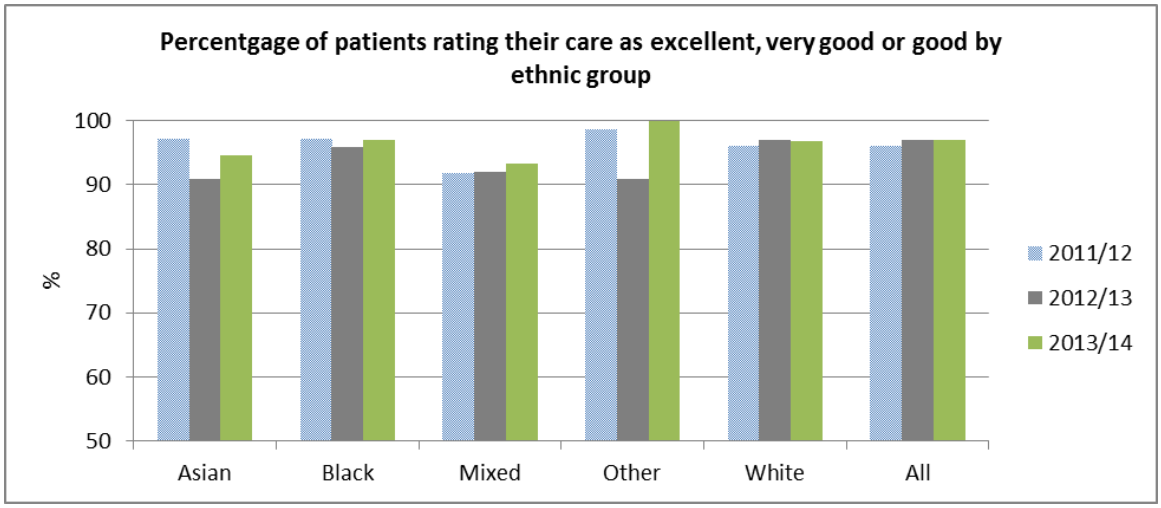


Source: UH Bristol monthly inpatient (patients aged 12 and over)

We continue to monitor patient-reported experience data to ensure that there is no evidence of statistically significant variation in reported experience according to the ethnicity of our patients. The differences shown in Figure 19 are not statistically significant, i.e. they are most likely caused by chance fluctuations in the data.

Figure 19

[24] provisional data



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

Complaints

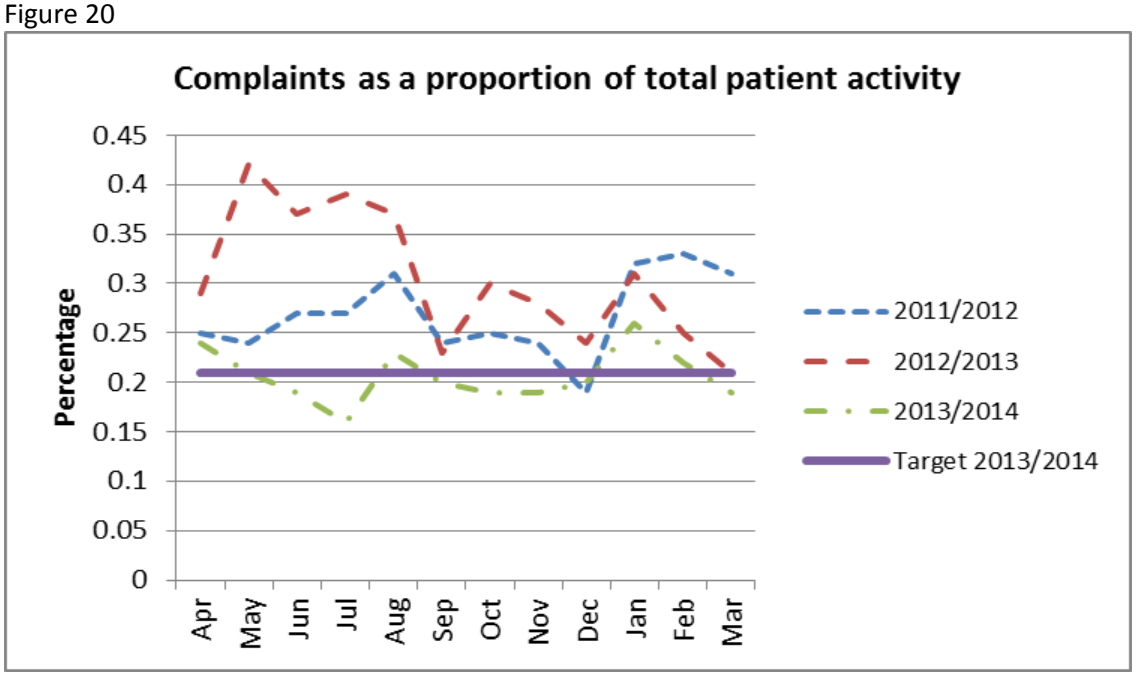
In 2013/14, 1,442 complaints were reported to the Trust Board, compared with 1,651 in 2012/13, 1,465 in 2011/12 and 1,532 in 2010/11). This equates to 0.21% of all patient episodes, against a target of <0.21%.

Figure 20 demonstrates shows the number of complaints received each month as a proportion of patient activity. The volume of complaints received throughout the year has remained steady. The sharp increase in complaints in March 2014 was largely attributable to the cancellation of routine surgery and outpatient clinics during a period when the Trust was experiencing significant pressures on services, including an increase in emergency admissions. 40% of complaints received in March were attributable to appointments and admissions.

Staff in our Trust work hard to ensure that complaints are investigated thoroughly and that our response letters are open, honest and comprehensive. Our target for 2013/14 was that no more than 47 complainants would tell us that they were dissatisfied with the quality of our response. In the event, 62 complainants told us that they remained unhappy: a significant and disappointing increase compared to the 20 cases we reported in 2012/13. All response letters are carefully checked our Patient Support and Complaints Team before being sent to the Chief Executive's office for further checking and then signing. We continue to educate and train staff in response-writing skills: a recent example being collaborative training events with the Patients' Association. In 2014/15 we plan to introduce a new system of routinely asking complainants to confirm the key objectives of making their complaint, in order to ensure that the Trust provides responses which reflect the complainant's core concerns.

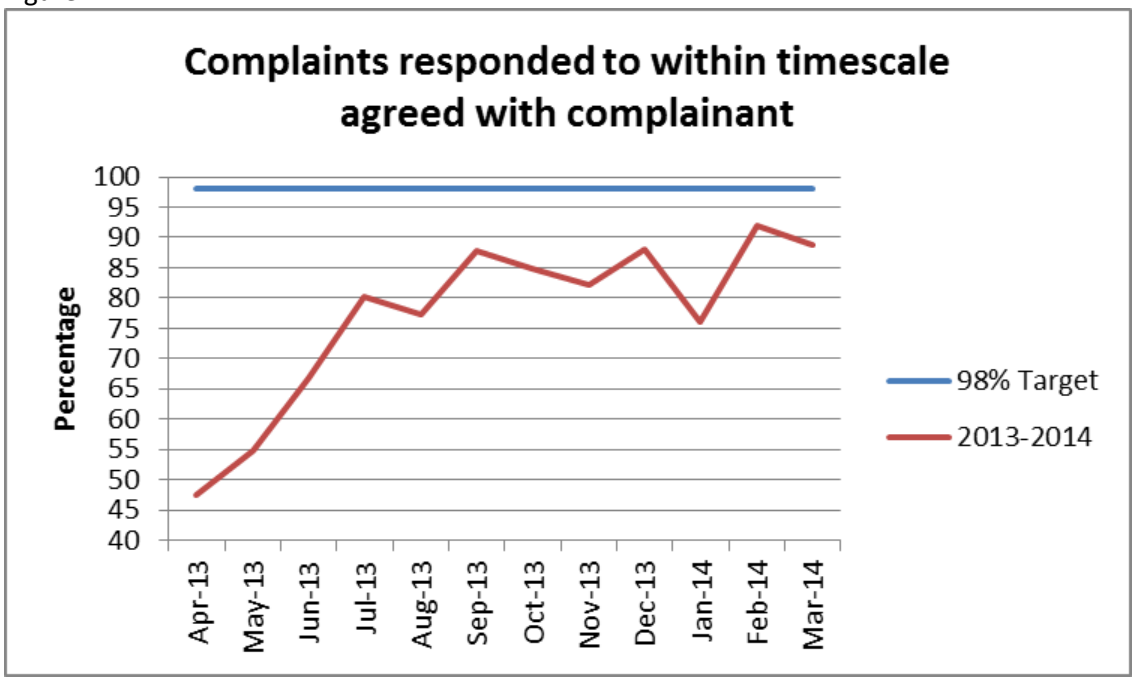
Last year, we reported that we had identified an administrative error affecting the validity of data about whether the Trust was responding to complaints within agreed timescales. This error affected our historic data, so it is not possible to provide accurate comparative data for years prior to 2013/14, suffice to say that the true picture will have been notably worse than the one previously reported. The error was identified in May 2013, after which concerted effort was put into improving response times, including improvements in our internal monitoring of the progress of complaints investigations. As a result, Figure 21 below shows significant improvement during 2013/14. We are confident that we will see this pattern of improvement sustained in 2014/15. In 2013/14 as a whole, 76.4% of complaints were responded to within the timescale agreed with the complainant, against a target of 98%.

Figure 20



Source: UH Bristol Ulysses Safeguard system

Figure 21



Source: UH Bristol Ulysses Safeguard system

2013/14 has been a year of change for our Patient Support and Complaints team. In December 2013, the team relocated from its temporary home in the Bristol Dental Hospital to a prominent location in the new Bristol Royal Infirmary Welcome Centre. Complaints management has had a high profile across the whole of the NHS in 2013/14, partly as a result of the Francis Report into failings at Mid Staffordshire NHS Foundation Trust, partly in response to the subsequent Clwyd-Hart Report, and also following important recommendations published by the Parliamentary and Health Service Ombudsman. Our action plan in response to these various publications was presented to our Trust Board in January 2014 and will be implemented throughout 2014/15. One of the early actions in this plan is the above-mentioned collaborative project with the Patients Association (ongoing at the time of writing), the overall objective of which is to gain a

better understanding of, and learn from the experience of people who complain about our services.

More detailed information about complaints themes and learning will be published in the Trust's annual complaints report later in 2014.

Improving patient experience in outpatients services

The Trust has been working hard in 2013/14 to improve its outpatient services. An outpatients improvement programme, led by the Director of Finance, has involved the majority of outpatient departments across the Trust, focussing on productivity, efficiency and improving patient experience.

First and foremost, we have been listening to our patients. One of the things that patients have complained about is not being able to speak to outpatient staff to enquire about their appointment or to book and rebook their appointment, leading to frustration, anxiety and appointment slots being wasted. In order to address this, the Trust has invested in a central appointment centre, located in the new Bristol Royal Infirmary Welcome Centre and manned by experienced call handlers who work to a target of 95% of calls being answered within 60 seconds. This has significantly improved patient access and has seen a marked reduction in complaints. We aim to continue to extend the appointment centre service in 2014/15 to cover the majority of outpatient services in the Trust.

We have also been working to reduce waiting times in clinic, another significant source of patient complaints. In particular, we have been working with staff at the Bristol Eye Hospital to smooth out the flow of appointments and reduce queues and waits in clinic.

We understand that it is not always easy for patients to get into the city for their appointment, so - where clinically appropriate - we have been offering telephone appointments where a clinician can consult with a patient over the phone.

Finally, we have been working hard to reduce the number of patients who do not turn up for their appointment. In 2013/14, approximately 62,000 patients "did not attend". This represents 7% of appointments: a significant improvement compared to almost 10% in 2012/13. The Trust

has invested in an appointment reminder system that sends a text message to the patient seven days and 24 hours before their appointment (or an automated call reminder to their landline). We will continue to improve the productivity and efficiency of our outpatient services in 2014/15 to ensure we offer the public value for money and patients a better experience of our outpatient services.

NHS Staff Survey 2013

As in previous years, in line with the recommendations of the Department of Health, we are including in our Quality Report a range of indicators from the annual NHS Staff Survey which have a bearing on quality of care. Relevant results from the 2013 survey are presented below. Questionnaires were sent to a random sample of staff across the Trust (this includes only staff employed directly by the Trust): 439 Trust staff took part in this survey, representing a response rate of 52% (around the average for acute hospital trusts in England). This compares with a 55% response rate in 2012.

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

Table 5

'Key finding'	UH Bristol Score 2013	UH Bristol score 2012	UH Bristol score 2011	UH Bristol score 2010	National average score 2013	National best score 2013
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	74% Lowest (worst) 20% [25]	79% (average)	74%	76%	79%	86%
Percentage of staff agreeing that their role makes a difference to patients	91% (average)	92% Highest (best) 20%[26]	92%	92%	91%	95%
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (to other staff or to patients)	39% Highest (worst) 20%	39% Highest (worst) 20%	39%	39%	33%	18%
Percentage of staff stating that they or a colleague had reported potentially harmful errors, near misses or incidents in the last month	90% Average	91%	96%	91%	90%	97%

[25] i.e. this score was in the lower quintile (worst 20%) of NHS acute trusts
[26] i.e. this score was in the upper quintile (best 20%) of NHS acute trusts

Staff recommendation of the Trust as a place to work or receive treatment *(Mandatory indicator[27])*	3.76 Above (better than) average	3.66	3.65	3.68	3.68	4.25

Source: NHS Staff Survey

The score for staff recommending the Trust as a place to work or receive treatment is a statistical aggregation of responses to four related questions in the annual survey, as detailed below:

Table 6

Question / statement	UH Bristol score 2013	National average (median) score for acute trusts 2013	UH Bristol score 2012
"Care of patients / service users is my organisation's top priority"	69	68	63
"My organisation acts on concerns raised by patients / service users"	72	71	72
"I would recommend my organisation as a place to work"	60	59	60
"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	74	64	71
Staff recommendation of the trust as a place to work or receive treatment	3.76	3.68	3.66

Source: NHS Staff Survey

The Trust considers that this data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. The reported data is taken from a national survey[28], which the Trust participates in through an approved contractor, adhering to guidance issued by the Department of Health.

A key priority for the Trust is to ensure that our patients not only receive excellent clinical treatment but are treated with dignity, respect and compassion at every stage of their care. It is also vital for us to ensure that our staff are treated and treat each other with the same level of dignity and respect we expect for our patients.

Whilst the 2013 staff survey results are positive in terms of overall staff engagement and the recommendation of the Trust as a place to work or receive treatment, the overall results are mixed. Key actions for 2014/15 will therefore include:

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

[28] Important note: the UH Bristol figures quoted for 2010 and 2011 and 2012 are those which will be found in the 2010, 2011 and 2012 NHS Staff Attitude Survey reports. The 2010 figures may differ slightly from the 2010 figures quoted in the 2011 NHS Staff Attitude Survey report; the 2011 figures may differ slightly from the 2011 figures quoted in the 2012 report and the 2012 figures may differ slightly from the 2012 figures quoted in the 2013 report. This is because the Picker Institute, which runs the surveys, re-calculates the data each year. The Picker Institute has advised that either version of the data is appropriate for publication: we have chosen to use the original data for purposes of consistency and transparency.

- Working with leaders to share the Trust's vision and mission
- Reviewing our staff appraisal system and the quality of appraisals
- Setting clear expectations for leaders in the organisation and supporting their development
- Developing a Trust-wide work related stress action plan
- Reviewing e-learning package to support managers in addressing work-based discrimination
- Implementation of the NHS Family and Friends Test for staff and other 'pulse checks' to gauge staff perceptions on a regular basis
- 360 degree feedback on lived values for all senior leaders.

CLINICAL EFFECTIVENESS

Our ongoing commitment

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

Report on our clinical effectiveness objectives for 2013/14

Objective 11

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

AMBER

Improving the care of stroke patients is a national priority within the NHS Outcomes Framework. There is extensive evidence to show that care on a dedicated stroke unit care reduces patient mortality, disability and the likelihood of requiring institutional care following stroke. There is a national standard which states that at least 80% of stroke patients should be treated for at least 90% of the time on a dedicated stroke unit. Our local stretch objective is that 90% of patients should spend 90% of their time on ward 15, our dedicated stroke unit. The Trust operates with a protected bed standard operating procedure for stroke care, designed to ensure that a direct admission bed is always available on ward 12 to support direct admissions. In 2012/13, we were disappointed that only 79.3% of stroke patients spent at least 90% of their time on ward 12: we therefore retained this as a quality objective for 2013/14.

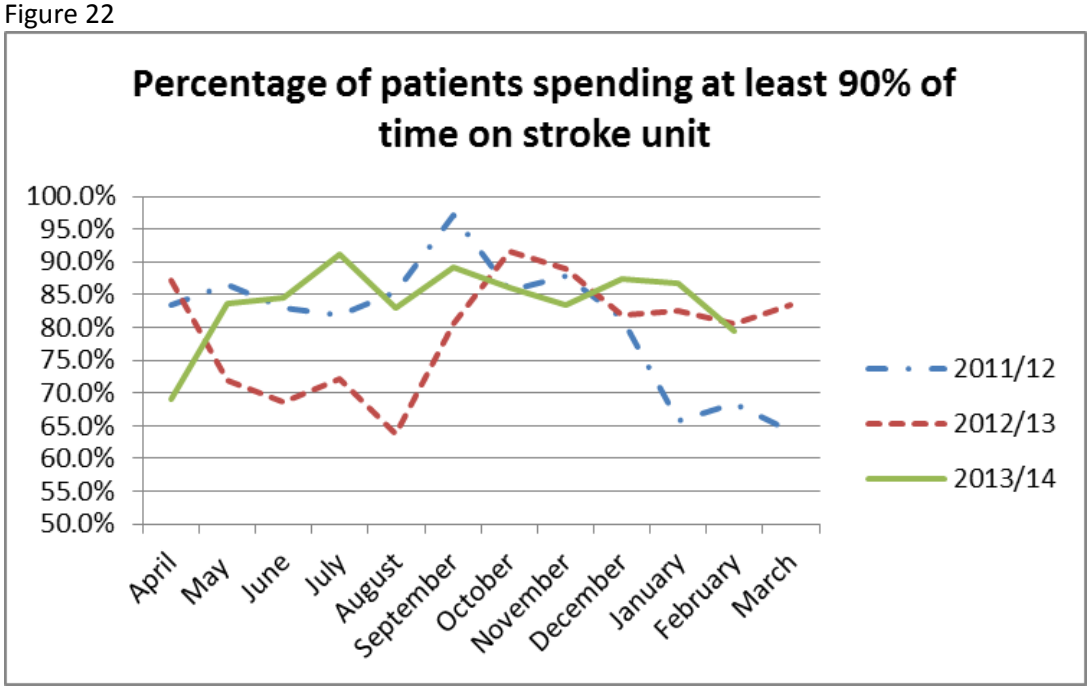
In 2013/14, we reviewed and reissued our stroke pathway, emphasising the importance of direct admissions. As a result of this review, 'sit rep'[29] meetings are now used to discuss whether a protected bed for stroke admissions is available and if not, what plans in place to address this. In 2013/14 to date (data to February 2014) we are pleased to have improved our performance to 84.0% - better than the national target, but still short of our own. We achieved our 90% target in one month during the year. Our performance reflects the operational challenges of protecting a dedicated stroke bed at all times as there are occasions when all the stroke beds are occupied and therefore an empty bed is not available. In 2014, the stroke unit will increase its bed base to 25 beds from 19 currently to reflect activity and support delivery of this ambition.

What patients said in our monthly survey:

"My father had previously had a stroke two years ago and at times he finds it difficult to understand what people are saying but all the staff he encountered during his stay went out of their way to make sure that he understood what was being done and why. He cannot praise your staff at the BRI highly enough and would recommend to anyone the BRI hospital."

[29] Twice daily clinical operations meetings where all bed-holding divisions and the clinical site managers meet to review predicted and actual patient activity, designed to ensure the smooth flow of patients into and out of hospital

Figure 22



Source: weekly discharge data validated by consultant

Objective 12

We wanted to achieve the best practice tariff for hip fractures

AMBER

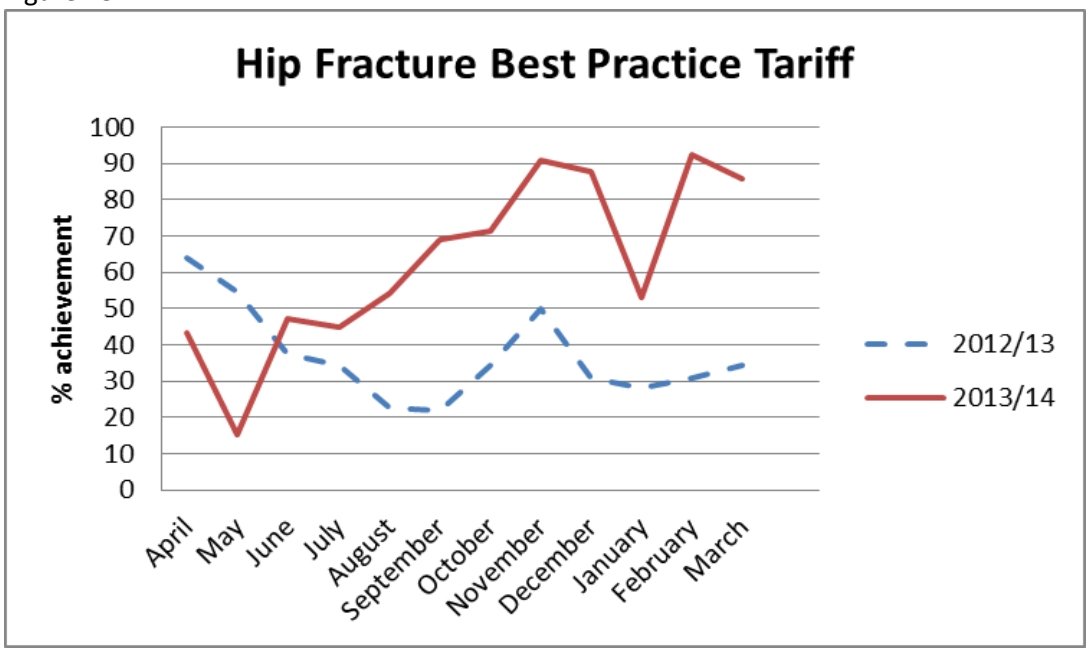
Best Practice Tariffs (BPTs) help the NHS to improve quality by reducing unexplained variation between providers and universalising best practice. Best practice is defined as care that is both clinical and cost effective: to achieve the BPT for hip fractures, trusts have to meet eight indicators of quality as recorded in the national hip fracture database. The indicators are:

- Surgery within 36 hours from admission to hospital
- Ortho-geriatric review within 72 hours of admission to hospital
- Joint care of patients under a trauma and orthopaedics consultant and ortho-geriatrician consultant
- Completion of a joint assessment proforma
- Multi-disciplinary team (MDT) rehabilitation led by an ortho-geriatrician
- Falls assessment
- Bone health assessment
- Abbreviated mental test done on admission and pre-discharge.

We are pleased to report that University Hospitals Bristol NHS Trust's performance against the national best practice tariff for hip fracture management has significantly improved in 2013/14, compared to 2012/13 as shown in Figure 23. In November 2013 and February 2014, we achieved our target: more than 90% of cases achieved the BPT. Overall performance for 2013/14 was 59.7% (to February 2014): significantly better than in 2012/13 (36.5%), but we know that there is much work still to do. The Trust has historically struggled to achieve the BPT due to poor performance against time to theatre and ortho-geriatric review, despite consistently achieving over 90% for the other six indicators. The improvement in 2013/14 performance has been as a result of increased access to trauma theatre, with a daily consultant-led trauma list running since April 2013; and the appointment of two consultant ortho-geriatricians since November 2013.

Despite the increased investment in resources, delivering best practice consistently remains a challenge, especially during times of peak demand, as demonstrated in Figure 23. Time to theatre performance is affected by overall trauma admissions, and by occasions when more than three hip fracture patients are admitted in a 24 hour period.

Figure 23



Source: National Hip Fracture Database

In 2014/15, our Hip Fracture Steering Group will be focussing on delivering best practice in a sustainable way by improving the utilisation of trauma theatre sessions to reduce delays in patients undergoing surgery.

Objective 13

We wanted to ensure patients with diabetes have improved access to specialist diabetic support

GREEN

Previous studies have identified that at least 15% of the Trust's inpatient population at any one time is likely to have diabetes. We know that specialist input and advice for this group of patients, over and above the treatment and care they receive for the cause of their admission, can improve clinical outcomes and longer term health.

In 2013/14, funding was agreed to expand the Trust's diabetes inpatient specialist nurse (DISN) team. We appointed 3.5 whole time equivalent diabetes inpatient specialist nurses and agreed a CQUIN target with commissioners that at least 39% of patients with diabetes in our Division of Surgery Head and Neck services would be reviewed by a DISN during their stay in hospital and at least 22% in our Division of Medicine and Division of Specialised Services, measured across the final two quarters of the year. We were delighted to achieve this CQUIN: 42% for Surgery Head and Neck; and 22.1% for the combined Divisions of Medicine and Specialised Services.

Looking ahead to 2014/15, funding has been secured to make the DISN post in Surgery Head and Neck services into a permanent position, and discussions are currently ongoing in other divisions in the hope of achieving similar longer term appointments. Funding has also been

secured to develop, organise and deliver a Trust-wide diabetes educational programme in 2014/15.

What patients said in our monthly survey:

"I am now in regular telephone contact with the [Diabetes Inpatient Specialist Nurse] team… I am hugely grateful for these services and convinced they have kept me out of hospital. As a diabetic I feel that much closer liaison with DISN team is essential to get well whilst in hospital and after discharge."

Objective 14

We wanted to ensure that ensure that patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan

GREEN

The Trust's learning disabilities steering group is committed to ensuring that we constantly seek to improve the experience of care amongst patients with learning disabilities / autism and their carers, and that in doing so we meet our legislative obligations, for example with regards to the Equality Act (2010) and Mental Capacity Act (2005). This includes 'reasonable adjustments' to the ways in which services are delivered, including the removal of physical barriers and/or providing extra support for people during their time in hospital.

Recent developments include:

- An admission pack including staff photographs, information about accommodation, facilities and car parking.
- Differentiated inpatient comments cards using an 'easy read' format.
- Accessible patient information leaflets for Avon Breast Screening and the Congenital Heart Team at the Bristol Heart Institute.
- The ongoing development of patient and carers' appointment and admission letters in easy read formats.
- The launch of a 'Hospital Passport' across the Trust – this is a document which patients complete prior to admission and which moves with them as their care is transferred. The passport is accessible for download from the Trust external web page and can be emailed via a secure link direct to the learning disabilities nurse in preparation for admission.
- The recruitment of over 100 link nurse in adult services throughout the Trust supporting the role of the hospital liaison nurse and raising awareness about patients with learning disabilities.
- Development of an online referral system which will be launched in 2014.

Our quality objective for 2013/14 was to ensure that patients with an identified learning disability and additional health needs or conditions such as autism were risk assessed within 48 hours following admission, and that they received full reasonable adjustments.

For the year to February 2014), 86.3%[30] of adult patients with a learning disability were risk assessed within 48 hours, therefore meeting our target of 85%. We consistently achieved – and bettered – this target throughout the second half of 2013/14.

[30] Data source – audit of learning disability and autism risk assessment and reasonable adjustment documentation

83.1% of adult patients with a learning disability received full reasonable adjustments during their stay in hospital (significantly exceeding our board-reported target of 58%[31]). When performance dipped notably in July 2013 (50%), recovery actions were immediately and successfully put in place including additional staff training and support, and identifying link nurses in underperforming areas.

What patients said in our monthly survey:

"My daughter has a severe learning disability so we completed the hospital passport prior to admission. This proved to be invaluable and provided her with a specialist bed and enabled both my husband and I to stay with her at all times."

Objective 15
We committed to continuing to implement our dementia action plan

AMBER

The term "dementia" covers a range of progressive, terminal brain conditions which currently affects more than 73,000 people in the South West of England. Enhancing the quality of life of people with dementia is a priority of the NHS Outcomes Framework.

In 2013/14, we made significant progress both in relation to meeting the requirements of the NICE quality standard for dementia (statements 1, 5 and 8) and the South West Dementia Standards. In November 2013 our lead nurse for dementia received a national award in the category of "Best Dementia Nurse Specialist / Dementia Lead" in recognition of the Trust's progress in improving care for people with dementia. By the end of the financial year, 93% of relevant staff had attended "An Hour to Remember" training. All new staff receive dementia awareness training as part of their induction to the Trust.

Progress in relation to the South West Dementia Standards in 2013/14 has been evidenced by our annual dementia care audit, which has demonstrated an increase in compliance in the use of:

- The visual identification system ("Forget-me-not") used to identify patients with cognitive impairment / dementia
- The "This is me" booklet, which is designed to give staff a better understanding of who the patient is, in order to facilitate person-centred care
- Cognitive screening undertaken upon admission to identify baseline cognitive function and the identification of delirium or possible dementia.

The lead nurse for dementia co-ordinates this work through approximately 130 dementia "champions" across the Trust. A local conference for dementia champions is held twice a year, one of which is organised jointly with North Bristol NHS Trust.

We have established a befriending scheme pilot project using volunteers to offer activities and companionship to frail older adult inpatients and frail older adults with a dementia. The scheme

[31] Target agreed with commissioners using baseline audit data

was launched in October 2012 and has received positive feedback from staff and patients. We are currently developing a ward-based volunteer model to sustain this service in the longer term. Elsewhere, the environmental work undertaken on ward 4, funded by the Prime Minister's Challenge fund has provided a dementia-friendly environment which has influenced the new build and refurbishment work plan in the Bristol Royal Infirmary. This includes the use of way-finding cues, i.e. appropriate signage, use of colour, artwork and hand rails.

The expansion of the older person's assessment unit (OPAU) in January 2014 has assisted in minimising unnecessary moves and transfers of our most complex frail patients whilst facilitating timely comprehensive assessment by our older adult care physician team. In October 2013, we achieved a score of 100% in our "transfer" audit, i.e. no patient with cognitive impairment was moved unnecessarily between the hours of 8pm and 8am. This audit will be repeated at the end of April 2014.

The national CQUIN for dementia continues to challenge us: we partially achieved the CQUIN for 2013/14. Plans are underway to develop an electronic data capture solution by the autumn of 2014 to help us to identify, assess and refer patients with dementia[32].

Finally, on 22nd January 2014, the Care Quality Commission undertook an unannounced dementia themed inspection. Inspectors observed care on the older person's assessment unit, as well as visiting the medical assessment unit and the emergency department. The inspection team identified a range of practice: some excellent, some inconsistent. Trust has developed an action plan to address the issues identified.

What patients said in our monthly survey:

"As a nurse/health visitor myself I was delighted to observe the care and compassion shown by the nursing, medical auxiliary staff to two elderly women: one lady with dementia, another in significant pain. The staff, although busy, were calm, positive, smiled and listened.

"The care I received was excellent. The only comment I have to make was that another patient on my ward was suffering with dementia and the staff did not seem to know how to deal with her behaviour. I own a nursing home specialising in dementia care and feel staff training in this area would be beneficial."

[32] Our aim has been to use case-finding questions with at least 90% of patients aged 75 years within 72 hours of emergency admission to hospital, in order to identify dementia; to assess and investigate at least 90% of those patients who have been assessed as at-risk of dementia from the case finding question and/or presence of delirium; and to refer at least 90% of clinically appropriate cases to a general practitioner to alert that an assessment has raised the possibility of the presence of dementia.

Objective 16

We committed to commence a baseline review of available clinical outcome data

GREEN

As part of the Trust's Clinical Effectiveness and Outcomes Strategy for 2013-2016, The Trust committed to undertaking a baseline review of available clinical outcomes data in all major clinical specialities. An initial meeting, chaired by the medical director, took place in September 2013. In October 2013, the Clinical Effectiveness Group agreed that a pilot scoping exercise should be undertaken to better understand the current clinical, process and patient-reported outcomes currently available within the Trust. A selection of clinical areas were chosen for this to be explored in more detail and discussed with clinical staff. Current national clinical audits were also reviewed to establish the type of outcomes reported.

National clinical audits focus largely on process measures. Around half of the national audits in which the Trust is currently participating also report clinical outcomes, focused largely around mortality/survival rates. Only three collect patient-reported outcome measures (PROMs) or patient-reported experience measures (PREMs), although newly commissioned projects are increasingly planning to incorporate these measures.

Locally, more in-depth discussions have been held with physiotherapy, dermatology, rheumatology and respiratory medicine. The Trust's physiotherapy department has already developed a clinical outcomes group to take this work forward and has a system in place for the collection and reporting of outcome measures according to each clinical pathway. This work is in its early stages but pathway leads have been identified and possible PROMs identified (a combination of EQ5D and other condition-specific measures). An electronic system has been developed to capture heath status before intervention/treatment and the team is now working on capturing data post-intervention. In dermatology, rheumatology and respiratory medicine, disease severity scoring systems are used pre and post intervention, however this data is not captured electronically for aggregation and analysis. Elsewhere, surgical specialties participate in relevant national PROMs (see page 45).

By coincidence, the Trust has therefore seemingly been through a very similar thought process to the Care Quality Commission who have developed 'intelligent monitoring'[33] during the last year, based to a large extent on mortality measures. From the work we have undertaken so far, it is clear that there is enthusiasm from clinical staff to understand outcomes in more depth. The Trust will continue to explore this area, looking at how electronic systems might contribute to this agenda. We will also continue to publish outcome data as part of NHS England's 'Consultant Level Outcome' requirements.

[33] At the time of writing, the CQC's intelligence monitoring places the Trust in Band 6, which indicates the lowest level of risk of non-compliance

Review of clinical effectiveness 2013/14

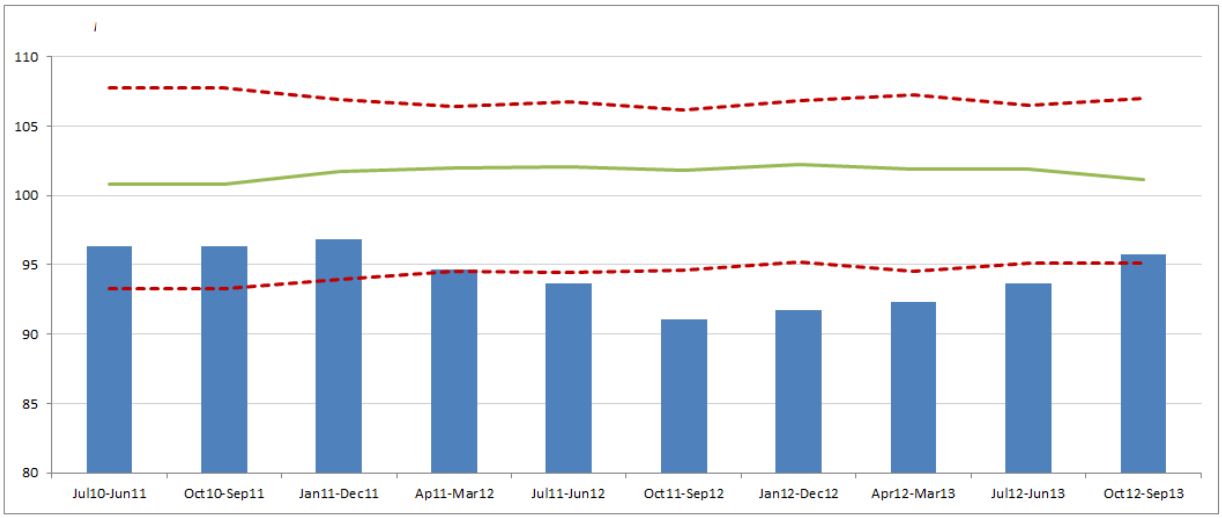
This section explains how the Trust performed during 2013/14 in a number of other key areas relating to clinical effectiveness, which are in addition to the specific objectives that we identified.

Summary Hospital-Level Mortality Indicator (SHMI)

(Mandatory indicator)

The Summary Hospital-Level Mortality Indicator (SHMI) is a measure of all deaths in hospital, plus those deaths occurring within 30 days after discharge from hospital. It should be noted that SMHI does not provide definitive answers: rather it poses questions which trusts have a duty to investigate. In simple terms, the HSMR 'norm' is a score of 100 – so scores of less than 100 are indicative of trusts with lower than average mortality. In Figure 24, the blue vertical bars are University Hospitals Bristol NHS Trust data, the green solid line is the median for all trusts, and the dashed red lines are the upper and lower quartiles. The graph shows that patient mortality at UH Bristol, as measured using SHMI, is consistently lower than the national norm. The most recent comparative data available to us at the time of writing is for the period October 2012 to September 2013 and shows the Trust as having a SHMI of 95.7.

Figure 24



Source: CHKS benchmarking

Note: in this chart, the vertical bars are UH Bristol data, the solid line in the median for all NHS trusts and the dashed lines represent the upper and lower quartile range.

The Trust considers its SHMI data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework (full details are available upon request). This includes data quality and completeness checks carried out by the Trust's IM&T Systems Team. SHMI dated is governed by national definitions.

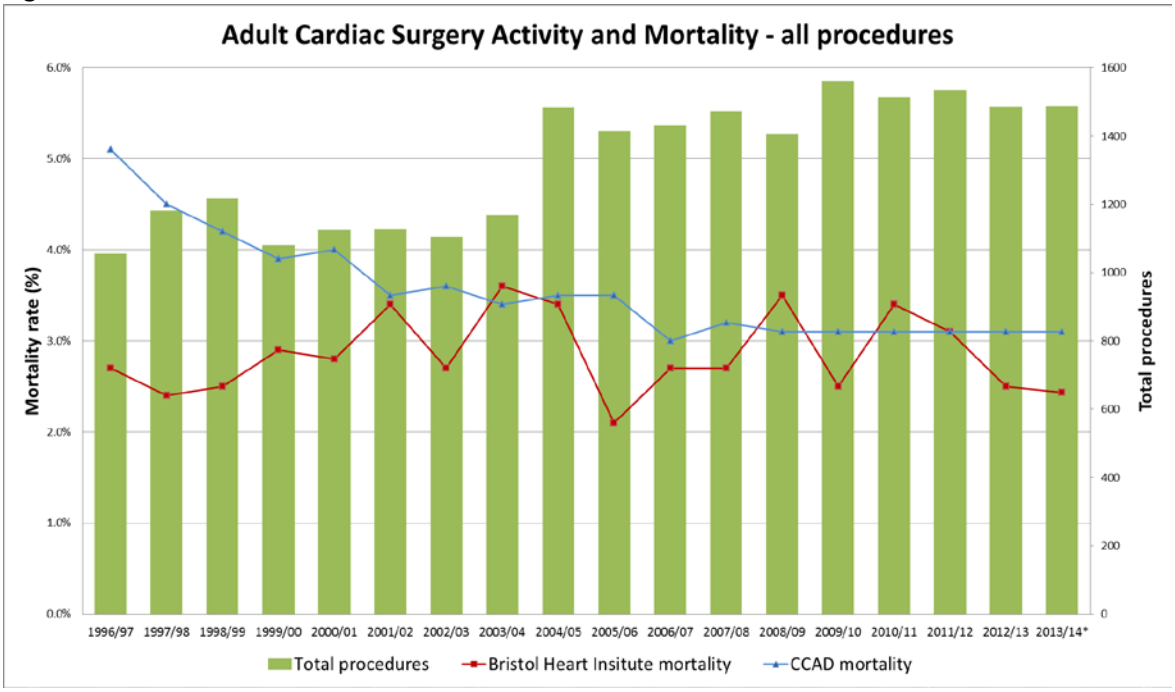
Adult Cardiac Surgery Outcomes

The Bristol Heart Institute is one of the largest centres for cardiac surgery in the United Kingdom. The centre currently performs approximately 1,500 procedures per annum. The Trust has supported a cardiac surgical database for more than 20 years which now contains information relating to clinical outcomes for more than 25,000 patients. This is an extremely valuable resource for research and audit, service planning and quality assurance. An annual

analysis of cardiac outcomes is published and can be viewed in detail on the trust website (http://www.uhbristol.nhs.ukabout-us/key-publications)

In general, our adult cardiac outcomes measured in terms of mortality have been better than the UK average for all procedures. Figure 25 shows a pattern of increasing activity and a crude mortality rate which is below the national average. It should be noted that the 2013/2014 data is preliminary at the time of writing (April 2014) as the discharge status of some patients is still awaited.

Figure 25



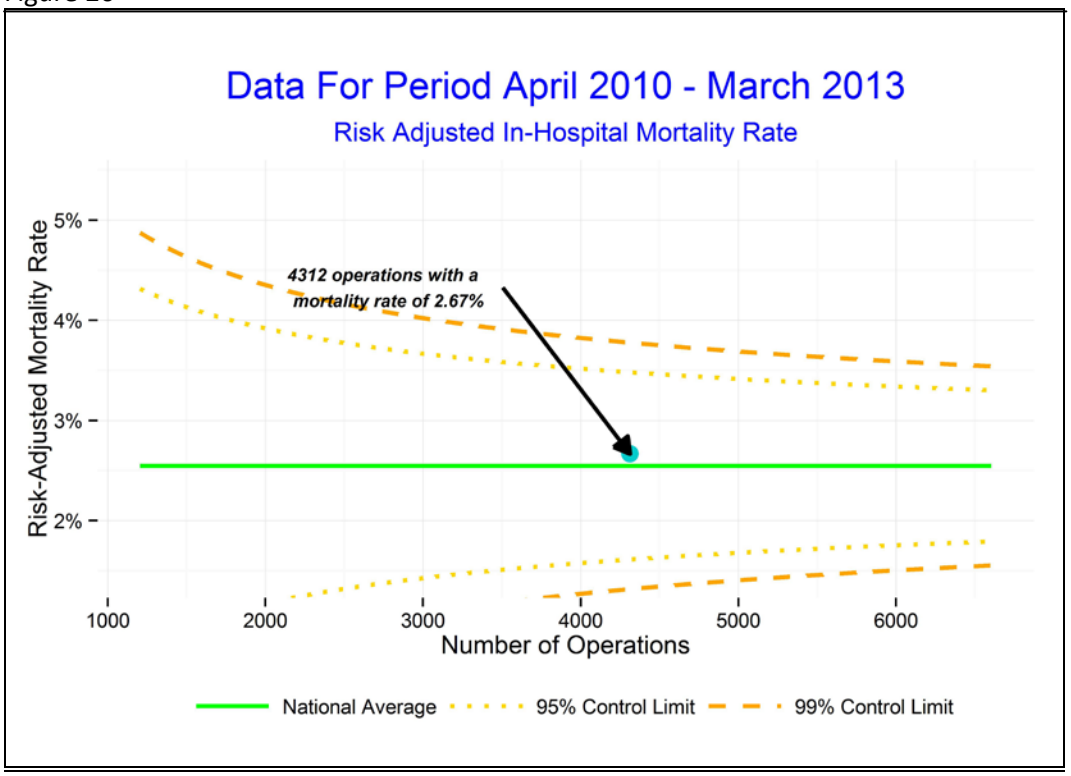
Source: Central Cardiac Audit Database / Patient Analysis Tracking System

Cardiac surgical outcomes data is collected and analysed under the auspices of the National Institute for Cardiovascular Outcomes Research (NICOR) at University College London. NICOR publishes reports on national cardiac surgery outcomes periodically and these can be viewed at http://www.ucl.ac.uk/nicor/audits/adultcardiac/reports. On an annual basis, NICOR provide data for individual surgeons and for the organisation as a whole using national contemporary comparators.

Figure 26 is a funnel plot of crude mortality for all cardiac surgical operations. This data is analysed in three year epochs to ensure the cohort is of adequate size. Alert lines are included at various levels to draw attention to levels of mortality which might be of concern. The outcomes predicted are adjusted to compensate for differences in the risk profile of different centres. Figure 26 shows that for the period 2010-2013, for all cardiac surgical operations and with appropriate risk adjustment, outcomes for patients at UH Bristol was very close to UK average performance.

Adult paediatric surgery outcome data is governed by nationally agreed definitions through NICOR.

Figure 26



Source: Central Cardiac Audit Database / Patient Analysis Tracking System

Paediatric Cardiac Surgery Outcomes

The Bristol Royal Hospital for Children (BRHC) provides a congenital cardiac service to the whole of the South West of England and South Wales serving a population of 5.5 million people functioning as a network with the cardiac centre at University Hospital of Wales in Cardiff with the Welsh consultants also providing sessions in BRHC. The pathway starts in the antenatal period with close collaboration with fetal cardiology and fetal medicine and transitions into the adult congenital cardiac services provided at the adjacent Bristol Heart Institute.

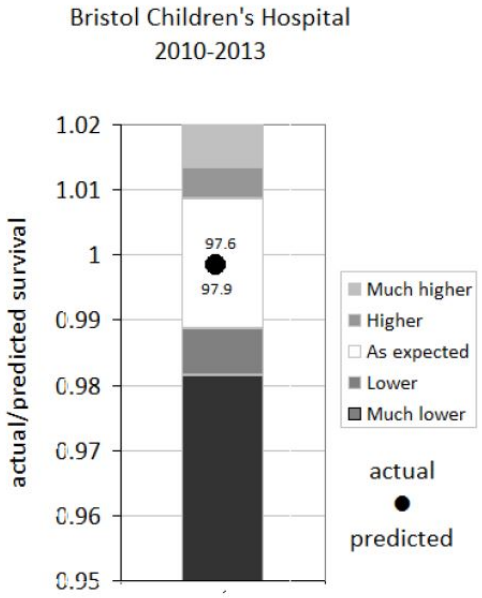
Patient safety is our priority. We actively seek to learn from incidents and have a positive reporting culture. Mortality from cardiac surgery remains very low and is well within expected limits. Each child death is subject to a child death review to enable any aspects of care to be scrutinised and recommendations made to ensure that we can continually improve our care. We report each death to the Child Death Overview Panel for further scrutiny and where appropriate to the Coroner.

We have seen approximately 325 surgical cases in each of the last four years. Crude survival has remained constant at approximately 98% which is the same average survival reported over all centres in the country. This has been achieved despite the continuing increase in complexity of cases. Crude survival is however a very coarse demonstration of the quality of outcomes because children born with congenital heart disease frequently have associated co-morbidities that influence their clinical outcome as much as the cardiac defect. Consequently, as risk profiles vary between centres, direct comparison between units is inappropriate. Recently, more sophisticated statistical analysis has been introduced by the National Institute for Cardiovascular Outcomes Research (NICOR) that includes risk-stratification using a scoring system called the PRAiS score. In this analysis, the overall risk of a child dying following cardiac surgery is considered in the context of the risks of a number of independent co-morbidities and this risk is then compared against the centre's own risk profile rather than a pooled national average. The

most recent analysis is shown in Figure 27; essentially the expected survival rate following cardiac surgery in Bristol in the period 2010-2013 is exactly what would be expected from the risk profiles of the cases treated.

Paediatric surgery outcome data is governed by nationally agreed definitions through NICOR.

Figure 27 – Funnel plot slice based on 869 patient episodes



The last year has seen cardiac services in Bristol Royal Hospital for Children come under scrutiny. In 2013, we opened a high dependency area on ward 32 as part of a continual development in service provision and in response to concerns raised previously by the Care Quality Commission. Prior to this, high dependency care was provided on PICU and supported by the PICU outreach team on the ward. An independent review into paediatric cardiac services in Bristol was announced in February 2014 by Professor Sir Bruce Keogh, medical director of NHS England, after he met with a group of families who have expressed concerns about their experience of care in Bristol. Although the precise nature of the review is still to be confirmed, the Trust has welcomed it and hopes that it will restore trust and confidence in the service. Our aim is to work in partnership with the review team and the families themselves, to demonstrate the safety and quality of the service today, and to address any residual concerns that the review may highlight.

Our ongoing monthly survey of parents of children cared for on ward 32 shows that 98% of parents consistently rate their experience of care as good, very good or excellent[34].

[34] Data for 12 months prior to and including December 2013

Patient Reported Outcome Measures (PROMs)
(Mandatory indicator)

Since 2009, Patient Reported Outcome Measures (PROMs) have been collected by all NHS providers for four common elective surgical procedures: groin hernia surgery, hip replacement, knee replacement and varicose vein surgery. Two of these procedures - groin hernia surgery and varicose vein surgery - are carried out at the Bristol Royal Infirmary, part of the University Hospitals Bristol NHS Foundation Trust. PROMs comprise questionnaires completed by patients before and after surgery to record their health status. Outcomes are measured in three ways: a tool called the 'EQ-5D index' asks patients questions about things like mobility, activities and pain levels; patients also rate their health on a scale of 0-100 using a 'visual analogue scale' (VAS); and finally (in the case of varicose veins) patients are asked questions about the specific condition for which they are having surgery.

The most recent full-year data available from the NHS Health and Social Care Information Centre is for 2012/13 (provisional). The number of UH Bristol patients who underwent varicose vein surgery and returned PROM questionnaires was too small for the data to be publishable due to inherent statistical unreliability and to protect patient confidentiality. In 2012/13, 17 patients returned groin hernia PROM questionnaires in this time period, 70.6% of whom (12/17) scored more highly on the EQ-5D index after surgery than before; this compares with 50.2% in England (10,113/20,161).41.2% of UH Bristol patients (7/17) scored more highly on the EQ-VAS scale after surgery than before; this compares with 37.7% in England (7775/20642).

The Trust considers its groin hernia PROM data to be as described. The Trust follows nationally determined PROM methodology and outsources administration to an approved contractor. The Trust recognises that gaps in staff and process from October 2012 until November 2013 have meant that PROM participation rates are lower than expected. These issues have been addressed and we are hopeful of improving our response rate for the groin hernia PROM. However, based on the number of varicose vein operations currently being performed at the Trust, it is doubtful whether publishable data will become available for this PROM in the future.

28 day readmissions
(Mandatory indicator)

The Trust monitors the level of emergency readmissions within 30 days of discharge from hospital. Readmission within 30 days is used as the measure, rather than 28 days, to be consistent with Payment by Result rules and contractual requirements. The level of emergency readmissions within 30 days of a previous discharge from hospital was lower in 2013/14 than in the previous year (2.70% in 2013/14 v 3.03% in 2012/13). The most recent national risk adjusted data (2011/12) for the 28-day emergency 'indirectly standardised' readmission rates for patients aged 16 years and above, shows the Trust to be better than average for our peer group (acute teaching trusts). Of the 23 acute teaching trusts for which data is available, the Trust is ranked sixth best (i.e. the sixth lowest readmission rate), with an indirectly standardised emergency readmission rate of 11.15% compared to the median for the group of 11.87% (lower and upper confidence intervals of 10.80% and 11.51% respectively). For patients under the age of 16, the Trust has a standardised readmission rate of 7.8%, which is lower (i.e. better) than the national median readmission rate of 8.4%, despite the Trust's case-mix being biased towards the more complex cases. The readmission rates for both age groups are significantly lower than that of the previous reported year, with the readmission rate for patients aged 16 years and over dropping from 11.93% in 2010/11 to 11.15% in 2011/12, and from 8.2% in 2010/11 for patients under the age of 16 to 7.8% in 2011/12.

The Trust considers its readmission data is robust because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. These includes checks on the completeness and quality of the clinic coding, checks conducted of the classification of admission types and lengths of stay as recorded on the patient administration system, and the reviews undertaken of the data quality returns on the commissioning data sets received from the secondary uses service.

The Trust continues to review specialty-level benchmarking data through its Quality Intelligence Group, to monitor and improve readmission rates, and so the quality of its services. Where specialties are identified as having higher readmission rates than expected, relative to the national and/or clinical peer group, in-depth case notes reviews are conducted to identify any underlying causes of the increased levels of readmissions.

OBJECTIVES FOR 2014/5

We have applied a different approach this year in determining out annual quality objectives. In recent years, we have set ourselves a large number of goals, many of which we have achieved. In some cases, objectives have been continued from one year to the next as part of continuous improvement. This year we felt that these recurring objectives should be seen as "business as usual" and that we should instead focus on a much smaller number of objectives that have the potential to genuinely transform patient care. Following a public consultation event in January 2014, an on-line survey which attracted over 200 responses (including from staff) and in discussion with our governors, we have agreed five objectives:

Reducing numbers of cancelled operations
Cancelled operations are a waste of time and resources; and the process of cancelling operations is distressing and inconvenient for patients. Our aim is to significantly reduce the number of last minute cancellations (i.e. on the day of admission) for non-clinical reasons.

Minimising patient moves between wards, including out of hours
Risks of healthcare associated infection are greatly increased by the extensive movement of patients. We also know from patient feedback that moves between wards for non-clinical reasons impact adversely on their experience of care. Our aim is to reduce the average number of ward moves per patient (excluding assessment and observation wards), measured using a baseline which we will establish using data gathered in the first quarter of 2014/15. We also want to ensure that no patients are moved out-of-hours other than for clinical reasons.

Ensuring patients are treated on the right ward for their clinical condition
There is emerging evidence of a correlation between increased mortality and the practice of 'outlying' patients[35]. Our aim is to reduce the number of days patient spend as 'outliers' using a baseline which we will establish using data gathered in the first quarter of 2014/15.

Ensuring no patients are discharged from our hospitals out of hours
Our aim is to ensure that no patients are discharged out of hours, as defined in our hospital discharge policy[36].

We will achieve these four objectives through implementation of five key executive-led transformation projects:

- Creation of integrated discharge services, co-locating organisations responsible for managing patients with complex care needs
- Commissioning of out of hospital transitional care beds
- Earlier supported discharge pathways; a Trust-wide review of critical care services
- Implementation of an operational model which enables elective and urgent tertiary activity to continue during periods of high demand for acute medical care through the emergency department.

Reviewing and refreshing the Trust's approach to patient and public partnership
The Trust has a strong record of patient and public involvement, but we recognise that this involvement is not always systematic and mainstreamed within the organisation. In 2014/15, we will undertake at least two significant pieces of work, one of which will focus on the experience of a 'seldom heard' patient group (to be determined during quarter 1 of the year), and use these as a basis for developing a new model of engagement for wider implementation.

[35] NHS Institute for Innovation and Improvement
[36] Currently 10pm – 7am

How we will monitor our quality objectives

The four objectives relating to patient flow will be owned by the Trust's transformation board. The objectives about patient and public partnership will be overseen by the Trust's patient experience group. Progress in achieving all five quality objectives will additionally be monitored via the Board Assurance Framework and detailed quarterly reports to the Trust's Clinical Quality Group and the Quality and Outcomes Committee of the Board.

PERFORMANCE AGAINST KEY NATIONAL PRIORITIES

Summary of performance against national priorities and access standards

In the 2013/14 Annual Plan, risks to compliance with the Accident and Emergency 4-hour standard, the *Clostridium difficile* quarterly trajectory and the Referral to Treatment Time (RTT) Non-admitted standard were declared. This gave the Trust an Annual risk rating of Amber-Red. The Trust held an Amber-Red Governance Risk Rating during the first two quarters of the year. Following the introduction of the new Risk Assessment Framework, which came into effect on the 1st October 2013, the Trust achieved a Green rating in quarter 3. Disappointingly, the Trust triggered the criteria for potential escalation in quarter 4, with a Service Performance Score of 4.0 and repeated failure against three standards (*Clostridium difficile*, A&E 4-hours and RTT Non-admitted standard). At the time of this report, the Trust is awaiting the outcome of this anticipated escalation.

Last year proved to be another challenging year for the Trust, although improvements in performance against the national standards continued to be made in some key areas, in particular healthcare associated infections. Whilst the target reduction in the annual number of *Clostridium difficile* infections was not achieved, there has been a 21% reduction in *Clostridium difficile* infections in 2013/14 compared with 2012/13. Although the Department of Health target of zero MRSA (Meticillin Resistant *Staphylococcus Aureus*) bacteraemias was not achieved in 2013/14, material reductions in the number of cases were also realised, from the 10 reported in 2012/13 to one confirmed case in 2013/14[37].

The waiting times standards for the treatment patients within 18 weeks of referral (Referral to Treatment Times - RTT) were achieved in each month of the year for patients requiring an admission as part of their treatment (admitted pathways), and also for those patients not yet treated and waiting at month-end (ongoing pathways). However, the standard for patients not requiring an admission for their treatment within 18-weeks (non-admitted pathways) was only achieved in the first quarter of the year. This was due to a combination of long waiting times for patients that were transferred to the Trust as part of the Head & Neck service transfer from North Bristol NHS Trust, but also lengthening waits in a number of specialties for first outpatient appointments, due to rising demand. Overall, performance against the cancer waiting times standards remained strong, with seven of the eight national standards being achieved in every quarter. The 62-day wait from referral to treatment for patients referred by their GP with a suspected cancer, was not achieved in quarters 2 and quarter 4. The standard was achieved in quarters 1 and 3 with agreed reallocation of breaches of standard to other providers, following late referral. Further details of the analysis of the causes of the failure of this standard are provided in extended narrative section of this report. A programme of rapid improvement work was instigated at the end of quarter 2 to address the leading causes of breaches of cancer waiting times standards, as identified through reviews of individual breaches. This work will continue to be progressed in 2014/15. Following the work undertaken in 2012/13 to reduce delays to specialist screening practitioner appointments and colonoscopy diagnostic procedures, significant improvements in performance were seen against the 62-day standard for screening referred patients in 2013/14, with the standard being achieved in every quarter.

Disappointingly, the Trust failed to achieve maximum 4-hour wait in A&E for at least 95% of patients in three quarters of the year, but did achieve the national standard in six individual months. The failure to achieve the 95% standard for the year as a whole was despite a significant programme of improvement work undertaken on patient flow during the year. Improvements in key measures of patient flow and patient experience have, however, been

[37] Although two MRSA bacteraemias were formally reported in 2013/14, one was a contaminated sample, with the patient being confirmed as negative for MRSA on repeated testing.

demonstrated. These include a reduction in ambulance hand-over delays (46% reduction in delays in December, and a 60% reduction in delays in January, compared with the same month last year), 33 fewer last-minute cancellations due to ward bed availability in 2013/14 compared with 2012/13, and a 26% reduction (between October and March) in the number of days patients spent outlying from their correct specialty ward, compared with the same period in the previous year.

In quarter 4 the Trust launched a programme of seven projects to be taken forward as part of the Trust's 2014/15 operating model, led by the Trust's senior leadership team. These projects build upon the work already undertaken as part of the patient flow programme. The Trust did not achieve the national standard for operations cancelled at the last minute for non-clinical reasons, but unlike last year, reductions in cancellations were realised, primarily through improved ward bed availability. The planned programme of work on patient flow should significantly improve bed availability, which was the leading cause of last-minute cancellations of surgery in those months when the 0.8% national standard was not achieved.

Full details of the Trust's performance in 2013/14 compared with 2013/12 are set out in the table below, which shows the cumulative year-to date performance. Further commentary regarding the 18 week RTT, A&E 4 hour, cancer and other key targets is provided overleaf.

Extended narrative about national access targets and priorities

18 weeks Referral to Treatment (RTT)
The Trust achieved a maximum wait of 18 weeks from Referral to Treatment for over 90% of patients requiring an admission for treatment, in every month in 2013/14. In addition, the Trust achieved the target for patients whose RTT clock had not yet stopped, with over 92% of patients waiting less than 18 weeks at each month-end. The Trust only achieved the standard of at least 95% of patients that don't require an admission as part of their treatment waiting less than 18 weeks from referral, in quarter 1 in 2013/14. This dip in performance followed the transfer of the Head & Neck service from North Bristol NHS Trust in March 2013, with more patients transferring, and more patients having a longer waiting time than expected, at the point of transfer. In addition, there was a significant rise in the level of outpatient referrals during 2013/14, which has resulted in waiting times for first outpatient appointments lengthening. During quarter 4, work has been undertaken to re-assess the level of capacity required to meet this new level of demand. Target waiting times for new outpatient appointments have also been reviewed, from which weekly activity plans have been generated. These plans will be enacted during quarters 1 and 2, following which the non-admitted standard should be achieved again from the start of quarter 3.

A&E 4-hour maximum wait
The Trust failed to meet the 95% national standard, for the percentage of patients discharged, admitted or transferred within four hours of arrival in one of the Trust's emergency departments. As in 2012/13, performance was below the national standard in quarters 1, 3 and 4. Despite the failure to achieve the 4-hour standard in these three quarters, there have been some demonstrable improvements in key aspects of patient flow, including a reduction in ambulance hand-over delays, the number of last-minute cancellations due to ward bed availability, and the number of bed-days patients spend outlying from their correct specialty ward. The Trust also achieved each of the A&E clinical quality indicators, in particular showing an improvement in performance against the 15-minute Time to Initial Assessment for patients arriving by ambulance.

Performance against national standards

National standard	2011/12	2012/13	2013/14 Target	2013/14[38]	Notes
A&E maximum wait of 4 hours	96.0%	93.8%	95%	93.7%	Target met in 1 quarter in 2013/14 (Q2)
A&E Time to initial assessment (minutes) 95th percentile within 15 minutes	26	57	15 mins	15	Target met in 3 quarters in 2013/14 (not Q1)
A&E Time to Treatment (minutes) median within 60 minutes	20	53	60 mins	52	Target met in every quarter in 2013/14
A&E Unplanned re-attendance within 7 days	1.7%	2.6%	< 5 %	1.6%	Target met in every quarter in 2013/14
A&E Left without being seen	1.0%	1.9%	< 5%	1.8%	Target met in every quarter in 2013/14
MRSA Bloodstream Cases against trajectory	4	10	Trajectory	2	One of the two cases was a contaminated sample only
C. diff Infections against trajectory*	54	48	Trajectory	38	Cumulative target failed in each quarter in 2013/14
Cancer - 2 Week wait (urgent GP referral)	95.9%	95.0%	93%	96.6%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (First treatment)	98.1%	97.0%	96%	96.9%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	96.7%	94.9%	94%	95.1%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	99.9%	99.8%	98%	99.8%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	99.3%	98.7%	94%	97.6%	Target met in every quarter in 2013/14
Cancer 62 Day Referral To Treatment (Urgent GP Referral)*	87.0%	84.1%	85%	80.7%	Target met in 2 quarters in 2013/14 (not Q2 or Q4)
Cancer 62 Day Referral To Treatment (Screenings)	94.4%	90.0%	90%	93.7%	Target met in every quarter in 2013/14
18-week Referral to treatment time (RTT) admitted patients	91.7%	92.6%	90%	92.7%	Target met in every month in 2013/14
18-week Referral to treatment time (RTT) non-admitted patients	97.9%	95.7%	95%	93.1%	Target met in every month in 1 Q1 2013/14
18-week Referral to treatment time (RTT) incomplete pathways	N/A	92.2%	92%	92.5%	Target met in every month in 2013/14
Number of Last Minute Cancelled Operations	0.87%	1.13%	0.80%	1.02%	Target failed in each quarter in 2013/14
28 Day Readmissions *(following a last minute cancellation)*[39]	93.3%	91.1%	95%	89.6%	Target failed in each quarter in 2013/14
6-week diagnostic wait	99.5%	89.7%	99%	98.6%	Target failed in 3 quarter in 2013/14 (achieved in Q3)
Primary PCI - 90 Minutes Door To Balloon Time	91.0%	91.7%	90%	92.9%	Target met in every quarter in 2013/14
Infant Health - Mothers Initiating Breastfeeding[40]	76.2%	80.6%	76.3%	81.6%	Target met in every quarter in 2013/14

* defined in Appendix C

Achieved for the year and each quarter

Achieved for the year, but not each quarter

Not achieved for the year

Target not in effect

[38] Due to the timing of this report the figures shown in the above table are for the year to date ending March 2014, with the exception of cancer and primary PCI, which are up to and including February 2014.

[39] IMPORTANT NOTE: this indicator must not be confused with the mandatory indicator reported elsewhere in this Quality Report which measures readmissions to hospital within 28 days *following a previous discharge*

[40] The Infant Health standard shown is a target set by the Trust

During each month in 2013/14, the level of ambulance arrivals was significantly higher than the same month in the previous year, averaging a 9% increase year-on-year. However, the level of emergency admissions remained similar to that in previous years within the Bristol Royal Infirmary, which is thought to be a result of the ambulatory care unit being able to manage appropriate patients without an admission to hospital. Although the number of emergency admissions did not increase, the proportion of over 75 year olds being admitted rose during the winter of 2012/13 and remained at these levels into quarter 1 2013/14. A further 8% increased on the 2012/13 winter levels was experienced during the winter of 2013/14. Older patients often have more complex health conditions and need more intensive medical input before they can leave hospital. This steep rise in the age of patients being admitted to hospital was a main contributor to the dip in performance in each quarter in 2013/14.

In the Bristol Royal Hospital for Children, the increased level of ambulance arrivals was associated with an increase in emergency admissions via the emergency department, with levels increasing by an average of 39% across November and December 2013, relative to the same period in the previous year. This level of increase in emergency admissions is exceptional and resulted in record high levels of admissions. This was due to the high levels of respiratory illness in the community, which mirrored the national picture. This led to significant bed pressures, which heavily contributed to the failure to achieve the A&E 4-hour standard in quarter 3 at a Trust level.

The Trust's senior leadership team has initiated a review of the Trust's operating model for adult services, which includes seven projects aimed at improving the efficiency with which the Trust operates. This programme of work focuses on a range of initiatives aimed at improving patient flow, including the development of discharge services integrated with Bristol City Council and Bristol Community Health, to promote better ways of working between the three organisations responsible for managing patients with complex health needs, the commissioning of more out of hospital beds, establishing early supported discharge pathways, and a Trust-wide review of Critical Care. This work programme will not only help to reduce extended stays in hospital and demand for beds, especially from elderly patients that have the most complex of care needs, but it will also help to improve quality of care and patient experience. Reducing pressure on beds will also improve flow through the front door of the hospital, and in so doing support the Trust in recovering performance against the A&E 4-hour target.

Cancer

As reported in the summary section above, performance against seven of the eight key national cancer waiting times standards remained strong in 2013/14, with full achievement of these seven standards in every quarter of the year. The 62-day wait from GP referral with a suspected cancer to treatment failed to be achieved in quarter 2 or quarter 4. This was due to a combination of high volumes of the more 'unavoidable' causes of breaches of standard, such as late referrals from other providers, clinical complexity, and patient choice to delay diagnostics and treatments, but also some more avoidable causes of breaches, such as elective cancellations due to critical care capacity, delays in outpatients for certain specialties and delays to admitted diagnostic procedures being booked due to capacity constraints. Unlike in 2013/14, the 62-day wait from referral to cancer treatment for patients referred from one of the three national screening programmes was, however, achieved in each quarter. This follows the sustained reduction in waiting times for the initial specialist screening practitioner appointments (SSP), and colonoscopy diagnostic procedures, as a result of work undertaken to reduce delays in the latter half of 2012/13.

Following the transfer-out of the high performing breast and urology cancer services, and the transfer in of the head and neck cancer service at the end of 2012/13, the Trust now has a more complex portfolio of cancer services. In combination with increasing levels of breaches due to late referral by other providers, medical deferral and patient choice to delay pathways,

consistent achievement of the 62-day standard will require performance significantly above the national average in most tumour sites. A rapid improvement group was established at the end of quarter 2 in order to effect improvements in those pathways for which breach analysis had identified avoidable causes of breaches. Improvements in performance were demonstrated in quarter 3, across a range of tumour sites. However, there was a deterioration in performance during quarter 4. This was primarily due to a further increase in the number and proportion of breaches attributed to unavoidable reasons, increasing from 49% in quarter 2 to 69% in quarter 4. Further improvement work will be undertaken in 2014/15, using the information gained from the monthly review of the causes of breaches, and learning from other organisations obtained from telephone interviews conducted with better performing equivalent providers.

Other standards

During 2013/14, the Trust cancelled 1.02% of operations on the day of the procedure for non-clinical reasons, such as bed availability and emergency patients need to take priority. This represents an improvement on 2012/13 when 1.13% of procedures were cancelled. This improvement was primarily due to a reduction in cancellations due to the lack of a ward bed being available, and reflects the significant programme of work on improving patient flow, implemented during the year. However, the lack of a ward bed resulted in higher levels of cancellations in January and February 2014 in particular. The lack of a critical care bed also resulted in a high level of cancellations relative to that seen in previous years. The programme of work developed to support the 2014/15 operating model should further improve both ward and critical care bed availability in 2014/15 and reduce the last-minute cancellation rate. This should also help the Trust readmit patients within 28 days of their operation being cancelled, as achievement of this standard is very dependent upon the level of cancellation of operations at any point in time.

During quarter 3, the Trust received a performance notice from Bristol Clinical Commissioning Group. This made reference to the failure to achieve the RTT, 4-hour and cancer standards, as outlined in the summary above, but also the failure to consistently meet the standard of 99% of diagnostic tests being carried-out within six weeks of referral. Significant improvements in performance have been realised in 2013/14, with performance against the 6-week diagnostics standard increasing from 89.7% in 2012/13 to 98.6% in 2013/14. This was a result of service capacity for gastrointestinal endoscopies being increased to meet the higher level of demand. Following further work to increase capacity in services such as cardiac stress echo and cardiac MRI scanning, which have also seen a significant recent growth in demand, the 99% standard was achieved for quarter 3 2013/14 as a whole. However, further work is being undertaken to ensure a more consistent performance against the standard in 2014/15.

In 2013/14, the Trust reported further improvements in the percentage of mothers initiating breast feeding, from 80.6% to 81.6%. Improvements were also reported in the door to balloon 90 minute reperfusion standard. The reperfusion standard relates to a procedure that is carried-out to improve blood flow to the heart. A catheter is inserted into a blood vessel in the groin or arm and then moved up to near the heart, through which a small balloon is inflated to squash the fatty plaques or deposits in the blood vessel to improve blood flow to the heart. The door to balloon time measures the time from the arrival of the patient in the Trust through to the time when the reperfusion treatment commences (i.e. balloon inflation in the blood vessel). During the year, 92.9% of patients received reperfusion within the 90 minute standard, compared with 92.4% in 2012/13. The call to balloon times 150 minute standard measures the time from the call for professional help through to the commencement of reperfusion treatment. As in 2012/13, the Trust failed to meet the 90% local stretch target. However this continued to reflect the time it took for the patient to get to the hospital (call to door time), rather than the time from arrival to treatment.

APPENDIX A - Statements of assurance from the Board

1. Review of services

During 2013/14, University Hospitals Bristol NHS Foundation Trust provided clinical services in 70[41] specialties via five clinical Divisions (i.e. Medicine; Surgery Head & Neck Services; Women's & Children's Services; Diagnostics and Therapy; and Specialised Services).

During 2013/14, the Trust Board has reviewed selected high-level quality indicators (e.g. infection control, SHMI) as part of monthly performance reporting. The data reviewed covered the three dimensions of quality i.e. patient safety, patient experience and clinical effectiveness. Sufficient data was available to provide assurance over the services provided by the Trust. The Trust also receives information relating to the review of quality of services in all specialties via, for example, the Clinical Audit Annual Report. The income generated by University Hospitals Bristol NHS Foundation Trust services reviewed in 2013/14 therefore, in these terms, represents 100% of the total income generated from the provision of NHS services by the Trust for 2013/14.

2. Participation in clinical audits and national confidential enquiries

For the purposes of Quality Accounts and Reports, the Department of Health publishes an annual list of national audits and confidential enquiries, participation in which is seen as a measure of quality of local clinical audit programmes. This list is not exhaustive, but rather aims to provide a baseline for trusts in terms of percentage participation and case ascertainment[42]. The information which follows relates to this list.

During 2013/14, 39 national clinical audits and three national confidential enquiries covered NHS services that University Hospitals Bristol NHS Foundation Trust provides. During that period, the Trust participated in 95% (37/39) national clinical audits and 100% (3/3) national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2013/14 are as follows:

Name of audit / Clinical Outcome Review Programme	Eligible	Participated
Acute		
Case Mix Programme (CMP)	Yes	Yes
Emergency use of oxygen (British Thoracic Society)	Yes	No
Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death	Yes	Yes
National Audit of Seizures in Hospitals (NASH)	Yes	Yes
National emergency laparotomy audit (NELA)	Yes	Yes
National Joint Registry (NJR)	Yes	Yes
Paracetamol overdose (care provided in emergency departments)	Yes	Yes
Severe sepsis and septic shock	Yes	Yes

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

[42] i.e. the number of individual patents we submit data on compared to how many we should have submitted data on (usually outlined through Hospital Episode Statistics or similar)

Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme	Yes	Yes
Cancer		
Bowel cancer (NBOCAP)	Yes	Yes
Head and neck oncology (DAHNO)	Yes	Yes
Lung cancer (NLCA)	Yes	Yes
Oesophago-gastric cancer (NAOGC)	Yes	Yes
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes
Cardiac Rhythm Management (CRM)	Yes	Yes
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Yes	Yes
Coronary angioplasty	Yes	Yes
National Adult Cardiac Surgery Audit	Yes	Yes
National Cardiac Arrest Audit (NCAA)	Yes	Yes
National Heart Failure Audit	Yes	Yes
National Vascular Registry	Yes	Yes
Long term conditions		
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)*	Yes	Yes
Diabetes (Paediatric) (NPDA)	Yes	Yes
Inflammatory bowel disease (IBD)	Yes	Yes
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Yes
BTS Paediatric bronchiectasis (British Thoracic Society)	Yes	No
Renal replacement therapy (Renal Registry)	Yes	Yes
Rheumatoid and early inflammatory arthritis**	Yes	Yes
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes
Other		
Elective surgery (National PROMs Programme)	Yes	Yes
Women's & Children's Health		
Child health clinical outcome review programme (CHR-UK)	Yes	Yes
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes
Moderate or severe asthma in children (care provided in emergency departments)*	Yes	Yes
Neonatal intensive and special care (NNAP)	Yes	Yes
Paediatric asthma	Yes	Yes
Paediatric intensive care (PICANet)	Yes	Yes

* Organisational aspects only

The Trust did not participate in two national audits under the auspices of the British Thoracic Society and is undertaking relevant local audit activity instead.

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 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Name of audit / Clinical Outcome Review Programme	% cases submitted
Acute	
Case Mix Programme (CMP)	1190*
National Audit of Seizures in Hospitals (NASH)	100% (30/30)
National Joint Registry (NJR)	98% (49/50)
Paracetamol overdose (care provided in emergency departments)	100% (50/50)
Severe sepsis & septic shock	100% (50/50)
Severe trauma (Trauma Audit & Research Network, TARN)	68% (200/294)
Blood and Transplant	
National Comparative Audit of Blood Transfusion programme	38*
Cancer	
Bowel cancer (NBOCAP)	94% (162/173)
Head and neck oncology (DAHNO)	90*
Lung cancer (NLCA)	80% (144/180)
Oesophago-gastric cancer (NAOGC)	99% (149/150)
Heart	
Acute coronary syndrome or Acute myocardial infarction (MINAP)	985*
Cardiac Rhythm Management (CRM)	100% (792/792)
Congenital heart disease (Paediatric cardiac surgery) (CHD)	100% (742/742)
Coronary angioplasty	100% (1423/1423)
National Adult Cardiac Surgery Audit	100% (1481/1481)
National Cardiac Arrest Audit (NCAA)	133*
National Heart Failure Audit	100% (403/403)
National Vascular Registry	98% (145/148)
Long term conditions	
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	99% (100/101)
Diabetes (Paediatric) (NPDA)	1354*
Inflammatory bowel disease (IBD)	100% (40/40)
Older People	
Falls and Fragility Fractures Audit Programme (FFFAP)	345*
Sentinel Stroke National Audit Programme (SSNAP)	100% (121/121)
Other	
Elective surgery (National PROMs Programme)	27% (33/122)
Women's & Children's Health	
Moderate or severe asthma in children (care provided in emergency departments)	100% (50/50)
Neonatal intensive and special care (NNAP)	100% (2739/2739)
Paediatric intensive care (PICANet)	100% (671/671)

*No case requirement outlined/unable to establish baseline from HES data

The reports of ten national clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2013/14. The Trust is taking the following actions to improve the quality of healthcare provided:

College of Emergency Medicine (CEM) audits

- The Medway system has been altered to allow better electronic capture of data relating to consultant review or discussion.
- Monthly reporting against the CEM quality standard has been introduced to inform further actions required by pinpointing times / days when standards are less likely to be adhered to.

National Audit of Dementia

- A care pathway for frail older people which incorporates people with a dementia will be developed. Access to intermediate care services to allow people with dementia to be admitted to intermediate care directly will be part of this review.
- A review of the model of care for the older adult admissions wards is to be undertaken.
- A clinical guideline is being developed to ensure that patients with dementia or cognitive impairment are assessed for the presence of delirium at presentation using a recognised tool (confusion assessment method).
- An electronic discharge summary for all patients who are 75 years and over will be developed which contains mandatory fields to include abbreviated mental test score, cause of cognitive impairment, symptoms of delirium, and behavioural and psychological symptoms of dementia.

National Cancer Audits

- Significant progress has been made with the lung, bowel and head and neck audits in 2013. All three audits returned their best ever standard of submission in terms of data completeness and quality.
- Easy format written guidance on data entry has been produced, along with reports that allow multidisciplinary team coordinators to easily identify and rectify data gaps, and their managers to monitor this. This system has received positive feedback from coordinators and clinicians.
- All national audit submissions have undergone clinical quality assurance prior to submission. Monthly submission has been introduced along with a robust system for identifying 'rejected' records enabling these to be quickly fixed.
- The Trust's cancer manager continues to work closely with the Somerset Cancer Register to ensure the best use of the register and influence its development.

National Diabetes Audit (NADIA)

- Increased diabetes specialist nursing input was allocated via CQUIN funding to help improve the care that diabetic patients receive as inpatients.

National Cardiac Arrest Audit (NCCA)

- All cardiac arrests are now reported on the Trust incident reporting system (Ulysses Safeguard) to enable learning from these incidents.

Falls and Fragility Fractures Audit Programme - National Hip Fracture Database

- The appointment of a specialist hip fracture nurse (and audit nurse responsible for data) has resulted in a significant improvement in data quality, and patient care as a whole.
- A business case was approved and implemented to increase ortho-geriatrician input, increase trauma theatre allocation and implement direct access beds.

National Vascular Registry

- A written pathway of care for Transient Ischaemic Attacks (TIAs) and non-disabling stroke for Bristol Bath and Weston Vascular Network is being developed to ensure that the agreed protocol for referral is followed to help avoid any unnecessary delay.

National Neonatal Audit Project

- A preterm breast feeding project has been started aiming to improve rates of breastfeeding at discharge.

The outcome and action summaries of 205 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2013/14; summary outcomes and actions reports are reviewed on a bi-monthly basis by the Trust's Clinical Audit Group. Details of the changes and benefits of these projects will be published in the Trust's Clinical Audit Annual Report for 2013/14[43].

3. Participation in clinical research

Developing and delivering research of the highest quality to improve outcomes for patients is at the centre of what we do at University Hospitals Bristol NHS Trust. Research is embedded within the care we provide and our aim is to offer the chance to participate in research to as many of our patients as we can. As evidence of our continued commitment to providing research to our patients, the number of patients receiving relevant health services provided or sub-contracted by University Hospitals Bristol NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 9739 and 86% of these were recruited into NIHR research. We currently have 775 active research projects, 85 of which are our own sponsored trials which include clinical trials of investigational medicinal products and other interventional trials in areas such as surgery. We recognise that the speed with which research is set up impacts on how quickly we can gather the evidence to change patient care. We have been working hard to improve our set up times: as testament to this, there were three international studies in 2013/14 where the Trust was first to recruit patients.

We believe that strong collaborations underpin our ability to deliver effective healthcare through research across our region. We were therefore delighted that UH Bristol was selected as the host NHS Trust for the new Clinical Research Network: West of England, which launched in April 2014 and will be the local branch of the NIHR for the region. We also saw further exciting developments with UH Bristol awarded the hosting of the CLAHRC West (Collaboration for Leadership in Applied Health Research & Care), which will bring £9 million in new funding to the region. CLAHRC West will increase the scale and pace of translating research into practice and implementation of novel applied health research findings, and will support clinicians and researchers in changing the way services are provided across the region.

Alongside our two biomedical research units – Cardiovascular and Diet, Lifestyle and Nutrition - which support the translation of basic research into patients, UH Bristol-led research continued to grow in 2013/14 with seven project and programme grants awarded and two grants opened to recruitment. This included the work of Sarah Hewlett, Arthritis Research UK Professor of Rheumatology Nursing. Her work on fatigue associated with rheumatoid arthritis which patients had considered to be an overwhelming problem that was previously ignored by health care teams, has led to international consensus that fatigue must be measured in all clinical trials of rheumatoid arthritis treatments, putting it firmly on the international research agenda. As a

[43] Available via the Trust's internet site from July 2014

continuation of this the research team is currently recruiting to a multi-site research trial led from UH Bristol to test a potential therapy for reducing arthritis fatigue.

4. CQUIN framework (Commissioning for Quality and Innovation)

A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between University Hospitals Bristol NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The amount of potential income in 2013/14 for quality improvement and innovation goals was approximately £10.32 million, based on the sums agreed in the contracts.

The delivery of the CQUINs is overseen by the Trust's Clinical Quality Group. Further details of the agreed goals for 2012/13 and 2013/14 are available electronically at http://www.uhbristol.nhs.uk/about-us/how-we-are-doing/ .

In line with national guidance, in order to qualify for CQUIN payments in 2013/14, the Trust had to satisfy at least 50 percent of the pre-qualification criteria applicable to the Trust, namely demonstrating that plans/trajectories were in place for: intra-operative fluid management, international and commercial activity, Digital First, and carers for people with dementia. Commissioners confirmed that the Trust had met these criteria.

The CQUIN goals were chosen to reflect both national and local priorities. Twenty seven CQUIN targets were agreed, covering more than sixty measures. There were four nationally specified goals: Friends and Family Test (expand coverage; improve response rate and improve performance on staff test), NHS Safety Thermometer (reduce incidence of pressure ulcers); venous thromboembolism (increase percentage of patients risk assessed and ensure a root cause analysis performed in all hospital acquired cases); dementia care (improve case finding and referral for emergency admission; provide clinical leadership and education; provide support to carers).

The Trust achieved 19 of the 27 CQUIN targets and eight in part, as follows:

- NHS Safety Thermometer
- Venous thromboembolism (VTE)
- Intra operative fluid management (High Impact Innovation)
- Digital First (High Impact Innovation)
- End of life care: preferred place of death
- Medication errors
- Cancer treatment summaries
- Deteriorating patient
- Inpatient diabetes specialist nurse
- Adult learning disability
- Children's learning disability
- Quality dashboards
- Neonatal breast feeding
- Paediatric Intensive Care Unit: minimise number of patients accidentally extubated
- Paediatric Intensive Care Unit: prevention of unplanned readmissions in 48 hours
- BMT donor acquisition measures
- Cardiology access to catheter laboratory within 24 hours
- Radiotherapy increased access to Image Guided Radiotherapy (IGRT)

- Haemophilia, ensuring patients have joint scores
- Friends and Family Test (in part)
- Dementia (in part)
- Patientflow measures (in part)
- System flow measures (in part)
- Nutrition and dietetics (in part)
- Enhanced recovery (in part)
- Transition (in part)
- Cardiac inpatient waits less than 7 days (in part)

5. Care Quality Commission registration and reviews

University Hospitals Bristol NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without compliance conditions'. The Trust received three CQC inspections during 2013/14.

On 26 April 2013, the CQC inspected maternity services (St Michael's Hospital) and Ward 32 (Bristol Royal Hospital for Children) in order to check that the Trust had implemented action plans and achieved compliance following a previous scheduled inspection (Outcome 13, staffing, in maternity services) and responsive review (Outcome 4, care and welfare of people who use services and 14, supporting staff, on Ward 32). The Trust was found to be compliant.

On 19 November 2013, the CQC undertook a responsive review of theatres and adjacent areas in the Bristol Royal Hospital for Children. The CQC concluded that the Trust was non-compliant with Outcome 8 (cleanliness and infection control) and Outcome 16 (assessing and monitoring quality of service provision). The subsequently agreed action plan has been completed and the Trust is currently awaiting re-inspection to test compliance.

On 22 January 2014, the CQC visited the Trust's main site as part of a national themed inspection of dementia care. The CQC inspection team's report noted a number of areas of good practice, but also that practice in some aspects of dementia care was inconsistent. The CQC concluded that the Trust was non-compliant with Outcome 4 (care and welfare of people who use services). An action plan has been submitted to the CQC with the majority of actions scheduled for completion by the end of June 2014.

The CQC has not taken enforcement action against the Trust in 2013/14 or issued any formal outlier alerts. University Hospitals Bristol NHS Trust's most recent CQC Intelligent Monitoring report lists the Trust in Band 6, i.e. the CQC's lowest (best) inspection risk band.

6. Data quality

University Hospitals Bristol NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was: 99.4% for admitted patient care; 99.7% for outpatient care; and 96.0% for accident and emergency care (these values are the same as in 2012/13 for outpatients but higher for both admitted patients and A&E which improved from 93.7% in 2012/13).

- which included the patient's valid General Practice code was: 99.9% for admitted patient care; 99.9% for outpatient care; and 99.4% for accident and emergency care.

(Data source: NHS Information Centre, SUS Data Quality Dashboard, April 2013 - January 2014 as at Month 10 inclusion date)

The Trust's 2013/14 score for Information Quality (Secondary Use Assurance) in the Information Governance Toolkit was 87%. The Information Governance Assessment Report overall score was 85% and was graded green.

University Hospitals Bristol NHS Foundation TRUST was subject to the Payment by Results clinical coding audit during 2013/14 by Capita Health (which has replaced the Audit Commission).

The audit covered 200 Finished Consultant Episodes. The audit was for 100 admissions in the single Healthcare Resource Group (HRG) of CZ (Mouth, Head, Neck and Ear) and 100 cases admitted via A&E with a length of stay of zero days. The following levels of accuracy were achieved:

- Primary procedure accuracy: 94.5%
- Primary diagnosis accuracy: 95.5%

(Due to the sample size and limited nature of the audit these results should not be extrapolated.)

The Trust has taken the following actions to improve data quality:

- The data quality programme involves a number of regular data quality checks and audits throughout the year including checking against patient notes. This takes place across the Trust and all issues with data quality are reported back to the Information Risk Management Group for appropriate action.
- Internal Audit has audited a sample of outpatient areas to check the accuracy of outpatient data on the Medway Patient Administration System this year. Results to be finalised.

APPENDIX B – Feedback about our Quality Report

a) Statement from the Council of Governors of the University Hospitals Bristol NHS Foundation Trust

The Council of Governors again welcomes the opportunity to make comment on the Trust's quality report on patient safety, patient experience and clinical effectiveness for all service users.

Governor involvement

The Trust's Council of Governors receives reports relating to quality issues from its governor groups and challenges the Trust Board to account for any failings in the quality of care.
Early in 2014 the governors Quality Project Focus Group contributed suggestions on the format and content of the report. The group is chaired by the Deputy Chief Executive with the Medical Director and the Chief Nurse also in attendance. It meets every two months and reviews the trust's quality and access performance as a standing agenda item using the data in the most recent board reports together with any views from personal observation and reports from members and users of our services.

Comments about the Quality Report

Corporate objectives were affected by higher than expected levels of activity, acuity and the increased numbers of elderly patients needing treatment. The inability to discharge to suitable providers of care in the community put severe pressures on bed availability. This Quality Report examines the trust performance against the targets it set itself last year. The final section outlines objectives for further service improvement during next year, 2014/15. We think that this is the right approach in that it facilitates comparisons year to year.

Overview section:

Opening paragraph could state the relationship UHBristol has with the two Universities, in terms of teaching, learning, education and research / clinical based evidence practice. Quality objectives are set out on page 4 of the report and shows an overall improvement in quality, which is to be commended. A further breakdown of each of the 16 quality objectives has been provided on subsequent pages of the report. From the initial presentation of how UHBristol performed against each of quality indicators, it is pleasing to see an overall improvement in care, particularly in:

- Reduce hospital-acquired healthcare infections (although the clostridium difficile average for UHBristol is still above the national average (table 2))
- Reduce medication errors
- Improve the early identification and escalation of care of deteriorating patients (particularly post-Francis / Keogh etc)
- Ensure that patients continue to be treated with kindness and understanding on our wards
- Achieve best practice tariff for hip fractures management
- Patients with diabetes have improved access to specialist support
- Patient centred care is offered to those patients who may require it the most
- Establish a baseline for clinical outcome data within the Trust

It is also helpful to have some background in terms of the rationale behind the inclusion of table 2 (page 5) and it is acknowledged that this table is still incomplete at the point of publication of version 2.

Patient safety:

Patient safety - The NHS Safety Thermometer: Objective #1:

The trust reported achievement of its objectives in delivering improvements in harm free care in respect of the incidence of pressure ulcers, patient falls, venous thromboembolism and catheter related urinary tract infections. We note that target achievement is based on harm free care being delivered to not less than 97.7% of patients overall using benchmarking from similar best performing trusts.

It would be helpful to know what the annual target values for harm free care will be for the Trust in 14/15, it is unclear at present what the rebase value is. The graph (figure 1) is however helpful and it is encouraging to see the work being undertaken by staff to reduce the incidence of patient falls. There is an important statement around the incidence of falls amongst patients in the 75 plus age group, which does have significance, along with the introduction of the 'Fallsafe' initiative across the Trust, which reports to the falls steering group. It would be helpful to have some of the key findings / themes from the Fallsafe initiative included within the report, even if it just some headlines.

The achieved results for pressure ulcer management are good and the Trust has achieved its target set in line with commissioners. It is also helpful to see some qualitative examples of actions that have been undertaken to reduce the incidence of pressure ulcers within the Trust. Having projected actions for 2014/15 was also helpful, in particular the introduction of a pan-Avon dressing formulary, which could be brought to a future Governors meeting, in terms of providing an educational session.

Screening for VTE prevention continues to improve within the Trust along with the introduction of a root cause analysis for patient who had experienced incidence of VTE. Greater education and the introduction of sequential compression devices is to be commended and as such good practice is now being disseminated out to South Bristol Community Hospital.

Patient safety- Reduce hospital-acquired healthcare infections: Objective #2:

C Diff target was not met as part of the Trust's focus on preventing HCAIs, however it should be noted that achieving an overall reduction of 21% in reported cases is a significant improvement. Figure 6 (page 12) is very helpful in demonstrating how significant the results are over a 7 year period and the on-going actions to further reduce this figure.

MRSA incidences have also significantly improved and the Governors welcome the use of root cause analysis to identify the base of the two reported cases. Investment in an IV access co-ordinator post within the Trust demonstrates commitment to further resolving any potential future cases and also to promote effective / standardised practice across the Trust.

MSSA and norovirus results show an improvement compared with the previous year's report and it is pleasing to see the Trust achieve its target of 90% for hand hygiene and antibiotic compliance. The governors have requested that this is a standing item on report.

Patient safety- Reduce medication errors: Objective #3:

Improvement on the 2012-13 quality report with reference to the reduced moderate / major medication related incidents. The reason behind this reduction is provided and it is pleasing to see that learning and feedback from reported incidents forms part of the quality enhancement process. The trend presented in figure 8 is helpful in terms of further highlighting the significant improvements made over the last 4 years in terms of reducing the incidence of medication errors within the Trust. It is also pleasing to see that the Trust will aim to comply with the PSA and the 2014-14 Trust quality report will benchmark against this external quality standard. The governors have however specifically asked for this indicator to be included as they had highlighted it as a performance issue during the current year.

Patient safety – Extend medicines reconciliation: Objective #4:

Medicines reconciliation figures for 2013/14 are improved and the Trust should be commended for exceeding their set CQUIN target. It would be helpful if wards 61, 62 and 78 (table 3) could be labelled (i.e. are these the oncology, haematology and gynaecology wards?). It would also be useful if an actual target could be set for 2014/15, rather than stating a 'similar percentage'. This will help to quantify the improvements made year on year, especially for the new wards that have come on-line this year as part of the quality review process.

Patient safety – Improve the early identification and escalation of care of deteriorating patients: Objective #5:

The background to the use of an EWS is helpful, especially in the context of how care is initially provided, mapped against the implementation of SBAR, where required. It is pleasing that the Trust's CQUIN target of 95% has been exceeded and the use of the SBAR communication tool has been effective overall. It would be useful to provide some further explanation as to why it has taken some time for the SBAR tool to become established practice. Is there, for example, the need for greater education and training?

Patient safety – Improve levels of nutritional screening and specifically 72 hour nutritional review of patients: Objective #6:

Why was the agreed CQUIN target of 90% (for patients who had initially been assessed as being at risk of malnutrition would receive a nutritional review after 72 hours) only introduced in the final quarter of the financial year? The overall compliance is disappointing and it would be useful to know what additional measures are being put into place for 2014-15. Were there any particular patient groups that were more at risk than others with reference to malnutrition when admitted to hospital?

It is reassuring that the rate of patient safety incidents reported and proportion resulting in severe harm or death has reduced and the actions for 2014/15 are encouraging. There is also appropriate linkage to the Trust's quality objectives for 2014/15, which is provided towards the end of the document.

The case studies presented under the sub heading of 'Never events' are useful and highlight the subsequent actions / investigation process. It may be helpful to have some examples of what the proactive review would look like (mentioned on page 20 of the Quality report).

Patient Experience:

The experience of maternity patients was an indicator in last year's quality report and was included as a focus for action as a result of some poor results in the previous national survey.

Obviously, some progress was made because the national survey in 2013 recorded some excellent results, with some deterioration in the 3rd quarter. Medication side effects are not consistently explained on discharge, disappointing in common with most trusts.

The Productive Outpatient Project is helping to improve the outpatient communication process and is worth a mention. Table 5 on page 31 is disturbing and suggests that conditions at work for staff have deteriorated such that we now find ourselves in the bottom 20% of trusts but then the same survey gives a better than average score for staff recommending the trust as a place to work or receive treatment.

Patient experience - Implement the friends and family test: Objective #7:

It is pleasing to see that the results for the FFT initiative are higher than the national average for the Trust, although it would be helpful to state why there was underachievement in the first quarter of the year with the response rate (8.4% against a target of 15%). The actions being proposed in terms of capturing additional feedback from maternity wards is encouraging, along with the increased response rates for emergency departments and inpatients for 2014/15. What is the payment from meeting the CQUIN targets used for? Is it re-invested in training for example?

Patient experience - Ensure that patients continue to be treated with kindness and understanding on our wards: Objective #8:

It is really pleasing to see the survey scores consistently above 90 throughout the year. Inclusion of qualitative information is useful, but this could have been expanded upon. I would have personally put 3 or 4 qualitative statements in this section. This is a real achievement for the Trust and it should be celebrated.

Patient experience - Explain potential medication side effects to inpatients when they are discharged: Objective #9:

Are that any plans to have additional training and education for staff and / or patient forums, in order to further promote the available knowledge and understanding around potential medication side effects? This has been recorded as 'red' on the performance dashboard and there probably a need for a sentence around commitment to training / education etc.

Patient experience - Improve the experience of maternity patients: Objective #10:

This has been recorded as 'amber' on the performance dashboard; however it is good to see the creation of the three specific projects within the Trust. Improving the patient experience on the wards should ideally build upon the initial findings of the three specific projects.

Looking at figure 20 (complaints as a proportion of total patient activity) there appears to be a cyclic trend with the data (i.e. in terms of peaks when complaints are made). The governors are encouraged that the Trust will be continuing to work collaboratively with the Patients Association in 2014/15. It is acknowledged that 2013/14 has been a year of change for the Patient Support and Complaints team and there is reference to reports such as the Francis enquiry and making sure that dealing with patient complaints is more high profile than in previous years.

The provision of a central appointment centre is seen as being a positive move by the Governors, which will hopefully alleviate patients / carers anxieties around appointments and access to services. Furthermore the use a text messaging service to remind patients about their

forthcoming appointment is also a positive move by the Trust, with the hope of further reducing the DNA rates within the Trust.

With reference to the results presented in table 5 (page 31 / 32) it is a concern that 39% of staff have witnessed potentially harmful errors, near misses or incidents in the last month. This figure is the same as the last three consecutive years and the Trust should consider how they should look to action this key finding.

The proposed actions for 2014/15 are welcomed, particularly the expectations for leaders within the organisation, a Trust wide stress action plan and the implementation of an e-learning package to support managers in addressing work based discrimination.

Clinical effectiveness:

Clinical effectiveness - 90% of stroke patients were treated for at least 90% of their time of a dedicated ward: Objective #11:

We share the disappointing figures related to this particular outcome (79.3% vs a local stretch objective of 90%). The review of reissuing of the Trust's stroke pathway is welcomed and improvements appear to be under way and the data presented in figure 22 for 2013/14 indicates less fluctuation throughout the months of the year, compared to previous years. This should be seen as a positive outcome for the Trust. These results are the same as last year probably for the same reason – protected beds not always available due to black escalation bed pressures. Note: to be carried forward to next year's objectives.

Clinical effectiveness - Achieve best practice tariff for hip fractures: Objective #12:

The overall improvement in achieving BPT for this particular objective is welcomed, however (as stated in the report) there is still work to be done. It would be helpful to know more details of the objectives set for the Hip Fracture Steering Group, particularly for the pressure points during the year in terms of being able to meet the BP. The Governors highlighted this as a performance issue for action during the year.

Clinical effectiveness - Ensure patients with diabetes have improved access to specialist diabetic support: Objective #13:

It is pleasing to see that this CQUIN target has been met and DISN post in SNH services will now be permanent. Positive feedback statement from a patient example is helpful.

Clinical effectiveness - Ensure that patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan: Objective #14:

The recent developments within the Trust in relation to this particular objective are welcomed. In addition the target set by the Trust for adult patients with a learning disability being risk assessed within 48 hours was exceeded, which is pleasing.

Commitment to continuing to implement our dementia action plan: Objective #15:

It is pleasing to see the inclusion of the award given to the Best Dementia Nurse Specialist / Dementia Lead within the Trust. The introduction of the 'hour to remember' scheme has also been a positive move for the Trust. The increased use of the visual identification scheme (linking with the SW Dementia Standards) is pleasing, as is the provision of a local conference, in conjunction with NB NHS Trust. Would it be useful to involve the city's two universities in future

conferences, with a view to including healthcare students and academic staff who are involved in education and training?

The qualitative comments included within this section of the report are helpful and reflects the hard work of staff within the Trust, however there is no presentation of results as to the current position of the Trust in terms of how the CQUIN target is being met. From board reports the governors know that the Trust fell a long way short of our target for assessment and follow-up here. Governors have just raised it as a performance issue (last quality project focus group). It would be useful to know what specific actions will be taken in 2014/15 to address this particular objective.

Commitment to commence a baseline review of available clinical outcome data: Objective #16:

It is pleasing to see this being introduced across all major clinical specialists.

Review of clinical effectiveness 2013/14:

It is pleasing to see that the overall patient mortality rates within the Trust are significantly lower than the national norm. The same is true for the adult cardiac outcomes and the data within figure 26 (funnel plot) is really useful, as is the date within figure 27. It demonstrates transparency to include the independent review of paediatric cardiac services within the Trust and the governors see this as a positive step. The figure of 98% for parents of children feedback on the care received whilst at the BRH for Children is also a very positive reflection of the overall delivery of care by staff within the Trust.

Objectives for 2014/15:

It is really helpful to have a summary of the objectives for the 2014/14 quality cycle within the Trust. These are clear and transparent objectives that resonate with the areas of improvement required within the Trust. The review and refresh of the Trust's approach to patient and public partnership is also welcomed by the governors. Again, it would be good if the two Universities were also asked to be involved in this work stream.

Summary of performance against national priorities and access standards:

This is helpful, however there are challenges with meeting national standards (that has been highlighted in previous governor reports), particularly access targets (pages 48-53).

Summary:

We commend this report for its transparency and thoroughness and feel that it is an accurate representation of the Trust's position on quality issues. Progress on quality objectives has been achieved during the year but the rate of improvement has slowed and, as stated at the beginning of this commentary there are factors at play which can only be mitigated by additional resources (or reduced activity) either internally generated (by further efficiency savings) or through initiatives by our external healthcare partners. The theme of clinical research is present within the report, which should also be commended.

The Trust will have a delicate balance to manage with the challenges to its quality agenda by increasing levels of activity, greater sickness in the community it serves, the increasingly elderly patient profile, and funding. Demand management in the 4th quarter is still a problem.

The Council of Governors will explore any questions raised in this statement via the governors' quality project focus group.

b) Statement from Healthwatch Bristol and Healthwatch South Gloucestershire

Healthwatch Bristol and Healthwatch South Gloucestershire welcome the opportunity to comment on the University Hospitals Bristol Quality Account and applaud the Trust on its overall financial and clinical health. Healthwatch Bristol and Healthwatch South Gloucestershire fully supports the Trust's identification of its "hallmarks of quality" and notes the full achievement of eleven of the sixteen quality objectives. Healthwatch also finds the document well structures and likely to be informative and helpful to the general reader. By and large the QA document is balanced and readable although rather lengthy. Figures tend to be supported by annotations and descriptive and explicatory passages in the text, which again is helpful to lay readers. The footnotes are also a useful and helpful support for the public understanding of sometimes rather difficult data.

Healthwatch Bristol and Healthwatch South Gloucestershire applauds the overall green light on the NHS Safety Thermometer and commends the Trust's participation in the piloting of 'Fallsafe' and the efforts of the Trust's Falls Steering Group. In this respect, as falls are an ever present concern of the public, Healthwatch appreciates the imaginative formula for calculating and comparing expected and actual falls and applauds the strenuous efforts that the Trust has made and its achievement of its goals in this area in four out of twelve months. It strongly supports the participation of staff in clinical applied research and complements the Trust on the long overdue acquisition by Bristol and hosting of a CLAHRC at UH Bristol attracting substantial new funds and recommends appropriate public participation in such research projects.

Healthwatch Bristol and Healthwatch South Gloucestershire also commend the reduction achieved in HCAIs and share the Trust's disappointment that it did not achieve its stated target for C.diff. It notes the commendable achievements in hand hygiene and antibiotic compliance. Conversely, Healthwatch can only express its concern at the occurrence of two never events and although infinitesimal in statistical terms reminds the Trust that for each such patient the effect is 100%. It notes with satisfaction the rigour and robustness of the Trust's proactive review. Similarly with the SHMI indicator it strongly applauds the fact that the score is substantially better than the national median score but notes that it is far from the national best.

Healthwatch Bristol and Healthwatch South Gloucestershire compliments the Trust on its above average achievements in the community midwifery and care during birth elements of the survey. It also strongly applauds the Trust's achievement in compassionate care, a reflection of basic values in a Trust. Perhaps Figure 13 and Table 4 could have been a little clearer in helping lay readers to separate out response rates and scores based on respondents.

Healthwatch Bristol and Healthwatch South Gloucestershire notes with some concern that almost 30% of staff would apparently not recommend the provider but takes some comfort from the fact that this achievement is substantially higher than the 2013/14 national average. It is disappointing also to note that more than one fifth of staff do not feel happy with the quality of work and patient care they are able to deliver and to note the statistically fairly steady score in this regard over the last couple of years. Healthwatch notes the slight improvement in the score staff recommending the Trust as a place to work but also notes the relative immobility of that score over the past few years. (The flow-over of Table 5 makes it rather difficult to read.)

Given the very positive results on the experience of care quality tracker, Healthwatch Bristol and Healthwatch South Gloucestershire shares the Trust's disappointment that explication of the side effects of medication to inpatients when they are discharged was not satisfactorily achieved, and it notes with resigned sadness that this was in line with the national average. It welcomes the remediation strategy proposed, including the new e-tool and it looks forward to improvement over the coming year, whilst noting the need for such a strategy to take account

of vulnerable populations, such as but not exclusively older persons and those with learning difficulties. In this respect Healthwatch commends the Trust on its evolving strategies and action plans in its approach to those with special needs and dementia. In spite of the amber result on nutritional screening, Healthwatch commends the innovatory approach using volunteer staff and the achievement of universal screening of patients on entry. Prudent caution is needed when assessing the number of complaints, which can be a very fluid indicator, elusive in its interpretation and reflecting to some extent the ease and security, with which complaints can be made, as well as affording a genuine reflection of dissatisfaction on the part of patients. Although the number of complaints is tiny compared with the volume of patients, it is an important dimension of the perceived reputation of the Trust and the Trust is to be commended for its continuing efforts to improve its performance in the area and to give satisfaction to patients, as reflected for example in the agreed timescale response scores.

Finally Healthwatch thanks the Trust for the professional transparency and openness of the Quality Account combined with its accessibility and informative format Healthwatch strongly supports the Trust's approach to continuous improvement of quality and staff professional development. It also supports the chosen five objectives for 2014/15 and looks forward to their achievement.

c) Statement from South Gloucestershire Health Scrutiny Select Committee

The Trust was invited to a meeting of the South Gloucestershire Public Health & Health Scrutiny Committee on 23rd April to give a short presentation on the highlights of its draft Quality Report 2013/14 and answer members' questions.

The Committee welcomed the news that of the 16 objectives set last year, the Trust had achieved 14[44], which included reducing hospital acquired infections, reducing medication errors and ensuring patients with an identified special need, including those with a learning disability, have a risk-assessment and a patient-centred care plan.

The Trust provided more detail on the two objectives that it had not made as much progress on as it would have liked: ensuring that at least 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke ward; and explaining medication side effects to inpatients when they are discharged. In relation to the latter issue a member suggested that the patient or carer could be asked to sign a document to confirm they have been advised of side effects or the potential consequences of not taking a medicine. The Trust acknowledged this point and responded that it would consider the introduction of a tick sheet to record that contact had been made.

The Committee probed further about the objective for 2014/15 "Making sure patients are cared for on the right ward for their clinical condition" and whether this relates to the objective in the previous quality account about the cancellation of planned procedures due to emergency patients being admitted onto wards? In response it was confirmed that this has been a challenge for the Trust and a lot of work has already been done to reduce the impact on planned operations.

In addition the Trust was asked for more information on how patient panels and patient experience drive improvements, to which the Trust reported that its patient survey work helps develop its patient experience plans and allows it to formulate objectives.

[44] Later revised to 11 in light of year-end data which had been unavailable at the time of this meeting

In response to a question about whether the Trust had any concerns with local commissioners not supporting bids / business cases the Trust stated that it had no concerns and was working collaboratively with commissioners.

Finally, the Committee would like to make one comment on its scrutiny of pathology services. At a meeting earlier this year members were disappointed to learn that University Hospitals Bristol had withdrawn from Severn Pathology, a joint venture with the North Bristol Trust. The Committee felt that good progress had been made and was, therefore, concerned about this decision. A further scrutiny meeting will take place in due course.

d) Statement from Bristol Health and Adult Social Care Scrutiny Commission

At its meeting of 15th April the Commission received a presentation setting out the Trust's progress against its 2013/14 priorities, and its proposed priorities for 2014/15. There was general consensus amongst members that the priorities chosen were appropriate. The Commission was particularly pleased to note the progress made against the Objectives for 2013/14, especially those listed under Achieved/targets met. Members were disappointed about the 2013/14 Objective for stroke patients only being partially achieved. They supported more resources being put into this service. Members had concerns about the 2013/14 Objective relating to medication side effects being underachieved. Members supported the Quality Objectives for 2014/15.

e) Statement from Bristol Clinical Commissioning Group

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Account 2013/14 is made by Bristol Clinical Commissioning Group following a review by the Governing Body.

Bristol CCG welcomes UH Bristol's quality account, which provides a comprehensive reflection on the quality performance during 2013/14. The data presented has been reviewed and is in line with data provided and reviewed through the monthly quality contract performance meetings.

The CCG is pleased to note UH Bristol's improved achievement against its objectives for 2013/14 with 11 of the 16 objectives met. The CCG also supports the plan to see these objectives as 'business as usual' for the coming year, and welcomes the approach to focus on a smaller number of transformational objectives to support improved patient care and patient experience following wide public consultation.

The quality account identifies progress in relation to:

- Early identification of the deteriorating patient and appropriate escalation of their care
- Reduction of hospital–acquired healthcare infections. We note that the targets for both MRSA and C Difficile were not met, however, the CCG acknowledges the significant reduction in the number of these infections and the work undertaken to support improvements to clinical environments following a Care Quality Commission unannounced inspection to children's cardiac theatres.
- Improving patient experience in outpatients. The CCG supports the learning implemented in this specific area which has led to improved patient experience and increased productivity and efficiency in the outpatient services.
- Successful implementation of the Friends and Family Test within adult inpatient, emergency department and maternity services and achievement in both the response rate and net promoter targets.

- Comprehensive monthly patient experience surveys demonstrating a high percentage of positive responses.

The CCG is pleased to see how UH Bristol has improved specialist diabetic support for patients and would welcome the continued focus on this area going forward into 2014/15 in line with one of the CCG priorities.

The quality account also demonstrates the improvements made in the management of patients suffering from a stroke and the CCG supports the on-going work in this area to achieve further improvements.

The CCG will continue to work closely with the Trust in areas which need further improvement:

- Nutritional screening
- Dementia action plan implementation
- Experiences of maternity patients
- In delivering the eight indicators of quality for best practice tariff for hip fractures
- With improvement plans to support staff engagement and wellbeing including the implementation of the NHS Friends and Family Test for staff.

We would welcome seeing in the 2014/15 objectives greater identification on learning from complaints and experiences of both patients and staff and the presentation of the data by service level. We would also welcome strong reference to effective partnership working across the community and good communication and engagement with key stakeholders with the aim of improving and developing patient safety and quality centred clinical pathways within the 2014/15 objectives.

Having reviewed the quality account we welcome the improvements and progress made by the Trust and acknowledgement of where further improvement work is needed and we look forward to working with UH Bristol in 2014/15.

APPENDIX C – Performance indicators subject to external audit

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer;
- An urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant;
- The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait);
- The clock start date is defined as the date that the referral is received by the Trust; and
- The clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice. In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.

Clostridium Difficile

Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- Infections relate to patients aged two year old or more;
- A positive laboratory test result for Clostridium Difficile recognised as a case according to the Trust's diagnostic;
- Positive results on the same patient more than 28 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken; and
- The Trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one).

APPENDIX D – Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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 NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;

- 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 2013 to April 2014
    - Papers relating to Quality reported to the board over the period April 2013 to April 2014
    - Feedback from the commissioners dated 14/5/2014
    - Feedback from governors received 16/05/14
    - Feedback from Local Healthwatch organisations received 15/5/14
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009[45]
    - The 2013 national patient survey (published 8/4/2014)
    - The 2013 national staff survey (published 25/2/2014)
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 28/05/2014
    - CQC quality and risk profiles dated 31/07/2013[46]

- 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.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual)).

[45] This report is due to be received by the Board in July 2014

[46] After which, QRPs for acute trusts were replaced by Intelligence Monitoring Reports (commencing October 2013)

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
28 May 2014

Robert Woolley, Chief Executive
28 May 2014

APPENDIX E – External audit opinion

Independent Auditors' Limited Assurance Report to the Council of Governors of University Hospitals Bristol NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of University Hospitals Bristol NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Bristol NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

Specified indicators	Specified indicators criteria
Clostridium Difficile	Appendix C of the Quality Report
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Appendix C of the Quality Report

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "*Detailed requirements for quality reports 2013/14*" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "*Detailed requirements for quality reports 2013/14*";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "*2013/14 Detailed guidance for external assurance on quality reports*".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2013 to the date of signing this limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2013 to the date of signing this limited assurance report;
- Feedback from the Bristol Clinical Commissioning Group dated 14/5/2014;

- Feedback from Governors dated 16/05/2014;
- Feedback from Healthwatch Bristol and Healthwatch South Gloucestershire dated 15/5/2014;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
    - The 2013 national patient survey dated 08/04/2014;
    - The 2013 national staff survey dated 25/02/2014;
    - Care Quality Commission quality and risk profiles dated 31/07/2013; and
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 27/05/2014

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the **"**documents**"**). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales ("ICAEW") Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospitals Bristol NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospitals Bristol NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospitals Bristol NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2013/14";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;

- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and

- reading documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by University Hospitals Bristol NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2014,

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "*Detailed requirements for quality reports 2013/14*";

- The Quality Report is not consistent in all material respects with the documents specified above; and

- the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "*2013/14 Detailed guidance for external assurance on quality reports*".

PricewaterhouseCoopers LLP
Chartered Accountants
Bristol
28 May 2014

The maintenance and integrity of the University Hospitals Bristol NHS Foundation Trust website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

University Hospitals Bristol NHS
NHS Foundation Trust

Accounts for the year ended 31 March 2014

Paul Mapson
Director of Finance CPFA

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Finance Department
Marlborough Street
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UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Accounts for the year ended 31 March 2014

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2014 have been prepared by the University Hospitals Bristol NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Services Act 2006.

Signed ……

Robert Woolley
Chief Executive

Statement of Comprehensive Income for the year ended 31 March 2014

	Note	Year ended 31 March 2014 £'000	Year ended 31 March 2013 £'000
OPERATING INCOME			
Income from activities from continuing operations	3	451,601	413,709
Other operating income from continuing operations	4	102,805	101,123
Other operating income from discontinued operations	4	-	13,377
TOTAL OPERATING INCOME		**554,406**	**528,209**
OPERATING EXPENSES			
Operating expenses from continuing operations	5-6	(549,283)	(500,261)
Operating expenses from discontinued operations	5-6	-	(13,377)
TOTAL OPERATING EXPENSES		**(549,283)**	**(513,638)**
OPERATING SURPLUS/(DEFICIT)			
Surplus from continuing operations		5,123	14,571
TOTAL OPERATING SURPLUS/(DEFICIT)		**5,123**	**14,571**
FINANCE COSTS			
Finance income	9.1	145	222
Finance costs	9.2	(1,850)	(431)
Finance expense unwinding discount on provisions	18	(4)	(6)
Public dividend capital dividends payable		(9,289)	(9,672)
NET FINANCE COSTS		**(10,998)**	**(9,887)**
SURPLUS/(DEFICIT) FOR THE YEAR*		**(5,875)**	**4,684**
OTHER COMPREHENSIVE INCOME/(EXPENDITURE)			
Impairments charged to revaluation reserve		-	(1,833)
Revaluation losses on property plant and equipment		(4,719)	-
Revaluation gains on property plant and equipment		8,737	430
Other recognised gains and (losses)		-	(30)
TOTAL COMPREHENSIVE INCOME/(EXPENDITURE) FOR THE YEAR		**(1,857)**	**3,251**

*The deficit of £5.875m includes a net impairment cost of £12.713m (2012/13: £1.1m) following the quinquennial revaluation of assets by the District Valuer. Discontinued operations in 2012/13 related to the cessation of the hosting arrangements for Skills for Health at the close of business on 31 March 2013.

The notes on pages 6 to 58 form part of these Accounts.

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014	31 March 2013
		£'000	£'000
NON CURRENT ASSETS			
Intangible assets	10	7,062	6,740
Property, plant and equipment	11	381,780	344,385
TOTAL NON CURRENT ASSETS		**388,842**	**351,125**
CURRENT ASSETS			
Inventories	12	10,934	8,816
Trade and other receivables	13	22,368	20,656
Other financial assets	14.1	104	104
Assets held for sale	14.2	700	700
Cash and cash equivalents	19	47,535	35,118
TOTAL CURRENT ASSETS		**81,641**	**65,394**
CURRENT LIABILITIES			
Trade and other payables	15	(61,472)	(56,617)
Borrowings	17	(509)	(472)
Provisions	18	(163)	(445)
Other liabilities	16	(3,975)	(2,782)
TOTAL CURRENT LIABILITIES		**(66,119)**	**(60,316)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**404,364**	**356,203**
NON CURRENT LIABILITIES			
Borrowings	17	(79,985)	(30,431)
Provisions	18	(185)	(211)
TOTAL NON CURRENT LIABILITIES		**(80,170)**	**(30,642)**
TOTAL ASSETS EMPLOYED		**324,194**	**325,561**
TAXPAYERS' EQUITY			
Public dividend capital		191,501	191,011
Revaluation reserve		53,448	63,899
Other reserves		85	85
Income and expenditure reserve		79,160	70,566
TOTAL TAXPAYERS' EQUITY		**324,194**	**325,561**

The accounts on pages 2 to 58 were approved by the Board on 28 May 2014 and signed on its behalf by:

Signed ..... Date 28 May 2014

Robert Woolley, Chief Executive

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2014

Changes in Taxpayers' equity in the current year	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	Total £000
Taxpayer's Equity at I April 2013	**191,011**	**63,899**	**85**	**70,566**	**325,561**
Surplus/(deficit) for the year	-	-	-	(5,875)	(5,875)
Revaluation losses on property plant and equipment and intangible assets	-	(4,719)	-	-	(4,719)
Revaluation gains on property plant and equipment and intangible assets	-	8,737	-	-	8,737
Asset disposals	-	(11)	-	11	-
Transfers between reserves	-	(14,458)	-	14,458	-
Total comprehensive income for the year	-	(10,451)	-	8,594	(1,857)
PDC received	490	-	-	-	490
Taxpayers' Equity at 31 March 2014	**191,501**	**53,448**	**85**	**79,160**	**324,194**

Changes in Taxpayers' equity in the prior year	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	Total £000
Taxpayer's Equity at I April 2012	**191,011**	**69,773**	**85**	**61,441**	**322,310**
Surplus/(deficit) for the year	-	-	-	4,684	4,684
Impairments	-	(1,833)	-	-	(1,833)
Revaluation gains on property plant and equipment and intangible assets	-	372	-	-	372
Asset disposals	-	(1,321)	-	1,321	-
Other recognised gains and (losses)	-	-	-	(30)	(30)
Transfers between reserves	-	(3,150)	-	3,150	-
Other reserve movements	-	58	-	-	58
Total comprehensive income for the year	-	(5,874)	-	9,125	3,251
Taxpayers' Equity at 31 March 2013	**191,011**	**63,899**	**85**	**70,566**	**325,561**

Statement of Cash Flows for the year ended 31 March 2014

	Note	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus from continuing operations		5,123	14,571
OPERATING SURPLUS/(DEFICIT)		**5,123**	**14,571**
NON CASH INCOME AND EXPENDITURE			
Depreciation and amortisation	10-11	18,722	18,729
Impairments	9.3	20,523	1,086
Reversals of impairments	9.3	(7,810)	-
(Gain)/loss on disposal		111	97
(Increase)/decrease in trade and other receivables	13	(1,446)	(2,873)
(Increase)/decrease in other assets	14	-	42
(Increase)/decrease in inventories	12	(2,118)	(1,698)
Increase/(decrease) in trade and other payables	15	(3,059)	8,253
Increase/(decrease) in other liabilities	16	1,193	(1,316)
Increase/(decrease) in provisions	18	(312)	(5,926)
(Gain)/loss on disposal of discontinued operations		-	6,175
Other movements in operating cash flows		(142)	(1,224)
NET CASH GENERATED FROM OPERATIONS		**30,785**	**35,916**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		146	223
Purchase of property, plant and equipment	11	(56,122)	(58,063)
Purchase of intangible assets	10	(1,544)	(2,838)
Sales of assets held for sale		-	7,568
Sales of intangible assets		43	-
Cash flows attributable to investing activities of discontinued operations		-	(4,940)
NET CASH USED IN INVESTING ACTIVITIES		**(57,477)**	**(58,050)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		490	-
Public dividend capital repaid		-	-
Loans received from the Independent Trust Financing Facility		50,000	24,950
Loans repaid to the Independent Trust Financing Facility		(260)	-
Capital receipts		-	967
Capital element of finance lease rental payments		(227)	(188)
Interest paid		(921)	(12)
Interest element of finance leases		(370)	(387)
PDC dividend paid		(9,603)	(9,559)
NET CASH GENERATED/(USED) IN FINANCING ACTIVITIES		**39,109**	**15,771**
INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**12,417**	**(6,363)**
CASH AND CASH EQUIVALENTS AT START OF YEAR	19	**35,118**	**41,481**
CASH AND CASH EQUIVALENTS AT END OF YEAR	19	**47,535**	**35,118**

Notes to the Accounts

1. Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust 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 2013/14* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (*FReM)* to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared on a going concern basis under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. Income from partially completed spells is calculated on a pro-rata basis based on the expected length of stay.

1.3 Expenditure on employee benefits

Employee benefits - short term

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

An estimate of annual leave owing to staff at 31st March 2014 has been calculated using a sample of staff across all staff groups of a size sufficient to ensure above 95% confidence in the value. 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 2014. 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, GP practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

a) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions
The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

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 operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

- individually its cost is in excess of £5,000; or
- it forms a group of similar assets with an aggregate cost in excess of £5,000 (where the assets have an individual cost in excess of £250, are functionally interdependent, have broadly similar purchase dates, are expected to have similar lives and are under single management control); or
- it forms part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of individual or collective cost;
  and
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be provided to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably.

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

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

All assets are measured subsequently at fair value.

Land and buildings
All land and buildings are revalued using professional valuations every five years. 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 new valuations are completed on a Modern Equivalent Assets (MEA) basis. For specialised operational property the depreciated replacement cost is used. For non-specialised property and non-operational specialised property fair value is used as market value for its existing use.

Assets in the course of construction are initially recorded at cost and then valued by professional valuers as part of the five year review, or, for significant properties, when they are brought into use.

Other assets
Other assets include plant, machinery and equipment and are held at depreciated historical cost which is considered to be an appropriate proxy for current value.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred will flow to the Trust and the cost of the item can be determined reliably. Where an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the year in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment, which have been reclassified as 'Held for Sale', cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until they are brought into use.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining useful lives of the assets assessed by the Trust's professional valuers. Leaseholds are depreciated over the primary lease term. Other items of property, plant and equipment are depreciated on a straight line basis over their estimated remaining useful lives, as assessed by the Trust. The remaining maximum and minimum economic lives of property, plant and equipment assets held by the Trust are as follows:

Asset type	Minimum Life	Maximum Life
Buildings excluding dwellings	3 years	44 years
Dwellings	17 years	29 years
Plant and machinery (including medical equipment)	1 year	10 years
Transport equipment	1 year	7 years
Information technology	1 year	9 years
Furniture and fittings	1 year	8 years

When assets are revalued, 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.

Residual values and useful lives of assets are reviewed on an annual basis with any changes accounted for prospectively as a change in estimate under IAS 8.

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 are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

The Trust transfers the difference between depreciation based on the historical amounts and revalued amounts from the revaluation reserve to retained earnings.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;

- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

Donated and grant funded plant property and equipment assets are capitalised at their current value on receipt. The donation/grant is credited to income at the same time unless the donor has imposed a condition that the future economic benefits are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised where they have a cost in excess of £5,000, where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

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 are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value.

Intangible assets are held at amortised historical cost which is considered to be an appropriate proxy for fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

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.
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	9 years

Purchased computer software licences are amortised over the shorter of the term of the licence and their estimated economic lives.

1.7 Government grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups 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 or net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of inventories. A provision is made where necessary for obsolete, slow moving and defective inventories.

1.9 Financial instruments (financial assets and liabilities)

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.10 below.

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

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement
Financial assets are categorised as 'Fair value through income and expenditure', loans and receivables or 'Available-for-sale financial assets'. Financial liabilities are classified as 'Fair value through income and expenditure' or as 'Other financial liabilities'.

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

cash 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.

Financial liabilities

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to 'Finance Costs'. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices where possible, otherwise by appropriate valuation techniques.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision. The allowance/provision is then used to write down the carrying amount of the financial asset, at the appropriate time, which is determined by the Trust on a case by case basis.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Lessee accounting:

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the 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 the liability is de-recognised when it 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 released to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Lessor accounting:

Operating leases
Assets acquired and held for use under operating leases are recorded as fixed assets and are depreciated on a straight line basis to their estimated residual values over their estimated useful lives. Operating lease income is recognised within operating income.

1.11 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates as per the table below, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 1.80% in real terms.

Expected cash outflows	Years	HMT real rate (%)	
		2013/14	2012/13
Short term	1-5	-1.9	-1.8
Medium term	6-10	-0.65	-1.0
Long term	10 or more	2.2	2.2

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the 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 Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 18.3.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses 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 Trust's control) are not recognised as assets, but are disclosed in note 22.1 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 22.2, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the NHS Foundation Trust's predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services and National Loans Fund deposits, excluding cash balances held in GBS accounts that relate to a short term working capital facility, and (iii) any PDC dividend balance receivable or payable. Average relevant net assets are calculated as a simple average (mean) of opening and closing relevant net assets. In accordance with the requirements laid down by the Department of Health (as issuer of the PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.14 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation tax

NHS foundation trusts are potentially liable to corporation tax in certain circumstances. A review of other operating income is performed annually to assess any potential liability in accordance with the guidance on the HM Revenues and Customs website. As a result of this review, the Trust has concluded that there is no corporation tax liability for the year ended 31 March 2014.

1.16 Financial risk

IFRS 7, 'Financial Instruments: Disclosures', requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities (see note 26).

The Trust's activities expose it to a variety of financial risks: market risk (including interest rate risk, and foreign exchange risk), credit risk and liquidity risk. Risk management is carried out by the Trust's Treasury Management Department under policies approved by Trust Board.

a) Market risk

(i) Interest-rate risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only elements of the Trust's assets that are subject to variable rate are short-term cash investments. The Trust is not, exposed to significant interest-rate risk.

(ii) Foreign currency risk

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 there is 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 and a provision is made to provide for this.

c) Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. Therefore the Trust has little exposure to liquidity risk. Loans are serviced from planned surpluses.

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 Trust has no beneficial interest in them. However, they are disclosed in note 27 to the accounts, in accordance with the requirements of HM Treasury's *Financial Reporting Manual*.

1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note 29 is compiled directly from the losses and compensations register which reports on a cash basis with the exception of provisions for future losses.

1.19 Accounting standards that have been issued but not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretation Committee (IFRIC) but not yet required to be adopted.

Change published	Published by IASB	Financial year for which the change first applies
IFRS 9 Financial Instruments Financial Assets: Financial Liabilities:	October 2010	Uncertain. Not likely to be adopted by the EU until the IASB has finished the rest of its financial instruments project.
IFRS 10 Consolidated Financial Statements	May 2011	Effective from 2014/15, reflecting the EU-adopted effective date rather than the effective date of the standard
IFRS 11 Joint Arrangements	May 2011	Effective from 2014/15, reflecting the EU-adopted effective date rather than the effective date of the standard
IFRS 12 Disclosure of Interests in Other Entities	May 2011	Effective from 2014/15, reflecting the EU-adopted effective date rather than the effective date of the standard
IFRS 13 Fair Value Measurement	May 2011	Effective date of 2013/14 but not yet adopted by the HM Treasury
IAS 27 Separate Financial Statements	May 2011	Effective from 2014/15, reflecting the EU-adopted effective date rather than the effective date of the standard
IAS 28 Associates and joint ventures	May 2011	Effective from 2014/15, reflecting the EU-adopted effective date rather than the effective date of the standard
IAS 32 Financial Instruments: Presentation-amendment. Offsetting financial assets and liabilities	December 2011	Effective from 2014/15

The Trust has not adopted any new accounting standards, amendments or interpretations early. The new standards set out above will either have no significant impact on the Trust, or in the case of IFRS 13, any impact is unknown as the implementation of this standard in the public sector is still under consideration by HM Treasury.

1.20 Critical accounting estimates and judgements

Estimates and judgments are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Critical judgements in applying the entity's accounting policies
The Trust has made no judgements in applying the accounting policies other than those involving accounting estimates.

Critical accounting estimates and assumptions
The Trust makes estimates and assumptions concerning the future. The resulting accounting estimates will, by definition, seldom equal the related actual results. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are addressed below.

a) Depreciation
Depreciation is based on automatic calculation within the Trust's Fixed Asset Register which is calculated on a monthly basis throughout the year. When an asset is added to the Fixed Asset Register, it is given a useful economic life by the capital accountant, depending on the class of asset (i.e. vehicle, IT equipment etc). Buildings can be assigned a useful economic life of up to 50 years by the District Valuer as part of their valuations, depending on their state of repair and intended use. Useful economic life can be adjusted on the Fixed Asset Register if required. For example where an external valuation by the District Valuer report identifies a change in existing useful life or where management review identifies a requirement. This judgement will take into account past experience. Typically more expensive items have a longer lifespan which reduces the degree of sensitivity of charges.

b) Holiday Pay Accrual (see 1.3)

c) Revaluation
Unless subject to the quinquennial revaluation by the District Valuer, the Trust's assets are revalued using indexation, based on indices provided to the Trust by the District Valuer. The District Valuer is an expert, therefore there is a high degree of reliance on the valuer's expertise (see note 1.5).

d) Impairment
Impairments are based on the District Valuer's revaluation, on application of indices or on revaluation of individual assets e.g. when brought into operational use, or identified for disposal. Assumptions and judgments are that indices or valuations used are applicable to the Trust's circumstances. Additionally, management reviews would identify circumstances which may indicate where an impairment has occurred.

e) Month 12 income from activities
As the NHS Annual Accounts and invoicing deadlines fall before actual month 12 activity data is available, it is necessary to make an estimate for the accounts. Estimated invoices are raised based on the forecast outturn at month 11. Forecast outturn activity and value is calculated throughout the year using established profiles as the basis for estimating the full year activity. Profiles are set up at the beginning of the year to reflect the anticipated spread of activity throughout the year and are used to spread the annual plan as well as to forecast the activity. The main profiles used are:

- Twelfths – used for block contracts
- Actual days – (calendar days in month) used for non elective and emergency work
- Working days – (excludes weekends and bank holidays plus an additional day at Christmas) used for elective work and outpatients
- Specific profiles – more detailed profiles are set up for example where it is known that particular activity is not planned to start until part way through the year, e.g. date of service transfer, commencement of new development or implementation dates of a NICE tag.

f) 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 host Clinical Commissioning Group and the Foundation Trust agree a realistic estimate. The day of admission counts as an unfinished day.
Estimated unfinished days are valued using specialty bed day rates. The rates will be weighted to ensure they are consistent with the proportion of actual income received, using information from previous months incomplete spells. 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 is 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 Clinical Commissioning Groups/NHS England.
In making this estimate the volume of unfinished activity is calculated using an average of months 5 to 11. Months 1 to 4 are not included as the implementation of the revised identification rules for specialist commissioning were not authorised by the commissioners until month 5, and this could have an impact on the activity allocation by commissioner. The rates used are calculated at specialty level, the greatest level of detail that can be determined for unfinished activity, and reflect the distribution of costs through the spell in recognition of the early days of the spell generally being the most expensive. Rates are calculated based on the final position on the spells originally unfinished at the end of months 1 to 6.

As the identification of specialist activity for unfinished spells is limited due to the fact this activity is uncoded, the final estimated value of partially completed activity has been apportioned over commissioners on the basis of the distribution across commissioners of the value of finished spells in the same dataset.

g) Maternity pathway – incomplete antenatal spells
This is an estimate of income received in advance in relation to patients who commenced their antenatal pathway in one financial year but who will not finish it until after the end of the financial year. It is calculated on the following basis:
- Assume the length of an ante natal pathway is 182 days (c 6 months)
- Estimate the proportion of pathways that will be incomplete at the end of the financial year. The position at 28th February 2014 has been used as a proxy, as the year end activity was not available at the time the accounts were prepared
- Using the ante natal booking date, calculate how many days of the ante natal period are likely to occur after 28th February 2014
- Value these days as a proportion of the pathway tariff.

1.21 Discontinued operations

Discontinued operations are defined as activities that genuinely cease without transferring to another entity, or which transfer to an entity outside the boundary of Whole of Government Accounts, such as the private or voluntary sectors. The Trust reviews its activities to determine whether any meet the definition of a discontinued operation and is recognised in the accounting year in which the decision is made to discontinue the operation.

1.22 Changes in accounting policy

Foundation Trusts may change an accounting policy only where it is required by a new standard or interpretation (including any revisions to the FT ARM) or voluntarily only if it results in the Trust's financial statements providing reliable and more relevant information about transactions, events, conditions, or the financial position, financial performance or cash flows.

The changes arising from the introduction of a new standard or interpretation will be implemented in accordance with the specific transitional provisions, if any, of that standard or interpretation. Where no such specific transitional provisions exist, or where the Trust changes an accounting policy voluntarily, the changes will be applied retrospectively i.e. through a prior period adjustment. In accordance with IAS 8 any prior period adjustments will be effected by restating each element of equity (reserves) at the start of the prior year as if the accounting policy had always applied. There were no such changes this year.

2. Segmental analysis

In 2012/13 the Trust had two reportable operating segments; Healthcare and Skills for Health. With effect from 1st April 2013, Skills for Health transferred to a new company, Skills for Health Ltd, which is outside the 'Whole of Government Accounting'. For 2013/14 the Trust has only its Healthcare segment.

The Healthcare segment delivers a range of healthcare services, predominantly to Clinical Commissioning Groups and NHS England. The Trust has a number of divisions, all of which operate in the healthcare segment. These divisions 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. The majority of income for Skills for Heath was received from the Department of Health. For 2012/13 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 2014			
Income	554,406	-	554,406
Retained surplus (deficit) for year	(5,875)	-	(5,875)
Net assets at 31 March 2014	324,194	-	324,194
Year ended 31 March 2013			
Income	514,832	13,377	528,209
Retained surplus (deficit) for year	4,684	-	4,684
Net assets at 31 March 2013	325,561	-	325,561

For 2013/14, University Hospitals Bristol Healthcare was operationally managed through five clinical divisions and a corporate service function. Expenditure and non-service agreement income is reported against these operational areas for management information purposes and reported to the Board. The out-turn position reported for 2013/14 is shown below with comparator figures for 2012/13. In 2012/13, financing costs and technical items were reported within corporate services.

	2013/14 £'000	2012/13 £'000
Expenditure net of non-service agreement income		
Diagnostic and Therapies	(46,175)	(43,027)
Medicine	(66,049)	(61,198)
Specialised Services	(73,436)	(67,317)
Surgery, Head and Neck	(94,793)	(93,499)
Women's and Children's	(96,674)	(90,612)
Corporate Services	(61,839)	(84,999)
Total net expenditure	(438,966)	(440,652)
Service agreement income	474,134	445,336
Financing costs	(28,980)	-
Net surplus before technical items	6,188	4,684
Technical items	(12,063)	-
Surplus/(deficit) for year	(5,875)	4,684

Notes to the Accounts

3. Income from activities

3.1 Income by classification

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Elective income	78,579	77,657
Non elective income	91,481	98,782
Outpatient income	64,374	68,271
Accident and emergency income	12,855	11,920
Other NHS clinical income *	189,153	147,235
Private patients	1,553	1,114
Other clinical income	13,606	8,730
TOTAL	**451,601**	**413,709**

*Significant items comprise:	£000	£000
Critical care bed days	34,575	33,914
'Payment by results' exclusions	19,521	16,838
Bone marrow transplants	5,867	7,071
Excess bed days	6,870	7,654
Radiotherapy inpatient treatments	6,324	7,175
Diagnostic imaging	5,126	1,328
Direct access	5,537	5,937
Regular day and night attenders	1,312	1,061
'At cost' contracts	5,285	5,576
Rehabilitation	4,603	5,068
N.I.C.E. drugs and devices	25,837	21,299
Audiology, Cochlear implants & bone anchored hearing aids	2,924	-
Contract penalties and rewards	5,882	1,043
Cystic fibrosis pathways	2,334	-
Maternity pathways	9,159	-
Service recharges	4,334	-
Soft facilities management and LIFTCO	7,290	2,395

3.2 Income by type

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Income from activities		
NHS Foundation Trusts	1	17
NHS Trusts	1,839	134
Strategic Health Authorities	-	1,154
Clinical Commissioning Groups and NHS England (previously PCTs)	434,602	401,957
Local Authorities	4,495	1
Non-NHS private patients	1,553	1,114
Non-NHS overseas patients	78	108
Territorial Bodies	7,986	8,435
Bodies outside of Whole of Government Accounts	387	208
NHS Injury Scheme/DVLA	660	581
Total	**451,601**	**413,709**

3.3 Income from activities arising from Commissioner Requested Services

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 Commissioner Requested Service income. Of the total income from activities, £436.6m is from Commissioner Requested Services and £15.0m is from all other services. In 2012/13 this was described as mandatory income. Of the total income from activities in 2012/13 £402.5m was mandatory and £11.2m was non-mandatory.

4. Other operating income

4.1 Other operating income

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Research and development	26,104	27,334
Education and training	37,733	39,043
Charitable and other contributions to expenditure	590	578
Donated assets – property, plant & equipment	1,501	1,044
Non-patient care services to other bodies	11,655	27,312
Reversal of impairments of property, plant, and equipment	7,810	-
Profit on disposal of assets	19	462
Rental income from operating leases	1,402	1,312
Salary recharges	4,289	4,715
Other*	11,702	12,700
TOTAL	**102,805**	**114,500**

*The 'Other' category above comprises mainly:	£000	£000
Clinical excellence awards	2,934	3,451
Patient transport	374	628
Trading services income	2,672	2,093
Clinical testing	589	501
Catering	623	721
Staff accommodation rentals	360	328
Car park income	770	786
Childcare vouchers	1,248	1,407
Property rentals	200	39

The Trust's trading services income totals £2.672m and includes Medical Equipment Management Organisation (£1.342m), Pharmacy income (£1.036m) and IT income (£0.293m).

4.2 Operating lease income

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Rental income	1,402	1,312
TOTAL	**1,402**	**1,312**

4.3 Future minimum lease receipts due to the Trust

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Future minimum lease receipts due		
- not later than one year	1,465	1,221
- later than one year but not later than five years	2,033	600
- later than five years	3,344	1,639
TOTAL	**6,842**	**3,460**

As part of the Trust's strategic development programme, the Welcome Centre opened in 2013/14 providing retail space for which the Trust receives operating lease income.

Notes to the Accounts

5. Operating expenses

5.1 Operating expenses by type

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Services from other bodies:		
- NHS organisations	9,080	7,766
- non NHS organisations	3,251	2,782
Purchase of healthcare from non NHS bodies	433	1,809
Executive directors costs	1,235	1,202
Non-executive directors costs	168	168
Staff costs	317,316	311,772
Drug costs	64,880	59,271
Supplies and services:		
- clinical	51,459	39,427
- general	6,844	6,767
Establishment costs	5,827	3,268
Transport:		
- business travel	771	1,404
- other	376	368
Premises costs	10,553	15,143
Change in provision for bad debts	1,145	(1,508)
Depreciation on property plant and equipment	17,922	17,848
Amortisation on intangible assets	800	881
Impairments	20,523	1,086
Auditor's remuneration:		
- statutory audit	60	50
- regulatory reporting	10	8
- other non-audit services	529	309
Rentals under operating leases	4,853	5,834
Research and development:		
- hosting payments	13,292	14,364
- other	2,718	3,068
Clinical negligence	5,865	7,120
Loss on disposal of property, plant, equipment & intangibles	130	559
Other*	9,243	12,872
TOTAL	**549,283**	**513,638**

*Other expenditure includes the following:	£000	£000
Consultancy	761	1,501
Exit payments (note 6.5)	565	859
Training, courses and conferences	1,512	4,094
External contractors	457	933
Childcare vouchers	1,297	1,207

There is a limitation of £1 million liability in respect of external audit services unless unable to be limited by law.

5.2 Operating leases

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Land	23	-
Buildings	4,084	5,344
Plant and machinery	742	485
Other	4	5
	4,853	**5,834**

Future minimum lease payments due under operating leases are as follows:

Future minimum lease payments	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Not later than one year	5,082	4,974
Later than one year but not later than five years	14,474	19,363
Later than five years	5,335	5,207
TOTAL	**24,891**	**29,544**

The Trust leases various equipment and buildings. The most significant is the South Bristol Community Hospital which the Trust has leased for a 5 year period from 1 April 2012 at an annual cost of £4.084m.

6. Staff costs and numbers

6.1 Staff costs

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Salaries and wages	262,545	258,532
Social security costs	21,248	21,226
Employer contributions to NHS Pension Scheme	29,378	28,635
Termination benefits	565	859
Income in respect of salary recharges netted off	(1,899)	(2,177)
Agency contract staff	7,643	7,079
TOTAL	**319,480**	**314,154**

Staff costs include all persons with a permanent contract of employment and others engaged in the work of the Trust, such as agency/temporary staff, those on short term contracts and staff recharged by other organisations. It therefore includes staff costs capitalised as part of assets and excludes non-executive directors when comparing to total staff expenditure stated in note 5.1.

In 2013-14, the Trust made £137k (2013, £133k) contributions to the NHS Pension Scheme in respect of executive directors.

6.2 Average number of employees

	Year ended 31 March 2014 Number	Year ended 31 March 2013 Number
Medical and dental staff	1,024	999
Administration and estate staff	1,470	1,535
Healthcare assistant & other support staff	760	737
Nursing, midwifery & health visiting staff	2,587	2,510
Nursing, midwifery & health visiting learners	6	6
Scientific, therapeutic and technical staff	1,180	1,114
Bank and agency staff	407	377
TOTAL	**7,434**	**7,278**

Numbers are expressed as average whole time equivalents for the year.

6.3 Retirement benefits

The NHS Pension Scheme is a defined benefit plan. As at 31 March 2013 the pension liabilities of the NHS Pension Scheme were valued at £284.2 billion. This is an increase of £37.2 billion from the liabilities at 31 March 2012 of £247.0 billion. This is due to an actuarial gain of £23.0 billion (£18.9 billion relating to the impact of the change in discount rate and £4.1 billion to changes in assumption and experience) and current year net additions to the liability of £14.2 billion. As the NHS Pension Scheme is an unfunded scheme, these liabilities are underwritten by the exchequer.

The Trust anticipates that their pension contributions for 2014/15 will be in line with those made in 2013/14.

6.4 Employee Benefits

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

6.5 Retirements due to ill health

During the year ended 31 March 2014 there were 12 (2013: 5) early retirements from the Trust on the grounds of ill health. The estimated additional pension liabilities of these ill-health retirements will be £0.904m (2013: £0.147m). 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	2 (5)	9 (6)	11 (11)
£10,000 - £25,000	2 (3)	1 (10)	3 (13)
£25,001 - £50,000	2 (2)	4 (5)	6 (7)
£50,001 - £100,000	0 (4)	4 (1)	4 (5)
Total number of exit packages by type	**6 (14)**	**18 (22)**	**24 (36)**
Total resources cost (£'000)	**120 (432)**	**446 (427)**	**565 (859)**

Comparative figures for 2012/13 are shown in brackets. The 2012/13 figures include Skills for Health and the segmental split is shown in the table below:

Notes to the Accounts

Analysis for 2012/13	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Skills for Health			
Total number of exit packages by type	7	0	7
Total resources cost (£'000)	229	-	229
University Hospitals Bristol Healthcare			
Total number of exit packages by type	7	22	29
Total resource cost (£'000)	202	427	630

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.

The type of non-compulsory departure payments made in 2013/14 are as follows:

Type	Number	Total Value (£'000)
Mutually agreed resignation contractual costs	9	389
Contractual payments in lieu of notice	8	27
Non-contractual payments requiring HMT approval	1	30
Total	18	446

There were no non-contractual payments made with a value greater than 12 months of the individual's salary.

6.7 Hutton review of fair pay

The Trust is required to disclose the relationship between the remuneration of the highest-paid director in the organisation and the median remuneration of the organisation's workforce.

The annualised banded remuneration of the highest-paid director in the financial year 2013/14 was £195k-£200k (2012/13, £195k-£200k). This was 7.0 times (2012/13, 7.0) the median remuneration of the workforce, which was £28,314 (2012/13, £28,209). In 2013/14, nil (2012/13, nil) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £14.3k to £191.6k.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The figures exclude bank and agency staff.

	2013/14	2012/13
Band of highest paid directors total remuneration (£'000)	195-200	195-200
Median total remuneration (£)	28,297	28,209
Ratio	7.0	7.0

Notes to the Accounts

6.8 Director's remuneration: Salaries and allowances for the 12 Months to 31 March 2014	Salary (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Chair			
John Savage	50-54		50-54
Executive Directors			
Robert Woolley, Chief Executive	170-174	82.5-84.9	250-254
Paul Mapson, Director of Finance and Information	150-154	135-137.4	285-290
Claire Buchanan, Acting Director of Workforce and Organisational Development (until 6 October 2013)	50-54	35-37.4	85-89
Sue Donaldson, Director of Workforce and Organisational Development (from 4 November 2014)	45-49	12.5-14.9	60-64
Helen Morgan, Acting Chief Nurse (until 1 February 2014)	80-84	192.5-194.9	275-279
Carolyn Mills, Chief Nurse (from 6 January 2014)	25-29	10-12.4	40-44
Deborah Lee, Director of Strategic Development and Deputy Chief Executive	130-134	100-102.4	230-234
Sean O'Kelly, Medical Director	195-199	65-67.4	260-264
James Rimmer, Chief Operating Officer	120-124	40-42.4	160-164
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
Paul May (until 31 July 2013)	5-9		5-9
John Moore	15-19		15-19
Guy Orpen	10-14		10-14
Alison Ryan (from 28 November 2013)	0-4		0-4
David Armstrong (from 28 November 2013)	0-4		0-4
Jill Youds (from 28 November 2013)	0-4		0-4
Julian Dennis (from 28 November 2013)	0-4		0-4

There were no taxable benefits, annual performance related bonuses, long-term performance related bonuses or exit packages paid to any director in either period. Aggregate salary cost for 2013/14 was £1,134k (2012/13, £1,108k). The aggregate employer contribution to the pension scheme was £137k (2012/13, £133k). The total number of directors to whom benefits are accruing under defined benefit schemes is 7 (2012/13, 7).

Notes to the Accounts

6.9 Director's remuneration: **Salaries and allowances for the 12 Months to 31 March 2013**	Salary (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Chair			
John Savage	50-54		50-54
Executive Directors			
Robert Woolley, Chief Executive	170-174	107.5-109.9	275-279
Paul Mapson, Director of Finance	140-144	95-97.4	235-239
Steve Aumayer, Director of Workforce and Organisational Development (until 30 April 2012)	5-9	0-2.4	5-9
Claire Buchanan, Acting Director of Workforce and Organisational Development (from 1 May 2012)	90-94	115-117.4	205-209
Alison Moon, Chief Nurse and Director of Governance (until 17 March 2013)	110-114	22.5-24.9	130-134
Helen Morgan, Acting Chief Nurse (from 18 March 2013)	0-4	0-2.4	5-9
Deborah Lee, Director of Strategic Development (and Deputy Chief Executive from 23 January 2013)	110-114	42.5-44.9	155-159
Sean O'Kelly, Medical Director	195-199	85-87.4	280-284
James Rimmer, Chief Operating Officer	120-124	100-102.4	220-224
Non-Executive Directors			
Emma Woollett	15-19		15-19
Kelvin Blake	10-14		10-14
Iain Fairbairn	15-19		15-19
Lisa Gardner	15-19		15-19
Selby Knox (until 31 May 2012)	0-4		0-4
Paul May	15-19		15-19
John Moore	15-19		15-19
Guy Orpen (from 1 June 2012)	10-14		10-14

Notes to the Accounts

6.10 Pension benefits for the year ended 31 March 2014

Name and title	Real increase in pension at age 60 at 31 March 2014	Real increase in lump sum at age 60 at 31 March 2014	Total accrued pension at age 60 at 31 March 2014	Lump sum at age 60 related to accrued pension at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2013	Real Increase in Cash Equivalent Transfer Value	Employer funded contribution to growth in CETV
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Robert Woolley, Chief Executive	2.5-4.9	7.5-9.9	45-49	140-144	957	858	85	43
Paul Mapson, Director of Finance and Information	2.5-4.9	12.5-14.9	64-69	200-204	1,506	1,334	151	77
Claire Buchanan, Acting Director of Workforce and Organisational Development (until 6 October 2013)	0-2.4	2.5-4.9	25-29	80-84	467	405	29	15
Sue Donaldson, Director of Workforce and Organisational Development (from 4 November 2014)	0-2.4	0-2.4	10-14	40-44	241	210	11	6
Helen Morgan, Acting Chief Nurse (until 1 February 2014)	7.5-9.9	22.5-24.9	25-29	105-109	687	484	164	87
Carolyn Mills, Chief Nurse (from 6 January 2014)	0-2.4	0-2.4	35-39	105-109	598	545	10	6
Deborah Lee, Director of Strategic Development and Deputy Chief Executive	2.5-4.9	10-12.4	20-24	70-74	435	345	84	43
Sean O'Kelly, Medical Director	0-2.4	5-7.4	55-59	170-174	1128	1040	71	36
James Rimmer, Chief Operating Officer	0-2.4	2.5-4.9	35-39	110-114	627	582	36	19

This table includes details for the directors who held office at any time in 2013/14.

Real increases and employer's contributions are shown for the time in post where this has been less than the whole year.

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

6.11 Pension benefits for the year ended 31 March 2013

Name and title	Real increase in pension at age 60 at 31 March 2013	Real increase in lump sum at age 60 at 31 March 2013	Total accrued pension at age 60 at 31 March 2013	Lump sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real Increase in Cash Equivalent Transfer Value	Employer funded contribution to growth in CETV
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Robert Woolley, Chief Executive	2.5-4.9	10-12.4	40-44	130-134	858	724	114	64
Paul Mapson, Director of Finance and Information	2.5-4.9	7.5-9.9	60-64	180-184	1,334	1,206	94	53
Steve Aumayer, Director of Workforce and Organisational Development (until 30 April 2012)	(0-2.4)	n/a	5-9	n/a	72	69	-	-
Claire Buchanan, Acting Director of Workforce and Organisational Development (from 1 May 2012)	2.5-4.9	12.5-14.9	20-24	70-74	405	306	83	49
Alison Moon, Chief Nurse and Director of Governance (until 17 March 2013)	(0-2.4)	(0-2.4)	35-39	110-114	682	646	18	10
Helen Morgan, Acting Chief Nurse (from 18 March 2013)	0-2.4	0-2.4	25-29	70-79	484	427	2	1
Deborah Lee, Director of Strategic Development (and Deputy Chief Executive from 23 January 2013)	0-2.4	2.5-4.9	15-19	55-59	345	303	34	19
Sean O'Kelly, Medical Director (from 18 April 2011)	0-2.4	5-7.4	50-54	160-164	1,040	942	72	40
James Rimmer, Chief Operating Officer (from 4 July 2011)	2.5-4.9	10-12.4	35-39	105-109	582	497	70	39

This table includes details for the directors who held office at any time in 2012/13.

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

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

Notes to the Accounts

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. In some cases, the real increase in the CETVs show a significant difference, when comparing this year's values with last year's. This difference is due to a change in the factors used to calculate CETVs, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for CETVs (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine cash equivalent transfer values (CETV) from Public Sector Pension Schemes came into force on 13 October 2008.

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

Signed ……
Robert Woolley,
Chief Executive

7. Better Payment Practice Code

7.1 Measure of compliance

	Year ended 31 March 2014		Year ended 31 March 2013	
	Number	Value £000	Number	Value £000
Total non NHS trade invoices paid in the year	167,561	225,243	159,332	195,884
Total non NHS trade invoices paid within target	149,423	200,144	138,690	175,413
Percentage of non NHS trade invoices paid within target	89.2%	88.9%	87.0%	89.5%
Total NHS trade invoices paid in the year	4,159	54,266	4,561	60,075
Total NHS trade invoices paid within target	3,363	49,418	3,735	54,828
Percentage of NHS trade invoices paid within target	80.9%	91.1%	81.9%	91.3%

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 (2013: £nil) arising from claims made under this legislation. No other compensation was paid to cover debt recovery cost under this legislation.

8. Loss on disposal of property, plant and equipment

The net loss on the disposal of property, plant and equipment of £0.111m (2013: net loss of £0.097m) related exclusively to non-protected assets. No assets used in the provision of Commissioner Requested Services have been disposed of during the year.

9. Finance

9.1 Finance income

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Interest on loans and receivables	145	222
TOTAL	**145**	**222**

9.2 Finance costs

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Loan interest from the Independent Trust Financing Facility	1,480	44
Finance leases	370	387
TOTAL	**1,850**	**431**

9.3 Impairments

Net impairment of property plant and equipment, intangibles and assets held for sale	Year ended 31 March 2014	Year ended 31 March 2013
	£000	£000
Loss or damage from normal operations	412	-
Impairment of enhancements to existing assets	17,871	-
Changes in valuation	2,240	2,919
Reversal of impairments	(7,810)	-
TOTAL	**12,713**	**2,919**

Property impairments occur when the carrying amounts are reviewed by the District Valuer through formal valuation. Plant and equipment impairments are identified following an assessment of whether there is any indication that an asset maybe impaired e.g. obsolescence or physical damage.

The property review is undertaken annually to ensure assets are reflected at fair value in the accounts, when they are brought into use or when they are identified as assets held for sale. At the first valuation after the asset is brought into use any write down of cost is treated as an impairment and charged into the Statement of Comprehensive Income. The impairment losses charged to the Statement of Comprehensive Income relate to the following:

	Land £000	Buildings £000	Equipment £000	Total £000
Loss or damage from normal operations	-	-	412	412
Impairment of enhancements to existing assets				
Queens building	-	1,551	-	1,551
Bristol Royal Hospital for Children	-	11,862	-	11,862
Bristol Haematology and Oncology Centre	-	4,458	-	4,458
Changes in valuation				
District Valuer's revaluation of land & buildings	85	2,155	-	2,240
Total	**85**	**20,026**	**412**	**20,523**

10. Intangible assets

	Software licences £000	Other £000	Assets under construction £000	Total £000
Cost at 1 April 2013	5,492	165	4,667	10,324
Additions	345	-	1,199	1,544
Reclassifications with PPE	259	-	(577)	(318)
Reclassifications within intangibles	4,851	-	(4,851)	-
Disposals	(2,835)	(165)	-	(3,000)
Cost at 31 March 2014	**8,112**	**-**	**438**	**8,550**
Accumulated amortisation at 1 April 2013	3,523	61	-	3,584
Charged during the year	800	-	-	800
Disposals	(2,835)	(61)	-	(2,896)
Accumulated amortisation at 31 March 2014	**1,488**	**-**	**-**	**1,488**
Net book value at 31 March 2013				
Purchased	1,969	104	4,667	6,740
Total net book value at 31 March 2013	1,969	104	4,667	6,740
Net book value at 31 March 2014				
Purchased	6,624	-	438	7,062
Total net book value at 31 March 2014	**6,624**	**-**	**438**	**7,062**

Included within gross cost and accumulated depreciation is £180k of software assets still in use by the Trust with nil net book value. These assets are reviewed on an annual basis and disposed of when no longer in use.

Other intangibles assets are emission allowances granted under the EU Emissions Trading Scheme which were held at fair value. All remaining balances were disposed of in 2013/14.

	Software licences £000	Other £000	Assets under construction £000	Total £000
Cost at 1 April 2012	4,894	266	2,072	7,232
Additions	304	-	2,534	2,838
Reclassifications from PPE	95	-	285	380
Reclassifications within intangibles	224	-	(224)	-
Revaluations	-	(58)	-	(58)
Disposals	(25)	(43)	-	(68)
Cost at 31 March 2013	**5,492**	**165**	**4,667**	**10,324**
Accumulated amortisation at 1 April 2012	2,667	61	-	2,728
Charged during the year	881	-	-	881
Disposals	(25)	-	-	(25)
Accumulated amortisation at 31 March 2013	**3,523**	**61**	**-**	**3,584**
Net book value at 31 March 2012				
Purchased	2,227	205	2,072	4,504
Total net book value at 31 March 2012	2,227	205	2,072	4,504
Net book value at 31 March 2013				
Purchased	1,969	104	4,667	6,740
Total net book value at 31 March 2013	**1,969**	**104**	**4,667**	**6,740**

11. Property, plant and equipment

The Trust's land and buildings were valued at 31st March 2014 on a depreciated replacement cost, Modern Equivalent Asset Valuation (MEA) basis by the District Valuer which resulted in a net increase in the value of the Trust assets of £9.588m.

The valuations have been undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the NHS Foundation Trust Annual Reporting Manual. The valuations also accord with the requirements of the RICS Valuation - Professional Standards 2014 UK edition (known as 'the Red Book'), including the International Valuation Standards, in so far as these are consistent with IFRS and the above mentioned guidance; RICS UKVS 1.15 refers.

The following are the agreed departures from the RICS Professional Standards and special assumptions :

- The Instant Building approach has been adopted, as required by HM Treasury FReM for the UK public sector. Therefore, no building periods or consequential finance costs have been reflected in the costs applied when the DRC approach is used.
- It should be noted that the use of the terms "Existing Use Value" and "Market Value" in regard to the valuation of the NHS estate may be regarded as not inconsistent with that set out in the RICS Professional Standards, subject to the additional special assumptions that:
  (a) no adjustment has been made on the grounds of a hypothetical "flooding of the market" if a number of properties were to be marketed simultaneously and in the respect of the Market Value of 'held for sale' assets only;
  (b) the NHS is assumed not to be in the market for the property interest; and
  (c) regard has been had to appropriate lotting to achieve the best price

Notes to the Accounts

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	25,639	202,880	3,527	75,661	73,466	709	17,520	1,252	**400,654**
Additions – purchased	-	1,826	-	52,808	7,893	43	882	34	**63,486**
Additions – donated	-	25	-	-	252	-	-	-	**277**
Impairments	-	(17,871)	-	-	(915)	-	-	-	**(18,786)**
Reclassifications with intangibles	-	-	-	(259)	-	-	577	-	**318**
Reclassifications within PPE	-	49,593	-	(52,017)	733	-	1,685	6	**-**
Revaluations	(1,189)	(763)	(39)	-	-	-	-	-	**(1,991)**
Disposals	-	-	-	-	(3,950)	(39)	(2,684)	(36)	**(6,709)**
Cost or valuation at 31 March 2014	24,450	235,690	3,488	76,193	77,479	713	17,980	1,256	**437,249**
Accumulated depreciation at 1 April 2013	**-**	**1,083**	**427**	**-**	**43,091**	**365**	**10,367**	**936**	**56,269**
Charged during the year	-	9,925	144	-	6,051	89	1,641	72	**17,922**
Impairments	-	-	-	-	(503)	-	-	-	**(503)**
Revaluations	-	(11,008)	(571)	-	-	-	-	-	**(11,579)**
Disposals	-	-	-	-	(3,881)	(39)	(2,684)	(36)	**(6,640)**
At 31 March 2014	-	-	-	-	44,758	415	9,324	972	**55,469**
Net book value at 31 March 2014									
Purchased	24,450	215,707	3,488	77,979	29,302	298	8,398	284	**359,906**
Donated	-	13,783	-	-	1,573	-	258	-	**15,614**
Finance leases	-	6,200	-	-	60	-	-	-	**6,260**
Total at 31 March 2014	**24,450**	**235,690**	**3,488**	**77,979**	**30,935**	**298**	**8,656**	**284**	**381,780**
Net book value at 31 March 2013									
Purchased	25.639	185,912	3,100	75,661	28,674	344	7,126	316	**326,772**
Donated	-	10,464	-	-	1,701	-	27	-	**12,192**
Finance leases	-	5,421	-	-	-	-	-	-	**5,421**
Total at 31 March 2013	**25,639**	**201,797**	**3,100**	**75,661**	**30,375**	**344**	**7,153**	**316**	**344,385**

Depreciation expenses of £17.922m (2012/13: £17.848m) have been charged to operating expenses (note 5) within the Statement of Comprehensive Income.

Notes to the Accounts

	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 2012	**26,317**	**230,278**	**4,711**	**41,380**	**72,681**	**607**	**17,405**	**2,243**	**395,622**
Additions – purchased	-	247	-	49,148	4,142	116	1,229	-	**54,882**
Additions – donated	-	-	-	-	222	-	-	-	**222**
Impairments		(1,833)	-	-	-	-	-	-	**(1,833)**
Reclassifications to intangibles	-	-	-	(380)	-	-	-	-	**(380)**
Reclassifications within PPE	-	7,088	-	(13,917)	6,389	5	391	44	**-**
Transferred to assets held for sale	(248)	(151)	(175)	-	-	-	-	-	**(574)**
Revaluations	283	(9,701)	73	-	-	-	-	-	**(9,345)**
Disposals	-	-	-	(570)	(9,968)	(19)	(1,505)	(1,035)	**(13,097)**
Reclassification of historic presentation	(713)	(23,048)	(1,082)	-	-	-	-	-	**(24,843)**
Cost or valuation at 31 March 2013	**25,639**	**202,880**	**3,527**	**75,661**	**73,466**	**709**	**17,520**	**1,252**	**400,654**
Accumulated depreciation at 1 April 2012	**713**	**23,768**	**1,371**	**-**	**46,181**	**292**	**10,026**	**1,820**	**84,171**
Charged during the year	-	9,296	144	-	6,344	91	1,822	151	**17,848**
Impairments charged to operating expenses	-	836	-	-	-	-	-	-	**836**
Revaluations	-	(9,769)	(6)	-	-	-	-	-	**(9,775)**
Disposals	-	-	-	-	(9,434)	(18)	(1,481)	(1,035)	**(11,968)**
Reclassification of historic presentation	(713)	(23,048)	(1,082)	-	-	-	-	-	**(24,843)**
At 31 March 2013	**-**	**1,083**	**427**	**-**	**43,091**	**365**	**10,367**	**936**	**56,269**
Net book value at 31 March 2013									
Purchased	25,639	185,912	3,100	75,661	28,674	344	7,126	316	**326,772**
Donated	-	10,464	-	-	1,701	-	27	-	**12,192**
Finance leases	-	5,421	-	-	-	-	-	-	**5,421**
Total at 31 March 2013	**25,639**	**201,797**	**3,100**	**75,661**	**30,375**	**344**	**7,153**	**316**	**344,385**
Net book value at 31 March 2012									
Purchased	25,604	189,938	3,340	41,380	24,349	315	7,347	422	**292,695**
Donated	-	10,877	-	-	2,151	-	32	1	**13,061**
Finance leases	-	5,695	-	-	-	-	-	-	**5,695**
Total at 31 March 2012	**25,604**	**206,510**	**3,340**	**41,380**	**26,500**	**315**	**7,379**	**423**	**311,451**

The reclassification of historic presentation line has been included to adjust the brought forward balances for 2013/14 in line with the NHS Foundation Trust Annual Reporting Manual. The line corrects the previous format which presented impairments charged to operating expense within accumulated depreciation and those charged to reserves, reducing asset costs.

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 2014 £000**	**Year ended 31March 2013 £000**
Cost or valuation at 1 April	6,417	6,356
Additions	118	-
Revaluation	(264)	-
Reclassifications	-	61
Cost or valuation at 31 March	**6,271**	**6,417**
Accumulated depreciation at 1 April	996	661
Provided during the year	352	335
Revaluation	(1,337)	-
Accumulated depreciation at 31 March	**11**	**996**
Net book value at 31 March	**6,260**	**5,421**

11.2 Net book value of land building and dwellings

The net book value of land, buildings and dwellings comprises:

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Freehold	257,428	225,115
Long leasehold	6,200	5,421
TOTAL	**263,628**	**230,536**

12 Inventories

Year ended 31 March 2014	Drugs £000	Consumables £000	Energy £000	Totals £000
Carrying value at end of year	4,040	6,698	196	10,934
Inventories recognised as an expense in the year	49,984	37,969	21	87,974

Year ended 31 March 2013	Drugs £000	Consumables £000	Energy £000	Totals £000
Carrying value at end of year	3,516	5,110	190	8,816
Inventories recognised as an expense in the year	48,033	32,521	94	80,648

13. Trade and other receivables

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Current:		
NHS receivables	9,924	13,091
Other receivables	9,608	8,636
Provision for impaired receivables	(4,694)	(3,987)
PDC Dividend receivable	267	-
Prepayments	2,646	2,326
Accrued income	4,617	590
Total current:	**22,368**	**20,656**
Non-current:		
Other receivables	-	-
Provision for impaired receivables	-	-
Total non-current:	**-**	**-**

Provision for irrecoverable debts (impairment of receivables):	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Balance at start of year	**3,987**	**5,639**
New provisions	1,145	144
Utilised in year	(438)	(144)
Reversed in year	-	(1,652)
Balance at end of year	**4,694**	**3,987**

Ageing of impaired receivables	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
By up to three months	8,176	7,246
By three to six months	1,621	1,662
By more than six months	2,503	3,011
TOTAL	**12,300**	**11,919**

Ageing of non-impaired receivables past their due date	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
By up to three months	5,008	124
By three to six months	258	-
By more than six months	216	-
Total	**5,482**	**124**

14. Other assets

14.1 Other financial assets

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Loans and receivables	104	104
TOTAL	**104**	**104**

This relates to a section 106 deposit paid to Bristol City Council.

14.2 Assets held for sale

	PPE land £000	PPE buildings excluding dwellings £000	Dwellings £000	Total £000
Net book value at 1 April 2013	460	111	129	700
Assets classified as available for sale in the year	-	-	-	-
Assets sold in year	-	-	-	-
Impairment of assets held for sale	-	-	-	-
Net book value at 31 March 2014	**460**	**111**	**129**	**700**

	PPE land	PPE buildings excluding dwellings	Dwellings	Total
	£000	£000	£000	£000
Net book value at 1 April 2012	2,772	4,124	586	7,482
Assets classified as available for sale in the year	248	151	175	574
Assets sold in year	(2,396)	(4,124)	(586)	(7,106)
Impairment of assets held for sale	(164)	(40)	(46)	(250)
Net book value at 31 March 2013	**460**	**111**	**129**	**700**

The assets held for sale relate to Kingsdown Garage and 6 Kingsdown Parade following the approval of the Finance Committee.

15. Trade and other payables

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Current amounts:		
NHS payables – revenue	4,717	2,789
Amounts due to related parties – revenue	4,161	3,828
Other payables – revenue	10,022	15,377
Capital payables	8,906	1,517
Tax and social security	6,275	6,383
Accruals	27,391	26,676
PDC dividend payable	-	47
TOTAL	**61,472**	**56,617**

Non-current amounts:
There are no non-current trade and other payables.

Outstanding pension contributions of £4.160m (2013: £3.828m) to the NHS Pension scheme, £0.001m (2013: Nil) for NEST local pensions and £3.304m for PAYE (2013: £3.443m) and National Insurance £2.971m (2013: £2.940m) are included in other payables.

16. Other liabilities

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Current liabilities:		
Deferred income	3,975	2,509
Deferred government grants	-	273
TOTAL	**3,975**	**2,782**

17. Borrowings

17.1 Current borrowings:

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Loans from Independent Trust Financing Facility	260	260
Finance lease obligations	249	212
TOTAL	**509**	**472**

17.2 Non-current borrowings:

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Loans from Independent Trust Financing Facility	74,430	24,690
Finance lease obligations	5,555	5,741
TOTAL	**79,985**	**30,431**

During the year the Trust has taken out an unsecured loan of £50.000m from the Independent Trust Financing Facility at a fixed interest rate of 3.71% over 16.5 years repayable in instalments from June 2015.

17.3 Finance lease obligations

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Payable:		
Not later than one year	594	575
Later than one year but not later than five years	2,360	2,300
Later than five years	5,415	5,990
Sub-total	**8,369**	**8,865**
Less finance charges allocated to future years	(2,565)	(2,912)
Net obligation	**5,804**	**5,953**

The finance lease arrangement relates to buildings comprising the Education Centre which will expire in June 2028 and catering equipment which is being leased until 2018.

17.4 Net finance lease obligations

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Payable:		
Not later than one year	249	212
Later than one year but not later than five years	1,238	1,091
Later than five years	4,317	4,650
Net obligation	**5,804**	**5,953**

17.5 Finance lease commitments

There are no finance lease commitments at 31 March 2014 (31 March 2013 Nil.)

18. Provisions for liabilities and charges

	Legal Claims	Other	Total
	£000	£000	£000
At 1 April 2013	434	222	656
Arising during the year	74	-	74
Utilised during the year	(113)	-	(113)
Reversed unused	(51)	(222)	(273)
Unwinding of discount	4	-	4
At 31 March 2014	**348**	**-**	**348**
At 1 April 2012	475	6,427	6,902
Arising during the year	109	43	152
Utilised during the year	(122)	(6,248)	(6,370)
Reversed unused	(34)	-	(34)
Unwinding of discount	6	-	6
At 31 March 2013	**434**	**222**	**656**

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 below.

Timing of economic outflow	Legal Claims	Other	Total
	£000	£000	£000
Not later than one year	163	-	163
Later than one year but not later than five years	113	-	113
Later than five years	72	-	72
Total	**348**	**-**	**348**

18.1 Legal claims

The provision for legal claims at 31 March 2014 includes the following:

a) Provision for staff injuries
A staff injuries provision of £0.214m, (2013: £0.240m) in respect of staff injury allowances payable to the NHS Business Services Authority (pensions division).

b) Provision for liabilities to third parties
A provisions for liabilities to third parties of £0.134m (2013: £0.194m) representing the excess payable by the Trust, under the NHS Litigation Authority (NHSLA) Liabilities to Third Parties Scheme.

18.2 Other provisions

Other provisions at 31 March 2013 related to the charge for carbon emissions under the EU Emissions Scheme. The EU Emission provision was stated at market value. This has been reversed unused (utilised) during 2013/14.

18.3 Clinical negligence

The NHS Litigation Authority has included a £66.316m provision in its accounts (2013: £55.394m) in respect of clinical negligence liabilities of the Trust.

19. Cash and cash equivalents

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Cash with the government banking service	47,403	34,881
Commercial bank and cash in hand	132	237
Total cash and cash equivalents	**47,535**	**35,118**

20. Capital commitments

Commitments under capital expenditure contracts at 31 March 2014 were £9.562m (2013: £68.272m) for the Bristol Royal Infirmary redevelopment.

21. Post-Statement of Financial Position (SoFP) events

There are no post-Statement of Financial Position events.

22. Contingencies

22.1 Contingent assets

The Trust has no contingent assets at 31 March 2014 (2013: £nil).

22.2 Contingent liabilities

Contingent liabilities at 31 March 2014 comprise:

Equal pay claims
The NHS Litigation Authority is co-ordinating a national approach to the litigation of equal pay claims and is providing advice to the Trust. The likely outcome of these claims and hence the Trust's financial liability, if any, cannot be determined until these claims are resolved. There have been no claims made to the Trust.

Other contingencies
The Trust has contingent liabilities in relation to any new claims that may arise from past events under the NHS Litigation Authority's "Liability to Third Parties" and "Property Expenses" schemes. The contingent liability will be limited to the Trust's excess for each new claim.

23. Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1st April 2013 by the Health and Social Care Act 2012. The Trust is therefore no longer required to disclose details regarding its Prudential Borrowing Limit and its compliance with the code.

24. Related party transactions

The University Hospitals Bristol NHS Foundation Trust is a Public Benefit Corporation authorised under the National Health Service Act 2006.

During the year none of the Board members or members of the key management staff has undertaken any material transactions with the University Hospitals Bristol NHS Foundation Trust. With regards to related parties, one Trust Board member was a Trustee of the Above and Beyond Charity until September 2013 and another commenced employment with them in February 2014. One Trust Board member is a Pro-vice Chancellor of the University of Bristol and another is a visiting professor with the University of Bath.

Notes to the Accounts

The income and expenditure and outstanding balances as at year end for these bodies are listed below for the relevant years:

Figures stated in £m	31 March 2014		31 March 2013		2013/14		2012/13	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
University of Bristol	0.30	1.07	0.14	0.31	2.11	7.42	1.97	7.78
University of Bath	0.02	-	n/a	n/a	0.07	0.14	n/a	n/a
Above and Beyond Charity	See notes re charitable funds below							

All bodies within the scope of Whole of Government Accounting are related parties to the Trust. This includes the Department of Health and its associated departments. Entities where income or expenditure, or outstanding balances as at 31 March, exceeded £500,000 are listed below.

Figures stated in £m	31 March 2014		31 March 2013		2013/14		2012/13	
	Receivables	Payables	Receivables	Payables	Income	Expenditure	Income	Expenditure
Avon and Wiltshire Mental Health Partnership NHS Trust						0.65	0.72	0.61
NHS Bath and North East Somerset CCG (previously PCT)		1.09			8.43		13.50	
NHS Birmingham East and North							0.99	
NHS Bristol CCG (previously PCT)	1.83	1.56	4.58		146.25		269.11	6.52
Central Manchester University Hospitals NHS FT					0.80		0.50	
NHS Kernow CCG (previously PCT)					1.09		1.21	
NHS North, East, West Devon CCG (previously PCT)					1.56		1.90	
NHS Dorset							0.94	
South Devon Healthcare NHS Foundation Trust					0.54			
NHS Gloucestershire CCG (previously PCT)					3.92		11.16	
Great Western Hospitals NHS FT						0.70		0.68
Gloucestershire Hospitals NHS FT						2.56		1.48
Dorset County Hospitals NHS FT						0.56		0.54
NHS Hampshire							0.76	
Health Protection Agency								2.83
NHS Blood and Transplant						5.18		5.62
NHS Litigation authority						5.88		7.13
NHS Business Services Authority						0.62		0.57
North Bristol NHS Trust	1.58	1.86	1.33	1.78	5.73	8.29	4.62	7.72
NHS North Somerset CCG (previously PCT)	1.79		1.43		38.00		48.32	
London SHA							1.56	
North West SHA							4.22	
NHS South Devon and Torbay CCG (previously PCT)					0.56			
Poole Hospital NHS FT						0.93		0.97
Bristol City Council					3.45	1.95		2.07
Royal Bournemouth & Christchurch Hospitals NHS FT						0.98		1.32
Royal Nat Hosp Rheumatic Diseases NHS Foundation Trust						0.50		
Northern Health and Social Care Trust (N. Ireland)					0.51			
Royal United Hospital Bath NHS Trust						1.58		1.27
Royal Devon and Exeter Foundation Trust						1.17		1.11
NHS Somerset CCG (previously PCT)					7.40		15.67	
NHS South Gloucestershire			0.58		24.31		35.31	
Salisbury NHS FT						0.66		0.70
South West SHA							38.74	
South Gloucestershire Council					0.86			
NHS Swindon CCG (previously PCT)					0.91		1.44	
Taunton and Somerset NHS Foundation Trust						1.25		1.10
Welsh Assembly Government					7.56		8.16	
Weston Area Health NHS Trust	0.53				2.30	1.06	1.56	0.85
Yeovil District Hospitals NHS FT						0.70		0.72
NHS South East Essex							0.52	
NHS Wiltshire CCG (previously PCT)					3.98		8.26	
National Insurance Fund				2.94		21.25		21.26
NHS England	5.41				201.36			
Public Health England					0.83	2.89		
Health Education England					37.37			
Community Health Partnerships						5.36		
HM Revenue and Customs	1.94	6.28	1.32	3.44				
Department of Health	0.52		1.08		23.43	1.02	29.20	2.59
Department of Work and Pensions					0.64			
NHS Pension Scheme		4.16		3.83		29.39		28.72

In addition the Trust pays HM Revenue and Customs tax and national insurance on behalf of employees which totalled £54.00m in 2013/14 (£55.82m in 2012/13). The Trust also pays the NHS Pension Scheme for employees' contributions which totalled £19.83m in 2013/14 (£17.20m in 2012/13).

The Trust has also received income from a number of charitable funds, including Above and Beyond and the Grand Appeal. Transactions in 2013/14 relating to Above and Beyond were receipts of donated assets (£251k), income (£749k) and expenditure (£17k). Transactions relating to the Grand Appeal were income (£11k) and expenditure (£6k).

25. Private Finance Transactions

At 31 March 2014 the Trust has no PFI schemes (2013: none).

26. Financial Instruments

26.1 Financial instruments by currency

The Trust has negligible foreign currency transactions or balances.

26.2 Financial instruments by category

Financial assets per Statement of Financial Position	31 March 2014 £000	31 March 2013 £000
Loans and receivables:		
Trade and other receivables	18,017	17,012
Other financial assets	104	104
Cash at bank and in hand	47,535	35,118
Total	**65,656**	**52,234**

Loans and receivables are held at amortised cost.

Financial liabilities per Statement of Financial Position	31 March 2014 £000	31 March 2013 £000
Other financial liabilities:		
Trade and other payables	55,197	50,187
Borrowings	74,690	24,950
Finance lease obligations	5,804	5,953
Total	**135,691**	**81,090**

Financial liabilities are held at amortised cost.

26.3 Fair values

At 31 March 2014 and 31 March 2013 there was no significant difference between the fair value and the carrying value of the Trust's financial assets and liabilities which are all classified as current assets.

26.4 Maturity of financial assets

At 31 March 2014 all financial assets were due within one year.

26.5 Maturity of financial liabilities

	Year ended 31 March 2014 £000	Year ended 31 March 2013 £000
Less than one year	55,706	50,449
In more than one year but not more than two years	4,776	497
In more than two years but not more than five years	14,470	5,270
In more than five years	60,739	24,874
Total	**135,691**	**81,090**

27. Third Party Assets

At 31 March 2014 the Trust held £nil (2013: £nil) cash at bank and in hand which relates to moneys held by the Trust on behalf of patients.

28. Intra-government balances

	Receivables: current £000	Payables: current £000	Borrowing: current £000	Borrowing: non-current £000
At 31 March 2014				
Foundation Trusts and NHS Trusts	3,345	2,963	-	-
Department of Health	783	38	260	74,430
NHS England & Clinical Commissioning Groups	10,078	3,872	-	-
NHS WGA bodies	270	165	-	-
TOTAL NHS	**14,476**	**7,038**	**260**	**74,430**
Other WGA bodies	2,063	10,502	-	-
TOTAL at 31 March 2014	**16,539**	**17,540**	**260**	**74,430**

	Receivables: current £000	Payables: current £000	Borrowing: current £000	Borrowing: non-current £000
At 31 March 2013				
Foundation Trusts and NHS Trusts	2,577	2,789	-	-
Department of Health	1,083	79	260	24,690
Strategic Health Authority	-	64	-	-
Primary Care Trusts	9,526	445	-	-
NHS WGA bodies	169	220	-	-
TOTAL NHS	**13,355**	**3,597**	**260**	**24,690**
Other WGA bodies	1,366	10,634	-	-
TOTAL at 31 March 2013	**14,721**	**14,231**	**260**	**24,690**

There are no non-current receivables or payables in either year.

29. Losses and special payments

There were 348 cases of losses and special payments totalling £ 0.222m paid during the year ended 31 March 2014 (2013: 359 cases totalling £0.156m). These are categorised as follows:

	2013/14		2012/13	
	Number	£'000	Number	£'000
Cash losses	56	51	46	18
Fruitless payments	1	1	9	-
Bad debts and claims abandoned	228	76	256	47
Stores losses inc damage to buildings	1	55	5	82
Ex gratia payments	61	9	43	9
Special severance payments	1	30		
Total	348	222	359	156

Note that the fruitless payments in 2012/13 totalled less than £1,000.

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

The NHS Act 2006 states that the chief executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the University Hospitals Bristol NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Bristol NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

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

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

Signed

Robert Woolley, Chief Executive Date: 28th May 2014

Annual Governance Statement 2013-14

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 2014 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership

The strategic direction of the Trust Board of Directors is the key driver for addressing risks associated with achieving its stated strategic and corporate objectives. The Board also retains responsibility for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The strategic direction set by the Board is documented in the strategic and corporate objectives which it approves each year.

The Board's tolerance of risk associated with the achievement of these objectives is defined in a 'statement of risk appetite' specified by the Board after due consideration of opportunities and threats within the operation and performance of the Trust. The statement of risk appetite is set out in the Risk Management Strategy which is reviewed at the beginning of each Financial Year. The Board monitors the achievement of its objectives, and the management of associated risks, through the annual cycle of Board reporting— including the Quality and Performance Report, Board Assurance Framework, Corporate Risk Register and quarterly reports supporting Board self-certifications to Monitor. The Board's monitoring and scrutiny is extended by the Board Committees.

Whilst the Board retains accountability for ensuring that risk is effectively addressed throughout the Trust's operations, responsibility for the management of risk is delegated to the Chief Executive. This duty is discharged through the formal leadership, accountability and management frameworks established by the Chief Executive as part of the system of internal control, including the Trust's risk and performance management arrangements.

The Trust Secretary and Deputy Chief Executive have continued to lead a programme of work to further increase our capacity and capability to handle risk with particular focus on developing a risk-aware culture. The Board deploys two committees to augment its monitoring of risk management and the system of internal control generally. The Audit Committee reviews the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities; the Quality and Outcomes Committee reviews the suitability and implementation of risk mitigation plans with regard to their impact on patient outcomes.

Risk Training and Awareness

Whilst considering priorities for action in relation to strengthening risk and patient safety arrangements, the Senior Leadership Team continues to recognise that a pervasive culture of risk-awareness and standardised practice throughout the Trust remain the key factors in ensuring the achievement of strategic aims and objectives. The Executive continued to run a broad programme of staff training and awareness throughout the year, providing suitable training to staff depending on their responsibilities and authority with regard to risk. Extending this programme of awareness and training is a core function of the Trust Risk Manager.

The Risk Management Strategy, reporting protocols and guidance were again refreshed and re-issued as part of this programme, and we continue to see increased levels of risk and incident reporting through the year in comparison to previous years. Increased risk reporting supports the Trust's approach to learning from experience and demonstrates increased risk awareness in practice.

The risk and control framework

The 'Risk Appetite' defined by the Trust Board of Directors is defined in the Risk Management Strategy and takes into account organisational risk across potential areas of exposure to risk.

In determining its risk appetite, the Board's overarching objective is to achieve maximum sustainable outcomes and value from all the activities of the Trust. In particular, the Board considers the challenge of maintaining the quality, safety and sustainability in the provision of services to patients in the context of exacting savings targets to be the most significant potential source of risk to achieving its corporate or strategic objectives.

For 2013/14, the Trust Board of Directors defined its Risk Appetite as follows:

- The Trust Board of Directors has zero tolerance for harm to patients and staff through the actions or omissions of the Trust[1],
- The Trust will consider strategic and operational decisions in the context of risk-assessed strategies, business cases and projects to allow for these decisions to be taken with due regard to the quality, safety and sustainability of services to patients,
- The Trust Board of Directors requires the reporting of risk exceptions of high and extreme risks to the Board by quarterly presentation of the Corporate Risk Register and the Board Assurance Framework.

The Board Assurance Framework was used to identify any key risks to our strategic objectives, the controls in place to mitigate these risks, our framework for taking assurances that our controls were effective throughout the year, and the positive assurances received in the form of progress reports against actions. Where appropriate, risks to strategic objectives on Divisional Risk Registers were added to the Corporate Risk Register and cross-referenced with the Board Assurance Framework.

Risks-based decision-making supported business planning in 2013/14, and divisional operating plans were drawn up to explicitly address risks to divisional objectives with treatment plans to address risks that may arise as a result of service developments and redesigns.

TheRisk Management Group, consisting of the Executive Directors supported by the Trust Risk Manager, specialist risk advisers and divisional risk management leads, takes overall responsibility for the co-ordination of risk management across the Trust. This formal management group, chaired by the Chief Executive, and reporting to the Senior Leadership Team, is supported by the Service Delivery and Clinical Quality Groups which

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

respectively address risks to operations and clinical quality as described in the their Terms of Reference and those of the Risk Management Group.

The Service Delivery Group oversees the management of operational service provision, including the management of operational risk. The Clinical Quality Group is tasked with ensuring the continuation of good risk management practices in all clinical services, ensuring the required standards are achieved, investigating and taking action on sub-standard performance, planning and driving continuous improvement, identifying, sharing and ensuring delivery of best-practice, and, identifying and managing any risks to the quality of care.

Named senior officers of the Trust, including each of the Executive Directors, Clinical Chairs of Divisions and Divisional Directors have personal responsibility for the management of risk. Clinical Chairs have discharged these responsibilities through the divisional risk management arrangements, including Divisional Management Boards and Divisional Risk Management Groups. These two new management provisions have adopted standardised Terms of Reference across all clinical divisions.

These 'hub and spoke' arrangements are systematically linked into the Trust-wide management groups with standardised risk registers, risk reporting arrangements and risk calculation algorithms. The hub and spoke model allows for the identification, evaluation and control of changing risk profiles. Examples of this identification and control process include the use of a standard Clinical Risk Impact Assessment employed during any proposed change to services, such as during a transformation programme; and, the inclusion of standard Equality Impact Assessments during any proposed change to procedural documentation (i.e. strategy, policy, procedure and protocol documents or savings programmes).

The Risk Management Policy sets out provisions for the escalation of risks from a Divisional 'hub' to the corporate 'centre' and the circumstances where this is required. Divisional Management Boards are each required to maintain a Divisional Risk Register and to provide assurance to the Risk Management Group that divisional processes for managing risk remain effective. The performance of Divisional risk management arrangements is appraised by the Executive during regular Divisional reviews.

To complement the risk management strategy and management provisions, the Trust Board of Directors maintains comprehensive standards for the governance of quality in the Trust, using Monitor's Quality Governance model as a guide to good practice. These standards are reported at each of the public meetings of the Board in the regular Quality and Performance Report. Statistical variances are identified through trend analysis and are addressed through agreed prioritised action plans which are monitored by the Quality and Outcomes Committee and Board.

The quality of performance information used by the Board is regulated as described in the Data Quality Strategy which sets out the responsibility of individuals and groups within the Trust for ensuring the reliability of data used in performance monitoring and reporting. Data contained in reports to the Trust Board of Directors, including quarterly Monitor certifications, are reviewed for accuracy at specified stages of the Board reporting process.

Key data for Monitor compliance submissions are prepared as part of the Trust management reporting process and are incorporated into the regular Board reporting schedule. Data are extracted by experienced analysts directly from the Trust's management systems, including the patient administration system and the general ledger. Draft reports are reviewed for consistency by the Senior Leadership Team. The Finance Committee and the Quality and Outcomes Committee each review relevant sections of performance reports and monitor submissions for which they have oversight. Reports and Monitor submissions are amended if necessary to take into account any recommendations from a Board Committee or the Senior Leadership Team. In this regard, I take assurances from the Internal Auditor's conclusions following a 'Monitor compliance code review' that the Trust's procedures to provide accurate and reliable data for the completion, approval and submission of annual plans and quarterly reports submitted to Monitor are sound and operating effectively.

The Board continued its practice of receiving a narrative account of patient experiences at each of its public meetings. These accounts are presented and discussed to place patients' experiences of our services at the centre of the Board's focus and to identify organisational learning from errors and omissions and from exemplary practices.

In seeking on-going assurance as to the suitability and efficacy of its provisions for governing quality, the Board has directed the Quality and Outcomes Committee to have due regard for the Monitor Quality Governance Framework as a guide to good practice. Monitor developed the Quality Governance Framework in response to the findings of their internal audit report into the lessons learned from the failings at Mid Staffordshire NHS Foundation Trust. It is used by Monitor to assess NHS Trusts seeking authorisation as NHS Foundation Trusts.

Whilst the Quality and Outcomes Committee is deployed by the Board to augment its own monitoring and scrutiny of quality, the management of quality is addressed through the management arrangements established by the Senior Leadership Team. The Clinical Quality Group, which reports to the Senior Leadership Team, takes overall responsibility for the co-ordination of quality management across the Trust.

The role of the Clinical Quality Group is to discharge the responsibility of the Senior Leadership Team to manage clinical quality and clinical risk to achieve the best possible outcomes for patients, their families, carers, and staff. Its function is to ensure the continuation of good clinical practices and clinical risk management to ensure that required standards of quality (as defined by Monitor) are achieved. It conducts investigations into and takes action on sub-standard performance whilst planning and driving continuous improvement, identifying, sharing and ensuring delivery of best practice, and identifying and managing risks to the quality of care.

The Clinical Quality Group oversees the work of a set of sub-groups with responsibility for providing specialist management functions for: quality intelligence, patient safety, patient experience, clinical effectiveness, clinical audit, infection prevention and control, quality in care, safeguarding adults and children, clinical record keeping, mental health, resuscitation, medicines, cancer services, dementia, end of life care, and regulatory compliance.

Each of these specialist functional areas is monitored and co-ordinated through a rolling programme of quality and compliance reporting to the Clinical Quality Group. For example, the Regulatory Compliance Group assesses compliance with the sixteen Care Quality Commission (CQC) Judgement Framework (registration) requirements and the fifty criteria of the NHS Litigation Authority Risk Management Standards for Acute Trusts. It reports to the Clinical Quality Group on compliance with these each quarter. Reports are generated by the operational leads for each of the requirements who actively monitor and test operational compliance within the Divisions.

Prominent Risks

The Risk and Control Framework addressed a number of prominent clinical and non-clinical risks during 2013/14. For example, risks to the achievement of savings could have compromised the achievement of the planned income and expenditure surplus. These risks were mitigated through the active engagement of Executive Directors in close monitoring of achievement versus plan throughout year and the proactive risk-assessment of any schemes under development. Control of staff vacancies and procurement were both monitored at monthly performance meetings.

The savings risk remained prominent in 2013/14. Our savings targets are challenging—but the Trust continues to develop capacity to achieve these savings through a programme of service transformation. Outcomes were assessed through monthly reports to the Finance Committee and exception reports are made to the Trust Board of Directors.

The risk that patients may receive sub-optimal care whilst waiting to be seen in the Emergency Department due to the increased incidence of ambulance-queuing remained a focus in 2013/14. The risk was mitigated through an agreement with the South Western Ambulance Service NHS Foundation Trust to ensure appropriate care for

patients in waiting ambulances, initial assessment by Emergency Department staff of all patients awaiting handover, and prioritising high risk or deteriorating patients for transfer to the Emergency Department.

The Emergency Department risk remained in 2013/14. We continued to work with our partners and other stakeholders across the healthcare system in and around Bristol to reduce the incidence of ambulances queuing through coordinated and integrated health and social care approaches. Outcomes have been closely monitored through monthly quality and performance reports, and quarterly risk register reports to the Trust Board of Directors with on-going monitoring by the Senior Leadership Team and Risk Management Groups.

During 2013/14 the risk of harm to patients due to the acquisition of pressure ulcers, falling whilst in hospital, and from contracting healthcare-acquired infections, has been recorded in risk registers. Mitigation of these risks continued to be a focus of the Trust Board of Directors when considering essential standards of care with encouraging reductions seen through the year.

Looking ahead, and in addition to those risks continuing from 2013/14, a key new risk for 2014/15 is that activity is likely to exceed the levels agreed in contracts and anticipated in the operating plan. This might arise as a result of demographic pressures and/or unsuccessful demand-management or from unanticipated changes in emergency flows or primary care referral patterns following the planned closure of Frenchay Hospital by North Bristol NHS Trust in May 2014. The result would be a negative impact on the ability of the Trust to maintain performance in key areas such as Accident and Emergency, cancer pathways and cancelled operations. We will continue to mitigate this risk through robust assessment of activity against plan in monthly reviews with commissioners and in operational reviews with both commissioner and provider organisations.

Care Quality Commission (CQC) Registration

At the time of drafting the Annual Governance Statement, the Trust was not compliant with CQC registration requirements for Outcomes 4, 8 and 16. The CQC found the Trust's 'Main Site' to be non-compliant with Outcomes 8 (cleanliness and infection control) and 16 (assessing and monitoring quality of service provision) following a responsive review of theatres and adjacent areas at the Bristol Royal Hospital for Children in November 2013 during major building works. The Trust has completed the consequent action plan and is currently awaiting re-inspection to test compliance. Non-compliance with Outcome 4 (care and welfare of people who use services), with a "minor impact" on service users, followed a themed inspection of dementia care at the Bristol Royal Infirmary (also part of the Main Site registration) in January 2014; the Trust's action plan is due to be completed in the summer of 2014.

Involvement of Public Stakeholders

The Trust Board of Directors further increased its interaction with the Council of Governors with a regular representation of governors at meetings of the Trust Board of Directors and a complementary attendance of Directors at meetings of the Council of Governors.

Additionally, the Trust Executive utilised Project Focus Groups for governors to support the Board's duty to take into account the views of the Council of Governors in its planning. The purpose of the Project Focus Groups is to ensure the formal engagement of governors by the Trust Board of Directors on matters of:

- constitution (including membership);
- strategy and planning (including significant transactions); and,
- reporting (including quality and performance monitoring and metrics).

Meetings of the Project Focus Groups are part of the annual cycle of business managed on behalf of the Board by the Trust Executive.

Project Focus Groups are chaired and facilitated by the appropriate Executive Director, and are open to attendance by any interested governor. These interactions were in addition to the formal joint meetings of the Council of Governors and the Trust Board of Directors. In addition, the Chairman hosted regular Chairman's Counsel meetings to encourage open dialogue between the Council of Governors and the Trust Board of Directors. These meetings encourage the exchange of views and ideas in a spirit of openness and transparency towards the governors and the public.

The Trust continued to build on previous public and patient involvement mechanisms and worked actively with a number of groups involving patient and public representatives in the design and planning of its services. This engagement is designed to reduce risks associated with the design or re-design of services, and to ensure that any blind spots where services may not be meeting the needs of patients are illuminated through direct feedback.

Public and patient stakeholder engagement has been extended through significant participation in consultations and other dialogues between the Trust, the public, voluntary organisations, staff, and Overview and Scrutiny Committees.

The Trust Board of Directors has continued to pursue the principles set out in its Membership Strategy and continues to maintain and develop systems to involve the public and particularly, members of seldom heard groups. A number of membership engagement activities were attended by staff, governors, members and the public in this reporting period, including the popular 'health matters' events for members and the public with significant interest demonstrated by large numbers of attendees.

The Trust began its preparations for Governor elections with a publicity and advertising campaign designed to reach a diverse range of potential candidates. The elections will conclude in May 2014 and we expect to successfully fill each of the governor seats.

Information Governance

The Trust is a Data Controller as defined by the Data Protection Act 1998 and takes its responsibility for the security of personal and corporate information very seriously. This year, I moved the reporting arrangements for compliance with the Information Governance Toolkit to the Trust Secretary on behalf of the Executive. Oversight of the Information Governance agenda was undertaken by the Risk Management Group with the intention of "mainstreaming" the functions and activities of information governance. This function was previously managed in the information technology department, but my intention in moving the management to the Executive was to ensure the information governance agenda became a day-to-day activity for all managers and staff across the Trust. I am assured by the result that this has been a successful development.

The Information Risk Management Group, chaired by the Medical Director, who is the Senior Information Risk Owner, oversaw the Trust's plan to demonstrate compliance with the requirements of the Information Governance Toolkit on behalf of the Risk Management Group.

For version 11 of the Information Governance Toolkit Standards, our published position at 31 March 2014 was 85%, a significant improvement over previous years. The Trust achieved at least Level 2 for all the 44 requirements of the Toolkit and was consequently adjudged to be "satisfactory" (as opposed to "unsatisfactory").

The information risk ownership structure continues to be consolidated in line with the requirements of the Information Governance Toolkit, and significant emphasis has been placed on ensuring that all staff receive information risk management (governance) training.

No serious untoward (information) incidents were reported in year.

Climate Change

University Hospitals Bristol NHS Foundation Trust has undertaken climate change risk assessments and our Sustainable Development Management Plan is in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. We continue to work with our partners in the Avon Health Executive Resilience Group in this regard.

The Trust Board continued to review progress with our environmental campaign 'The Big Green Scheme' and we are progressing with embedding sustainability in all our activities, including the development of sustainable models of care, procurement and travel. In Partnership with the University of Bristol, the Trust is continuing with 'Green Impact Hospitals' to inspire staff action in reducing the Trust's impact of our activities on the environment.

We are implementing projects to reduce our energy consumption across the estate, focussing on reducing waste, improving efficiency and impact control. This includes installing a heat recovery system to capture and re-use otherwise waste heat from our boiler house flue gases.

We are working with Bristol City Council to develop projects to reduce environmental impacts on our city, exploring opportunities for a city-wide district heating scheme and the installation of renewable technologies to our buildings.

The Trust has developed a sustainability action plan to drawing all of the environmental activities of the Trust under the Big Green Scheme, including the development of sustainable models of care, procurement and travel. We continue to work in partnership with the University of Bristol to encourage and recognise staff through the Green Impact awards scheme in the NHS.

NHS Pension Scheme

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

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

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

The Trust Board of Directors continues to adopt a structured approach to ensuring the economy, efficiency and effectiveness of the use of resources, the importance of which is underscored by the scale of medium-term cost savings required in the current economic and operating environment. This structured approach emphasises the importance we place on taking a transformational approach to the way the Trust provides patient care. The Trust has a well-developed approach to service transformation, having first established an innovation team in 2006, formalising these arrangements in 2009 as the former 'Making Our Hospitals Better' programme with revised governance arrangements agreed in 2010, and a rolling 'Transforming Care' programme of innovation and transformation being pursued since then.

I established the Transformation Programme Board in 2011 to lead, oversee and coordinate the programme of change and service improvement to achieve improvements in quality, productivity and economic efficiency across the Trust. It is authorised by me to commit and deploy resources to the programme of work within the limits of the authority delegated to the Chief Executive in the Scheme of Delegation and other provisions of the

Standing Financial Instructions. This authority extends to the deployment of the transformation budget as set out within the Annual Operating Plan of the Trust. The Transformation Programme Board reports to the Senior Leadership Team and I provide a quarterly update report (or an immediate exception report where significant) to the Trust Board of Directors on the progress of the transformation programme.

The Transforming Care Programme aims to achieve improvements in the quality, efficiency, effectiveness and sustainability of patient care whilst supporting a wider programme of savings, which are monitored routinely by the Finance Committee and the Trust Board of Directors.

The Internal Auditor has reviewed and reported upon internal control, governance and risk management processes, based on an audit plan approved by the Audit Committee. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Audit Standards. Where scope for improvement was identified during an internal audit review, appropriate recommendations were made and action plans were agreed for implementation.

Annual Quality Report

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

Whilst these reporting requirements contribute to ensuring that the content of the Quality Report presents a balanced view of the quality of services provided by the Trust, we also take steps to ensure that appropriate controls are in place to ensure the accuracy of the data upon which we base our statements on quality. These controls are undertaken in accordance with the Quality Strategy (2011-2014) and the Data Quality Strategy which describe the standards of data quality assurance required for data supporting information used by the Board and for public reporting. Examples of data accuracy controls for the Quality Report include checks by the author to ensure that published data is consistent with that reported to the Board during the year, a Data Quality Framework covering metrics mandated for Quality Reports from 1 April 2013, and the External Auditor examines the accuracy of three of the indicators.

The Clinical Quality Group monitors the progress of quality objectives at quarterly intervals during the year; this monitoring is reported to the Board. This process ensures there is continuity throughout the production of Quality Reports, and any inconsistencies are challenged by the Clinical Quality Group.

Our governors are instrumental in agreeing the content of sections of the Quality Report in which we have freedom to report other key quality themes from the past year. The governors undertake this work formally under the auspices of the Quality Project Focus Group.

We follow good practice guidance such as those issued by the Kings Fund by ensuring a wide degree of continuity for clinical themes reported from one year to the next. This ensures that we remain demonstrably committed to ensuring transparency as well as keeping the Quality Report current and fresh.

We invite third parties to comment on an early draft of the Quality Report and listen to requests to amend content or introduce any new quality themes which those third parties feel might be necessary to achieve a fair and balanced view of quality during the year.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors,

clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality and Outcomes Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In my previous Annual Governance Statement, I reported that the Board had undertaken a broad revision of its corporate governance provisions, and had adopted revised ways of addressing its responsibilities. The Board's review of corporate governance indicated areas where the Board could establish clearer lines of accountability, particularly with regards to risk management. This resulted in the formal delegation of responsibility for risk management to the Chief Executive. The Board also established the Quality and Outcomes Committee, and refocused the Audit and Assurance Committee in a revised format as the Audit Committee.

I introduced revised Executive management and accountability arrangements to coincide with the revised Board governance arrangements. These are described in more detail earlier in this Annual Governance Statement under the 'risk and control framework'. These revised management arrangements are considered by the Trust Board of Directors, and the Senior Leadership Team, to ensure a robust treatment of any identifiable risks to quality and safety. This is a conclusion we have reached having derived significant assurances as to the efficacy of the system of internal control from a range of internal and external sources which are summarised in reports received by the Board throughout the year. These are recorded in the Board Assurance Framework document, the corporate risk register, the reported work of the Senior Leadership Team and Risk Management Group, reports of the Board Committee Chairs, and the results of a number of external visits, inspections and accreditations. These have included Monitor, the Care Quality Commission and the NHS Litigation Authority.

The effectiveness of the system of internal control is constantly assessed by the Trust Senior Leadership Team through the work of the Risk Management Group, and by the Board through the work of the Audit Committee and the Quality and Outcomes Committee. The overall effectiveness of the Assurance Framework and its ability to support the system of internal control is reviewed as part of the work of the Internal Auditor.

I also consider the views of Monitor with respect to Board governance and the reductions in the Trust's NHS Litigation Authority (NHSLA) premiums as a result of our minimal claims history as external indicators that the Trust's systems of internal control are competent and responsive.

The Board's revised governance arrangements were assessed by the Internal Auditor who, having concluded that there were no significant concerns to report, provided the Head of Internal Audit Opinion as follows:

> *"Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.*
>
> *Although our audit work over the year has identified areas where improvements could be made to the system of internal control, we highlight the Trust's continued emphasis on the control environment and the* ***very proactive approach that the Trust has taken over the year*** *over its response to internal audit work and the clearance of internal audit recommendations."*

Taking this opinion into account, and noting that two 'never events' occurred during the year (which are described in the Quality Report), I initiated a review of divisional accountability and performance management, replacing the previous senior management arrangements in the clinical divisions both in structure and in personnel. I expect to see the returns iterated in the 2014-2015 Annual Governance Statement.

Conclusion

No significant systematic internal control issues have been identified. I consider the revised corporate governance, accountability, management and reporting arrangements to have significantly improved provisions for risk management, patient safety, internal control and Board assurance, and will continue to develop the system of internal control by addressing any inconsistent application of controls where this is identified.

Robert Woolley
Chief Executive
Date: 28 May 2014

Independent auditors' report to the Council of Governors of University Hospitals Bristol NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion the financial statements, defined below:

- give a true and fair view of the state of University Hospitals Bristol NHS Foundation Trust's affairs as at 31 March 2014 and of its income and expenditure and cash flows for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

This opinion is to be read in the context of what we say in the remainder of this report.

What we have audited

The financial statements, which are prepared by University Hospitals Bristol NHS Foundation Trust, comprise:

- the Statement of Financial Position as at 31 March 2014;
- the Statement of Comprehensive Income for the year then ended;
- the Statement of Cash Flows for the year then ended;
- the Statement of Changes in Taxpayers' Equity for the year then ended; and
- the notes to the financial statements, which include other explanatory information.

The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual 2013/14 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

In applying the financial reporting framework, the directors have made a number of subjective judgements, for example in respect of significant accounting estimates. In making such estimates, they have made assumptions and considered future events.

What an audit of financial statements involves

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)"). 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 University Hospitals Bristol NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinions on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion:

- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Other matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- we have not been able to satisfy ourselves that University Hospitals Bristol NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- we have qualified, on any aspect, our opinion on the Quality Report.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the directors

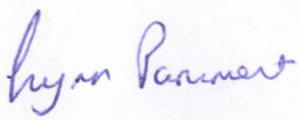
As explained more fully in the Directors' Responsibilities Statement the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of University Hospitals Bristol NHS Foundation Trust in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



Lynn Pamment (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Bristol
28 May 2014

(a) The maintenance and integrity of University Hospitals Bristol NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.